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

1	PART A - STANDARD BUSINESS (2.00pm - 4.00pm)
1.1	Welcome & Opening Remarks (Verbal) - Chair
1.2	Apologies (Verbal) - Chair
	Apologies received from Craig Greenstock, Local Counter Fraud Services
1.3	Declarations of Interest (Verbal) - Chair
1.4	Minutes of Meeting Held on 22 January 2019 - Chair
	1.4 DRAFT Minutes of Audit Cttee Part A 22.01.19.docx
1.5	Matters Arising - Chair
	1.5 Matters Arising.doc
2	COUNTER FRAUD
2.1	Counter Fraud Progress Report - Nigel Price
	2.1 Counter Fraud Position Statement 31032019.doc
	2.1 Appendix 1 Counter Fraud Position Statement.doc
3	ASSURANCE, RISK & GOVERNANCE
3.1	Governance Matters - Andy Butler
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3.2	Tracking of Audit Recommendations - Rox Davies
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	Appendix A - Summary of Latest Audit Reports by Service Area.pdf
	Appendix B - Recs with Revised Deadlines for Approval.docx
3.3	Corporate Risk Register - Peter Stephenson
	3.3 Corporate Risk Register.doc
	3.3 Appendix 1 Corporate Risk Register 20190326.xlsx
3.4	Draft Annual Governance Statement - Peter Stephenson
	3.4 Cover DRAFT Annual Governance Statement 2018-19.doc
	3.4 Appendix 1 DRAFT Annual Governance Statement 2018-19.docx
3.5	Audit Committee Effectiveness Survey - Rox Davies
	3.5 Audit Committee Effectiveness Survey.doc
4	EXTERNAL AUDIT
4.1	Wales Audit Office Position Statement - Gillian Gillett
	4.1 Wales Audit Office Position Statement.pdf
5	INTERNAL AUDIT
5.1	Internal Audit Progress Report - James Quance
	NWSSP Internal Audit Progress Report April 2019 FINAL.pdf
5.2	Recruitment and Retention Advisory Report - James Quance
	NWSSP-1819-05 Recruitment and Retention - Final Report.pdf
5.3	General Opthalmic Services Internal Audit Report - Sophie Corbett
	5.2 NWSSP General Opthalmic Services Final Report.pdf
5.4	Business Continuity Plans Internal Audit Report - James Quance
	5.3 NWSSP Business Continuity Plan Final Report .pdf
5.5	Risk Management and Assurance Internal Audit Report - James Quance
	NWSSP-1819-14 Risk Management & Assurance FINAL Internal Audit Report.pdf
5.6	Employment Services Payroll Internal Audit Report - Sophie Corbett
	NWSSP-1819-12 Payroll Services - FINAL Report.pdf
5.7	Review of Internal Audit Operational Plan 2019-20 - James Quance

NWSSP Operational Plan 201920 Final Draft for Audit Cttee.pdf

6 ITEMS FOR INFORMATION

6.1 Audit Committee Forward Plan

6.1 Audit Committee Forward Plan.docx

6.2 Review of Procedure for NHS Staff to Raise Concerns

6.2 Procedure for NHS Staff to Raise Concerns.doc

6.2 Appendix 1 Procedure for NHS Staff to Raise Concerns.docx

6.3 NWSSP Counter Fraud Policy

6.3 NWSSP Counter Fraud Policy.doc

6.3 Appendix 1 NWSSP Counter Fraud Policy.pdf

7 ANY OTHER BUSINESS (Prior Approval Only)

8 DATE OF NEXT MEETING: Tuesday, 9 July 2019, from 2.00pm-4.00pm, at NWSSP HQ, Boardroom, Unit 4-5 Charnwood Court, Heol Billingsley, Parc Nantgarw, CF15 7QZ

8.1 Meeting Review (Verbal) - Chair

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

MINUTES OF MEETING HELD TUESDAY 22 JANUARY 2019
14:00 – 16:00
BOARDROOM, NWSSP HQ, NANTGARW
Part A

ATTENDANCE	**DESIGNATION**	
INDEPENDENT MEMBERS:		
Martin Veale (Chair)	Chair & Independent Member	
Phil Roberts (PR)	Independent Member	
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
ATTENDEES:		
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	Personal Assistant	NWSSP
Nigel Price (NP) *(part-meeting only)*	Local Counter Fraud Specialist	Cardiff & Vale UHB
Gillian Gillett (GG)	Audit Representative	Wales Audit Office
Mark Osland (MO)	Director of Finance	Velindre NHS Trust
Melanie Goodman (MG)	Internal Auditor	SSu, NWSSP
ATTENDANCE	**DESIGNATION**	**ORGANISATION**
IN ATTENDANCE:		
Iain Hardcastle (*Item 0.1 only*)	Head of IMTP Implementation and Development	NWSSP

Item		**Action**
PRESENTATIONS		
0.1	**Draft Integrated Medium Term Plan 2019-22 (Presentation by Iain Hardcastle)** IH gave an informative presentation on the main features and the progress being made in respect of the IMTP, which was now ready for submission to Welsh Government.	

Item		Action
STANDARD BUSINESS		
1.1	**Welcome and Opening Remarks** The Chair welcomed Committee members to the January 2019 Audit Committee meeting. The Chair introduced new Independent Member, Phil Roberts, who had previously been a member of the Committee.	
1.2	**Apologies** Apologies were received from: • Margaret Foster, Chair of NWSSP • Ray Singh, Independent Member • Ann-Marie Harkin, Wales Audit Office • Craig Greenstock, Cardiff & Vale UHB	
1.3	**Declarations of Interest** No declarations were received.	
1.4	**Unconfirmed Minutes from meeting held on 23 October 2018** The minutes of the meeting held on the 23 October 2018 were **AGREED** as a true and accurate record of the meeting.	
1.5	**Matters Arising from meeting held on 23 October 2018** It was noted that all matters arising were completed.	
2. ASSURANCE, RISK AND GOVERNANCE		
2.1	**Governance Matters** AB advised that the paper follows the standard format with no departures from the Standing Orders. There were three contracts from 10.07.18 to 31.12.18: • Provision of batteries to Mamhilad Data Centre to prevent uninterrupted power supply; • IM&T Internal Audit Services; and • Provision of Welsh Courses.	

Item		Action
	The Chair advised that he had previously been a Director of Audit with TIAA Ltd, which was one of the providers that we had contracted with for internal audit services. It was noted that 37 contracts were progressed last year, however a question was raised as to the values attributed to some of them, as they seemed to be very large. AB advised that the values reflected the lifetime costs of each contract. He agreed to check the value of the Stoma Care contract. In stores, we had written off £8k of stock, which was relatively immaterial in the context of a turnover of £36m a year. <u>Gifts and Hospitality</u> Eight applications were made with four being for sponsorship from Finance Academy. GG enquired as to why there were flights to Newcastle recorded as gifts. AB explained that there have been some administrative issues with Fleet Solutions and it was difficult to sort things out over the telephone/skype, so it was easier for the staff to fly to Newcastle and meet with Fleet solutions face to face. It was classed as a gift as the flights were paid for by Fleet Services. There was discussion as to whether this needed to be classed as a gift; however, the Committee were content with the declaration.	**AB**
2.2	**Tracking of Audit Recommendations** RD advised that the Audit Tracker was taken to SMT on a monthly basis. At present, we have seven recommendations, which were not yet due, and were are medium or low risk. We have 116 recommendations; 109 of which had been implemented. PR enquired as to whether Audit were checking that the implementations had been completed. It was noted that this was not done routinely as it was over to management to monitor once they have accepted the recommendations. JQ advised that if Audit had issued a limited report, this would be followed up. In addition, an audit of the audit tracker and associated process was completed six months ago and resulted in a substantial assurance opinion. Any recommendations from national audits would also be looked at.	

Item		Action
	It was noted that the number of recommendations would change after the audit section of the meeting, as the recommendations would be added to the tracker. PR enquired as to whether it was possible to check the whole of the audit tracker at least annually. RD advised that this was already the case and is scheduled to be included in the October Audit Committee agenda.	
2.3	**Corporate Risk Register** PS reminded all present that the Risk Register was split into two sections; those that require action and those that were at the required level but which we still need to monitor. There were currently two red risks: • NHAIS – a meeting was being held 22 January with Northern Ireland to try and progress this; and • Brexit – a lot of work was being undertaken with Welsh Government. There are also four other risks where the scores had gone down: • Security – separate security review report had been produced; • Performance management – a framework had now been drafted; • Payroll – there had been some recent issues, however some have diminished. There were still a few issues, but this had reduced the risk score; and • Business Continuity – a lot of work had been undertaken in this area, which was currently being reviewed by Internal Audit and the report would be discussed at the next meeting. PR enquired as to how he would know which risks were new or old. PS advised that there was an icon on the report. It was requested that dates were added to the report to confirm when a risk had been added to the register. It was noted that the Corporate Risk Register had already been through SSPC and SMT.	**PS**
2.4	**Review of Standing Orders for the Shared Services Partnership Committee** PS advised that the report had been included within the Committee papers for information only.	

Item		Action
	Various updates had been made such as the following: • Velindre name change; • Establishment of HEIW; • Standing Financial Instructions – Scheme of Delegation; and • Voting rights for SSPC. The revised Standing Orders have already been to SSPC and were approved. There was also a requirement to take them to Velindre Trust Board.	
2.5	**Declarations of Interest Annual Report** PS advised that this was an annual exercise for Directors and senior staff to complete. The data for 2017/18 had been presented to SMT, it would be updated in May for 2018/19. Some declarations had been received and there was a new Relationship Policy being submitted to SMT next week, so that there would be clarity on what and who should be declared, including how any declarations of personal relationships will be mitigated and managed.	
3. COUNTER FRAUD		
3.1	**Counter Fraud Position Statement** NP gave an update on the Counter Fraud Position Statement. Work was progressing with another six days to add to the reported schedule of completed activity. There were four active cases at the moment, with one being closed recently: • SSP1405 – repayment figure of £5k, with a £2.5k debt will remain open until full settlement received; • SSP1902 – interview is scheduled to take place next week, breach of data protection rules and possibly working else where; • SSP1903 – was now closed; and • SSP1904 – was a false bursary application, which had a possibility of £10k fraud.	

Item		Action
	The fraud awareness sessions would be picking up again shortly, following the Christmas period. The Fraud Unit had another investigator trained, but require approval to go through the system so that they may start work within the department. The Chair enquired as to whether there were any cases where we had found any weaknesses in the system and if so, what we had done about them. NP stated that when a case was concluded, any learning points were communicated so that system weaknesses can be rectified.	
4. EXTERNAL AUDIT		
4.1	**Wales Audit Office Position Statement** GG stated that report states where we are with the programme and covers the work that the WAO stated that they would do. GG confirmed that the programme would be finished in March with a report being available in June or July. GG advised that if anything arises it would be brought to the Committee, as well as matters that have been identified by Health Boards that need to be highlighted.	
4.2	**Wales Audit Office 2019 Audit Arrangements Report** GG advised that the report established the 2019 arrangements as to what the WAO would be auditing going forward, as requested by the local External Audit teams and Health Boards. The assurances were the same as last year, so no significant changes had been made.	
5. INTERNAL AUDIT		
5.1	**Internal Audit Position Statement** JQ reported that progress was on track. There had been a slight delay on contractor services due to staff sickness but these audits would be completed within the specified time. All reports that were on the agenda for today's meeting had achieved reasonable assurance. They contained 35	

Item		Action
	recommendations, three of which were high priority and all had been accepted by management. In terms of key performance indicators, all were fine with the exception of the Management Response Days. JQ stated that this was generally very good but there was one new-in-post Director who then went on annual leave, which adversely affected the figures.	
5.2	**Welsh Language Standards Internal Audit Report** JQ advised that the audit was completed at management's request, due to the Standards being implemented within the coming months. It was noted that as the team came to the end of the audit, more clarity was received with regards to the implementation dates for the Standards. The key audit objectives were to look at what we had in place at present, the pace at which things were happening, how it changes into action planning and ensure that the resources were in place to deliver the implementation of the Standard. One of the key findings was that to develop a summarised action plan, to be monitored by the SMT. Management had already intended for this to happen and the action plan had already been produced. All of the findings in the report were underpinned by the need to have sufficient Welsh Language resource and interviews had recently taken place in order to recruit more translators due to the demand on the department (Update – two additional translators have since been appointed). The Chair stated that even though the Committee does not have to oversee the implementation of the action plan, it would keep an eye on progress. PR enquired as to whether the plans spelt out what we were going to do to provide support to other health bodies. AB confirmed that the SSPC had requested that we set up a Language Hub, but this would be done on a gradual basis to ensure that we do not over-commit. There was a piece of work underway where common job descriptions across NHS Wales were being translated, so that they are done on a once-for-Wales basis. There were some Health Boards though that were less keen to collaborate than others. NWSSP would be investing in translation software to help the process.	

Item		Action
	It was also highlighted that the Standards that we sign up to (as we still retain the right to appeal) should be consistent with Velindre.	
5.3	**Cwmbran Stores Internal Audit Report** SC1 stated that IA had reported reasonable assurance in respect of the arrangements in place for the management of inventory within Cwmbran Stores, which supplies Aneurin Bevan University Health Board (ABUHB). Two findings were identified; one being high priority, in relation to the volume of stock adjustments and lack of evidence of investigations and one being medium priority, in relation to compliance with the stocktake procedure. The Chair asked for context in terms of the findings as it stated that 62% of items were adjusted. It was noted that the net value of adjustments was £8k and there were no major issues, as they were low value items that needed to be amended. SC1 stated that there had been an improvement in this area as there were wider issues previously. Some of the root cause may be the revolving door regarding staffing, but the discrepancies were more of an efficiency point rather than anything more sinister. It was more about the counting inaccuracies, the audit team had offered their services to show the staff the requirements during an audit and they had accepted the offer.	
5.4	**Patient Medical Records Internal Audit Report** SC1 gave an update on the Patient Medical Records Store and Scan on Demand Service that was provided by PCS. It was a service that has been offered to Health Boards since 2016, which freed up space in GP surgeries to allow them to offer a greater range of services. The team reviewed the process for managing the records and were able to report that it achieved reasonable assurance. Three medium priority findings were identified in relation to: - Transfer of records from GP surgeries to NWSSP; - Accountability and reporting of missing records; and - Audit checks, They also identified three low priority findings.	

Item		Action
	There were issues around control, as PCS do not know how many files they would be due to receive until they arrive, they were not confirmed missing and we did not know if they had been sent in the first place. There could have been a number of reasons as to why a file may not have been sent (for example, the death of a patient or maybe the patient had transferred to another surgery that did not currently use the service). The records were currently stored in Mamhilad and was potentially an All Wales system. Welsh Government have instructed us that we must retain all records (including deceased patient records) due to the Infected Blood Enquiry that as currently being investigated. ABUHB ere the pathfinders in the system and the process frees up space for clinical practices for GPs. 23% of surgeries use the service now and we have invested in roller-racking which had doubled the size of the capacity that we can hold. There was space at Mamhilad to expand the service, but we need to invest in more roller-racking and fire suppression systems.	
5.5	**Annual Leave Management Internal Audit Report** It was expected when Internal Audit undertake work on Workforce compliance areas such as this, that there would be some small degree of non-compliance and this was no exception. Although given an overall rating of reasonable assurance, there was a high priority recommendation regarding the need to ensure that ESR was used throughout NWSSP as the primary mechanism for requesting and approval of annual leave. Within PCS, the Canol system was being inappropriately used for this purpose and IA had recommended that this stop, which had been accepted by management for action by the end of January.	
5.6	**Wales Infected Blood Support Service Internal Audit Report** SC1 advised that we had reported reasonable assurance in respect of the processes and controls in place for the management and administration of the Wales Infected Blood Support Scheme, which was established in October 2017. Five medium recommendations were identified in respect of: - Finalising policies and procedures; - Developing a risk register;	

Item		Action
	- Recognising the inherent risk associated with the service on the risk register; - Review of payment data loads and month end reconciliations; and - Approval of data-loads. There were also five low priority findings identified.	
5.7	**Primary Care Rental Reimbursement Reviews Internal Audit Report** This review was undertaken to assess the GP premises rental reimbursement review process, operated within Specialist Estates Services (SES). The Health Boards were responsible for approving the value of rental reimbursements to be paid to GPs. SES was appointed by all Health Boards in Wales to provide professional advice to assist in discharging this responsibility, primarily by making recommendations as to the level of rental reimbursement that should be made. There were six areas that were reviewed, three were assessed as substantial and three were reasonable, which demonstrated a well-managed system in operation and accordingly the overall assessment was a reasonable assurance. Going forward, there were seven agreed actions, of which five were medium and two were low priority recommendations. The Chair stated that he found the report very helpful and clarified that where a GP was claiming the benefit, there were different ways of assessing the rent as it could be a notional rent or part of the rent that they could claim.	
ITEMS FOR INFORMATION		
6.1	**Audit Committee Forward Plan** The Forward Plan was received for information only.	
6.2	**Draft Integrated Medium Term Plan (IMTP) 2019-22** The Draft IMTP was received for information only.	
ANY OTHER BUSINESS (Prior Approval Only)		
7.1	No further items were raised during the meeting.	

Item		Action
DATE OF NEXT MEETING: Tuesday, 9 April 2019 from 13:30-16:00 NWSSP Boardroom HQ, Charnwood Court, Nantgarw		

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

Actions arising from the meeting held on 22 January 2019			
2.1	AB	**Governance Matters** AB advised that the values reflected the lifetime costs of each contract and agreed to check the value of the Stoma Care contract.	Complete
2.3	PS	**Corporate Risk Register** PS agreed to incorporate dates into the Register, to confirm when new risks had been added.	Complete

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2018
AGENDA ITEM	2.1
PREPARED BY	Craig Greenstock, Local Counter Fraud Specialist
PRESENTED BY	Nigel Price, Local Counter Fraud Specialist
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Counter Fraud Progress Report 31st March 2019

PURPOSE

The purpose of the Counter Fraud Progress Report is to provide the Audit Committee with and update report of all NHS Counter Fraud work undertaken, for the period ended 31st March 2019, within the Health Body. The report's style has been adopted, in consultation with the Finance Director, with the prime objective of informing, and updating, the Audit Committee members of the outline detail of significant changes in cases that have been worked on during the period, in addition to any current operational issues.

1. INTRODUCTION

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

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

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

2. CURRENT POSITION

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

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

3. RECOMMENDATION

The Audit Committee is asked to:

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

NHS WALES
SHARED SERVICES PARTNERSHIP

Audit Committee - 9th April 2019

Counter Fraud Progress Report
as at 31st March 2019

CRAIG GREENSTOCK
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

NHS WALES SHARED SERVICES PARTNERSHIP

AUDIT COMMITTEE 9th APRIL 2019

COUNTER FRAUD PROGRESS REPORT

Mission Statement

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

1. INTRODUCTION

1.1 In compliance with the Directions on Countering Fraud in the NHS, I detail below the standing of the current Counter Fraud and Corruption work carried out, by the nominated Local Counter Fraud Specialists, during the period ended 31st March 2019.

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

Progress against the NWSSP Annual CF Work-Plan of **75days,** has been reported in **Appendix 1** and as at 31st March 2019, **60days of** Counter Fraud work has been undertaken and this has also been reported in **Appendix 1**.

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

2. CURRENT CASE UPDATE

There are currently two (2) cases currently under investigation, one of which is an ongoing civil recovery due to a lengthy repayment period. A verbal update on the progress made in the other case will be given to the Audit Committee.

3. PROGRESS AND GENERAL ISSUES

3.1 Fraud Awareness Presentations

During the financial year, a total of five (5) separate fraud awareness sessions have been held in conjunction with staff based within the various Divisions.

Of the sessions held to date, these include two (2) sessions given to Procurement staff based in Nantgarw and Cwmbran Stores in addition to three (3) Corporate Induction sessions carried out in North Wales, Companies House in Cardiff and Matrix House in Swansea.

3.2 National Fraud Initiative 2018/19

For 2018/19, Velindre NHS Trust, as the governing body, has processed by October 2018, in conjunction with staff from the NHS Wales Shared Services Partnership, all relevant information (e.g. DOB, NI Number, Address, Creditor Name etc) from the individual Payoll and Accounts Payable database systems. The Trust then received it's NFI report in January 2019 which contains details of all relevant "matches". The "matches" will now be investigated during 2019 for any anomalies, examples of which if identified, will be reported to the Audit Committee and could form part of the Auditor General for Wales final report.

Due to the concerns that have previously been raised, by Wales Audit Office, in relation to the perceived lack of checking of the "matches", agreements are now in place with NWSSP Accounts Payable staff and the Velindre NHS Trust to ensure that any checks are recorded on the NFI database and also that regular audits will be undertaken by the Key Contacts to ensure compliance.

APPENDIX 1

COUNTER FRAUD SUMMARY PLAN ANALYSIS 2018/19

AREA OF WORK	NWSSP	Days to Date
General Requirements		
Production of Reports to Audit Committee	3	3
Attendance at Audit Committees	3	2
Planning/Preparation of Annual Report and Work Programme	5	5
Annual Activity		
Creating an Anti Fraud Culture	4	2
Presentations, Briefings, Newsletters etc.	14	6
Other work to ensure that opportunities to deter fraud are utilised	2	0
Prevention		
The reduction of opportunities for Fraud and Corruption to occur	3	0
Detection		
Pro-Active Exercises (e.g. Payroll etc)	3	0
National Fraud Initiative 2018/19	2	2
Investigation, Sanctions and Redress		
The investigation of any alleged instances of fraud	30	34
Ensure that Sanctions are applied to cases as appropriate	4	4
Seek redress, where fraud has been proven to have taken place	2	2
TOTAL NWSSP	**75**	**60**

APPENDIX 2

COUNTER FRAUD ASSIGNMENT SCHEDULE 2018/19

Case Ref	Subject	Status	Open/Closed
SSP14.05	Unauthorised Sale of NHS Property	Crown Court Hearing (Suspended Sentence) Civil Recovery (5k) still being made at £50 per month	Open - Balance o/s £2524.25
SSP15/04	False Claim for Costs	Crown Court Hearing 18.10.17. Female defendant was sentenced to 2yrs in prison and male defendant sentenced to 6mths in prison. Defendant also ordered to repay £9,545 in compensation to the NHS within three (3) months and a further £13,713 to be paid to the Dept of Works and Pensions (DWP). The remaining sum of £68,165, owed to the DWP, is to remain on file for further consideration.	Closed in Qtr 2 - NHS payment received in full.
SSP16/04	False Claim for Costs	Magistrates Court Hearing - March 2017. Subject was fined £200 and ordered to pay compensation of £120 and £400 Costs - Awaiting outcome of internal University Fitness to Practice.	Closed in Qtr 2
SSP18.01	False Sickness Absence	Interview under caution in Feb 2018. Prosecution case submitted to CPS. Magistrates Court hearing on 24th July 2018. Referred to Crown Court and trial started in November 2018	To be closed. Subject was found guilty after a four (4) day Crown Court trial. Sentenced to 12 weeks in jail but this was suspended for 12 months. Also ordered to complete a total of 180 hours of unpaid work and must pay £8,216.71 compensation to the NHS in addition the sum of £2,500 in costs.

SSP18.04	False Claim for Costs	No evidence to support allegation. Unable to trace named individual.	Closed in Qtr 1
SSP18.05	False Claim for Costs	Interview under caution on 13/4/18 - Prosecution case file submitted to CPS	Closed in Qtr 3. CPS advised not in public interest to prosecute but civil recovery of £2,434 being made via agreed monthly instalments
SSP19.01	Unauthorised DBS Computer Access and possible GDPR issues	Various background and internal system checks made.	Closed in Qtr 3 with various recommendations made to Management in relation to the systems, processes and internal controls being used regarding Data Protection and those employed to carry out DBS Checks.
SSP19.02	False Claim for Costs	Enquiries with childcare provider identified poor record keeping (attendance/payments).	Closed in Qtr 3. Poor record keeping by childcare provider. However, the subject didn't return to study and was then withdrawn from course.
SSP19.03	Alleged False Timesheets	Initial enquiries made and then referred to BCUHB (Denbigh Stores)	Closed in Qtr 3
SSP19.04	False Claim for Costs	Initial enquiries made and then IUC carried out on 14.1.19	Subject admitted to having received monies after providing "inaccurate" personal circumstances, but claimed only had done so following advice received which cannot be disputed. Subject seeking to agree repayment plan of £10,698.

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	3.1
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

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 **1 January 2019 to 27 March 2019**. A summary of activity for the period is set out in **Appendix A**.

Description	No.
Single Quotation Actions	4
Single Tender Actions	4
Invitation to competitive quote of value between £5,000 and £25,000 (exclusive of VAT)	2
Invitation to competitive tender of value between £25,000 and the prevailing OJEU threshold (exclusive of VAT)	0
File Note	0
Direct Call Off against National Framework Agreement	0
Contract Extensions	0
Invitation to competitive tender of value exceeding prevailing OJEU threshold (exclusive of VAT)	0
Total	**10**

3. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

During the period **1 January 2019 to 8 March 2019**, activity against **36** contracts have been completed. This includes **16** contracts at the briefing stage and **14** contracts at the ratification stage. In addition to this activity, extensions have been actioned against **6** contracts. A summary of activity for the period is set out in **Appendix B**.

4. STORES WRITE OFFS

The value of stores, at **28 February 2019**, amounted to **£2,831,104**. For **January – February 2019**, a stock write off of **£316.02** has been actioned for out of date stock. This equates to **0.01%** of the total stock holding value in **February**.

Stock Type	Bridgend Stores	Denbigh Stores £	Cwmbran Stores
Stock Value	1,524,138	711,178	595,788
Out of Date	47.98	132.55	135.49
Total	**0.00%**	**0.02%**	**0.02%**

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

5. GIFTS, HOSPITALITY & SPONSORSHIP

There have been **4** declarations made relating to gifts, hospitality and/or sponsorship, since the last Audit Committee meeting. A summary of the declarations made is set out in **Appendix C**.

6. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, we issue a letter to Dr Andrew Goodall at Welsh Government to confirm any Audit Reports which have achieved limited or no assurance. For Quarter 4 of 2018-19, we submitted a nil return.

7. RECOMMENDATIONS

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

APPENDIX A - NWSSP Contracting Activity Undertaken (01/01/2019 – 27/03/2019)

No.	Trust	Division	Procurement Ref No	Date	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required
1.	VEL	NWSSP-HCW	NWSSP_STA-40486	04/01/2019	Single Tender Action	Computer Aided Despatch System	Cleric Computers Services	£36,400.00	Compatibility with existing service	Endorsed – Interim agreement whilst full OJEU Tender exercise undertaken	OJEU Tender exercise to be undertaken
2.	VEL	NWSSP-Employment Services	NWSSP-STA-480	22/02/2019	Single Tender Action	Provision of Primary Care National Workforce Reporting System	NHS Digital	£92,700.00	System designed specifically for NHS use	Not endorsed – STA not required as this is a SLA not a contract – inter NHS	No action required
3.	VEL	NWSSP-PCS	NWSSP-STA-484	27/02/2019	Single Tender Action	Maintenance and support contract for Kodak Alaris Imagetrac Scanners	Kodak Alaris	£116,564.18	Compatibility with existing service	Endorsed – continuity of existing service	No action required
4.	VEL	NWSSP-Digital Workforce Services	NWSSP-STA-502	15/03/2019	Single Tender Action	ZenDesk Product used for Logging and Tracking Customer Support Requests	ZenDesk	£31,320.00	Compatibility with Existing service	Endorsed – on the basis of technical compatibility	No action required
5.	VEL	NWSSP-PCS	NWSSP-SQA-464	10/01/2019	Single Quotation Action	Replacement of 60 Argonite Fire Suppression Cylinders	Aspect Fire Solutions Ltd	£20,400.00	Compatibility with existing service	Endorsed – Not possible for equipment to be maintained by alternative supplier to that who provides the equipment	No action required
6.	VEL	NWSSP-Finance ICT	NWSSP-SQA-477	20/02/2019	Single Quotation Action	Extension/Renewal of Warranties on Dell Servers and Storage Devices	Dell Corporation	£24,430.80	Compatibility with existing service	Endorsed – sole supplier warranty extension	No action required
7.	VEL	NWSSP-Legal & Risk	NWSSP-SQA-479	22/02/2019	Single Quotation Action	Lawtel Subscription, an essential on-line Research Tool	Thomson Reuters	£5,590.00	Compatibility with existing service	Endorsed – whilst overall review of L&R agreements undertaken	No action required

8.	VEL	NWSSP-Finance Academy	NWSSP-SQA-499	14/03/2019	Single Quotation Action	Attendance by the Finance Academy Clinical/Financial Development Programme – conference in Rotterdam	ICHOM	£17,000.00	Sole supplier to provide this conference	Endorsed – Sole supplier to provide this service	No action required
9.	VEL	NWSSP-Procurement	NWSSP-RFQ-39936	01/02/2019	Invitation to Quote	ISO Information Security Certification	British Assessment Bureau Ltd	£8,500.00	Open invitation to quote, based on M.E.A.T	Compliant – 8 suppliers viewed the opportunity, 4 responses received	No action required
10.	VEL	NWSSP-Procurement	NWSSP-RFQ-39937	01/02/2019	Invitation to Quote	ISO Customer Service Excellence Certification	Excellence Squared	£11,458.00	Open invitation to quote, based on M.E.A.T	Compliant – 2 suppliers viewed the opportunity, 1 responses received	No action required

APPENDIX B - All Wales Contracting Activity In Progress (01/01/19 – 08/03/19)

No	Contract Title	Doc Type	Total Value	MR approval <£750K	WG approval >£500k	NF approval £750-£1M	Chair Approval £1M+
1.	BCU - Blood Gas Analyser Managed Service contract- measures the amount of oxygen and carbon dioxide in the blood. The contract will include equipment, maintenance and consumables	briefing	£ 2,400,000	02/01/2019	sent to WG 2/1	n/a	n/a
2.	Oxygen therapy & inhalation - Oxygen therapy devices fall into two categories, variable performance and fixed performance, both of which are catered for on the contract. The contract also caters for patients requiring aerosol therapy. This is where medication nebulisers (Small Volume Nebulisers – SVN) are used to turn medication into an aerosolized mist to deliver directly into the patient's lungs	briefing	£ 2,615,065	03/01/2019	22/02/2019	n/a	n/a
3.	POCT blood glucose & ketone testing Blood glucose monitoring refers to testing the concentration of glucose in the blood to aid in the management of Diabetes types 1 and 2. Similarly, monitoring the presence of ketones in the blood is also important as high levels can result in complications such as Ketoacidosis.	briefing	£ 5,008,338	04/01/2019	18/02/2019	n/a	n/a
4.	Orthotics (bespoke) - All Wales contracts for the provision of stock or "off-the-shelf" orthotic products. These contracts cover items such as knee braces, wrist supports, paediatric stability boots, and foot orthoses.	briefing	£ 10,047,175	08/01/2019	15/02/2019	n/a	n/a
5.	AB - Orthodontic services - contracts for the provision of the Primary Care NHS Orthodontic Service from all eligible ABUHB orthodontic providers across Gwent.	briefing	£ 13,300,000	08/01/2019	07/02/2019	n/a	n/a
6.	AB - Measured term minor works OJ35 - contract for the provision of a Minor Works Measured Term Framework Contract (MTFC) for all ABUHB sites in South East Wales. The contract is required for the provision of building fabric, mechanical and electrical services	briefing	£ 9,300,000	09/01/2019	08/02/2019	n/a	n/a
7.	Hepatitis C contract is for the provision of antiviral medicines for the treatment of Hepatitis C (HCV). These medicines are designed to stop the virus from multiplying inside the body and thereby preventing liver damage.	briefing	£ 20,705,364	11/01/2019	08/02/2019	n/a	n/a
8.	HDDA - Orthodontic services - to commission services that are led by Specialists in Orthodontics who are able to consider an appropriate skill mix to ensure effective and efficient delivery of NHS Orthodontic services	briefing	£ 11,620,000	15/01/2019	08/02/2019	n/a	n/a
9.	NEPTS - Welsh Ambulance Services NHS Trust (WAST) has identified the need to create and support a procured, compliant third party management solution for its non-emergency patient transport services (NEPTS) in addition to existing WAST NEPTS resources. This follows the recommendations of the NEPTS Business Case that was approved by the Welsh Government in 2016, appointing WAST as the single procurer of NEPTS on behalf of NHS Wales.	briefing	£ 6,300,000	22/01/2019	22/02/2019	n/a	n/a
10.	NWIS - End User Hardware - NWIS provides IT services to GPs in Wales, including a fully managed desktop computing service. This includes the ongoing replacement of desktop computers. Due to the end of Microsoft support for Windows 7 in 2020, all organisations need to invest in upgrading their computer estate over the coming years. GP practices, in particular, will require a considerable refresh.	briefing	£ 11,220,000	31/01/2019	20/02/2019	n/a	n/a
11.	AB - Managed vending service – delivery of a vending service contract for patients, staff and visitors	briefing	£ 1,500,000	31/01/2019	19/02/2019	n/a	n/a

12.	NWIS - Once for Wales case management system - a web-based risk and compliance management interface solution and it should help be a step-change in managing quality, health, safety, environment, risk and compliance across the whole of NHS Wales.	briefing	£ 3,150,000	05/03/2019	sent to WG 5/3	n/a	n/a
13.	Anti-Embolism Stockings specialist hosiery that apply graduated compression to the lower limbs, discouraging the pooling of blood in the feet and legs. They are used on the majority of patients at risk of developing deep vein thrombosis (DVT), and as a result the usage associated with this contract is high in acute hospitals across all Welsh Health Boards.	briefing	£ 1,343,754	14/02/2019	27/02/2019	n/a	n/a
14.	BCU - Digital Dictation – introduction of new technology can help us achieve efficient and effective use of admin services, reducing risks, eliminating waste and duplication and ensuring everyone has the right tools to do the job well.	briefing	£ 1,900,000	19/02/2019	05/03/2019	n/a	n/a
15.	Generic Drugs Injections/Infusions 3 contract have been re-categorized according to the BNF categories with a view to some products being re-tendered now and the rest extended and re-tendered at a later date. This will allow the procurement team to focus on the different areas, enabling them to work closely with the specialists within those areas; ensuring opportunities for achieving greater value for money are realized across the whole of Wales.	briefing	£ 10,393,964	19/02/2019	06/03/2019	n/a	n/a
16.	Home Oxygen contract is for the provision of prescribed oxygen services to patients in their place of residence	briefing	£ 59,780,000	22/02/2019	sent to WG 26/2		
17.	CVU - Partner To Keep Our Patients Safe And Well Next Winter 17/2398 Appointment of a strategic partner to bring transformational and improvement specialists with significant knowledge and expertise of delivering through an integrated and prudent health care approach to work directly with CVUHB, to realise unscheduled care improvement goals in accordance with the strategic design principles	extension	£ 990,999	07/01/2019	08/01/2019	trust gov applies	trust gov applies
18.	Plaster Room - contract encompasses a wide array of products that are used with plaster rooms, trauma clinics, accident and emergency units and various other NHS Wales departments for the effective treatment of broken bones and fractures. Products within the scope of the contract include casting tapes, plaster of paris, orthopaedic padding and cast shoes.	extension	£ 2,230,608	06/02/2019	original approval applies 5/10/16	07/02/2019	08/02/2019
19.	Bacon & Sausage consists of various fresh and frozen bacon and sausage products on a direct delivery basis to Health Boards	extension	£ 1,897,020	18/02/2019	original approval applies 10/2/15	18/02/2019	27/02/2019
20.	Thermometry The current contract incorporates Tympanic thermometry, where the reading is taken from within the ear. Tympanic Thermometry, by and large being the most widely used method throughout the NHS in Wales.	extension	£ 1,718,252	19/02/2019	original approval applies 6/7/16	27/02/2019	26/02/2019
21.	NPS poultry contract consists of various cuts of Fresh and Frozen Chicken and Turkey (Minced, Diced, Breast, Crown, and Whole) of which Castell Howell is the sole supplier servicing the contract on a direct delivery basis to Health Boards. The contract is currently monitored via 3rd party audits based upon the tender specification which denotes the cut, weight, fat level, butchery, as well as delivery criteria, packaging requirements and temperature.	extension	£ 2,598,239	22/02/2019	N/A NPS framework	27/02/2019	27/02/2019
22.	NPS Meat contract consists of various cuts of Fresh and Frozen Beef, Lamb and Pork (Minced, Diced, Steaks, Chops and Joints) of which Castell Howell is the sole supplier servicing the contract on a direct delivery basis to Health Boards. The contract is currently monitored via 3rd party audits based upon the tender specification which denotes the cut, weight, fat level, butchery, as well as delivery criteria, packaging requirements and temperature.	extension	£ 1,192,773	22/02/2019	N/A NPS framework	27/02/2019	27/02/2019

23.	Suction Consumables - Provision of Suction Catheters and Tubing to Health Boards including Suction Tubing, Closed Suction Catheters, Open Suction Catheters, Yankauer Suction, Ryles Tubes, Bile Bags and Sputum Traps	ratification	£ 1,527,894	11/01/2019	15/02/2019	18/02/2019	27/02/2019
24.	IV & Irrigation Solutions To contract for the IV & Irrigation Solutions to purchase for use by All Wales hospital pharmacy departments, as requested by the All Wales Drug Contracting Committee	ratification	£ 2,807,922	15/01/2019	30/01/2019	07/02/2019	08/02/2019
25.	Haulage, Set Up and Maintenance - Haulage and maintenance of specialist Public Health Wales screening vehicles and Welsh Blood Service donation vehicles.	ratification	£ 909,742	31/01/2019	19/02/2019	20/02/2019	27/02/2019
26.	ABMU - Replacement defibrillators – replace the defibrillators currently being used on 3 of acute sites – Morriston, Princess of Wales, Neath Port Talbot	ratification	£ 1,200,000	04/02/2019	07/02/2019	trust gov applies	trust gov applies
27.	HCS Fleet renewal - To renew Health Courier Service vehicles and maintain operational capacity.	ratification	£ 1,019,131	08/02/2019	22/02/2019	27/02/2019	27/02/2019
28.	Motor Fleet Insurance - insure Health Board and Trust vehicles and maintain legislate compliance.	ratification	£ 1,225,343	08/02/2019	25/02/2019	22/02/2019	26/02/2019
29.	Provision of Diploma in planning for NHS Wales The Contract is the next stage in the strengthening and development of healthcare planning skills within NHS Wales via the establishment of a postgraduate diploma in healthcare planning	ratification	£ 756,500	11/02/2019	05/03/2019	sent to NF 5/3	
30.	Wheelchair reconditioning - To provide Wheelchair Reconditioning Services to the Artificial Limb and Appliance Service which supports users and prolongs life cycle of wheelchair.	ratification	£ 827,896	14/02/2019	05/03/2019	sent to NF 5/3	
31.	Proprietary drugs 1 Proprietary Drugs Items to purchase for use by All Wales hospital pharmacy departments, as requested by the All Wales Drug Contracting Committee	ratification	£ 53,868,596	22/02/2019	06/03/2019	sent to NF 6/3	
32.	NWIS - GP Switch refresh contract is for the purchase of 700 Network Switches for GP practices across Wales. It also includes associated licencing, support & maintenance, and professional services to assist NHS Wales implement this replacement infrastructure.	ratification	£ 1,690,295	22/02/2019	N/A NPS framework	sent to NF 22/2	
33.	Chest and wound drainage Provision of Chest and Wound drainage products including Indwelling and multipurpose drainage sets, chest/thoracic drainage catheters, chest drainage sets and bags, closed system wound drainage, T-shaped Kehrs, digital chest drainage units and consumables	ratification	£ 2,309,455	05/03/2019	sent to WG 5/3		
34.	NWIS - End User Hardware purpose of this contract is to ensure equipment can be replaced in line with the NHS Wales Informatics [NWIS] and NHS Wales Shared Services Partnership [NWSSP] technical refresh schedules.	ratification	£ 10,397,700	05/03/2019	sent to WG 5/3		
35.	CT - Citrix licences contract for the provision of citrix subscription licences	ratification	£ 1,027,790	08/03/2019	12/03/19	trust gov applies	trust gov applies
36.	Intermittent Pneumatic Compression - contract includes the rental of machines for each Health Board and the purchase of consumables suitable for both foot and calf compression. The devices are one of the key methods by which patient DVT is prevented. This contract will supersede an existing contract which is currently utilised by all Health Boards in Wales requiring the use of such devices.	ratification	£ 1,645,400	Sent to MR 11/3			

APPENDIX C – GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATIONS

NWSSP Employee	Dept	Type of Sponsorship	Date of Event	Donated by / Source of Hospitality	Description	Estimated or Approximate Value	Approved	Accepted (Yes/No)	Date of Acceptance or Approval
Rebecca Richards	Director of Finance Academy	Hospitality	05.04.2019	ACCA Wales	Attendance at Wales Finance Awards Event and Dinner	£95	A Butler	Accepted	19.03.2019
Rebecca Richards	Director of Finance Academy	Hospitality	01.03.2019	ACCA Wales	Attendance at Breakfast Business Briefing at the Hilton Hotel, Cardiff	£50 Estimated	A Butler	Declined	20.03.2019
Rebecca Richards	Director of Finance Academy	Hospitality	20.06.2019	ACCA Wales	Attendance at Shaping the Future - Unlocking your Organisation's Potential Event	£325	A Butler	Declined	19.03.2019
Keir Warner	Head of Sourcing Non-Medical	Hospitality	11.04.2019	Hospital Caterers Association	Attendance at President's Dinner and Event, including HCA Awards Presentations	£170	A Butler	Accepted	20.03.2019

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	3.2
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Update on the Implementation of Audit Recommendations

PURPOSE

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

In this report, the base position has been taken from the previous report presented to the Audit Committee. Therefore, please note that this report does not include figures and assurance ratings for the audit reports listed on the present Audit Committee agenda.

1. INTRODUCTION

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

2. CURRENT POSITION

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

There are **32** reports covered in this review; **6** reports have achieved **Substantial** assurance; **18** reports have achieved **Reasonable** assurance, **0** reports have been awarded **Limited** assurance or **No Assurance;** and **8** reports were generated with **Assurance Not Applicable**. The reports include **167** recommendations for action.

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

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

Table 1 - Summary of Audit Recommendations

Recommendations		Implemented	Not Yet Due	Revised Deadline	Overdue	Not NWSSP Action
Internal Audit	**109**	**96**	**11**	**2**	**0**	**0**
High	9	9	0	0	0	0
Medium	54	49	5	0	0	0
Low	39	31	6	2	0	0
Not Applicable	7	7	0	0	0	0
External Audit	**30**	**26**	**2**	**2**	**0**	**0**
High	1	1	0	0	0	0
Medium	29	25	2	2	0	0
Low	0	0	0	0	0	0
Not Applicable	0	0	0	0	0	0
Other Audit	**28**	**24**	**4**	**0**	**0**	**0**
High	4	3	1	0	0	0
Medium	5	3	2	0	0	0
Low	9	8	1	0	0	0
Not Applicable	10	0	0	0	0	0
TOTALS:	**167**	**146**	**17**	**4**	**0**	**0**

3. REVISED DEADLINES FOR APPROVAL

There are **4** recommendations approaching or which have met their target completion dates and it is requested that the deadlines be extended, by way of Revised Deadlines. Full details of the recommendations are set out in **Appendix B**, for the **APPROVAL** of the Audit Committee.

WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18
- Central Team requested extension from 31/03/2019 to **30/06/2019**
- Primary Care requested extension from 31/03/2019 to **30/06/2019**

Welsh Infected Blood Support Service Internal Audit Report 2018-19
- Requested extension from 31/03/2019 to **30/06/2019**
- Requested extension from 31/05/2019 to **30/06/2019**

4. RECOMMENDATIONS

The Audit Committee are asked to:

- **NOTE** the report findings and progress made to date; and
- **APPROVE** the Revised Deadlines set out within **Appendix B**.

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	Not NWSSP Action
INTERNAL AUDIT REPORTS												
	CORP/16-17/1	Corporate Services	NWSSP	Risk Management	2016-17	Reasonable	4	4	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	3	0	0	0	0
NWSSP-1718-12	CORP/17/-18/3	Corporate Services	NWSSP	Audit Tracker Review	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-16	CORP/17-18/4	Corporate Services	NWSSP	Corporate Governance	2017-18	Substantial	2	2	0	0	0	0
NWSSP-1718-06	CORP/17-18/5	Corporate Services	NWSSP	Surgical Materials Testing Laboratory (SMTL)	2017-18	Reasonable	3	3	0	0	0	0
NWSSP-1718-09	CORP/17-18/6	Corporate Services	NWSSP	Performance Management	2017-18	Reasonable	3	3	0	0	0	0
NWSSP-1819-02	CORP/17-18/6	Corporate Services	NWSSP	BACS Bureau Review	2018-19	Advisory Report	4	4	0	0	0	0
NWSSP-1819-04	CORP/18-19/1	Corporate Services	NWSSP	Wales Infected Blood Support Scheme	2018-19	Reasonable	10	6	2	2	0	0
NWSSP-1819-10	CORP/18-19/2	Corporate Services	NWSSP	Welsh Language Standards	2018-19	Reasonable	3	3	0	0	0	0
						TOTAL	**36**	**32**	**2**	**2**	**0**	**0**
	EMP/16-17/2	Employment Services	All Wales	TRAC System	2016-17	Reasonable	3	3	0	0	0	0
NWSSP-1718-10	EMP/17-18/1	Employment Services	All Wales	Payroll Services	2017-18	Reasonable	6	6	0	0	0	0
						TOTAL	**9**	**9**	**0**	**0**	**0**	**0**
NWSSP-1718-12	PCS/17-18/1	Primary Care Services	All Wales	Contractor Payments	2017-18	Substantial	1	0	1	0	0	0
NWSSP-1819-15	PCS/18-19/1	Primary Care Services	All Wales	Patient Medical Records Store and Scan on Demand Service	2018-19	Reasonable	6	0	6	0	0	0
						TOTAL	**7**	**0**	**7**	**0**	**0**	**0**
	PROC/16-17/3	Procurement Services	All Wales	Supplier Master File **Follow Up**	2016-17	Reasonable	2	2	0	0	0	0
	PROC/16-17/4	Procurement Services	Velindre/PHW	Local Procurement Team	2016-17	Reasonable	5	5	0	0	0	0
	PROC/16-17/5	Procurement Services	All Wales	Denbigh Stores	2016-17	Reasonable	7	7	0	0	0	0
NWSSP-1718-19	PROC/17-18/1	Procurement Services	ABMU	Carbon Reduction Commitment (CRC) Payment Review	2017-18	Advisory Report	5	5	0	0	0	0
NWSSP-1718-01	PROC/17-18/2	Procurement Services	All Wales	WAO Audit RKC Associates Lessons Learned by NWSSP	2017-18	Advisory Report	2	2	0	0	0	0
NWSSP-1718-11	PROC/17-18/3	Procurement Services	All Wales	Accounts Payable	2017-18	Reasonable	6	6	0	0	0	0
NWSSP-1819-01	PROC/18-19/1	Procurement Services	All Wales	Health Courier Services	2018-19	Reasonable	7	7	0	0	0	0
NWSSP-1819-08	PROC/18-19/2	Procurement Services	All Wales	Cwmbran Stores	2018-19	Reasonable	2	2	0	0	0	0
						TOTAL	**36**	**36**	**0**	**0**	**0**	**0**
SSU SES 1819 01	SES/18-19/1	Specialist Estates Services	All Wales	Primary Care Rental Reimbursement Reviews	2018-19	Reasonable	7	6	1	0	0	0
						TOTAL	**7**	**6**	**1**	**0**	**0**	**0**
	WORK/16-17/1	Workforce	All Wales	WfIS ESR OH Bi-Directional Interface	2016-17	Reasonable	4	4	0	0	0	0
NWSSP-1718-17	WORK/17-18/1	Workforce	All Wales	WfIS ESR / Occupational Health Bi-Directional Interface (Immunisations)	2017-18	Substantial	1	1	0	0	0	0
NWSSP-1718-04	WORK/18-19/1	Workforce	All Wales	GP Specialty Training Registrars	2018-19	Reasonable	4	3	1	0	0	0
NWSSP-1819-09	WORK/18-19/2	Workforce	NWSSP	Annual Leave Management	2018-19	Reasonable	5	5	0	0	0	0
						TOTAL	**14**	**13**	**1**	**0**	**0**	**0**
WALES AUDIT OFFICE EXTERNAL AUDIT REPORTS												
	WAO/16-17/1	All Services	All Wales	WAO Nationally Hosted NHS IT Systems Assurance Report	2017-18	Not Applicable	27	23	2	2	0	0
	WAO/16-17/2	All Services	All Wales	WAO Management Letter	2016-17	Not Applicable	3	3	0	0	0	0
						TOTAL	**30**	**26**	**2**	**2**	**0**	**0**
OTHER AUDIT REPORTS												
	ICO/17-18	Corporate Services	NWSSP	Information Commissioner's Office (ICO) Training Audit	2017-18	Not Applicable	10	10	0	0	0	0
	ISO14001/18-19	Corporate Services	NWSSP	SGS UK Ltd Audit of ISO14001 Environmental Management System	2018-19	Not Applicable	0	0	0	0	0	0
	SECURITY/18-19	Corporate Services	NWSSP	Physical Security Review of NWSSP	2018-19	Not Applicable	18	14	4	0	0	0
						TOTAL	**28**	**24**	**4**	**0**	**0**	**0**
						TOTAL RECS	**167**	**146**	**17**	**4**	**0**	**0**

APPENDIX B – 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
PRIMARY CARE SERVICES										
1.	2018.1 5 WAO/17/18/2 Primary Care Service All Wales WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18	**REVISED DEADLINE**	At the time of our fieldwork in March 2018 Primary Care Services has commenced plans to approve the re-procurement for the SQL 2008 server support and maintenance. The SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up expired at the end of February 2018.	**Medium**	Replace and re-procure the SQL server 2008 support and maintenance contract over the Prescription Pricing system server set up that expired in February 2018.	Dave Hopkins, Director of Primary Care Services	Agreed	01/03/2019	Revised Deadline 30/06/2019	Ongoing. Replacement Servers ordered 8/1/19 and to be delivered middle of February for implementation. NWIS will have to prioritise work in line with our requirements. Neil Jenkins is pressing NWIS for a date of implementation for the servers which were delivered mid-February. He will seek an update, but as the servers are out of the extended warranty at the end of March, it may be helpful if there is merit in terms of corporate highlighting this risk. We could look at a further extension of the warranties needed, which would entail a significant cost and especially as we are now in a position to shortly commission the replacement.
CENTRAL TEAM										
2.	2018.11 WAO/17/18/2 Corporate Services - Central Team All Wales WAO Nationally Hosted NHS IT Systems Assurance Report 2017-18	**REVISED DEADLINE**	CTES has not completed and documented a gap analysis assessment of the Oracle FMS to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. It is good security management practice to assess and baseline a comparison to the ISO 27001 standard. CTES should then formally consider and whether the Oracle service aims for a formal IS027001 accreditation.	**Medium**	Complete a gap analysis assessment to the Information Security Management Standard (ISO 27001) to identify potential improvement areas. CTES should then formally consider and decide whether the Oracle service aims for a formal IS027001 accreditation.	Said Shadi, Associate Programme Director, Central Team	Agreed	31/03/2019	Revised Deadline 30/06/2019	Ongoing - this will now slip until 30/06/19. WAO are on site with us on Tuesday 19th March so will also raise with WAO at this point. The Oracle FMS services are managed and supported by our partners Version 1 Solutions Ltd who are ISO 27001 accredited. This work will be scheduled with Version 1 to progress during 2018-19.

APPENDIX B – RECOMMENDATIONS WITH REVISED DEADLINES FOR APPROVAL

FINANCE AND CORPORATE SERVICES										
3.	NWSSP-1819-046 CORP/18-19/1 Corporate Services NWSSP Wales Infected Blood Support Scheme 2018-19	**REVISED DEADLINE**	Officers responsible for scrutinising and approving applications to join the scheme are not identified within the WIBSS Staff Procedure Guide. We were informed that in practice they are signed off by the WIBSS Service Manager and Head of Finance. A sample of eight (out of 11) new applications was reviewed: - three had no evidence of authorisation – all three were prior to implementation of the WIBSS Approval Form in March 2018; and - three had a WIBSS approval form signed by the WIBSS Service Manager and the Head of Finance or Velindre Cancer Centre Director of Operations. Risk: New applications may not be appropriately scrutinised and approved, which could potentially result in ineligible applicants being added to the scheme	**Low**	Officers responsible for scrutinising and approving application forms should be identified within the WIBSS Staff Procedure Guide.	Mary Swiffen-Walker	Agreed. The WIBSS Staff Procedure Guide will be updated to reflect this.	31/03/2019	Revised Deadline 30/06/2019	Revised directions received from WG 1st April 2019. The Staff Procedure Guide will now be updated to reflect the changes to the scheme.
4.	NWSSP-1819-048 CORP/18-19/1 Corporate Services NWSSP Wales Infected Blood Support Scheme 2018-19	**REVISED DEADLINE**	Beneficiaries should receive payment to their bank account on the closest working day to the 20th of the month. Early or late payments can have a significant impact on beneficiaries, some of whom are particularly vulnerable. Payments are processed by NWSSP Accounts Payable in accordance with the payment run timetable for Velindre University NHS Trust. This has resulted in a late payment in November 2017 (the first payment by WIBSS) and early payments on 10 occasions between December 2017 and November 2018. In February 2018 payment was processed eight days early resulting in a gap of over five weeks (instead of the usual four weeks) between the February and March 2018 payments. Efforts to rectify this have resulted in duplicate payments as follows: - In November 2018 a payment of £34,875 was processed twice due to an error with the bank details and confusion as to whether or not the payment had been returned. This was immediately identified by Velindre University NHS Trust Finance Team and action instigated to recover the overpayment. The debt remains outstanding and is being pursued by Velindre University NHS Trust Debtors Team. - In January 2018 same day payments were processed by Velindre University NHS Trust Finance Team, at the request of WIBSS, as the data-load was not processed in time (due to a misunderstanding between WIBSS and Accounts Payable) to ensure payment by the 20th January. This resulted in 51 beneficiaries receiving duplicate payments. We confirmed that all have been recovered. Risk: Inconvenience or financial hardship caused to beneficiaries as a result of early/late payments. Reputational damage.	**Low**	Access to the NDS database should be arranged. Periodic checks of the WDS and NDS (if access is obtained), should be undertaken to verify the ongoing eligibility of beneficiaries. The Staff Procedure Guide should then be updated to reflect eligibility checking arrangements.	Mary Swiffen-Walker	Agreed	31/05/2019	Revised Deadline 30/06/2019	Revised directions received from WG 1st April 2019. The Staff Procedure Guide will now be updated to reflect the changes to the scheme.

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	3.3
PREPARED BY	Peter Stephenson, Head of Finance and Business Development
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	NWSSP Corporate Risk Register – April 2019

PURPOSE

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

1. INTRODUCTION

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

2. RISKS FOR ACTION

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

Current Risk Rating	Apr 2019
Red Risk	2
Amber Risk	10
Yellow Risk	1
Green Risk	0
Total	**13**

2.1 Red-rated Risks

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

Discussions continue with Northern Ireland on their proposal, and while some costs have been challenged and subsequently reduced, their suggested pricing structure is significantly in excess of current costs.

Delays to the implementation of the Capita model continue in England which provides NWSSP with more time to implement a solution, but this remains a red risk.

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

While we continue to contribute towards national and Trust initiatives to mitigate the impact of a no-deal Brexit, the main risk lies with procurement and the supply chain for NHS Wales. At the request of Welsh Government, NWSSP has acquired significant additional storage capacity and there is a separate paper on the agenda that provides more detail on this.

2.2 Changes to Risk Profile

Two new risks have been added to the Corporate Risk Register relating to:

- concerns over capacity within the Workforce & OD team; and
- a generic risk of fraud from suppliers, staff or the public.

One risk has been removed from the Risk Register since the last meeting of the Committee in January. This related to the multiple pressures on the Payroll team that peaked during last summer and autumn. Most of the issues have now been dealt with apart from the work required for the Bridged boundary change, and this is already recorded as a separate risk on the register.

3. RISKS FOR MONITORING

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

Current Risk Rating	April 2019
Red Risk	0
Amber Risk	1
Yellow Risk	3
Green Risk	1
Total	**5**

4. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the Corporate Risk Register.

Corporate Risk Register

Ref	Risk Summary	Inherent Risk			Existing Controls & Mitigations	Current Risk			Further Action Required	Progress	Trend since last review	Target & Date
		Likelihood	Impact	Total Score		Likelihood	impact	Total Score				
Risks for Action												
A1	Risks associated with the demise of the Exeter system coming to an end in 2015, with no replacement system designed for NHS Wales. The contract in NHS England has been outsourced to Capita. (Added Apr 2017) **Escalated Directorate Risk**	4	5	20	Establishment of NHS Wales Steering Group. High level option appraisal undertaken. Mapping exercise completed with Capita and PCS subject matter experts to identify gaps between NHSE and NHSW.	4	5	20	Review proposal received from Northern Ireland in terms of legal, financial and operational implications. DH 31 Mar 2019	Further discussions have taken place with Northern Ireland following receipt of their detailed proposal. This was delayed due to staff sickness on their side and concerns over the legal framework for providing the service. The costing contained within the proposal are significantly higher than our current level of payments, and we are currently challenging a number of these costs. Although continuing delays to the implementation of the Capita model in England reduce the pressure, this remains a high risk. **Risk Lead: Director of Primary Care Services**	→	**30-Jun-19**
A2	Threats to the supply of medical consumables, and potential employment issues, in the event of a no-deal Brexit. (Added Sept 2018) **Strategic Objective - Customers**	4	5	20	Regular discussions with UK and Welsh Governments Attend Ministerial Advisory Board Velindre Brexit Group IP5	4	5	20	Acquisition and preparation of additional storage facilities is on-going at the direction of Welsh Government (31 March)	Acquisition of IP5 completed on 22 March . **Risk Lead: Director of Procurement Services**	→	**30-Jun-19**
A3	Disruption to services and threats to staff due to unauthorised access to NWSSP sites. (Added May 2018) **Strategic Objective - Staff**	5	4	20	Manned Security at Matrix CCTV Locked Gates installed at Matrix. Security Review Undertaken (reported Dec 18) Increased Security Patrols at Matrix.	2	4	8	Review progress with findings from security review (PS 30/04/2019) On-going discussion with Landlord at Matrix (RD 31/03/2019)	Security Review undertaken and reported to SMT in Dec 2018. No major findings but all agreed actions will be followed up through audit tracker. Any high risk actions are due for completion by 30 April 2019 **Risk Lead; Director Specialist Estates Services/Director of Finance and Corporate Services**	→	**30-Apr-19**
A4	NWSSP are unable to recruit and retain sufficient numbers and quality of staff for certain professional services (Procurement Services) resulting in a potential failure to meet desired performance targets and/or deliver service improvements. (Added April 2017) **Strategic Objective - Staff**	5	4	20	Staff Surveys & Exit Interviews Monitoring of turnover and sickness absence Workforce & OD Framework Work with Great With Talent to develop On-Boarder, Absence & Exit questionnaires (3, 6 and 12 months) Development of Clerical Bank Strengthened relationship with local universities Work-based degree opportunities in some professional services Use of Social Media Use of Recruitment Consultants Targeted Advertising - Trade Journals	4	3	12	Exit interviews to assess rationale for staff leaving employment - 31 Mar 2018 (HR) - on hold due to procurement tender exercise	Recruitment and retention remains a concern, particularly within professional posts primarily with the procurement services function. Recruitment has improved in other professional functions. Work is taking place with all services to have in pace agile recruitment and retention strategies to attempt to address these concerns, utilising available data and information. **Risk Lead: Director of Workforce and OD**	→	**31-Mar-19**

A5	NWSSP is unable to adequately demonstrate the value it is bringing to NHS Wales due to insufficiently developed reporting systems. (Added April 2017) **Strategic Objective - Value For Money**	4	4	16	Quarterly Performance Reports to Health Boards & Trusts Performance Reporting to SSPC & SMT SSPC Assurance reports Periodic Directorate Meetings with LHBs & Trusts Quarterly meetings with LHB and Trust Exec Teams Regular updates to Peer Groups (DOF's, DWODS, Board Secretaries) Customer Satisfaction Surveys Internal Audit Review (May 2018) Presentations from CEB Gartner (June 2018)	2	4	8	1. Introduce consistent approach in reporting and meetings for all directorates and all LHBs & Trusts (AB) 2. Review and refine performance framework - (MR - 31 Dec 2018) 3. Work proactively to support NHS Wales in delivering the actions outlined within the NHS Wales Chief Executives National Improvement Programme (NIP)	1. Completed 2. Ongoing - draft framework produced and due to be implemented Apr 2019 3. Paper taken to All Wales Finance Directors meeting in 09/2017. **Risk Lead: Director of Finance & Corporate Services**	→	**30-Apr-19**
A6	The transfer of responsibilities and staff in Bridgend from ABMU to CTUHB wef April 2019 will have significant implications for NWSSP processes and workloads. (added March 2018) **Strategic Objective - Customers**	5	4	20	Standing item on SMT agenda Programme Director attends SMT periodically NWSSP on finance and governance workstreams	4	3	12	Respond to Programme Director with implications for NWSSP - AB/PS Complete Ensure representation on HR Workstream (GH) - Complete	NF has spoken with CEOs of both HBs and got agreement that NWSSP will be included in all relevant planning discussions. Transition Director attended January 2019 SMT. **Risk Lead: Director of Finance and Corporate Services**	→	**31-Mar-19**
A7	NWSSP's lack of capacity to develop our services to deliver further efficiency savings and introduce innovative solutions for NHS Wales and the broader public sector. (Added April 2017) **Strategic Objective - Service Development**	4	4	16	IMTP Horizon scanning days with SMT and SSPC to develop services Established new Programme Management Office (PMO) IT Strategy Regular reporting to SMT and SSPC	3	3	9	1. Implementation of project management software (AB) 2. Invest in Robotic Process Automation (AB)	1. Procurement pilot project completed - currently being rolled out in NWSSP 2. RPA pilot in progress **Risk Lead: Director of Finance & Corporate Services**	→	**31-Mar-19**
A8	Risks arising from changes introduced by the Welsh Government to the NHS Bursary Scheme whereby students now have to commit to work in Wales for the two years following completion of their course in order to receive the full package of benefits. (Added April 2017) **Strategic Objective - Service Development**	4	4	16	Governance Group with four workstreams established to meet all aspects of this announcement.	3	3	9	Further work required to develop the repayment mechanism. (PT)	The new scheme has been successfully implemented, however, further work required to develop the repayment mechanism. Developing an UCAS style system for placing students into jobs. **Risk Lead: Director of Finance and Corporate Services**	→	**31-Mar-19**
A9	Lack of capacity within Workforce limits ability to meet NWSSP agenda. (added Feb 2019) **Strategic Objective - Staff**	4	4	16	TBC	TBC			TBC	**Risk Lead: Director of Workforce and OD**	*	
A10	Lack of effective succession planning at a senior level will adversely impact the future and strategic direction of NWSSP due to the age profile of the SMT. (added April 2017) **Strategic Objective - Staff**	4	3	12	Workforce & OD Framework On-going development of existing staff to ensure a ready supply of staff to meet the maturing organisation's needs. Leadership Development Programmes	3	3	9	1. Develop a plan which includes likely key dates for each of the affected services and which prioritises succession planning based on proximity of risk (HR) 31 Dec 18 2. NHS Wales Leadership Programme - identify key staff with potential for future development and encourage them to undertake the leadership programme - (HR) 31 Dec 18 3. National Succession Strategy for NHS Wales - participate in the work of the national group and identify high performing staff who may be eligible for consideration to support succession planning requirements - (HR) 31 Dec 18	Recent appointments of senior staff have helped to address this risk - risk to be reviewed again to check whether still requires reporting at this level. **Risk Lead: Director of Workforce and OD**	→	**31-Mar-19**
A11	Operational performance is adversely affected through the use of some out-of-date software systems, lack of consistent IT support across NHS Wales resulting in interoperability issues and the limited capacity of NWIS to meet the demand for IT development to develop our services. (added April 2017)	4	5	20	Created a Business Systems and Informatics Department Service Level Agreement (SLA) in place with NWIS Significant additional capital funding obtained from Welsh Government in prior year for IT investment Development of draft IT strategy Quarterly Reporting of Performance to SMT	1	4	4	1. Finalise IT Strategy for NWSSP, to include an IT replacement strategy - complete 2. Consolidate Desktop support from one strategic partner - currently a mix of arrangements (NWIS & BCU) - 31 Mar 2019 (AB) 3.Finalise Cyber Security Action plan - complete 4. Develop an overarching Business Continuity plan for NWSSP incorporating operational, IT and building requirements and test the plan	All actions on track and a consultant from the Wales Quality Centre is currently working with NWSSP to enhance BCP arrangements. 1. Completed 2. Ongoing 3. Completed 4. Completed - plan developed and tested in Sept. Internal audit of BCP arrangements currently being undertaken.	→	**31-Mar-19**

	Strategic Objective - Excellence								annually - complete	**Risk Lead: Director of Finance & Corporate Services**		
A12	Suppliers, Staff or the general public committing fraud against NWSSP. (added April 2019)	5	3	15	Counter Fraud Service Internal Audit WAO PPV National Fraud Initiative Counter Fraud Steering Group Policies & Procedures Fraud Awareness Training	3	3	9	1. Increase level of counter fraud resource (AB 30/6/19) 2. Implement actions from Fighting Fraud Strategy (PS 30/6/19) 3. Formally present Counter Fraud Work Plan to SMT (AB 31/05/19)	Discussion with Craig Greenstock on 2/4/19 to increase level of resource. Fighting Fraud Strategy approved by CFSG on 26/3/19	✱	**30-Jun-19**
	Strategic Objective - Value For Money									**Risk Lead: Director of Finance & Corporate Services**		
A13	Failure to comply with Welsh Language requirements and capacity to meet the increased demand for Welsh translation services resullting from the implementation of the Welsh Language Standards leading to reputational damage for NWSSP. (added April 2017)	3	4	12	Welsh Language Officer appointed Staff required to populate Welsh language skillset in ESR Welsh Language Translator appointed WL awareness is included within the face to face corporate induction training day Accredited WL training in place at several NWSSP sites WL monitoring report submitted to SMT External comms - WIAP project ensuring all web information is bilingual, graphic design, public events, etc	2	4	8	1. Undertake a Cost/benefits analysis to justify further investment in Welsh Language capacity - complete 2.Bilingual interface of TRAC recruitment software to be fully bilingual - complete 3. Investigate the potential for introducing a WL hub to provide support with translation for NHS Wales - complete 4. Undertake Internal Audit review of progress against Welsh Language Standards - complete. Reasonable Assurance.	Regular updates to SMT and additional resource recruited Jan 2019. Reasonable Assurance from Internal Audit review. Undertaken joint recruitment with PHW.	➔	**31-May-19**
	Strategic Objective - Staff									**Risk Lead: Director of Finance and Corporate Services**		
	Risks for Monitoring											
M1	1. The Learning@Wales server provided and supported by NWIS requires enhancements to ensure user capacity is aligned with forecasted usage and is fully supported and managed to ensure provision of service does not degrade further. Further enhancements are required to reporting capability as this is affecting the service provided and reputation of NWSSP. 2. The ESR e-learning server is currently provided by NWSSP, via a server located in Manchester. This server has little resilience and requires hosting within NWIS DMZ with a fully supported service management wrap. Over 70% of learning undertaken in NHSW at 07/2017 was via e-learning. There would be a significant impact on the compliance of the workforce if the server failed. (added April 2017)	4	4	16	Additional support provided from NWIS to schedule reports out of hours to minimise impact on server disruption. Significant cleansing and formatting of reports by DWS Team before they are forwarded to organisations to enable them to manage compliance. NWSSP IT function have enabled a temporary solution via the Manchester server.	2	4	8	1. Escalation with NWIS for resolution. 2. Provision of fully supported server, hosted in NWIS, DMZ required.	1. A part-solution is in place for reporting but the final reporting solution is still to be sourced. NWIS are making progress and a recent meeting has taken place where the specification and possible solutions have been discussed. NWIS need to go out to advert for a specialist to support this work and they have also submitted a request for a new server build for this project. A further update will be available at the end of June following the next meeting. 2. We are awaiting confirmation from NWIS on the timeline for the server move. The server is currently resilient and there is a meeting with NWIS on 13/6 where we hope to get clarification on a new migration timeline.	➘	
	Escalated Directorate Risk									**Risk Lead: Director of Workforce and OD**		
M2	Reputational impact due to issues within the Accounts Payable (AP) team that have resulted in the delay in payment to suppliers in a number of Health Boards and Trusts leading to failure to achieve their Public Sector Payment Policy (PSPP) targets. (added April 2017)	4	4	16	Review of performance at regular meetings with LHBs and Trusts SMT review high level progress reports on regular basis Restructure of AP team to improve performance Action plan in place to address issues - has been subject to independent review Finance Academy has established P2P as a national project under the developing excellence initiative. Accounts payable helpdesk introduced	3	4	6	1. Complete implementation of action plan (RW) 2. Internal Audit to complete follow up review (SC) 3. The All Wales P2P group to provide regular updates on progress to the SMT (AB) 4. Appoint P2P Project Manager (AB)	1. Completed 2. Completed 3. Regular updates to Finance Directors and Committee 4. Completed Actions taken to date have resulted in improvement in PSPP performance not now considered a problem.	➔	
	Escalated Directorate Risk									**Risk Lead: Director of Procurement Services**		

M3	Failure to ensure compliance with GDPR requirements leading to a serious breach which damages the reputation of NWSSP (added April 2017) **Strategic Objective - Service Development**	4	3	12	Information Governance Steering Group Information Governance Manager Caldicott Guardian Senior Information Risk Owner (SIRO) Training programme for staff CPIP Annual Self-Assessment and Report Information Asset Owners in each Directorate ICO Audits Information Governance Risk Register Health and Care Standards	2	3	6	1. Information Governance Work Plan to be formally approved (AB) 2. Review lessons learned from IG breaches (AB) 3. GDPR Action Plan 4. Internal Audit review to be undertaken in 2018/19	1. Completed - IG Work Plan approved by IG Steering Group. 2. Ongoing - Standard agenda item on IG Steering Group; presentations delivered by each directorate, in turn. NWSSP achieved a score of 96% in the latest Caldicott Principles into Practice assessment. **Risk Lead: Director of Finance & Corporate Services in conjunction with Service Heads**	→	
M4	The establishment of HEIW from October 2018 will cause significant disruption and uncertainty for NWSSP staff. (added March 2018) **Strategic Objective - Staff**	5	4	20	Programme Board Regular presentation to SMT WEDS Legacy Statement produced	1	3	3	WEDS Legacy Statement to be produced for SSPC September meeting - Complete Review accuracy of suggested costs ahead of next Finance workstream - Complete	HEIW established 1 Oct 2018. Recognition now from WG that this will be a hugely expensive exercise. Concerns over impact on NWIS and whether our service from them will suffer as a result. **Risk Lead: Director of Finance and Corporate Services**	↓	
M5	The forecasting of the Risk Pool spend is complex. Any inaccuracies could have a major impact on NHS Wales' ability to achieve financial balance and could adversely impact the reputation of NWSSP. The change in the discount rate in February 2017 has increased the complexity of the calculations. (added April 2017) **Escalated Directorate Risk**	4	4	16	Appointment of a dedicated Risk Pool Accountant Introduction of Business Partnering Arrangements On-going development of robust forecasting arrangements Regular reporting to SSPC and Directors of Finance Subject to WAO review.	2	3	6	1. Closer working with Health Boards, Welsh Government and Solicitors required to maintain a current and accurate view of the level of risk. 2. Development of a forecasting model to map the financial impact of the discount rate change over the next 3 years.	Both actions completed. NWSSP have developed a forecasting system which incorporates all the latest information about cases over £250k available from the Solicitors. This has been agreed with Welsh Government. A dialogue system is in place and forecasting is always on the LARS monthly Senior Team meeting, chaired by the Director and attended by Martin Riley and Legal & Risk Services' Senior Solicitors/Team Leaders. Finance Directors regularly updated on the latest position. Additional funding has now been provided by HM Treasury. **Risk Lead: Director of Finance & Corporate Services**	→	

Key to Impact and Likelihood Scores

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

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

	New Risk
	Escalated Risk
	Downgraded Risk
	No Trend Change

Key to Impact and Likelihood Scores						
		Impact				
		Insignificant	Minor	Moderate	Major	Catastrophic
		1	2	3	4	5
Likelihood						
5	Almost Certain	5	10	15	20	25
4	Likely	4	8	12	16	20
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1	Rare	1	2	3	4	5

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

Consequence					
Likelihood	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	Yellow 5	Amber 10	Red 15	Red 20	Red 25
Likely	Yellow 4	Amber 8	Amber 12	Red 16	Red 20
Possible	Green 3	Yellow 6	Amber 9	Amber 12	Red 15
Unlikely	Green 2	Yellow 4	Yellow 6	Amber 8	Amber 10
Rare	Green 1	Green 2	Green 3	Yellow 4	Yellow 5
Red: Critical - Urgent action and attention by senior management to reduce risk					
Amber: Significant - Management consideration of risks and reduction within 6 months					
Yellow: Moderate - Monitoring of risks with a view to being reduced within 12 months					
Green: Low - These risks are considered acceptable					

	New Risk
	Escalated Risk
	Downgraded Risk
	No Trend Change

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	3.4
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	Draft Annual Governance Statement 2018-19

PURPOSE

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

1. BACKGROUND

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

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

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

The Annual Governance Statement for 2018-19 is presented at **Appendix 1.**

2. TIMELINE FOR APPROVAL

The timeline for approving the statement is as follows:

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

3. GOVERNANCE & RISK

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

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

Section 4 of the SSPC Standing Orders states that:

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

The Annual Governance Statement is substantially completed. However, there are a small number of areas where information is awaited (e.g. results of Audit Committee Effectiveness Survey and Carbon Footprint figures). These

areas are shaded, for reference. The Annual Governance Statement will be updated to reflect the information, once available.

4. RECOMMENDATION

The Audit Committee are asked to:

- **REVIEW** the Draft Annual Governance Statement;
- **DISCUSS** if the AGS accurately reflects the Committee's view of NWSSP's Assurance Framework; and
- **FEEDBACK** any comments to Peter.Stephenson2@wales.nhs.uk.

Annual Governance Statement 2018/2019

Version	Approved
1	SMT 28 February 2019 draft for information
2	SSPC 14 March 2019 draft for endorsement
3	Velindre Integrated Governance Group 8 April 2019
4	Audit Committee 9 April 2019
5	SSPC 16 May 2019 Final
6	Audit Committee 9 July 2019 (for Final Approval)

CONTENTS

ANNUAL GOVERNANCE STATEMENT 2018/2019

1. SCOPE OF RESPONSIBILITY

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

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

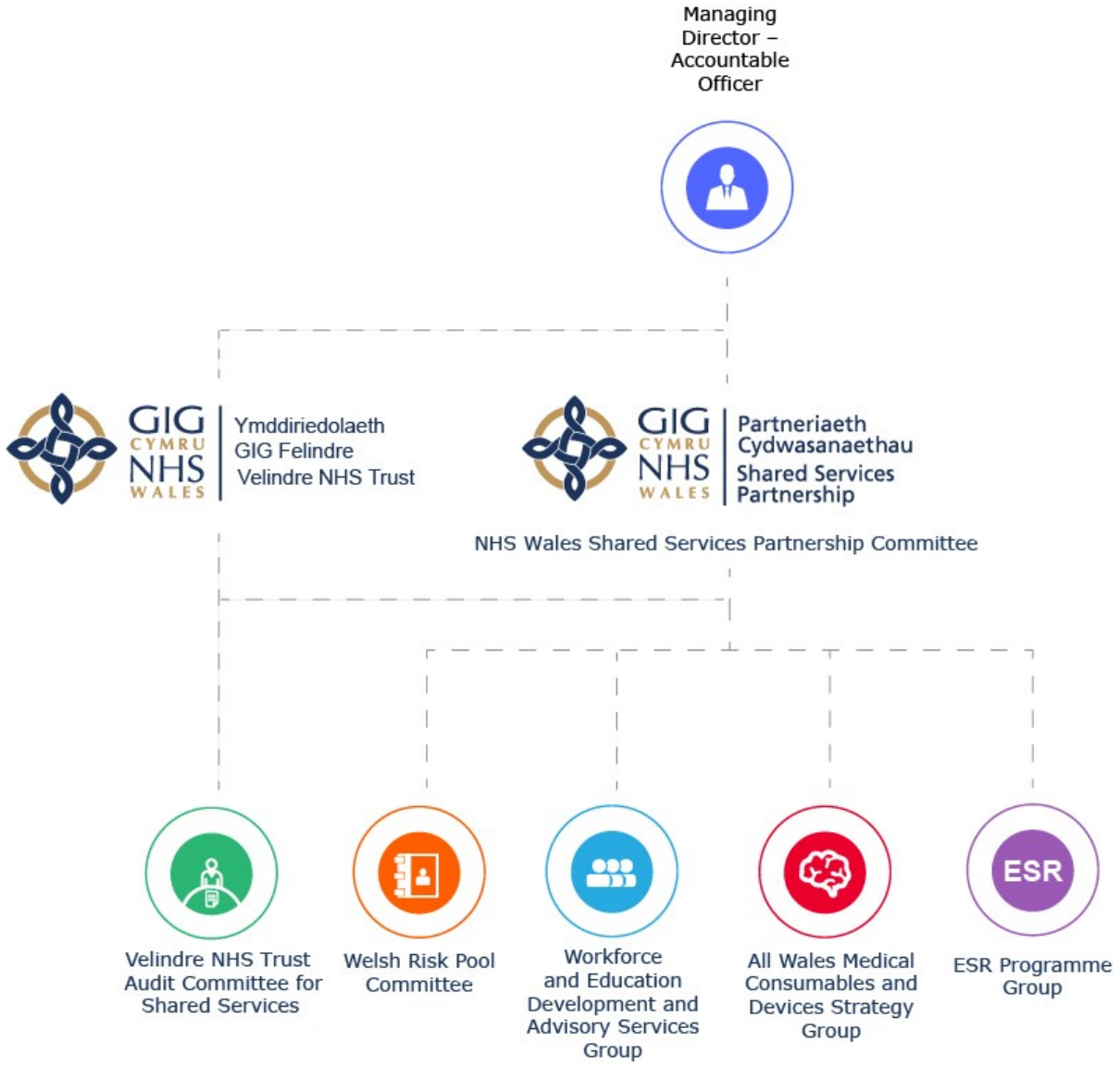
The Managing Director of Shared Services is accountable to the Shared Services Partnership Committee (Partnership Committee) in relation to those functions delegated to it. The Managing Director is also accountable to the Chief Executive of Velindre NHS Trust in respect of the hosting arrangements supporting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

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

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

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

Figure 1 –NWSSP's Governance Structure



Underpinned through the overarching Velindre NHS Trust legal and assurance framework

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

2. GOVERNANCE FRAMEWORK

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

2.1 Shared Services Partnership Committee

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

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

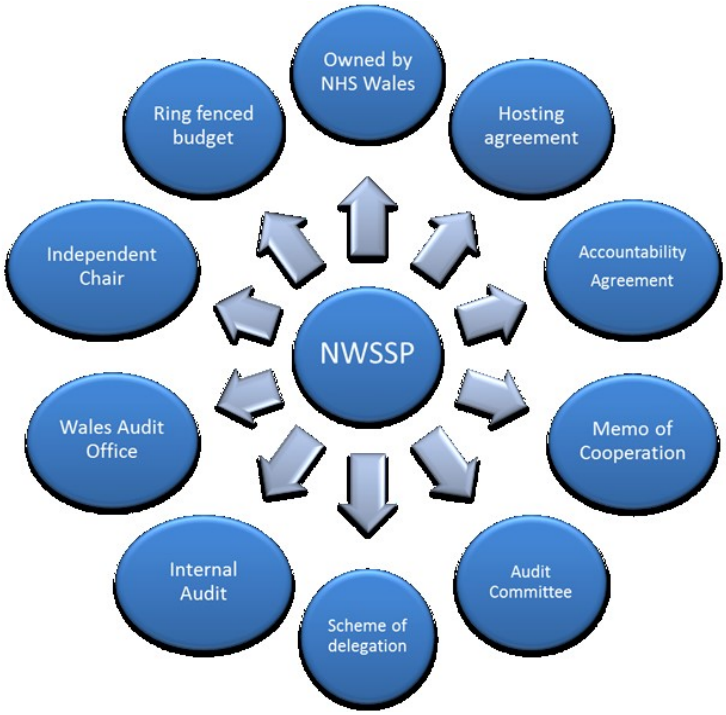
At a local level, Health Boards and NHS Trusts in Wales must agree Standing Orders for the regulation of proceedings and business. They are designed to translate the statutory requirements set out within the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, into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

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

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

NWSSP's governance arrangements are summarised below.

Figure 2: Summary of Governance Arrangements



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

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

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

The Membership of the Committee during the year ended 31 March 2019 is outlined in Figure 3 below. All meetings were quorate and attended by the Chair, and the attendance of the Committee is outlined in Figure 4.

Figure 3: Table of Members of the NHS Wales Shared Services Partnership Committee during 2018/2019

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

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

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

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

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

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

✓ Denotes the nominated member was present

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

× Denotes Health Body not represented

The purpose of the Partnership Committee is set out below:

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

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

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

2.2 Partnership Committee Performance

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

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

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

2.3 Velindre Audit Committee for NWSSP

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

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

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

The Committee attendees during 2018/2019 comprised of three Independent Members of Velindre NHS Trust supported by representatives of both Internal and External Audit and Senior Officers of NWSSP and Velindre NHS Trust. (NB Phil Roberts replaced Professor Jane Hopkinson as an independent member, with effect from January 2019).

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

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

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

2.4 Reviewing Effectiveness of Audit Committee

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

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

The survey questionnaire comprises self-assessment questions intended to assist the Committee in assessing their effectiveness with a view to identifying potential areas for development going forward. The survey for 2017/18, undertaken during May 2018, had an 80% response rate (8 responses received) and identified the following:

- *88% of all responses were positive;*
- *100% of respondents felt that the Committee had been provided with sufficient authority and resource to perform its role effectively;*
- *100% of respondents also considered that the Committee meets sufficiently frequently to deal with planned matters and that sufficient time is made available for questions and discussion;*
- *All respondents agreed that the atmosphere at Committee meetings is conducive to open and productive debate;*
- *All agreed that the behaviour of members and attendees was courteous and professional; and*
- *All agreed that the reports received by the Committee were timely and included the right format and content to enable the Committee to discharge its internal control and risk management responsibilities.*

Areas for further consideration included the use of the Welsh Language in meetings, and in promoting greater use of technology for Committee papers.

2.5 Sub Groups and Advisory Groups

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

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

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

- **Local Partnership Forum (LPF)**

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

2.6 Senior Management Team (SMT)

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

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

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

The SMT comprises:

Figure 7 – Composition of the SMT at NWSSP during 2018/2019

Name	Designation
Mr Neil Frow	Managing Director
Mr Andy Butler	Director of Finance and Corporate Services
Mr Gareth Hardacre	Director of Workforce and Organisational Development
Mr Mark Roscrow	Director of Procurement Services
Mr Paul Thomas	Director of Employment Services
Mr Simon Cookson	Director of Audit and Assurance
Mrs Anne-Louise Ferguson	Director of Legal and Risk
Mr Dave Hopkins	Director of Primary Care Services
Mr Neil Davies	Director of Specialist Estates
Mr Stephen Griffiths (until 30 September 2018)	*Director of Workforce Education and Development Services (WEDS)*

3. THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to the achievement of the policies, aims and objectives of NWSSP. Therefore, it can only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks, evaluate the likelihood of those risks being realised and the impact they would have, and to manage them efficiently, effectively and economically. The system of internal control has been in place in NWSSP for the year ending 31 March 2019.

3.1 External Audit

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

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

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

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

3.2 Internal Audit

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

Quarterly returns providing assurance on any audit areas assessed as having "no assurance" or "limited assurance" were issued to Welsh Government in accordance with the instruction received from Dr Andrew Goodall, Chief Executive NHS Wales/Director General in July 2016. During 2018/19 no internal audit reports were rated as limited or no assurance.

For both internal and external audit, the Audit Committee have ensured that management actions agreed in response to reported weaknesses were

implemented in a timely manner. Any planned revisions to agreed timescales for implementation of action plans requires Audit Committee approval.

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

3.3 Counter Fraud Specialists

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

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

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

During 2017/18, four new investigations into possible fraudulent or corrupt activity were instigated together with the five cases that were brought forward from 2016/17. Out of the four new cases, three involved alleged false claims submitted to the NHS Student Awards Service and which are still under investigation.

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

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

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

3.4 Integrated Governance

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

- The Quality Assurance and Improvement Plan arising from the 2017-18 Internal Audit self-assessment;
- Tracking of Audit Recommendations;
- Corporate Risk Register;
- Directorate Assurance Maps; and
- Governance Matters report on single tender actions, declarations of interest, gifts and hospitality received and declined.

During 2018/19, the Audit Committee reported any areas of concern to the Partnership Committee and played a proactive role in communicating suggested amendments to governance procedures and the corporate risk register.

3.5 Quality

During 2018/19, the Partnership Committee has given attention to assuring the quality of services by including a section on "Quality, Safety and Patient Experience" as one of the core considerations on the committee report template when drafting reports for Partnership Committee meetings.

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

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

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

3.6 Looking Ahead

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

Looking forward to 2019-20 the Audit Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of NWSSP.

Specifically, the Audit Committee will:

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

4. CAPACITY TO HANDLE RISK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- NWSSP is governed by Standing Orders and Standing Financial Instructions which are reviewed on an annual basis;
- The Partnership Committee and Audit Committee both have forward work plans for committee business which provide an assurance framework for compliance with legislative and regulatory requirements;
- The effectiveness of governance structures is regularly reviewed including through Committee self-effectiveness surveys;
- The front cover pro-forma for reports for Committees includes a summary impact analysis section to be completed prior to submission. This provides a summary of potential implications relating to equality and diversity, legal implications, quality, safety and patient experience, risks and assurance, Wellbeing of Future Generations, Health and Care Standards and workforce;

- The Service Level Agreements in place with the Health Boards and NHS Trusts set out the operational arrangements for NWSSP's services to them and are reviewed on an annual basis;
- NWSSP are proactive in completing the Welsh Government's Health and Care Standards framework and ensure that Theme 2 Safe Care provided a clear picture of NWSSP's approach to health, safety and risk management; and
- The responsibilities of Directors are reviewed at annual Performance and Development Reviews (PADRs).

5.2 Policies and Procedures

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

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

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

5.3 Information Governance

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

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

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

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

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

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

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

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

5.4 Counter Fraud

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

In addition, NWSSP lead the NHS Wales Counter Fraud Steering Group, facilitated by Welsh Government, which works in collaboration with the NHS

Counter Fraud Authority in NHS England to develop and strengthen counter fraud services across NHS Wales. The Director of Finance and Corporate Services chairs the group. During the year the Group has documented and approved a NHS Anti-Fraud Strategy for Wales.

5.5 Internal Audit

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

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

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

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

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

5.6 Integrated Medium Term Plan (IMTP)

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

The IMTP is formally reviewed and amended annually and approved by the Partnership Committee in March each year prior to submission to Welsh Government. The planning process for the 2019-2021 IMTP commenced with a stakeholder awayday in September 2018 and the completed IMTP was submitted to Welsh Government at the end of January 2019.

5.7 Health and Care Standards for NHS Wales

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

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

The process for undertaking the annual self-assessments is:

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

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

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

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

Theme	Executive Lead	2018/2019 Self-Assessment Rating	2017/2018 Self-Assessment Rating
Governance, Leadership and Accountability	Senior Management Team	4	4
Staying Healthy	Director of Workforce and Organisational Development	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	Not applicable
Timely Care	Not applicable	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 within Velindre University NHS Trust, we are required to adhere to their Equality and Diversity Policy, Strategic Equality Plan and Equality Objectives, which set out the Trust's commitment and legislative requirements to promoting inclusion.

Our Corporate Services Manager chairs the NHS Wales Equality Leadership Group, together with sitting on the All Wales Senior Offices Group for Equality. We work together with colleagues across NHS Wales to collaborate on events, facilitate workshops, deliver and undertake training sessions, issue communications and articles relating to equality, diversity and inclusion, together with the promotion of dignity and respect.

We also benefit from the proactive work undertaken by our host organisation to strengthen our offering, including the Positive About Disabled People "Double Tick" symbol, "The Rainbow Mark" and we are working towards achieving a place on the Stonewall Cymru Workplace Index. Furthermore, 2018 saw NWSSP supporting NHS Wales

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

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

Personal data in relation to equality and diversity is captured on the Electronic Staff Record (ESR) system and staff are responsible for updating their own personal records using the Electronic Staff Record Self-Service. This includes ethnicity; nationality, country of birth, religious belief, sexual orientation and Welsh language competencies. The "NHS Jobs" all Wales recruitment service, run by NWSSP adheres to all of the practices and principles in accordance with the Equality Act and quality checks the adverts and supporting information to ensure no discriminatory elements. NWSSP has a statutory and mandatory induction programme for all recruits, which includes the NHS Wales "Treat Me Fairly" e-learning module focusing on equality and diversity. The module is a national training package and the statistical information pertinent to NWSSP completion contributes to the overall figure for NHS Wales. NWSSP provides a "Core Skills for Managers" Training Programme and the "Managing Conflict" module includes an awareness session on the Dignity at Work Policy and Procedure. A corporate induction package on equality, diversity and inclusion was been included within the 2019 programme for new starters in the organisation.

6.2 Welsh Language

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

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

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

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

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

The preparation for the formal implementation of the standards is monitored through an action plan that is reviewed by the NWSSP SMT monthly. The arrangements for implementation were also the subject of an internal audit that reported in January 2019 and which provided reasonable assurance. Our achievements from the implementation plan will enable us to report on our performance against the Welsh Language Standards within our Annual Performance Report, which is bilingually to the Welsh Language Commissioner in June each year.

NWSSP has made significant progress in developing and growing its Welsh language services by successfully offering all staff the opportunity to learn Welsh at work. The NWSSP website is bilingual and we have invested in the development of a candidate interface on the TRAC recruitment system. We are now looking to offer our language services to other organisations and have already agreed to provide services to Public Health Wales, HEIW, and the All-Wales Therapeutics and Toxicology Centre.

6.3 Handling Complaints and Concerns

NWSSP is committed to the delivery of high quality services to its customers; the NWSSP mission is 'to enable the delivery of world class Public Services in Wales through customer focus, collaboration and innovation'.

NWSSP's Issues and Complaints Protocol is reviewed annually. The Protocol aligns with the Velindre NHS Trust Handling Concerns Policy, the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and Putting Things Right Guidance.

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

6.4 Freedom of Information Requests

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

Figure 12 – Freedom of Information Requests 2018- 2019

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

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

6.5 Data Security

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

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

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

There was one Information Governance breach reported in 2018/19 that was assessed as being of a category serious enough to report to the Information Commissioner's Office (ICO) for further investigation. However, this was done as a matter of course as the mitigations in place and the circumstances of the breach were handled in such a way that the data in question was not released into the public domain and was controlled

and secured to a point where there were no risks to the data subject's information. The ICO were satisfied with the processes involved and the recommendations made and did not consider it to be an issue that required enforcement action.

6.6 ISO14001 – Sustainability and Carbon Reduction Delivery Plan

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

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

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

Carbon Footprint

As part of our commitment to reduce our contribution to climate change, a target of 3% 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 2018-19, we committed to reducing our carbon reduction by implementing various environmental initiatives at our sites within the scope. Our Sustainable Statement explores this area in further detail. The main highlights from 2018-19 were as follows:

6.7 Business Continuity Planning/Emergency Preparedness

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

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

- People – the loss of personnel due to sickness or pandemic;
- Premises – denial of access to normal places of work;

- Information Management and Technology and communications/ICT equipment issues; and
- Suppliers internal and external to the organisation.

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

NWSSP is committed to ensuring that it meets all legal and regulatory requirements and has processes in place to identify, assess, and implement applicable legislation and regulation requirements related to the continuity of operations and the interests of key stakeholders. In 2018/19 work has been undertaken to document an overarching business continuity plan and supporting business impact assessment. This built on the local directorate plans that were already in place. Desktop exercises were undertaken in September 2018 to test NWSSP's resilience in a number of specific scenarios, and we also undertook a joint exercise with NWIS in October 2018 to consider our response in the event of a major cyber attack. Our resilience was also tested for real in April 2018 when travellers took over part of the Matrix House Car Park, and also through adverse weather conditions during the year.

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

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

6.8 UK Corporate Governance Code

NWSSP operates within the scope of the Velindre NHS Trust governance arrangements. Velindre NHS Trust has undertaken an assessment against the main principles of the UK Corporate Governance Code (which was updated in July 2018) as they relate to an NHS public sector organisation in Wales. This assessment was informed by the Trust's assessment against the "Governance, Leadership and Accountability" theme of the Health and Care Standards undertaken by the Board. The Trust is clear that it is complying with the main principles of the Code, is following the spirit of the

Code to good effect and is conducting its business openly and in line with the Code. The Board recognises that not all reporting elements of the Code are outlined in this Governance Statement but are reported more fully in the Trust's wider Annual Report. NWSSP have also completed the self-assessment on the "Governance, Leadership and Accountability" theme of the Health and Care Standards with a positive maturity rating of 4.

6.9 NHS Pension Scheme

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

7. MANAGING DIRECTOR'S OVERALL REVIEW OF EFFECTIVENESS

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

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

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

Internal Audit Opinion

Internal audit provide me and the Partnership Committee through the Audit Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered

in accordance with Public Sector Internal Audit Standards by the Audit and Assurance function within NWSSP.

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

The Head of Internal Audit opinion for 2018/2019 was that the Partnership Committee can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively:

RATING	INDICATOR	DEFINITION
Reasonable assurance	 - + 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 Risk Management

Internal Audit undertook a review of Risk Management in 2018/19 to assess the effectiveness of the systems in place to manage and assure risks. This audit provides assurance to the Audit Committee that risks material to the achievement of system objectives are managed appropriately.

Internal Audit concluded that the level of assurance given as to the effectiveness of the system of internal control in place to manage the risk 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 2018/19.

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

Financial Control

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

NWSSP Financial Control Overview

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

- **Governance Procedures** – As a hosted organisation NWSSP operates under the Governance Framework of Velindre NHS Trust. These procedures include the Standing Orders for the regulation of their proceedings and business. The statutory requirements have been translated into day-to-day operating practice, and, together with the Scheme of Reservation and Delegation of Powers and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust. These arrangements are supported by detailed financial operating procedures covering the whole of Velindre and also local procedures specific to NWSSP.

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

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

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

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

CONCLUSION

This Governance Statement indicates that NWSSP has continued to make progress and mature as an organisation during 2018/19 and that we are further developing and embedding good governance and appropriate controls throughout the organisation. No significant control weaknesses have been identified during the year. NWSSP has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads me to conclude that it has a robust system of control.

Looking forward – for the period 2019/20:

I confirm that I am aware of my on-going responsibilities and accountability to you, to ensure compliance in all areas as outlined in the above statements continues to be discharged for the financial year 2019/20.

Signed by:

Managing Director – NHS Wales Shared Services Partnership

Date: 2019

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	3.5
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Audit Committee Effectiveness Survey 2019

PURPOSE

To present the Committee with a copy of the questions and timetable for completion of the annual Audit Committee Effectiveness Survey. A summary of questions is set out at **Appendix 1**.

1. INTRODUCTION

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

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

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

2. EFFECTIVENESS SURVEY

The survey is based on the guidance contained within the NHS Audit Committee Handbook and to ensure both Velindre and NWSSP Committees have issued aligned survey questions, we have worked together to produce a template bringing together the best of both Committee self-assessments, to be used going forward. The agreed questions are set out in **Appendix 1**.

The results of the survey will provide a rich source of information and provide assurance in terms of existing arrangements and potential areas for development, going forward. A report of the findings will be presented to the Committee on 9 July 2019.

The survey will be issued during the week commencing **15 April 2019** and Committee members are requested to complete the survey anonymously online by **24 May 2019**.

Committee members requested to complete the survey are as follows:

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

3. RECOMMENDATIONS

Audit Committee Members are asked to:

- Complete the online survey by **24 May 2019**.

Appendix 1
Velindre University NHS Trust Audit Committee for NHS Wales Shared Services
Audit Committee Effectiveness Survey 2019

Composition, Establishment and Duties

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

Compliance With Law And Regulations Governing NHS Wales

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

Internal Control and Risk Management

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

Internal Audit

21. Are the Charter or Terms of Reference approved by the Audit Committee and regularly reviewed?
22. Does the Audit Committee review and approve the Internal Audit Plan at the beginning of the financial year?
23. Does the Audit Committee approve any material changes to the Plan?
24. Are Audit Plans derived from clear processes based on risk assessment with clear links to the system of assurance?

25. Does the Audit Committee receive periodic progress reports from the Head of Internal Audit?
26. Does the Audit Committee investigate the reason for management refusal to accept audit recommendations?
27. Does the Audit Committee effectively monitor the implementation of management actions from Audit Reports?
28. Does the Head of Internal Audit have a direct line of reporting to the Audit Committee and its Chair?
29. Does the Audit Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?
30. Has the Audit Committee evaluated whether Internal Audit complies with the Public Sector Internal Audit Standards (PSIAS)?
31. Has the Audit Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?
32. Does the Audit Committee receive and review the Head of Internal Audit's Annual Report and Opinion?

External Audit

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

Counter Fraud

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

Committee Leadership

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

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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

Date issued: April 2019

Document reference: APS201904

Contents

Progress update

About this document

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

Assurance arrangements

2 Details of the finalisation of our audit assurance arrangements for 2019 are set out in Exhibit 1.

Exhibit 1: assurance arrangements

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

Audit update

3 The progress of the audit assurance work detailed in our 2019 assurance arrangements report is set out in Exhibit 2.

Exhibit 2: audit work update

Area of work	Scope	Planned timetable	Current status
Audit assurance requirements			
Internal audit	Assess compliance with Public Sector Internal Audit Standards (PSIAS). Review annual audit plan and status of audits.	January 2019	Complete
Payroll	Update our understanding of the payroll system and identify key controls. Controls testing of exception reports.	March 2019	Complete

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

Area of work	Scope	Planned timetable	Current status
Management letter	Summary of work and any matters arising that need to be considered by the NWSSP management. This report will also include any issues relating to NWSSP identified by other Welsh health auditors.	June 2019	Report planned for July 2019

NHS-related national studies

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

5 Exhibit 3 provides information on recently published NHS-related or relevant national studies published since the previous Audit Position Statement. It also includes all-Wales summaries of work undertaken locally in the NHS. Exhibit 4 provides information on studies currently underway.

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

Topic	Details
What's the hold up? Discharging patients in Wales	NHS bodies need assurance that hospital discharge arrangements are safe and timely. We have produced this checklist to help NHS board members get this assurance. **Published 22 March 2019** http://www.audit.wales/publication/whats-hold-discharging-patients-wales
Expenditure on agency staff by NHS Wales	Expenditure on agency staff by NHS Wales has increased markedly in recent years. About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited. NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them. **Published 22 Jan 2019** http://www.audit.wales/system/files/publications/expenditure-on-agency-staff-by-nhs-wales-2019-eng-print-version.pdf

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

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

6 The Auditor General has also commenced a programme of work looking at the arrangements that the devolved public sector in Wales, including all NHS bodies, is putting in place to prepare for, and respond to, Britain's exit from the European Union. In autumn 2018, he issued a call for evidence to compile a baseline of arrangements being put in place. On 19 February, he issued a report, Preparations in Wales for a 'no deal' Brexit. This will be followed up by further audit fieldwork during the rest of 2019.

Good practice

7 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
Working in partnership to combat fraud	This seminar is aimed at all public service officers and members who have counter fraud responsibilities or interests within their organisations including, those: • with responsibility for the organisation's counter fraud strategy eg directors of finance. • with responsibility for undertaking investigative work. • exercising compliance functions which may result in counter fraud action. eg internal auditors. • responsible for assessing applications for services or benefits where there is a significant inherent fraud risk. We will share investigation techniques, intelligence and the use of data analytics in fraud prevention and detection. • **7 May 2019: 9:00am - 1:00pm** • **16 May 2019: 9:00am - 1:00pm** http://www.audit.wales/events/working-partnershipcombat-fraud

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Ffôn testun: 029 2032 0660

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Gwefan: www.archwilio.cymru

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

NHS Wales Shared Services Partnership

Audit Committee

9 April 2019

Internal Audit Progress Report

CONTENTS Page

1. INTRODUCTION

The purpose of this report is to highlight progress of the 2018/19 Internal Audit Plan at 3 April 2019 to the Audit Committee, together with an overview of other activity undertaken since the previous meeting.

2. PROGRESS AGAINST THE 2018/19 INTERNAL AUDIT PLAN

Number of audits in plan	20
Of which:	
Reported as final	13
Reported as draft	0
In progress	6
At scoping stage	1

Progress in respect of each of the reviews in the 2018/19 Internal Audit Plan is summarised at Appendix A.

3. 2019/20 PLANNING

Planning meetings have been held with Directors over recent months together with other planning procedures and the draft Internal Audit Operational Plan 2019/20 ('the Plan') is on the agenda of the 6 April 2019 Audit Committee meeting for approval. This is in line with the request of the Audit Committee for the Plan to be prepared in advance of the start of the financial year to which it relates.

4. ENGAGEMENT

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

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

5. RECOMMENDATION

The Audit Committee is invited to note the above.

2018/19 Internal Audit Plan

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
AUDITS FOR BOTH NWSSP AND INDIVIDUAL HEALTH BOARDS / TRUSTS								
PRIMARY CARE SERVICES								
General Medical Services (GMS)		Work in progress						
General Dental Services (GDS)		Work in progress						
General Ophthalmic Services (GOS)		Work in progress						
General Pharmaceutical Services (including Prescribing)		Work in progress						
EMPLOYMENT SERVICES								
Payroll Services		Final	Reasonable	0	6	0	-	April Audit Committee
PROCUREMENT SERVICES								
Purchase to Pay (P2P)		Work in progress						
AUDITS FOR NWSSP								

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
FINANCE & CORPORATE SERVICES								
Business Continuity Plans	18	Final	Reasonable	1	1	1	-	April Audit Committee
Risk Management and Assurance	13	Final	Substantial	0	1	1	-	April Audit Committee
BACS Bureau	5	Final	Reasonable	1	1	2	-	October Audit Committee
Welsh Language Standards	1	Final	Reasonable	1	2	0	-	January Audit Committee
Information Governance & GDPR		Work in progress						
Welsh Infected Blood Support Scheme	23	Final	Reasonable	0	5	5	-	January Audit Committee
PROCUREMENT SERVICES								
Cwmbran Stores	21	Final	Reasonable	1	1	0	-	January Audit Committee
Health Courier Services	5	Final	Reasonable	1	3	3	-	October Audit Committee

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
PRIMARY CARE SERVICES								
General Ophthalmic Services (GOS)	2	Final	Substantial	-	-	-	-	April Audit Committee
Patient Medical Records	2	Final	Reasonable	0	3	3	-	January Audit Committee
WORKFORCE & ORGANISATION DEVELOPMENT								
Annual Leave Management	75	Final	Reasonable	1	2	2	-	January Audit Committee
Recruitment and Retention (Advisory)	61	Final	n/a	-	-	-	3	April Audit Committee
IT								
IT Systems – virtualised environment		Scoping						
CAPITAL & ESTATES								
Primary Care Rental Reimbursement Reviews	12	Final	Reasonable	0	5	2	-	January Audit Committee

Assignment	Draft to Mgt Response (Days)	Status	Rating	Summary of Recommendations				Notes
				High	Medium	Low	N/A	
PROJECT MANAGEMENT GROUPS								
WfIS Programme Board: H2R	Ongoing		To sit on Project Board to provide advice on internal controls					
IT Steering Group	Ongoing		To sit on Project Board to provide advice on internal controls					
Information Governance Steering Group	Ongoing		To sit on Project Board to provide advice on internal controls					
Finance Academy P2P Group	Ongoing		To sit on Project Board to provide advice on internal controls					
Audit Tracker Register	Ongoing		Consider the development of audit recommendation tracker functionality within Teammate					
Primary Care Payments System	Ongoing		Monitoring developments for the replacement of the Exeter system					
AUDIT MANAGEMENT & REPORTING								
Audit Management & Reporting	Ongoing							

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

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

Assurance rating	Assessment rationale	Guide to Rating
	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.	Significant audit matters require management attention both in terms of materiality and number. Control design limitations (D) impact the majority of control objectives or risk areas. Alternatively compliance issues (O) are widespread indicating wholesale non-compliance irrespective of control design. Several high priority audit findings have been identified in a number of areas; and/or several Medium audit findings. Either individually or when taken together these are significant audit matters with moderate impact on residual risk exposure until resolved.

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

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

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

Recruitment and Retention

Advisory Review

Final Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

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Review reference:	NWSSP-1819-05
Report status:	Final
Fieldwork commencement:	11th September 2018
Debrief meeting:	16th & 23rd October 2018
Draft report issued:	13th December 2018
Management response received:	19th March 2019
Final report issued:	19th March 2019
Auditors:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Ian Parry, Principal Auditor
Executive sign off:	Gareth Hardacre, Director of Workforce and Organisational Design
Distribution:	Neil Frow, Managing Director Andrew Butler, Director of Finance & Corporate Services Gareth Hardacre, Director of Workforce and Organisational Development Mark Roscrow, Director of Procurement Services Dave Hopkins, Director of Primary Care Services
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

An advisory review of Recruitment and Retention within NHS Wales Shared Services Partnership (NWSSP) has been completed in line with the 2018/19 Internal Audit Plan. The recruitment and retention of staff remains a challenge for all NHS organisations in ensuring that key targets are met to provide safe healthcare functions and services to support them.

A key strategic objective for NWSSP is to ensure that there is an 'appropriately skilled, productive, engaged and healthy workforce in place', which is supported by the overarching goal to 'encourage people to want to work and stay with us by attracting, training and keeping them'.

NWSSP has a workforce of over 2,000 members of staff, split across 23 different sites and to support the above goal, a key priority for NWSSP is to improve recruitment and retention within a number of service areas.

1.2 Scope and Objectives

The objectives of this review focussed on ensuring whether services within NWSSP with known recruitment and retention issues are maximising their use of recruitment and retention initiatives and in particular are adopting alternative approaches where others have been unsuccessful. The objectives were to ensure that:

- there is a recruitment and retention strategy in place that focuses on initiatives to attract and retain a skilled workforce across the organisation and is aligned to NWSSP's objectives;
- there is a recruitment and selection policy / procedure in place which details the roles and responsibilities for the recruiting of staff;
- effective initiatives are in place to recruit staff, for example recruitment events, social media, engagement and interaction;
- effective initiatives are in place to assist in retaining staff, for example succession planning, reviewing the age of the workforce, analysis of why staff decide to leave or stay in the organisation, staff surveys, and Personal Appraisal and Development Reviews (PADRs);
- there is effective working with partners and other organisations; and
- adequate reporting mechanisms are in place to monitor staff recruitment and retention through the organisation, both locally and centrally.

The review focussed on Accounts Payable, Procurement and Primary Care Services. Our approach during the review was to interview key managers, obtain reports from Workforce and OD, analyse management information and review initiatives introduced by each area.

1.3 Associated Risks

The risk considered in the review is the inability to attract, recruit, retain and develop qualified staff with the appropriate skills and competencies in order to deliver services to clients and meet the organisation's aims and objectives.

2 CONCLUSION

2.1 Advisory review

As this is an advisory review, the assignment is not allocated an assurance rating, but advice and recommendations have been provided to facilitate change and improvement.

2.2 Overall Summary

The advisory review has identified that there is scope for improvement in looking more strategically across NWSSP, as some of the challenges faced are consistent throughout the organisation, for example, the inability to recruit into certain types of positions. Whilst the Divisions have introduced some initiatives to tackle specific concerns identified, an organisation-wide approach will ensure an appropriate and consistent strategy can be adopted.

Alongside that, retention is also key to understanding the reasons why staff choose to remain or leave the organisation across different services areas, bands and other classifications is crucial. Until this is achieved, initiatives will operate on a trial and error basis. For example, if Agenda for Change is the primary reason within professional bands for either recruitment or retention concerns, then this is key to understand and to what extent.

Furthermore, with the results of the staff survey now available, these should be analysed and used in conjunction with other business intelligence, to inform the overall Recruitment and Retention Strategy.

Also, NWSSP would benefit from some further analytical reports, specifically tailored to monitor or identify areas of concern or strengths highlighted from staff. For example, if a service area experiences low turnover of staff at a particular band, it may be useful to monitor this

particular band throughout the whole of the organisation, to identify any adverse movements or variances. Additionally, areas that have professional vacancies for a prolonged period of time may benefit from reviewing the job descriptions and streamlining responsibilities or setting out the expected time proportion of that responsibility – is line management 10% of time or 80% of the role. This may help address concerns that potential candidates may have with the role advertised.

As part of our review, we have included a range of additional initiatives that NWSSP may wish to consider. These are listed within Appendix B. These are in addition to the Management Action Plan within Appendix A.

3 Detailed Advisory Review Findings

3.1 Analysis of the problem

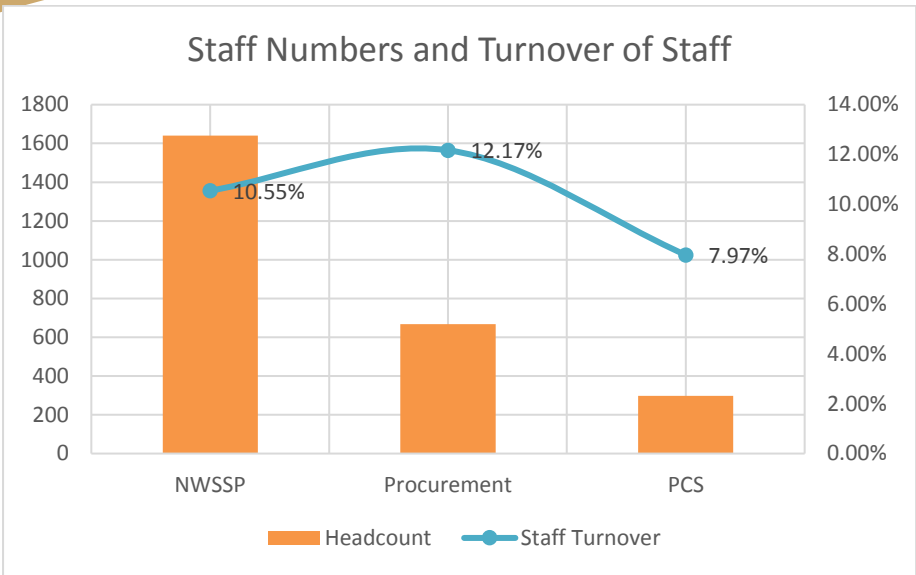
We examined three service areas (two divisions):

- Primary Care Services (PCS); and
- Procurement, including Accounts Payable.

A review of workforce information and discussions with senior managers identified the following difficulties recruiting to the posts advertised and retaining staff:

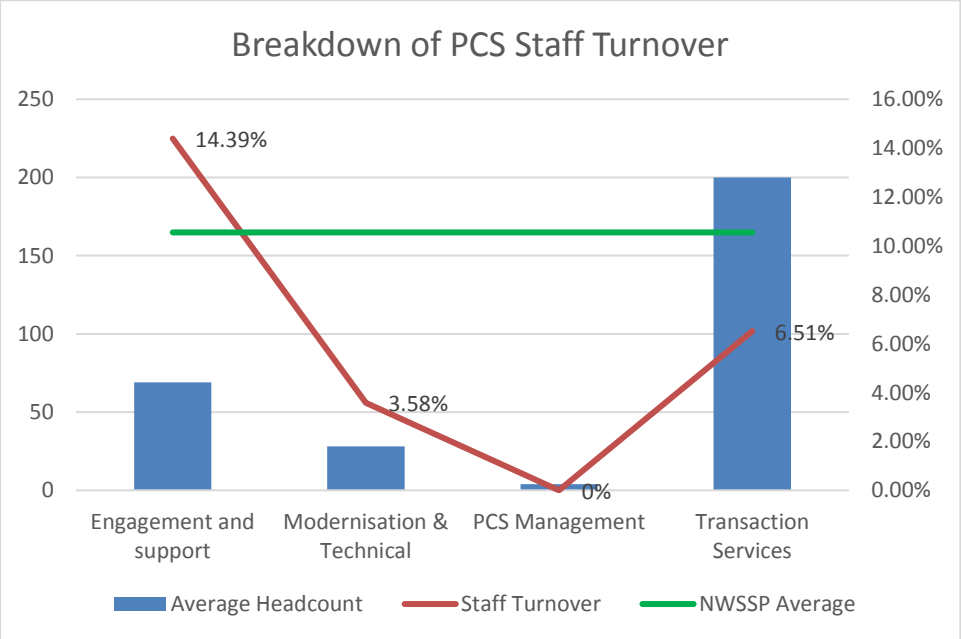
- the ability to recruit and retain Band 5 and 6 posts within Engagement and Support Services (PCS);
- within PCS, four Band 7 positions were advertised, but only four candidates applied;
- recruiting professional staff within Local Procurement, ; and
- data entry vacancies based upon geography (two vacancies within Alder House).

The turnover rates for each division are illustrated below:



By selecting both divisions, we have sought to identify any further patterns of recruitment and retention throughout the bands or service areas, irrespective of division.

Further interrogating the data above, we have been able to establish that the rates of turnover (recruitment and leavers) within each division, on a percentage basis, varies across the service areas, as illustrated below for PCS:



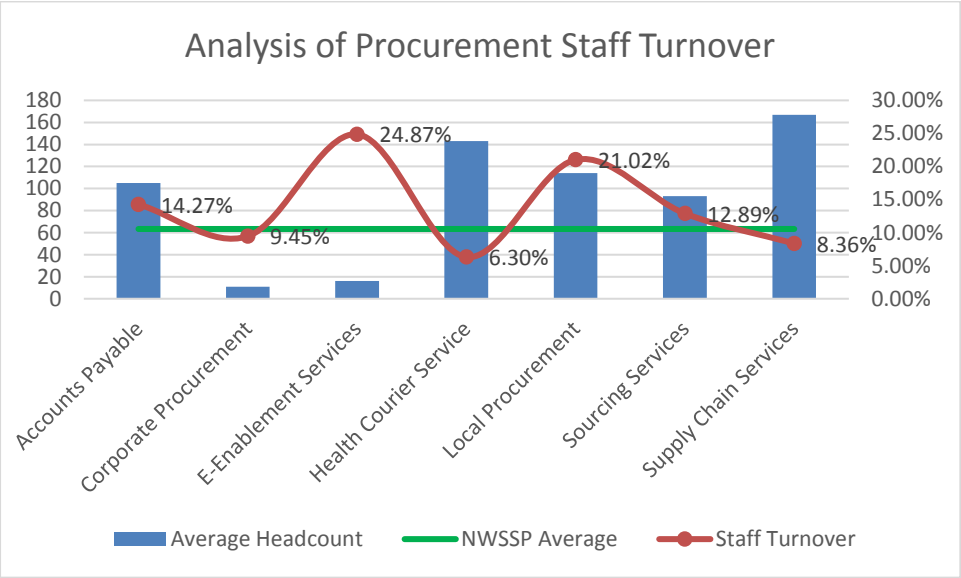
The above graph demonstrates the highest percentage of staff turnover sits within the Engagement and Support and Transactions Services teams. Typically, staff within these teams are lower bands (Bands 2 and 3), with 96% (23) of staff turnover within PCS throughout just these two areas.

However, at a percentage level the PCS total is still less than the NWSSP average.

By contrast, the Procurement division experiences higher than the NWSSP average turnover, and in particular within a number of the professional services offered. This is most notable within Local Procurement, where the turnover is nearly twice the NWSSP average at 21.02%. Furthermore, within the E-enablement Team, the staff turnover is at 24.87%, with an average headcount of 16.

Transactional services within Accounts Payable also experience higher turnover compared to the NWSSP average of 10.55%. At 14.27%, this is slightly higher than PCS, Engagement and Support (14.39%), but notably higher than Transaction Services within PCS (comparable bands), which is 6.51%.

This is illustrated below:



We found that the range of management information available on a real-time basis from Workforce and OD is limited. Whilst the metrics required for the senior management teams are produced regularly, the reports required to analyse data via different perspectives are not, for example, the turnover of staff at varying bands throughout the organisation – to allow comparisons to be drawn across teams. This has been raised as a recommendation below, to assist departments in understanding the patterns throughout the organisation.

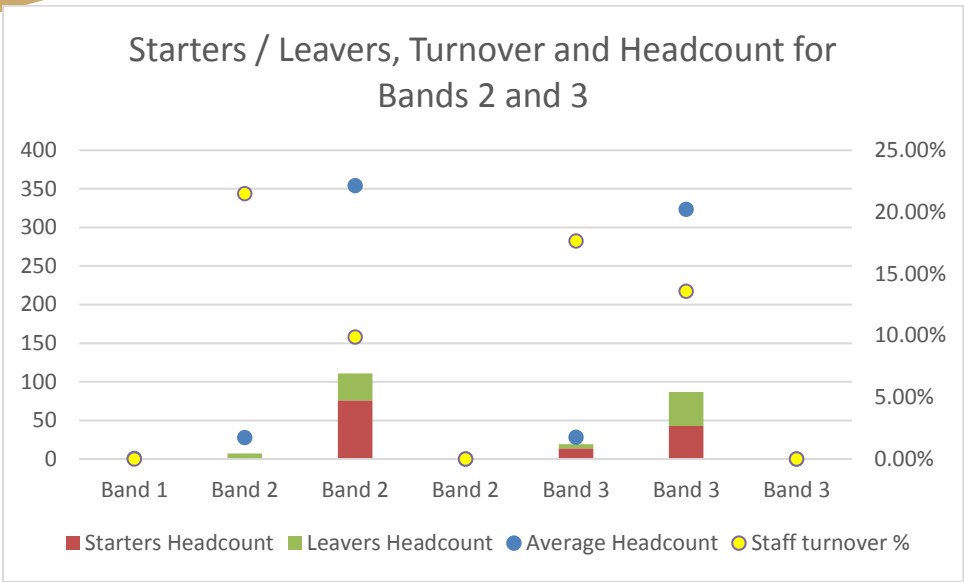
Recommendation 1

Details	Recommendation
Limited management / business intelligence reports are produced from ESR to allow teams to analyse the recruitment and retention positions within their remit.	1. The divisions should engage with Workforce and OD to help understand what reporting requirements are required for managing current and anticipated risks and issues related to recruitment and retention. 2. Develop / produce reports from ESR to assist management with analysing trends / patterns regarding the turnover of staff. 3. NWSSP should consider reporting its performance data, including staff turnover, independently from Velindre NHS Trust, to allow the publication of relevant data to NWSSP.

To illustrate the above point further, the graph below captures multiple bands 2 and 3 job categories and provides details of total headcount, the number of leavers and starters and the relative turnover by band.

However, it does not attribute each band to additional search criteria, without manually creating the reports each time. It would be very useful for the service areas to review the data from multiple perspectives, to obtain further intelligence. For example, to be able to determine the team within the service area that they have left and the length of service for Band 2 staff that have left, coupled with the ESR reasons for leaving to help understand patterns within NWSSP.

In addition, capturing trends around particular recruitment issues, e.g. vacancy profiles (length of time a job is unfilled or average time that role was filled previously) allows conclusions to be drawn up over emerging / existing problems.



The case study below focuses on retention concerns, but demonstrates how improved management information helped the Foundation Trust to reduce staff turnover.

Case Study

Within Newcastle upon Tyne Hospitals NHS Foundation Trust, a series of dashboards were developed to proactively manage potential retention hotspots before they occur, incorporating similar business intelligence referred to above.

They managed this by consolidating and creating a standard set of data for all departments and setting benchmarks to monitor trends against. The mechanisms developed aided decision making and reduced staff turnover.

3.2 What is being done

Primary Care Services

Primary Care Services (PCS) has recognised and undertaken a range of initiatives to reduce staff turnover and to improve retention. Some of them address the findings from the national staff survey and others through other channels of feedback within the Division, including reasons recorded within ESR.

Whilst the next step for NWSSP is to determine the underlying reasons why employees remain in a job, some feedback has been provided on a range of the initiatives undertaken by the service areas that we examined.

Noted below are some of the tools that have been utilised by PCS:

Taking each in turn, we have included details of the initiatives introduced by the service areas to address recruitment and retention concerns. In addition, we have detailed further suggestions of other initiatives that have been trialled by other organisations (detailed within Appendix B). However, it still remains important for NWSSP to determine what the main factors are to achieve job satisfaction.

Accounts Payable / Procurement

In the same manner as PCS, the directorates within the Procurement division have introduced a range of initiatives to improve recruitment and retention including:

Each initiative has been introduced to remedy a particular item of concern, which has been identified through numerous channels of feedback. However, as with PCS it remains important for an organisation led approach to recruitment and retention to be completed, to understand the reasons why staff choose to remain, but also to improve upon recruitment challenges. We have provided some narrative on the steps taken thus far.

Upskilling of Staff	•Able to retain existing staff and knowledge •Allows staff development and during the period of study, unlikely to leave
Bank Staff	•Assists with a quick mobilisation of staff at lower bands, to address any short term gains •Cheaper than agency costs, but difficult to roll out at professional levels
Homeworking	•This initiative allows a greater work / life balance, by reducing commuting time
IT Equipment	•IT equipment was replaced, as it was flagged as a reason for staff leaving within Legal
Recruitment of Graduates	•To assist with the throughflow of staff required, this option allows skilled staff to be recruited and trained to the level required for future succession
Recruitment via Social Media	•Alternative recruitment practices have been introduced to more appropriately target the professional audience for jobs

3.3 How Could Things be Done Differently

Recruitment

Both the recruitment and the retention of staff raises difficulties in maintaining staff levels in some areas. For the recruitment of staff, there is a significant challenge in recruiting professionally qualified individuals, in particular. A range of initiatives to assist with recruitment difficulties has been highlighted below and detailed further within Appendix B. Each should be considered alongside the overall strategy or direction for NWSSP and includes the following suggestions:

- the evaluation of recruitment campaigns;
- development and promotion of the NWSSP brand;
- promotion of NHS Wales / NWSSP as an employer of choice;
- enhancement of job advertising, including the use of SMS texts;
- efficient use of the recruitment process, to minimise the loss of good candidates;
- develop a system of offering jobs to candidates that scored highly in other selection processes. For example, they were unsuccessful on one position, but scored highly, which would make them suitable for other roles that may arise;
- review current vacancies or jobs vacated during a year to determine if the job specification can be designed differently;
- maintain links with Jobcentre Plus to recruit long term unemployed indivdiuals; and
- offer flexible careers (secondments, role re-design and rotational contracts).

Retention

To begin to improve retention rates, an understanding of what causes the turnover of staff will assist in the development of an organisation led strategy or initiatives to improve staff retention. This has been detailed below, under the next section.

<u>Underlying Principle of Inertia</u>

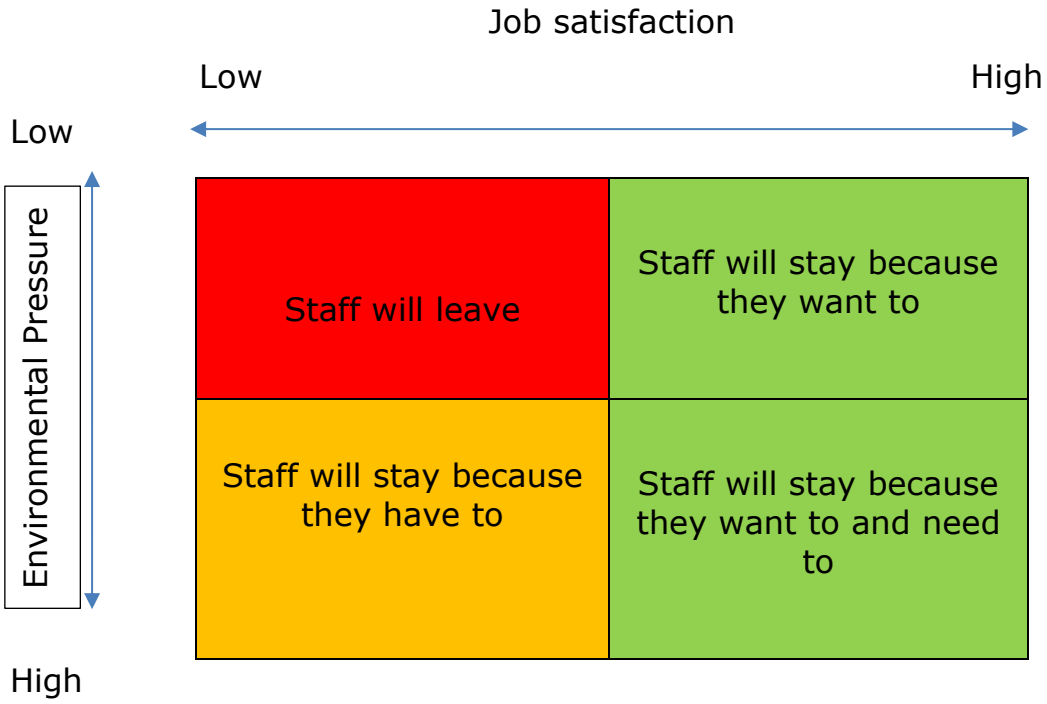
The reasons why an employee chooses to leave an organisation varies from one individual to the next. However, each person has an amount of 'inertia' and the greater the force applied, the more likely that they will leave an organisation. In essence there are four aspects that affect this:

1. the level of job satisfaction required (and offered), progression, role challenge, enjoyment of work etc.;

2. the degree of comfort that an employee experiences within an organisation, including salary, work / life balance, relationships with co-workers, flexible working conditions etc.;
3. perceived job opportunities elsewhere; and
4. non-work factors, such as financial commitments, family ties and relationships.

Each of the four aspects can make a significant difference between staff that 'want to stay' or 'have to stay'. In addition, staff that 'have to stay', typically report a lower degree of job satisfaction[1].This is illustrated further below:

The Relationship between Job Satisfaction and Environmental Pressure



Source: https://hbr.org/1973/07/why-employees-stay Exhibit 1

By reviewing the relationship above, the employee that will stay with the organisation is one where all of their job 'comforts' are met and job satisfaction is high. This reduces their level of 'inertia'. As opposed to staff that will leave because there is no external environmental reason to stay in the role and the level of job satisfaction required, is not being met. Staff that stay within their employment, due to an external environmental factor, may end up leaving the organisation in the future, once a non-work factor has changed.

[1] https://hbr.org/1973/07/why-employees-stay

A small exercise was undertaken by GWT (Great with Talent), to understand some of the reasons for staff choosing to leave NWSSP, where a sample of 52 surveys was issued, with a response rate of 31. It was identified that the lack of career progression was the main factor influencing exit decisions, with pay being fourth (although the two reasons may be intrinsically linked). It was also identified that a third of leavers left within the first two years.

For NWSSP, the requirement to undertake exit interviews is just one part of the solution, as it is limited to understanding why staff are choosing to leave NWSSP. However, as is shown above, the reason why staff stay is of paramount importance to ensure their continued job satisfaction and to improve retention. If this remains high, staff are less likely to leave. The 2018 staff survey resulted in 57% of staff stating that they either 'always' or 'often' look forward to going to work. The NHS Wales average is 60%.

However, exit interviews are not routinely undertaken, and job satisfaction surveys are also not completed across the organisation. This has been raised as a recommendation.

Recommendation 2

Details	Recommendation
NWSSP do not undertake exit interviews or surveys to understand the main reasons for staff to continue working within a team.	Workforce and OD should assist the teams with the following: 1. Exit interviews should be completed for all staff that have tendered their resignation, to understand why they are leaving the role. 2. Periodic surveys, focus groups or other initiatives (see appendix B) should be completed to understand the reasons why staff remain within a role. 3. The results of the exit interviews and staff surveys should be collated and action taken to address areas of concern, where possible.

Below is an example of an NHS organisation that struggled to achieve high response rates for exit questionnaires. They broadened the scope of and

undertook a complete review of why staff may leave or stay and updated the exit interview process to improve response rates, to make it as easy as possible for staff to complete one. However, prior to that they engaged with teams that experience low turnover, low sickness and high staff engagement to understand the reasons for staff staying.

Case Study

Tameside and Glossop Integrated Care NHS Foundation Trust identified that the exit questionnaire response rate was less than 10%. To help develop a full picture of why staff leave and why staff stay they set up focus groups in areas with low turnover, low sickness and high engagement. Furthermore, the exit questionnaire process was revamped with an electronic system, a dashboard for monitoring and promotion of it through social media. Finally, the Trust created a senior role for staff to have 'itchy feet' conversations with them, to help broker / explore career opportunities.

Furthermore, as part of the above model, further research was undertaken by Harvard Business Review to understand the balance between the internal environment (motivational and maintenance, which directly impact job satisfaction) and external environmental reasons for staying within a job.

This was analysed further by identifying a range of demographic parameters, including job roles (managers & professionals vs non-managers & professionals).

Through the questioning of workers, the research study identified the top 10 reasons for each demographic classification of employees and recorded the results between the internal environment and external environmental reasons, accordingly.

For example, professional staff (Band 6 and above) may depend more actively on job satisfaction and the degree of internal environmental comfort to remain within a role. Once this starts to erode, the possibility of an individual relocating / moving to another job increases. In fact, when examining the top 10 reasons for remaining within a role, just one related to external environmental factors for professionals / managers and nine to the environment in which they worked[2].

For clerical roles, there appears to be a stronger correlation to external environmental factors as to why the group may choose to remain in a role. Furthermore, within the study they typically experience lower levels of job

[2] https://hbr.org/1973/07/why-employees-stay Exhibit II, 4th Row

satisfaction. Within the top 10 reasons for remaining within a clerical role, three were external factors and seven internal[3].

For lower bands, this changes considerably, with seven external and three internal of the top 10 reasons for staying[4].

Within NWSSP, approximately 421 staff (all figures exclude GP trainees) are band 6 or above or 26% of staff (1,627 total). As such, a single strategy is unlikely to successfully improve retention across each group of employee and a more multi-faceted approach is required, based upon what is driving employees desire to remain. The strategy for each group of employees should target different aspects, to improve retention.

NWSSP Strategy

Each of the divisions sampled has undertaken a range of initiatives to address some of the recruitment and retention challenges that they are facing. The service areas require a steer at a corporate level to address the recruitment and retention difficulties that they are facing. As such, we recommend that NWSSP develops and implements an NWSSP wide recruitment and retention strategy to support the IMTP and build upon the initiatives developed locally by services and centrally by Workforce and OD. This should be completed once a more detailed analysis of the reasons for people staying and leaving has been undertaken. In conjunction with retention approaches, it should set methods for recruiting staff too.

Recommendation 3	
Details	**Recommendation**
Apart from what is contained in the IMTP there is no recruitment and retention strategy for NWSSP as a whole. Instead, each service assesses its own risk and develops its own action plan, in response to local circumstances supported by Workforce and OD. Whilst this enables each division to introduce and adapt initiatives freely, an organisation wide approach will allow the implementation of an action plan to tackle recruitment	1. Once the factors for staff, at different bands within the organisation, have been identified for remaining within NWSSP, an overall recruitment and retention strategy should be developed, to help guide directorates. This should be led by Workforce and OD. 2. Organisation wide initiatives should be undertaken to help address the more significant factors in retaining /

[3] https://hbr.org/1973/07/why-employees-stay Exhibit II, 3rd Row
[4] https://hbr.org/1973/07/why-employees-stay Exhibit II, 1st & 2nd Row

and retention issues throughout NWSSP.	recruiting staff. This should be led by Workforce and OD.

With the above recommendation, NWSSP should explore pathways for ensuring a consistent approach to the same recruitment and retention problems throughout NWSSP, particularly where it is difficult to attract staff to certain roles. Within the case study below, the only solution to improve staff retention was to adopt an organisation led strategy to improve employee morale. Once implemented, the strategy not only significantly improved staff morale, but also the staff retention rate.

Case Study

The Workforce and OD Team of Frimley Health NHS Foundation Trust collected a significant volume of data from staff, including interviews and questionnaires, which was triangulated with staff sickness, recruitment feedback and staff survey data to identify strengths and weaknesses to inform the strategy.

Staff recommending it as a place to work rose from 44 per cent to 77 per cent in one year.

Within Appendix B, a range of additional options has been listed to provide a range of alternative approaches to assist with improving retention and recruitment. These should be used in conjunction with the wider recommendation of understanding what is driving job satisfaction throughout the organisation and the strategy that NWSSP is seeking to adopt.

MANAGEMENT ACTION PLAN	
Finding 1: Management Reporting	**Risk**
During the advisory review we requested management information regarding recruitment and retention, to analyse by a range of parameters (bands, length of service, team etc.). However, limited management information reports are produced from ESR to allow teams to analyse the recruitment and retention positions within their remit. The reports requested for the review had to be manually generated.	To fully determine the reasons / patterns for areas within NWSSP that are experiencing recruitment or retention issues. Themes are not identified to inform management action.
Recommendation 1	
We recommend that: 1. The Divisions should engage with Workforce and OD to help understand what reporting requirements are required for managing current and anticipated risks and issues related to recruitment and retention. 2. Develop / produce reports from ESR to assist management with analysing trends / patterns regarding the turnover of staff. 3. NWSSP should consider reporting its performance measurement data, including staff turnover, independently from Velindre NHS Trust, to allow the publication of relevant data to NWSSP.	
Management Response 1	**Responsible Officer/ Deadline**
Turnover rates are reported in the monthly SMT and local SMT reports, along with detailed information outlining the reasons employees leave a post. These metrics can be further developed with the Divisions when the Senior Workforce Analyst is in post. Going	Senior Workforce Analyst/ Heads of Workforce and OD and Departmental Managers.

forward the Heads of Workforce and OD will work closely with the Divisions to develop and implement action plans to address recruitment and retention challenges. Despite limited capacity within the WOD Function due to vacancies, Exit Interviews have been carried out with all leavers (Bands 4 plus) in Procurement. The findings have been sent to the Director of Procurement Services. The newly appointed Head of WOD will work with the Procurement Division on the development and implementation of an Action Plan in response to these findings.	Review of current Metrics to be completed by Oct 2019 Action Plan (where applicable) to be developed by Dec 2019

Finding 2: Exit Interviews and Retention of Staff	Risk
The Exit Policy and Procedure published on both the NWSSP intranet was approved in June 2013 and was due for review in June 2016, but is still outstanding. The responsibility for undertaking the exit interviews resides with Workforce and OD. However, interviewees suggested that it was the responsibility of local managers to conduct exit interviews, although Workforce and OD have agreed to do this for Professional Procurement. However, exit interviews are not routinely undertaken or are captured via ESR, but it does not allow the depth of information to be obtained. Overall, a complete analysis of why people choose to leave the organisation is not being captured. Furthermore, an understanding of why staff choose to remain within a team or NWSSP is not being identified either. As a result, it is not possible to fully determine why staff may decide to leave or stay. Without understanding the main reasons, it becomes very difficult to inform an organisation wide strategy to address service areas with recruitment and retention issues.	Unable to effectively target why staff may leave NWSSP, within each service area. Without a full understanding of why staff decide to remain or work for NWSSP it becomes difficult to improve upon recruitment and retention. It is difficult to inform a Recruitment and Retention Strategy or determine the direction of NWSSP regarding recruitment and retention, without understanding the underlying reasons.
Recommendation 2	
We recommend that NWSSP: 1. Update the Exit Policy and Procedure and stipulate in detail where the responsibility resides for completing an exit interview. 2. Ensure that all leavers receive an exit interview and that the findings are collated centrally. 3. Undertake a range of initiatives (surveys, one-to-one interviews etc.) to obtain information regarding the reasons why staff remain with NWSSP and what is important to them.	

4. Collate the results and triangulate with other business intelligence (e.g. staff surveys) to corroborate findings / develop more detailed information around the reason or identify patterns.
5. With the information obtained from staff across the organisation, utilise the output to inform management action.
6. Where initiatives that have been successful in other divisions and they address specific actions identified above for the retention of staff, these should be rolled out throughout NWSSP.

Management Response 2	Responsible Officer/ Deadline
1. The current Exit Policy and Procedure will be reviewed by August 31 2019. It is currently a management responsibility to ensure that Exit Interview questionnaires interviews are issued to staff leaving NWSSP. There is functionality within ESR which can be switched on and which ensures that all staff leaving receive an Exit Interview Questionnaire. This will be fully switched in NWSSP by August 1st 2019. 2. A detailed analysis of Exit questionnaires submitted between 1st April and 31st August 2019, staff survey results and one to one meetings will be carried out. The findings will inform the development and recommendations outlined in NWSSP Recruitment and Retention Strategy. 3. There will be a sharing of good practice within NWSSP via a targeted "Talent Management Event. The purpose of this event for Managers will be to learn from internal good practice and successes and other exemplar organisations.	Deputy Director of Workforce and OD August 31st 2019 WOD from 1st April 2019 Senior Workforce Analyst/ Deputy Director of workforce and OD 30th September 2019 LED Manager, Heads of Workforce and OD, Departmental Managers. October 2019

Finding 3: Recruitment and Retention Strategy	Risk
Apart from what is contained within the IMTP there is no recruitment and retention strategy for NWSSP as a whole. Instead, each service assesses its own risk and develops its own action plan in response to local circumstances, supported by Workforce and OD. Whilst initiatives introduced may offer some improvement to recruitment and retention within a division, there is no organisation-wide targeting of the significant underlying reasons why staff may be leaving or looking to join NWSSP.	There is a limit to the scale of the improvements that can be made towards recruitment and retention without full Executive support. There is a risk of divisions focussing resources on initiatives that may not be significantly affecting recruitment or retention.
Recommendation 3	
We recommend that NWSSP: 1. Develops a strategy for recruitment and retention, seeking to address the reasons identified for people remaining and leaving. This should be led by Workforce and OD, with Executive support, to ensure involvement across NWSSP.	
Management Response 3	**Responsible Officer/ Deadline**
A Recruitment and Retention Strategy and Action plan for NWSSP will be developed by December 2019. Immediate actions will be focus on sharing good practice, and addressing the key recruitment and retention challenges facing those Departments with high turnover rates and vacancies.	Deputy Director of Workforce and OD December 2019.

Appendix B: Example Initiatives for Consideration

Throughout the review we identified a variety of practices in place within each division which may be of benefit elsewhere within the organisation. Furthermore, the review has identified examples of good practice from other organisations. Using these, we have tabled a list below of some example points for consideration when developing the Recruitment and Retention Strategy for the divisions to review and adopt / incorporate accordingly.

Consideration Points	Details
Rising Stars Programme / Talent Management	PCS has introduced a system to identify individuals, at all levels within the Division, that may possess management attributes. Through aptitude testing, the top performing individuals are identified and supported to realise their potential through work shadowing and secondment schemes.
Awards and Positive Culture	External organisations frequently highlight numerous awards that they have achieved, from personnel awards (Investors in People) to business achievements, as a sign of a successful organisation to work for. Amongst many initiatives, NWSSP frequently promotes internal recognition of staff, through the Staff Recognition Awards. NWSSP should promote the successes of the organisation in all job advertisements, to reinforce the positive environment in which the role sits.
Staff Benefits	A final salary pension scheme and increased annual leave are some of the additional benefits offered by the NHS in Wales. Whilst Agenda for Change ensures equitable pay across NHS Wales, this is just one component of the overall package. All benefits should be heavily promoted within job vacancies to highlight attractive elements of working for the NHS in Wales.
Training / Apprentice Schemes	The NHS Wales Finance Academy recruits high calibre graduates to train and following training, potentially promote candidates into professional roles. For the individual, the route provides development opportunities, encourages retention and once qualified, has a number of routes for specialising in. Essentially, the Academy provides highly trained and experienced staff ready to succeed professionals that leave the organisation, either through other career

	opportunities or retirement. NWSSP should consider, taking into account costs vs. benefits, rolling out other academies, for areas where particular challenges are faced – e.g. Procurement.
Promotion of the NHS in Wales	The NHS in Wales, whether through health boards or supporting services, offers a career path for people to undertake a public duty and develop a sense of pride. The staff survey showed that 75% of people were proud to tell other people that they work for NWSSP. The profile of the NHS in Wales is a considerable selling point to potential candidates and the marketing of this within jobs should increase the level of interest of positions.
Secondments	Support staff development through rotation of individuals across divisions, to improve skills and experience and to open new challenges and opportunities.
Review banding of Positions	Review job descriptions and ensure that they remain reflective of actual roles. Where discrepancies are identified undertake a banding review – i.e. are the bands the correct level for the actual roles undertaken.
Recruit based on Values	To ensure the most appropriate staff are employed, the social care sector have introduced a *Values Based Recruitment Toolkit* to determine if that career is the correct choice and the likelihood of remaining in the role. A similar approach by NHS Wales can help target the individuals most suited to the NHS in Wales and particular professions and be used as part of the selection process at interview. This initiative would sit alongside a Core Skills Strategy, to provide support for staff looking to develop their skills.
Pooled Resources	For service areas where it is difficult to recruit or retain staff, the use of pooled staff resources will allow the allocation of team members into areas of urgent need and priority.
Avoid Recruiting in Desperation	The Chartered Institute of Personnel and Development (CIPD) estimate that recruiting the wrong individual[5] can cost the organisation £8,200, rising to £12,000 for senior managers. Typically, the wrong appointments may be made in desperation, in areas where there is great difficulty in recruiting. This becomes more

[5] https://www.skillsforcare.org.uk/Document-library/Finding-and-keeping-workers/Recruitment-and-retention-strategy/recruitment-and-retention-strategy-2014---2017.pdf

	inefficient as time progresses (e.g. managing the individual), placing a greater demand on the workforce. Ensure that a suitable selection process is utilised for recruitment of the best (and right) candidates.
Flexible Working	Where suitable, flexible working arrangements should be considered to help staff balance their work and personal life. This should be heavily promoted.
Evaluation of Recruitment Campaigns	When a significant campaign is completed, undertake a review of what went well and improvements required, by contacting recruiting managers and successful candidates, to help inform future recruitment processes.
Enhance Job Advertising	To assist potential candidates with applying for jobs, develop alternative methods of advertising jobs. For example, send text messages for a job that meets the requirements for a candidate. Advertise on agency websites, although this will attract a charge.
Streamline Recruitment Process	A recruitment process that takes too long to bring the right candidate in, can increase the risk of candidates accepting other jobs offers in the meantime.
High Quality Candidates	Where candidates have been interviewed and failed to be offered a position, but possess high quality attributes, shortlist and offer them similar positions.
Review Vacancies	For long term vacancies, review the job description and seek to amend the role to target candidates for majority of the skills required for the jobs. For example, c.10% of a position may relate to line management, but the job description portrays this as a significant factor.
Jobcentre Plus	Maintain links and relationships with Jobcentre Plus to interview individuals that have been unemployed for a long period of time.
Flexible Careers	Design roles that are flexible and allow staff to try new roles without leaving the organisation. For example, secondments or rotational contracts.

Key:

Recruitment initiatives
Retention initiatives
Recruitment & retention initiatives

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Shared Services Partnership
Audit and Assurance Services

Primary Care Services

Actions Undertaken in Response to the NHS Protect Ophthalmic Loss Measurement Exercise Report

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Substantial Assurance

Previous Rating: **n/a – first review**

CONTENTS

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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 Action Taken in Response to the Ophthalmic Loss Analysis Report for NHS Wales Ophthalmic Services produced by NHS Protect (now NHS Counter Fraud Authority) in 2015/16 has been completed in line with the agreed 2018/19 Internal Audit Plan.

The relevant lead for the assignment was Dave Hopkins – Director of Primary Care Services.

A loss analysis exercise was undertaken by NHS Protect to measure the prevalence of suspected inappropriateness in patient and contractor ophthalmic claims within the NHS in Wales.

NHS Protect examined a random sample of individual General Ophthalmic Services (GOS) vouchers for services dated during the 2015/16 financial year. The review concluded that NHS Wales had suffered financial loss due to suspected false patient eligibility claims and inappropriate contractor claims.

Following issue of the NHS Protect report, senior managers of NHS Wales Shared Services Partnership (NWSSP), Primary Care Services (PCS) and NHS Counter Fraud Services (CFS) Wales reviewed the report in detail to agree the actions required in response to the report.

An update on the actions taken was provided to the Velindre University Trust Audit Committee for NWSSP in July 2018.

1.2 Scope and Objectives

This audit sought to verify the actions taken in response to the NHS Protect report, as reported to the Velindre University Trust Audit Committee for NWSSP in July 2018.

1.3 Associated Risks

The risks considered at this audit were as follows:

i. Actions to address matters arising in the NHS Protect report have not been identified or implemented.

2 CONCLUSION

2.1 Overall Assurance Opinion

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

The level of assurance given to the implementation of the actions agreed to be undertaken in response to the Ophthalmic Loss Measurement Exercise Report by NHS Protect is **Substantial Assurance**.

RATING	INDICATOR	DEFINITION
Substantial Assurance	 - + Yellow	The Trust 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 Summary of Actions

A summary of progress in implementing the actions is outlined below:

Priority	Outstanding	Ongoing	Completed	Total
Number of Actions:	**0**	**4**	**6**	**10**

2.3 Summary of Recommendations

There are no findings/recommendations arising from this review.

3 SUMMARY OF AUDIT FINDINGS

Action Plan

Primary Care Services (PCS) have developed an action plan in response to the NHS Protect report. Ten actions were identified for implementation:

1. Request details of exceptions identified in the loss measurement exercise report from NHS Protect
2. Produce information posters for opticians and residential/nursing homes
3. Inform the Deputy Director, Primary Care Division (Welsh Government) of the report and ambiguity in the regulations concerning domiciliary visits
4. Plan to identify and address potential loss within NHS Wales
5. Develop and implement a risk-based PPV audit programme
6. Inform Counter Fraud Services Wales / NHS Protect colleagues of the NHS Protect Loss Measurement report and the response action being taken
7. Enhance engagement with NHS CFS Wales and LCFS Teams
8. Call a Counter Fraud Steering Group meeting
9. Contractor loss initiative – enhanced monitoring and review of contractor claims
10. Internal Audit review

Progress has been reported to the Counter Fraud Steering Group, with a detailed update was presented to the NWSSP Audit Committee in July 2018.

Action 1: Write to NHS Protect requesting details of the exceptions identified in the loss measurement report

A formal meeting was held with NHS Protect in February 2017 to discuss the methodology used to calculate the potential loss figure indicated in the initial report issued in November 2016. Details of the exceptions identified in the report were requested during this meeting so written correspondence was not necessary.

NHS Protect issued a revised report in April 2017. However, concerns remained so PCS requested scanned images of the 235 potential inappropriate contractor claims from NHS Protect. The sample of potential inappropriate patient claims was not available as the data is with the Department of Work and Pensions.

A review was undertaken in July 2017 to establish whether the appropriate claim status had been captured within the NHS Protect report. The findings were as follows:

- 116/235 (49.36%) were considered valid under the regulations in Wales;
- 110/235 (46.81%) require further investigation by NHS Protect (although they have turned down requests for this); and
- 9/235 (3.83%) were appropriately identified as potential loss.

Internal Audit undertook a high-level review of the process undertaken by PCS in December 2017. We concluded that overall, the process was thorough and based on detailed scrutiny of each claim. PCS were able to justify the basis on which they believe the 116 claims to be valid and the 110 claims requiring further investigation.

Status: Complete

Action 2: Produce information posters for opticians and residential/nursing homes

The Head of Engagement & Support Services advised that a draft poster was prepared and approved following feedback from Optometry Wales and the Federation of Ophthalmic and Dispensing Opticians. The poster titled 'Be NHS Fraud Aware' contains information on record keeping, eligibility, unnecessary prescriptions etc. relevant to all primary care services.

We understand that release of the poster has been delayed at the request of Welsh Government whilst discussion with further stakeholders is undertaken. Development of the poster was led by CFSW however agreement over which organisation will take ownership for it, including arrangements for issuing and dealing with any challenges, is yet to be agreed.

Status: Ongoing, No Further Recommendations

Action 3: Inform Welsh Government of the report and the ambiguity in the regulations concerning domiciliary visits

A meeting was held with the Deputy Director, Primary Care Division (Welsh Government) in June 2017. This meeting was not documented however we were advised that a review of the Ophthalmic Domiciliary Regulations was requested, to clarify the position regarding arrangements for Nursing homes and Pension Credit advice. Welsh Government requested further information to support this request, and we were advised this was provided in April 2018.

We were provided with evidence that PCS have been maintaining a legislation review document highlighting areas of legislation which require updating, including the Ophthalmic Domiciliary Regulations. Welsh Government have advised that resource is not available for legislative review.

Status: Complete

Action 4: Plan to identify and address potential loss within NHS Wales
Action 5: Develop and implement a risk based PPV audit programme

In 2016 PCS worked with NHS Digital to obtain a full download of all ophthalmic claim data entered via Open Exeter for the purpose of establishing an Ophthalmic Data Warehouse. The intention was that ophthalmic claim data would be used to inform the Post Payment Verification (PPV) visits to ophthalmic contractors.

The objectives of the project are set out within the Ophthalmic Data Warehouse Project Brief and include the identification of potential patient and contractor fraud.

There are two phases to the project:

> ***Phase 1:*** establish reporting requirements and timeframes that will assist PPV reporting with Local Counter-Fraud Services (LCFS) and Counter-Fraud Services Wales (CFSW). A PPV Protocol was published in November 2018 providing a complete overview.
>
> ***Phase 2:*** establishment of a user group with stakeholders from PCS, Welsh Government, Counter Fraud and Health Boards, that would inform future reporting requirements and data sets.

The project timeline and dependencies have been identified and progress is monitored by the GOS Data Warehouse Programme Board (PCS Senior Management Team). The PPV sample creation function is due to be completed by February 2019 and reviewed by April 2019 to examine how the samples are created and identify if there is a better way to manage the creation process using the data.

A National Ophthalmic User Group has been established with clinical representation from Optometry Wales and Welsh Government. The purpose of the group is to *"define the scope of the development of ophthalmic information services driven by Primary Care Services (PCS) GOS Data Warehouse".* The inaugural meeting was held in December 2018.

Status: Ongoing, No Further Recommendations

Action 6: Inform CFS Wales / NHS Protect colleagues of the NHS Protect Loss Measurement report and the response action being taken

A report outlining the issues identified in the Wales loss measurement exercise and PCS' response to the findings of the NHS Protect report was presented to the Counter Fraud Steering Group in May 2018. Representatives from NHS Protect and CFSW were present at this meeting.

Emails were also provided as evidence of ongoing correspondence between PCS, CFSW and NHS Protect.

Status: Complete

Action 7: Implement mechanisms to enhance engagement with NHS CFS Wales and LCFS Teams

Bi-annual meetings are held between the PPV Team, CFSW and LCFS. Minutes of the meetings held in October 2017, March 2018 and October 2018 were provided as evidence of this.

A Joint Working Protocol between LCFS and the PPV Team was issued in May 2018. The protocol is a *"framework for general interaction between LCFS and PPV Team to aid the prevention, deterrence and detection of potential fraud and economic crime within the organisation"*. It also details the relevant liaison responsibilities during actual fraud investigations.

The Head of Engagement & Support Services advised that a number of operational changes have been made to improve PPV and LCFS engagement, including:

- LCFS are informed of Health Board visit plans
- PPV final reports for each practice are shared with LCFS
- LCFS are invited to attend team building days
- Fraud awareness training was delivered by LCFS to all PPV teams in November 2018

Status: Complete

Action 8: Call a Counter Fraud Steering Group meeting

The Loss Measurement Exercise Report was reviewed in detail at bi-annual group meetings, the most recent of which was held in December 2018, where the formal response from NWSSP to the NHS Protect report was discussed. The meetings include representation from CFSW, LCFS teams, NWSSP, Welsh Government, Wales Audit Office, NHS Counter Fraud Authority (formerly NHS Protect) and Internal Audit.

Status: Complete

Action 9: Contractor Loss Initiative

The PPV team piloted a programme of work with Betsi Cadwaladr University Health Board to enhance monitoring and review of contractor claims. This involves contacting a sample of patients on a monthly basis to confirm treatment and service delivery.

A presentation of the findings was made to the joint PPV and Counter Fraud group on 29th October 2018 which outlined the progress and outcomes of the pilot. Further work is being undertaken on the results of the pilot, on completion of which a national programme of work will be developed to verify contractor claims on an ad hoc basis.

Status: Ongoing, No Further Recommendations

Action 10: Internal Audit Review

This action has been actioned through completion of this audit.

Status: Complete

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 NWSSP. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

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

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

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

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Business Continuity Planning

Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance

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

CONTENTS

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Draft report issued:	14th February 2019
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Final report issued:	19th March 2019
Executive sign off:	Mark Roscrow, Director of Procurement Services (NWSSP)
Distribution:	Neil Frow, Managing Director (NWSSP) Andrew Butler, Director of Finance & Corporate Services (NWSSP) Peter Stephenson, Head of Finance & Business Development (NWSSP)
Auditors:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Chris Scott, Internal 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

The review of 'Business Continuity Planning' was completed in line with the 2018/19 Internal Audit Plan.

NHS organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential and business critical services will be maintained and normal services restored as soon as possible.

NWSSP began the process of developing a corporate level Business Continuity Plan in early 2018, bringing together in one programme the continuity risks of all of the directorates of which it is comprised and addressing them with an integrated approach. A number of directorates had previously operated their own Business Continuity Plans which the corporate plan now seeks to consolidate and at present there are local directorate plans in place for ensuring business continuity arrangements are effective for key services and buildings. Work is progressing in developing an overarching corporate level Business Continuity Plan which will bring these together with the objective of delivering a coordinated response to incidents and outbreaks.

As NHS Wales Shared Services Partnership ('NWSSP') continues to implement improvements towards its plans for the recovery of key business systems and processes within an agreed timescale, this review assessed the quality of the actions completed so far and the timeframe for implementing the remaining steps.

1.2 Scope and Objectives

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

The audit sought to provide assurance over the following key areas to ensure that:

- designated officers / committees are assigned the accountability for discharge of emergency planning and business continuity responsibilities;
- impact assessments have taken place to inform the development of emergency plans for critical areas, including areas recently integrated into NWSSP;
- disaster recovery plans are in place for the prompt recovery of information technology, including in the event of cyber security attacks;

- documented plans are embedded / being developed to ensure business as usual is maintained during periods of disruption; and
- any remaining business continuity actions / objectives are scheduled for implementation, based upon priority.

Limitation of scope

The audit was a high-level review of the NWSSP corporate level Business Continuity Plan and looked at the framework that the partnership is in the process of putting in place to protect and maintain services in the event of failures, incidents or outbreaks. The audit assessed the status of individual elements of the plan in line with the stated scope but did not test its overall operation and therefore cannot provide assurance in this respect.

1.3 Associated Risks

- lack of ownership and responsibilities relating to emergency planning, including the development of plans for critical areas;
- business critical services may not be maintained during periods of disruption; and
- insufficient progress made towards business continuity planning throughout NWSSP.

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.

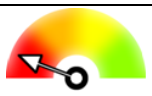
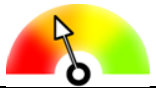
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Business Continuity Plan is **Reasonable** Assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or

		compliance with low to **moderate impact on residual risk** exposure until resolved.

The 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	designated officers / committees are assigned the accountability for discharge of emergency planning and business continuity responsibilities;			✓	
2	impact assessments have taken place to inform the development of emergency plans for critical areas, including areas recently integrated into NWSSP;			✓	
3	disaster recovery plans are in place for the prompt recovery of information technology, including in the event of cyber security attacks;		✓		
4	documented plans are embedded / being developed to ensure business as usual is maintained during periods of disruption; and			✓	

Assurance Summary					
5	any remaining business continuity actions / objectives are scheduled for implementation, based upon priority.		✓		

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 Business Continuity Planning.

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 Business Continuity Planning.

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**	**1**	**1**	**3**

3 SUMMARY OF AUDIT FINDINGS

The key findings are reported in the Management Action Plan in Appendix A.

We identified one **High priority** issue that we consider requires prompt management action. This concerned:

- ensuring all key IT systems are fully protected from cyber threat and recoverable in the event of failure.

We identified one **Medium priority** issue that we consider requires management's attention and provides scope for improvements to be made. This concerned:

- ensuring that deliverable timescales of remaining tasks needed for completion of the plan are determined and scheduled.

One **Low Priority** finding was identified where we have provided a recommendation to ensure the full integration of the Health Courier Service in the corporate level Business Continuity Plan.

Finding 1 Cyber security over key IT systems (Operation)	Risk
NWSSP actively manage cyber threats to their IT systems through their Cyber Action Plan. This records key IT systems and draws on control frameworks derived from current industry standards and protocols to assess residual risk for each system and derive appropriate actions/ responses to address these. We appreciate the Cyber Action Plan is a work in progress but that although all tasks within it record target completion dates in 2017 and 2018, it is not made clear in the document whether these have been delivered. The audit sought evidence of disaster recovery provision for a sample of 8 of the NWSSP key IT systems. For one of these systems we found a NWSSP PCS Senior Management Team owned Disaster Recovery Plan in place but for the remaining seven, NWSSP are substantially reliant on provider/ host arrangements to protect systems and assure service resilience. The same 8 systems were also tested against a short list of generic measures to preserve IT systems and their data (back-up, restore from back up) and protect them from cyber-attack (defence measures, testing of effectiveness of these) and we found the following exceptions: • in 3 cases we could not confirm the operation of regular system backups; • in 8 cases we could not obtain evidence of test restore of systems from backup; • in 5 cases we could not obtain assurance that the systems are currently fully protected from unauthorised access or electronic tampering; and • in 4 cases we could not obtain assurance that systems defence measures are tested regularly to ensure they are effective in defending against current threats.	Key IT systems fail and as a result business continuity is threatened. Failed IT systems cannot be recovered. Data from failed IT systems cannot be restored.
Recommendation 1	**Priority level**
We recommend that the Cyber Action Plan be updated to record current status of the tasks it lists and that NWSSP address the exceptions reported above regarding the backup, restore, protection and testing thereof and recovery planning for all systems, owned and 3rd party managed.	**High**

Where NWSSP are reliant for systems resilience on the disaster recovery procedures of system hosts, providers or third party suppliers they should seek regular confirmation of the successful testing of these or alternatively, implement their own measures to satisfy themselves of the service's resilience.	
Management Response 1	**Responsible Officer/ Deadline**
Of the eight systems tested, two are fully documented in terms of a formal disaster recovery plan (NHAIS and the Prescription Pricing System). Two more are in the process of transferring to an in-house provision and this should be completed for both by the end of May (CLERIC and EARL). Open Exeter is hosted by NHS England under a national contract and BRAVO is hosted by the National Procurement Service on behalf of the Welsh Government. TRAC is a third party system with a one hour target response time for any system failures and the Performers List Database is hosted by NWIS under a SLA. However, we will ensure that the Cyber Action Plan is brought up to date, and that the exceptions identified in the audit are considered and addressed as appropriate. Where systems are hosted and/or provided by third parties, we will seek confirmation of successful testing of disaster recovery procedures.	Head of Finance and Business Development 30 June 2019

Finding 2 Timeline of remaining tasks to complete the plan (Design)	Risk
We noted that progress in the development and delivery of remaining elements of the plan has been interrupted by other business priorities and that this has had an adverse effect on delivery targets. Whilst we appreciate that the plan documents will receive periodic review and update going forward, key remaining tasks that are at present outstanding – development of action cards for use in the event of incident, development of a programme of testing of the plans responses to events – have not been rescheduled and as a result, there is a risk that delivery of these is delayed unduly.	Risk of Business Continuity plan slippage. Ongoing risk to the organisation of continuity threats.
Recommendation 2	**Priority level**
We recommend that remaining plan tasks are recorded in an action plan and scheduled for timely delivery.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Work is largely complete in the higher risk directorates (e.g. Procurement/Employment Services) but an action plan for completion of the remaining tasks will be documented. Progress with these remaining tasks has been affected by a focus on Brexit, which represents a very significant challenge to our business resilience, resulting in sustained and focused testing of our key risk areas.	Head of Finance and Business Development 30 June 2019

Finding 3 Health Courier Services business continuity integration (Design)	Risk
We noted that, although NWSSP directorates are not required to have their own business continuity plans, a number of these do have (e.g. Procurement, Health Courier Services) from earlier years. Notwithstanding, in order that where they exist, dependencies/ links between directorates can be considered in developing responses, the corporate level plan seeks to consolidate, consider and address continuity threats for all directorates of NWSSP. Whilst inclusion is generally the case for directorates of the partnership, we did note a lack of integration of certain elements – key processes, staff, suppliers, premises and equipment - of the Health Courier Services in the corporate level plan. Whilst we didn't identify specific weaknesses within the standalone plan of the latter, there is a risk that as a result, interdependencies between this and other directorates are overlooked in the assessment of threats in the corporate plan with consequent impact on responses and priorities.	Risk that inter-dependencies between Health Courier Services and other directorates are overlooked in the business and other impact assessments of the corporate business continuity plan.
Recommendation 3	**Priority level**
We recommend the full integration of the Health Courier Service in the corporate level Business Continuity Plan.	**Low**
Management Response 3	**Responsible Officer/ Deadline**
Health Courier Services (HCS) were fully involved in the workshops and subsequent meetings that have resulted in the documentation of the Business Impact Assessments and the Business Continuity Plan. As they are not a directorate in their own right, but rather part of Procurement, their entries have been listed under Procurement rather than HCS. However, it has always been our intention to ensure that there is consistency in approach between the current HCS Business Continuity Plan and the Corporate Plan, and this will be documented in the action plan as per Recommendation 2.	Head of Finance and Business Development. 30 June 2019

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Confidentiality

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

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

Audit

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

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

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

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

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

Risk Management and Assurance

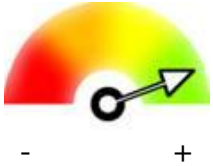
Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Substantial Assurance

Previous Rating: n/a – first review

CONTENTS

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Final report issued:	1st April 2019

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Auditors:	James Quance, Head of Internal Audit Stephen Chaney, Deputy Head of Internal Audit Clare Shaw, Principal Auditor
Committees:	Velindre University 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

Our review of Risk Management in 2016/17 found that the approach to risk management was relatively mature and there were established processes in place to ensure that corporate or organisational risks should be identified, mitigated, managed and monitored. Corporate and directorate risk registers were in a consistent format and were regularly reviewed at the respective Senior Management Team (SMT) meetings. The Corporate Risk Register was also regularly and proactively reviewed at Audit Committee and Partnership Committee meetings.

During 2017/18, we undertook a review of Corporate Governance, which included a follow-up of the recommendations raised in the Risk Management review in 2016/17. The follow-up review identified that two of the four prior recommendations had been fully implemented and two partially implemented. The outstanding actions concerned a lack of responsible officers assigned to the mitigation of some risks and an incorrect risk register format utilised.

Since the follow-up review of Risk Management, NWSSP has completed an assurance mapping exercise, to understand the different avenues through which assurance is provided within each service area that inherent operational risks are controlled effectively.

1.2 Scope and Objectives

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

As the assurance mapping process had been recently been completed, the review will determined, on a sample basis, if the sources of assurance were operating as intended.

The 2018/19 audit sought to provide reasonable assurance over the following areas and to:

Risk Management Policy

- ensure the Risk Management Policy is updated and adhered to;

Risk Identification & Management

- ensure that there is an effective process for identifying, managing and controlling risk, with clear lines of responsibility and effective escalation; and

- ensure that sufficient and effective risk management training is given to staff.

Assurance

- ensure that the sources of assurance that have been identified, are operating as intended; and
- determine whether management teams utilise the assurance tables to improve and develop assurance processes.

A sample of assurance sources were selected to ensure that they were operating as intended. Where possible, the same service areas were tested for each of the risk management objectives listed above.

1.3 Associated Risks

The potential risks considered in the review were as follows:

- lack of awareness of the Risk Management Policy and supporting processes;
- risks are not being identified, assessed or included on appropriate risk registers;
- risks are not being actively addressed;
- risks are not being escalated through the organisation as appropriate; and
- the sources of assurance are not operating as intended.

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.

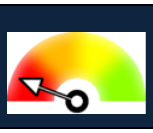
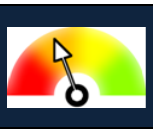
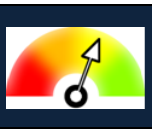
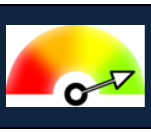
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Risk Management and Assurance is **Substantial** Assurance.

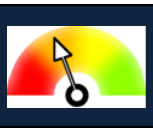
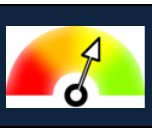
RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are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

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:

Audit Review Area					
1	Risk Management Policy is updated and adhered to.				✓
2	There is an effective process for identifying, managing and controlling risk, with clear lines of responsibility and effective escalation.				✓
3	Sufficient and effective risk management training is given to staff.				✓
4	Ensure that the sources of assurance that have been			✓	

Audit Review Area					
	identified, are operating as intended.				
5	Management teams utilise the assurance tables to improve and develop assurance processes.			✓	

** 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 no issues that are classified as a weakness in the system/control design for Risk Management and Assurance.

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 Risk Management and Assurance.

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**	**1**	**2**

3 SUMMARY OF AUDIT FINDINGS

The following examples of good practice were identified:

- written procedures are in place and outline the risk management and assurance process appropriately; and
- the Corporate Risk Register is updated frequently, with oversight from the Audit Committee.

We identified one **medium** priority finding:

Assurance Mapping – Management and Control

Whilst the assurance maps were updated or confirmation received that they are still current, no work has been undertaken to ensure that the sources of assurance identified are appropriate and are operating effectively, in line with best practice. We identified that 4 out of 26 were not appropriate and 7 out of 26 sources of assurance were not operating effectively.

See Finding 1 at Appendix A

We identified one **low** priority finding:

Risk Management Training

The NWSSP Risk protocol and Velindre Risk Management Policy both state that it is essential that all NWSSP staff receive basic risk management awareness as part of their statutory training. It was found that whilst there is ad-hoc training provided to the senior management team and Board there is no basic risk management awareness training for all staff.

See Finding 2 at Appendix A

MANAGEMENT ACTION PLAN

Finding 1: Assurance Mapping – Management and Control (Operation)	Risk
Whilst the assurance maps were updated or confirmation received that they are still current (during November 2018 Directorates were asked for an update), no work has been undertaken to ensure that the sources of assurance identified are appropriate and are operating effectively, in line with best practice. However, we identified that 4 out of 26 were not appropriate and 7 out of 26 sources of assurance were not operating effectively. **Sources of assurance not appropriate** Business Systems and Information had identified that the Information Governance Steering Group (ICSG) would provide assurance over the risks of disaster recovery and technology replacement. However, the terms of reference for this committee does not include these areas and no evidence was seen that these have been discussed at the ICSG. 2 out of 26 of the sample included Planning Directors meetings as a source of assurance, however it is not apparent that the subjects covered would negate the risks identified. 1 out of 26 of the sample included KPIs as one method of providing assurance against professional or administration errors. However, the KPIs do not record performance within this area. **Sources of assurance not operating effectively** 4 out of 26 of the sample tested included NWSSP Senior Management Team (SMT) meetings as a source of assurance. It was found that the risks identified had not been discussed at the SMT.	Management teams do not utilise the assurance tables to improve and develop assurance processes as they have not reviewed the adequacy and effectiveness of the assurances included.

2 out of 26 of the sample tested included CPD as a source of assurance. Whilst CPD would ensure that staff are suitably trained there was not sufficient detail recorded to confirm that each member of staff had completed sufficient CPD for their role or what the target level of CPD is for each staff member. 1 out of 26 of the sample included a cyber plan as mitigation for disaster recovery, however the plan has not been updated and includes target dates between 31 March and 1 July 2018. **Management teams do not utilise the assurance tables to improve and develop assurance processes** 2 out of 3 (the third did not respond) of the divisions stated that the assurance tables were an annual process and were not used to improve and develop assurances processes.	
Recommendation 1	**Priority level**
Whilst NWSSP has made significant progress on the introduction of assurance maps this is at an early stage and needs to be reviewed and embedded into the organisation. Best practice accepts that an assurance map can be created without an assessment of the quality of the assurance activities. However, the assurance map is not being used to its full extent if an assessment of quality is not performed, as reliance may be placed on activities of variable quality. Once it is understood what assurance activities are taking place, an assessment of their quality in terms of breadth of scope, depth of scope, competence of assurance provider, frequency of review and line of defence providing review. This type of review should be completed by NWSSP to ensure that the sources of assurance are adequate and appropriate. Once the assurance assessment has been performed, recommendations should be made for appropriate resulting actions. While there may be areas where there is no or insufficient assurance compared to the desired or required amount, there may be others where more assurance than needed is currently obtained. Action planning should be carried out with the	**Medium**

owner of the assurance mapping process and the directorates to ensure the outcomes are in line with their needs and expectations. Each action point should be specifically detailed, with a responsible person assigned and a timeline for follow up. This plan should be considered in the maintenance of the map. As actions are completed and gaps and overlaps are dealt with, the map should be updated on a timely basis to reflect those changes. A covering report should outline what the results of the map are, including gaps and overlaps, as well as the recommended action plan. This should be an ongoing process that is utilised to improve and develop assurance processes and understanding rather than an annual review.	
Management Response 1	**Responsible Officer/ Deadline**
The following points are relevant: ○ The degree of assurances are not equal, hence the colour coding, and the report does not specify the level of assurance that is being placed on the exceptions raised; ○ The fact that there was no evidence of a particular issue or risk being discussed in a meeting or committee does not necessarily mean that no assurance can be taken; and ○ The Assurance Maps were introduced to be owned by the Directorate SMTs and reported to the Audit Committee annually. They were not intended to be a particularly dynamic document, but were to be supportive of the overall risk management process. While we accept the need for Assurance Maps to be as accurate as possible, we are uncertain that the recommendation suggested by audit in its entirety justifies the effort that would be involved in undertaking a 100% review. We agree that key priority assurances should be reviewed, and we will therefore produce an action plan, which will include consideration of the audit recommendation. This will be discussed at Corporate SMT, and formally reported to the July Audit Committee.	Head of Finance & Business Development 30 June 2019.

Finding 2: Risk Management Training (Operation)	Risk
Whilst some training was initially provided to the Senior Management Team, then a further session with Assistant Directors in June 2017 and some training either on a one-2-one basis or at Directorates SMTs there is no formal training programme for risk management. The NWSSP Risk protocol and Velindre Risk Management Policy both state that 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: 1. principles of risk management; 2. roles and responsibilities for management of risk within NWSSP; 3. techniques for identification and evaluation of risk; 4. how to report hazards, incidents and near misses; 5. awareness that risk is everyone's business; and 6. policies that cover risk management and assessment. Currently, the Core Skills Training Framework (CSTF) is completed through ESR within the first eight weeks of employment. This comprises 10 modules, none of which relate to risk management. The NWSSP Risk Protocol and Velindre Risk Management Policy are not being followed, in respect of training for risk management and there is no formal programme for such training.	Staff are insufficiently trained in the principles of risk management, and the particular requirements for NWSSP, resulting in an inability to identify and manage corporate and/or directorate risks effectively.

Recommendation 2	Priority level
NWSSP should develop basic risk management awareness training for all staff in line with the NWSSP Risk Protocol and Velindre Risk Management Policy and that these policies are complied with and all staff receive basic risk management awareness training.	**Low**
Management Response 2	**Responsible Officer/ Deadline**
Training on risk management is being provided on a tailored basis. All staff receive mandatory training on the management of specific risks such as information governance, manual handling, health and safety, equality and diversity. In terms of those directly involved in the management of risk, training was provided to all directors and assistant directors as part of two specific workshops in 2017. Since then, it has been provided on a one-to-one basis, or at Directorate SMTs, with recent focus on PCS, Procurement, Employment Services and WIBSS. All Directorate Risk Registers were reviewed by the Head of Finance & Business Development in 2018, and feedback and guidance provided where necessary. However, we will review training needs for all staff going forward and will also review the wording on training in the NWSSP Risk Protocol to make it more reflective of our needs.	Head of Finance & Business Development June 30 2019

Audit Assurance Ratings

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

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

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

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, 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 NWSSP. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

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

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

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

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

Employment Services

Payroll Services

Final Internal Audit Report

2018/19

NHS Wales Shared Services Partnership

Audit and Assurance Services

Private and Confidential

Reasonable Assurance

Previous review rating: Reasonable Assurance

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Review Reference:	NWSSP-1819-12
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Executive sign off:	Paul Thomas, Director of Employment Services
Distribution:	Neil Frow, Managing Director Andrew 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 Matthew Smith, Senior Internal Auditor Sian George, 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 payroll processed by NHS Wales Shared Services Partnership (NWSSP) Employment Services on behalf of Welsh Health Boards and Trusts was completed in line with the 2018/19 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) *(referred to hereon in as the "Swansea Team")*;
- Alder House in St. Asaph, North Wales serving Betsi Cadwaladr University Health Board (BCUHB) and Welsh Ambulance Service NHS Trust (WAST) *(referred to hereon in as the "North Wales Team")*;
- Hafen Derwen in Carmarthen, serving Hywel Dda University Health Board (HDUHB) *(referred to hereon in as the "Carmarthen Team")*; and
- Companies House in Cardiff, with two teams serving Aneurin Bevan University Health Board (ABUHB) and Powys Teaching Health Board (PtHB) (referred to hereon in as the "AB Powys Team"); and Cardiff & Vale University Health Board (CVUHB), Cwm Taf University Health Board (CTUHB), Public Health Wales (PHW), Velindre NHS Trust (VNHST) and the newly established Health Education Improvement Wales (HEIW) (referred to hereon in as the "Cardiff Team").

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 payroll processing 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;
- employees of the newly established Health Education & Improvement Wales (HEIW) have been correctly recorded on the ESR system;
- gross payments to staff are timely and accurate;
- only employees of the organisation are paid; and

- overpayments are recovered;
- the Agenda for Change pay reform is accurately processed within the ESR system and appropriate checking mechanisms exist to ensure this; and
- adequate progress has been made with the implementation of agreed management actions from the previous internal audit (report NWSSP-1718-10 refers).

Computer aided audit techniques (CAATs) were used to analyse data from the ESR system to enable the identification of risk areas and sample selection. CAATs tests include:

- gross pay exceeding a pre-determined amount, and in excess of the top of the pay band;
- unusual monthly pay variations (of more than two standard deviations from the mean); and
- employees paid after leaving.

1.3 Associated Risks

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

i. gross payments are incorrect or not processed in a timely manner;
ii. employees of HEIW are incorrectly recorded on the ESR system resulting in incorrect payments;
iii. overpayments are not recovered resulting in financial loss to the Health Board/Trust;
iv. errors in the processing of the Agenda for Change pay reform resulting in additional administrative burden and reputational damage; and
v. previous internal audit recommendations have not been implemented.

2 CONCLUSION

2.1 Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with 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	Employees of HEIW Correctly Recorded on ESR				✓
3	Timely & Accurate Payments to Staff			✓	
4	Only Employees of the Organisation are Paid			✓	
5	Recovery of Overpayments			✓	

Assurance Summary					
6	Implementation of Previous Internal Audit Recommendations			✓	

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

2.3 Design of System / Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system/control design for Payroll Services. This is identified in Appendix A as *(D).*

2.4 Operation of System / Controls

The findings from the review have highlighted six 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

Issues from the previous audit (report NWSSP-1718-10 refers) have been followed up as part of the current year testing. The following issues are recurring:

- Missing documentation;
- Review of payroll checking reports;
- Review of payroll exception reports;
- Format and sign-off of enrolment, termination and change forms; and
- Accuracy of processing.

One new issue has been identified this year in relation to the management of overpayments, primarily due to a decline in performance within the Cardiff Team.

The following examples of **good practice** were identified:

- The Cardiff and AB Powys teams 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 facilitates senior review.
- Standard parameters for exception reporting have been agreed and implemented on an all-Wales.
- For PtHB the AB Powys Team use an excel workbook to document the calculation of overpayments and completion of key tasks. The template within the workbook guides the payroll officer through each stage of the calculation and recovery process.

We identified six **Medium Priority** findings:

1. Missing Documentation

There was no supporting documentation/explanation provided in support of:

- two of the 63 starters sampled;

- five of the 62 leavers sampled; and
- four of the 62 staff payments sampled. Three of these related to the Cardiff Team.

Consequently, we were unable to verify the authenticity and accuracy of these transactions in the payroll system.

2. 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.

The New Appointment Form (NAF) was developed and piloted by Employment Services in 2015/16. The form is pre-populated via the recruitment process, contains data validation controls and records the NADEX details of the user as evidence of manager and employee sign-off. Each section of the form is locked-down on completion so the data cannot be changed.

Employment Services has more recently developed the Payroll Instruction Form (PIF) which works on the same basis as the NAF but is used for terminations and changes that can't be completed via ESR self-service.

These forms provide additional controls to improve data quality and reduce the risk of fraud, compared to paper-based forms. However, the NAF had been used for 31 of the 65 new starters sampled, whilst the PIF had only been used for one of the 122 leavers/changes sampled.

We have previously reported an issue in the use of these forms. It is rare for a new employee to be allocated a NADEX 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 NADEX.

The NADEX logging provides an audit trail to confirm responsibility for information completed within the form, which is more reliable than a signature. Nevertheless, management should be aware that this control is not operating as intended.

Sample testing of starters, leavers and changes identified:

- three enrolment, 15 termination and 15 change forms which had not been signed by the employee;
- 16 NAF enrolment forms / PIF change forms where the employee declaration had been completed using the manager's NADEX;
- one termination form which had not been signed by the manager;

- one enrolment, three termination and one change forms which had not been signed as input by the Payroll Officer; and
- six enrolment, four termination and three change forms which had not been signed as checked by a Payroll Officer.

3. Timeliness and Accuracy of Processing

Starters

The first pay for the 63 starters sampled was checked for accuracy. One individual had been set-up on ESR on the incorrect band resulting in an overpayment. The error had been promptly identified by the Payroll Team and subsequently recovered.

Leavers

The final pay for 56 of the 62 leavers sampled was checked for accuracy (no documentation was received for six). We identified one overpayment as a result of a delay in processing within the Payroll Team, and a further two overpayments as a result of overtaken annual leave not being recovered. Two of these had been identified and either recovered through payroll or notified to the relevant health body. One had not been identified or recovered. We also identified one underpayment that had not been identified or rectified by the responsible Payroll Team.

Staff Payments

A sample of 62 staff payments was selected using CAATs reports to identify unusual or potentially erroneous payments and verify their accuracy through review of supporting documentation. Evidence was received for 58 of the 62 sampled. We identified two further overpayments that had not been identified or recovered, one of these was due to an error by the Pensions Team.

4. Management of Overpayments

Overpayment registers are maintained for each of the 11 organisations. There is variation in the arrangements for recording and managing overpayments across the five payroll teams – details are provided at Appendix A.

A sample of 36 overpayments was reviewed to assess whether overpayments are accurately calculated and dealt with promptly. The following issues were identified:

- Four of the 36 overpayments reviewed were as a result of payroll errors due to the duplicate processing of an enrolment form, incorrectly setting

up a bank (zero hours) appointment as a substantive post, and failure to process leavers and changes in a timely manner.

- In 11 cases the payroll teams had taken more than 30 working days to notify the employee of the overpayment. Within the Cardiff Team we observed delays of up to 117 days, with further overpayments dating back to May and November 2018 not yet notified to the employee. No delays were identified for the samples reviewed within the AB Powys Team (ABUHB only) and Carmarthen Team.
- In three cases the overpayment figures recorded in the trackers maintained by the Cardiff Team did not agree to those notified to the employee and finance teams for recovery. We confirmed, through recalculation of the overpayment figures, that the trackers had not been updated to reflect the correct amounts.

We also identified two overpayments that had not been recorded on the tracker during our testing of new starters. No action had been taken to recover one overpayment, whilst the other had been recovered through subsequent pay runs.

5. Payroll Checking Processes

There are two elements to the payroll checking process:

1. Checking the accuracy of data input into ESR
2. Checking that all starters, leavers and changes processed on ESR are supported by appropriate documentation (i.e. they are legitimate)

The approach to completing these checks varies across Wales – details are provided at Appendix A. Notably, the Swansea, Carmarthen and North Wales Teams do not produce and check reports of changes to payroll data.

Checking in the AB Powys and Cardiff teams is undertaken electronically using an extract from the ESR permanent amendments report (which includes starters, leavers and changes). Macros are used to automatically remove items that aren't subject to checking procedures from the report. There is a risk of transactions that require checking being removed from the report, either erroneously or to conceal a fraud.

The checking reports for a total sample of 31 months were selected for review. The Carmarthen Team advised that reports of starters and leavers are produced and checked for completeness. However, the checks are not evidenced. Testing confirmed that checking reports had been produced for the months sampled, however instances were identified where a small number of entries had not been evidenced as reviewed.

6. Exception Reports

The Payroll Exception report compares current period pay to the previous period. The previous audit reported variation across the Payroll Teams in the report parameters and requirement for senior review. Some variation remains in the way in which the reports are produced and checked. However, all-Wales exception reporting parameters were agreed and implemented in July 2018.

Testing confirmed that exception reports had been produced for the months sampled, however instances were identified where a small number of entries had not been evidenced as reviewed – details are provided at Appendix A.

Issues Outside of the Control of NWSSP

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 (NAF) & Payroll Instruction Form (PIF)

   Full implementation of the NAF and PIF forms needs to be progressed with the health bodies.

   These forms provide additional controls to improve data quality and reduce the risk of fraud, compared to paper-based forms. The NAF had been used for 31 of the 65 new starters sampled, whilst the PIF had only been used for one of the 122 leavers/changes sampled.

2. Timeliness of Submission of Enrolment and Termination Forms

   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. 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/explanations provided in support of: • two of the 63 starters sampled; • five of the 62 leavers sampled; and • four of the 62 staff payments sampled. Three of these related to the Cardiff Team. Consequently, we were unable to verify the authenticity and accuracy of these transactions in the payroll system.	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**
Payroll Managers will deliver a Payroll Audit de-brief to all Teams emphasising the requirements to ensure correct storage of documentation for ease or retrieval. Employment Services IMTP has identified the requirement to establish technology to deliver document management to include electronic storage and retrieval. The pilot established in Matrix House in 2018 has been successful, implementation timeliness is being developed to extend this functionality to Hafan Derwen Offices and Companies House.	Janet Carsley April 2019 Beverley Cokeley September 19 Janet Carsley / Christine Richards December 2019

Finding 2: Starters, Leavers & Changes – Format & Sign Off of Forms *(O)*	Risk
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. The 'New Appointment Form' (NAF) and Payroll Instruction Form (PIF) (for changes to payroll data) are still not fully implemented across all organisations however usage has increased since the previous audit. We have previously reported an issue in the use of these forms. It is rare for a new employee to be allocated a NADEX 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 NADEX. The NADEX logging provides an audit trail to confirm responsibility for information completed within the form, which is more reliable than a signature. Nevertheless, management should be aware that this control is not operating as intended. Sample testing of starters, leavers and changes identified: • three enrolment, 15 termination and 15 change forms which had not been signed by the employee; • 16 NAF enrolment forms / PIF change forms where the employee declaration had been completed using the manager's NADEX; • one termination form which had not been signed by the manager; • one enrolment, three termination and one change forms which had not been signed as input by the Payroll Officer; and	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation

• six enrolment, four termination and three change forms which had not been signed as checked by a Payroll Officer.	
Recommendation 2	**Priority level**
Continued effort should be made to achieve standardisation through the implementation of the NAF and PIF forms across health bodies. Forms (non PIF / NAF) which have not been appropriately signed by employee and/or manager as required by the form should be returned to the customer organisation for completion. Payroll Officers must evidence ESR input and checking.	**Medium**
Management Response 2	**Responsible Officer/ Deadline**
Employment Services has continued to work with Health Boards to roll-out the NAF and PIF (ABMUHB, ABUHB, CTUB). Implementation timescales to be agreed with HB representatives in Q1 with the view of all HB's signing-up to utilising the e-forms by Q2. Payroll Officers will be reminded of best practice to sign and date completion of ESR input and checking. This evidence will be in line with the specific payroll processes and will consist of manual sign-off or electronic sign-off as appropriate. Not all changes require an employee signature e.g. cost centre or changes for business purposes. Where instructions are received and there is no employee signature the instruction will be processed where there is a risk to the organisation of an over or under payment where a manager signature is provided e.g. Termination of employment. Communication to be issued to all Health Boards to remind managers of the requirement that all employment documentation must include an employees' signature and date of signing in addition to the managers authorisation and date of signing.	Christine Richards September 2019 Janet Carsley April 2019 Janet Carsley April 2019

Finding 3: Timeliness and Accuracy of Processing *(O)*	**Risk**
Starters The first gross basic pay for 63 of the 65 starters sampled (no documentation was received for two) was checked for accuracy. One individual had been set-up on ESR on the incorrect band resulting in an overpayment. The error had been promptly identified by the Payroll Team and subsequently recovered. Leavers The final gross basic pay for 56 of the 62 leavers sampled (no documentation was received for six) was checked for accuracy. We identified one overpayment as a result of a delay in processing within the Payroll Team, and a further two overpayments as a result of overtaken annual leave not being recovered. Two of these had been identified and either recovered through payroll or notified to the relevant health body. One had not been identified or recovered. We also identified one underpayment that had not been identified or rectified by the responsible Payroll Team. Staff Payments A sample of 62 staff payments was selected using CAATs reports to identify unusual or potentially erroneous payments and verify their accuracy through review of supporting documentation. Evidence was received for 58 of the 62 sampled. We identified two further overpayments that had not been identified or recovered, one of these was due to an error by the Pensions Team.	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation
Recommendation 3	**Priority level**
The identified discrepancies should be investigated and any under/overpayments addressed.	**Medium**

Management Response 3	Responsible Officer/ Deadline
Some Under/overpayments identified within this audit have been addressed, the remaining cases will be finalised by 30 April. Payment verification process to be reviewed for leavers last salary. Deputy Payroll Managers will make process change recommendations to Payroll Managers and implementation timescales on all Wales basis. Following this audit the process for managing pension refunds at Companies House has been amended with a requirement for a second Pension Officer to verify the pension refund calculations for accuracy prior to payment being received. This change in process will be presented at the next Deputy Payroll Managers meeting on the 29 April 2019 to roll-out across all regions.	Christine Richards April 2019 Brian Mcharg May 2019 Christine Richards May 2019

Finding 4: Management of Overpayments *(D+O)*	Risk
There is variation in the arrangements for recording and managing overpayments across the five payroll teams. For example, the Cardiff and North Wales Teams operate predominantly paper-based systems, albeit in some cases the manual records are subsequently scanned and stored electronically. In contrast, for PtHB the AB Powys Team use an excel workbook to document all calculations and completion of key tasks. The template within the workbook guides the payroll officer through each stage of the overpayment calculation and recovery process. The North Wales Team prepares the accompanying letter for the debtors invoice to be sent out by WAST, whereas the Swansea and Cardiff Teams submit a list of income due to their respective organisations so that an invoice can be raised. A sample of 36 overpayments was reviewed to assess whether overpayments are accurately calculated and dealt with promptly. The following issues were identified: • Four of the 36 overpayments reviewed were as a result of payroll errors due to the duplicate processing of an enrolment form, incorrectly setting up a bank (zero hours) appointment as a substantive post, and failure to process leavers and changes in a timely manner. • In 11 cases the payroll teams had taken more than 30 working days to notify the employee of the overpayment. Within the Cardiff Team we observed delays of up to 117 days, with a further two overpayments dating back to May and November 2018 not yet notified to the employee. No delays were identified for the samples reviewed within the AB Powys Team (ABUHB only) and Carmarthen Team. • In three cases the overpayment figures recorded in the trackers maintained by the Cardiff Team did not agree to those notified to the employee and finance teams for recovery. We confirmed, through recalculation of the overpayment figures, that the trackers had not been updated to reflect the correct amounts.	Overpayments are not recovered, resulting in financial loss to the customer organisation.

We also identified, through our testing of new starters, two overpayments that had not been recorded on the tracker. No action had been taken to recover one overpayment, whilst the other had been recovered through subsequent pay runs.	
Recommendation 4	**Priority level**
An all-Wales approach to the management of overpayments should be agreed and adopted across all Payroll Teams. Overpayments must be promptly notified to the employee, in accordance with the requirements of the relevant health body (where applicable), in order to increase the likelihood of recovery.	**Medium**
Management Response 4	**Responsible Officer/ Deadline**
Deputy Payroll Managers undertake a review overpayment processes within the Payroll Teams around Wales with the view to develop a once for Wales approach to the management of overpayments. This will maximise use of technology and interface with Health Board Finance Teams to avoid duplication (Quarter 4)	Brian Mcharg May 2019

Finding 5: Payroll Checking Processes *(O)*	Risk
There are two elements to the payroll checking process: 1. Checking the accuracy of data input into ESR 2. Checking that all starters, leavers and changes processed on ESR are supported by appropriate documentation (i.e. they are legitimate) The approach to completing these checks varies across Wales. Accuracy checking for starters, leavers and changes is undertaken by all teams to ensure that data entry is correct. Completeness checking of starters and leavers is undertaken by all teams. However, the Swansea, North Wales and Carmarthen teams do not produce and check reports of changes to payroll data. Checking in the AB Powys and Cardiff teams is undertaken electronically using macro-filtered report of permanent amendments (which includes starters, leavers and changes) from ESR. Using a modified report for checking presents the risk that transactions could be removed from the report, either erroneously or to conceal a fraud, and therefore not checked. The Swansea, North Wales and Carmarthen teams annotate printed reports. Some teams require an overall sign-off to once all entries on the reports have been checked, others don't. The timing of the accuracy checks also varies – in some teams this is done shortly after input on ESR, whereas in others it is combined with the completeness check at the end of the payroll period. The checking reports for a total sample of 31 months were selected for review. The Carmarthen Team advised that reports of starters and leavers are produced and checked for completeness, however the checks are not evidenced. Testing confirmed that checking reports had been produced for the months sampled, however instances were identified where not all entries had been evidenced as reviewed.	Inappropriate or erroneous payments, resulting in financial loss to the customer organisation

Recommendation 5	Priority level
An all-Wales approach to the payroll checking process should be agreed and adopted across all Payroll Teams. Management should note the risk associated with the macro-filtered reports used by the Cardiff and AB Powys teams for payroll checking and exception reporting. The source documents produced from ESR should be retained, and consideration given to the feasibility and benefit of checking the completeness of the macro-filtered reports against the source documents, to ensure that all transactions that require checking are included. Report of changes to payroll data should be produced and checked by the North Wales, Swansea and Carmarthen payroll teams.	**Medium**
Management Response 5	**Responsible Officer/ Deadline**
Working with internal audit to establish and agree permanent entry values to be checked as priority during pay run process. Revise MACRO process based on agreed data values with internal audit and implement standard checking process across regions.	Christine Richards September 2019

Finding 6: Exception Reports *(O)*	Risk
The Payroll Exception report compares current period pay to the previous period. The previous audit reported variation across the Payroll Teams in the report parameters and requirement for senior	Inappropriate or erroneous payments, resulting in

review. Some variation remains in the way in which the reports are produced and checked. However, all-Wales exception reporting parameters were agreed and implemented in July 2018. Testing confirmed that exception reports had been produced for the 32 months sampled, however eight instances were identified across the AB Powys, North Wales, Carmarthen and Swansea teams where not all entries on the report had been evidenced as reviewed.	financial loss to the customer organisation
Recommendation 6	**Priority level**
Ensure that exception reports are evidenced as reviewed.	**Medium**
Management Response 6	**Responsible Officer/ Deadline**
Payroll Officers and Team Leaders have been reminded to comply with the exception reporting process to ensure that evidence reflects all records have been reviewed, signed-off by Payroll Officer and Supervisor has reviewed that all exception reports have been completed.	Janet Carsley April 2019

Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

Confidentiality

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Audit

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

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

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

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

NHS Wales Shared Services Partnership

Internal Audit Operational Plan 2019/20

March 2019

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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 2019 to March 2020, 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 2019/20 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 Workforce & Organisational Development;
- Director of Employment Services;
- Director of Primary Care 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 395 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 2019/20.

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

March 2019

2019/20 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					
IR35	Corporate governance, risk and regulatory compliance	To assess whether controls are in place and operating effectively to ensure compliance with IR35 tax legislation.	10	Director of Finance and Corporate Services	Q1
Health and Safety	Corporate governance, risk and regulatory compliance	To review the effectiveness of arrangements in place to ensure that NWSSP complies with Health and Safety legislation.	15	Director of Workforce & OD	Q3

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
Procurement Directorate Review	CRRA2, M2 Operational service and functional management	To test compliance with a range of policies and procedures and to provide assurance over the reporting of procurement savings.	20	Director (Procurement Services)	Q2
Time recording	Workforce management	To review time recording arrangements within NWSSP to ensure compliance with workforce policies.	15	Director of Workforce and Organisational Development	Q2
Performance reporting	CRRA5 Strategic planning and performance	To provide assurance that performance reporting to the statutory bodies of NHS Wales is accurate and derived from robust systems.	20	Director of Finance and Corporate Services	Q2

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
Stores	CRRA2, A3 Operational service and functional management	To test the operation of controls within stores operating at IP5, Newport.	25	Director (Procurement Services)	Q1
Staff expenses	Operational service and functional management	To test compliance with the staff expenses policy.	15	Director (Employment Services)	Q3
Budgetary Control and Financial Reporting	CRRA8 Financial governance and management	To review budgetary control and financial reporting processes.	15	Director of Finance and Corporate Services	Q4
Salary Sacrifice	Financial governance and management	To review the arrangements in place for the administration of salary sacrifice schemes.	10	Director of Finance and Corporate Services	Q4

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
Strategic Planning	CRRA8 Strategic planning and performance	To review the strategic planning arrangements in place for the production of the Integrated Medium Term Plan, including engagement with stakeholders.	15	Director of Finance and Corporate Services	Q1
Post Payment Verification (PPV)	Financial governance and management	To review the effectiveness of PPV arrangements in respect of primary care contractors.	15	Director of Primary Care Services	Q4
IT Systems	CRRA11 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

Planned output	Corporate Risk Register (CRR) / Audit Area	Outline Scope	Indicative Audit days	Executive Lead	Outline Timing
ADVISORY REVIEWS AND RISK AREAS TO BE MONITORED					
Contact Centres	Operational service and functional management	Advisory review to establish areas of best practice in contact centres and areas where improvement is required.	20	Director of Workforce & OD	Q2
Primary Care Payments System	CRRA1 Financial governance and management	Support to the development and implementation of a solution to replace the Exeter system.		Director of Primary Care Services	Ongoing
Service Change	CRRA6, A7, M4	Monitoring of significant developments for NWSSP.		All	Ongoing
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

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MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	6.1
PREPARED BY	Roxann Davies, Compliance Officer
PRESENTED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Audit Committee Forward Plan 2019-20

PURPOSE

To provide a summary of items expected to be presented at forthcoming Audit Committee meetings, scheduled for 2019-20.

Month	Standing Items	Audit Reports	Governance	Annual Items
Q2 2019/20 **9 July 2019** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** Wales Audit Office Nationally Hosted IT Systems Report Wales Audit Office Management Letter **Internal Audit** As outlined in the Internal Audit Operational Plan Quality Assurance & Improvement Programme	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Counter Fraud Self-Review Submission Tool Counter Fraud Work Plan Counter Fraud Annual Report Results of Audit Committee Effectiveness Survey Review of Audit Committee Terms of Reference Audit Committee Annual Report Health and Care Standards Self-Assessment NWSSP Annual Review Including Sustainable Development Statement Caldicott Principles Into Practice Annual Report
Q3 2019/20 **22 October 2019** *Conference Room, Bridgend Stores, Princess of Wales Hospital, Coity Rd, Bridgend CF31 1UZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** As outlined in the Internal Audit Operational Plan	Governance Matters to include Annual Review of Stores Write-Off Figures Tracking of Audit Recommendations to include Annual Review of Audit Recommendations Not Yet Implemented Corporate Risk Register	Minutes & Matters Arising Health & Care Standards Action Plan Review of Risk Management Protocol, Assurance Mapping, Appetite Statement and Board Assurance Framework

Q4 2019/20 **21 January 2020** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**External Audit** Wales Audit Office Proposed Audit Work **Internal Audit** As outlined in the Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Pre-meet between Audit Committee Chair, Independent Members, Internal and External Auditors and Local Counter Fraud Review of Standing Orders for the Shared Services Partnership Committee Draft Integrated Medium Term Plan (IMTP) Summary & Overview
Q1 2020/21 **April 2020** *Boardroom* *NWSSP HQ, Unit 4/5* *Charnwood Court, Heol* *Billingsley, Parc Nantgarw,* *Cardiff, CF15 7QZ*	Minutes & Matters Arising External Audit Position Statement Internal Audit Progress Report Counter Fraud Position Statement	**Internal Audit** As outlined in the Internal Audit Operational Plan Head of Internal Audit Opinion Review of Internal Audit Operational Plan	Governance Matters Tracking of Audit Recommendations Corporate Risk Register	Audit Committee Effectiveness Survey Annual Governance Statement Counter Fraud Self-Review Submission Tool Counter Fraud Work Plan Counter Fraud Annual Report Counter Fraud Policy Review Integrated Medium Term Plan (IMTP) Review of Raising Concerns (Whistleblowing) Policy Head of Internal Audit Opinion and Annual Report

MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	6.2
PREPARED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	Velindre University NHS Trust Procedure for NHS Staff to Raise Concerns

PURPOSE

To provide the Committee with a copy of the Velindre University NHS Trust Procedure for NHS Staff to Raise Concerns, **for information only**.

At SMT on 28 February 2019, it was agreed that in accordance with the Welsh Government's Code of Practice on Ethical Employment in Supply Chains, we would incorporate our Statement on Raising Concerns, which can be accessed at http://nww.sharedservicespartnership.wales.nhs.uk/raising-concerns.

Velindre NHS Trust
Procedure for NHS Staff to Raise Concerns

Document Author: NHS Wales Partnership Forum

Approved By: NHS Wales Partnership Forum
January 2018

Velindre NHS Trust Workforce and OD Committee
25th April 2018

Introduction

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

The safety and wellbeing of patients and service users are seen as the responsibility of everyone involved in the provision of health and social care services. The Velindre NHS Trust and senior management are committed to providing an environment which facilitates open dialogue and communication so as to ensure that any concerns which staff may have are raised as soon as possible.

This procedure refers in the main to ‘raising concerns’ rather than ‘whistleblowing’ because the latter has come to denote a sudden, drastic or last resort act which can hold negative connotations.

Velindre NHS Trust is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage

It is, however, acknowledged that such processes take time to develop and embed into the organisation and until such time as such a culture exists comprehensively across Velindre NHS Trust that a clear process needs to be in place to guide individuals who wish to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. This procedure sets out Velindre NHS Trust's commitment to support individuals who raise concerns as well as setting out the processes for individuals to raise such concerns and to provide assurance on how such concerns will be listened to, investigated and acted upon as necessary.

'Whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation raises concerns to people who have the power and presumed willingness to take corrective action. The types of situation where this will be appropriate are outlined in Appendix 1. "Protected disclosure" is the legal term for whistleblowing and is referenced in the context of describing the protection is afforded to the person raising the concern in the interest of the public (see Appendix 2).

The development of this procedure is an ongoing process and is a part of the wider work across NHS Wales to ensure that an open culture exists to provide the highest standards of care and experience across all services. This procedure does not form part of an employee's contract of employment and may need to be amended from time to time.

1. A Commitment to Support Those Who Raise Concerns

1.1 Velindre NHS Trust actively encourages feedback and has a transparent and open approach to listening to and responding to all concerns.

1.2 Velindre NHS Trust aims to ensure that individuals:

- Are fully supported to report concerns and safety issues;
- are treated fairly, with empathy and consideration when raising concerns; and
- have their concerns listened to and addressed, when they have been involved in an incident or have raised a concern.

1.3 Velindre NHS Trust aims to develop and maintain a culture across all parts of the organisation that provides an environment where people feel able to raise concerns and are treated with respect and dignity when raising concerns.

1.4 Safety is at the heart of all care and must be underpinned by a culture which is open and transparent. This leads to increased reporting, learning and sharing of incidents and development of best practice. Velindre NHS Trust recognises that this is the responsibility of everyone involved in the provision of health and social care services. Velindre NHS Trust is committed to working towards ensuring that all individuals are treated in a service which is open to feedback and encourages as well as supports its staff to raise concerns.

1.5 Velindre NHS Trust will ensure that individuals always feel free to raise concerns through local processes and are supported to do so directly with Velindre NHS Trust, their professional regulatory body, professional association, regulator or union.

1.6 Velindre NHS Trust is committed to:-

- Working in partnership with other organisations to develop a positive culture by promoting openness, transparency and fairness;
- Fostering a culture of openness which supports and encourages staff to raise concerns;
- Sharing expertise to create effective ways of breaking down barriers to reporting incidents and concerns early on;
- Exchanging information, where it is appropriate and lawful to do so, in the interests of patient and public safety; and
- Signposting individuals to support and guidance to ensure that they are fully aware of and understand their protected rights under the Public Interest Disclosure Act 1998.

1.7 Velindre NHS Trust will monitor the use of this procedure and report to the Board or a sub-committee, as appropriate.

2. About this Procedure

2.1 The aims of this procedure are:
(a) To encourage staff to discuss concerns and safety issues as soon as possible, in the knowledge that their concerns will be taken seriously and acted upon as appropriate,
(b) To encourage staff to report more serious concerns and suspected wrongdoing as soon as possible, in the knowledge that their concerns will be taken seriously and investigated as appropriate, and where requested that their confidentiality will be respected.
(b) To provide staff with guidance as to how to raise those concerns.

(c) To assure staff that they should be able to raise genuine concerns without fear of reprisals, even if they turn out to be mistaken.

2.2 This procedure applies to all employees, officers, consultants, contractors, students, volunteers, interns, casual workers and agency workers.

3. Raising a Concern

3.1 All healthcare settings and workplaces should encourage ongoing open dialogue and feedback on matters relating to provision of care/service delivery through supervision, team or departmental meetings, staff forums. These ongoing mechanisms are the place where Velindre NHS Trust will actively seek suggestions for improvement and regularly review the safe and effective delivery of services and ways of working.

3.2 All managers will ensure that there is a shared responsibility to focus positively on the quality of service/care, continuous improvement and/or problem solving.

3.3 If concerns are held by an individual or individuals Velindre NHS Trust will ensure that such concerns are addressed and responded to with the outcome being verbally communicated, as a minimum, to the individual or individuals raising the concern.

3.4 More Serious Concerns

Confidentiality

As noted in section 1.3 of this procedure Velindre NHS Trust aims to develop and maintain a culture across all parts of the organisation that provides for an environment where people feel able to raise concerns". It is therefore hoped that all staff will feel able to voice concerns openly under this procedure. However, if an individual wants to raise a concern confidentially this will be respected. It is sometimes difficult however, to investigate a concern without knowing the individual's identity. In such circumstances if it is considered absolutely necessary to share the identity of the person raising the concern this will be discussed with them prior to any disclosure being made, and their permission sought.

Stage 1 – Internal (Informal)

If an individual has a concern about any issue involving malpractice/wrongdoing they are encouraged to raise it first either verbally or in writing with their line manager or the manager responsible for that area of work, unless it relates to fraud or corruption (see paragraph overleaf relating to this issue). They may also wish to involve their Trade Union/Staff Representative. Medical staff should report the issue to their Lead clinician.

It is important to remember that raising a concern is different from raising a personal complaint or grievance and in such circumstances the Grievance or Dignity at Work Policies may be appropriate (see Appendix 1). If the concern is around the abuse of children or adults with vulnerabilities then the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013 should be followed and initiated immediately.

To ensure effective operation of the Procedure for Raising Concerns, Velindre NHS Trust must provide an alternative route for issues to be raised where going through the line manager is not appropriate e.g.

- the member of staff feels there is an immediate issue of significant risk to safety which would not be addressed by line management
- the concern raised relates to the conduct or practice of one or more individuals in the line management accountability structures who would normally consider the concern
- the member of staff has strong experiential evidence that the line manager(s) would not address the concern
- the member of staff feels that similar concerns raised in the past had been ignored
- the member of staff feels that the raising of concern would place him/her at risk of harassment or victimisation from colleagues or managers

Accordingly, Velindre NHS Trust has set up the following arrangements. In circumstances where a member of staff feels that it is not appropriate to raise the issue with their line manager, they may instead raise the issue with any of the following Trust employees:

- Director of Corporate Governance – 02920 316972
- Head of Corporate Governance – 02920 316956
- Senior Workforce & OD Business Partner (VCC) - 02920 615888 Ext 6635
- Senior Workforce and OD Business Partner (WBS)- 01443 622000 Ext 2391
- VCC Divisional Director – 02920 615888 Ext 6122
- WBS Divisional Director – 01443 622000 Ext 2018

Any concerns regarding potential fraud or corruption should be raised initially with the Local Counter Fraud Specialist (LCFS) on 02920 742725. Alternatively, reports can be made via the Fraud and Corruption Reporting Line or Website. Full contact details are available via the Counter Fraud pages of the following intranet site. http://www.primarycareservices.wales.nhs.uk/lcfs

These concerns will then be managed in line with the Velindre NHS Trust's Counter Fraud Policy and Response Plan.

The individual will be entitled to a verbal response, as a minimum, and where appropriate detail needs to be conveyed a written response to their concern may be appropriate, provided that they have not wished to remain anonymous. The responsibility for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised as described in the previous paragraph.

Stage 2 – Internal (Formal)

If, having followed the approach outlined in stage 1, the individual's concerns remain, or they feel that the matter is so serious that they cannot discuss it with any of the above then they can move on to use the more formal steps as follows.

The individual should make their concerns known to an appropriate senior manager in writing. They may also wish to involve their Trade Union/Staff Representative.

When a concern is raised it is helpful to know how the individual considers the matter might be best resolved.

The senior manager will meet with the individual raising the concern within seven working days. The outcome of the meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Once an individual has told someone of their concern, whether verbally or in writing, Velindre NHS Trust will consider the information to assess what action should be taken. This may involve an informal review or a more formal investigation.

The individual will be told who is handling the matter, how they can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom they have reported their concern will appoint an Investigating Officer. If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible (usually within 28 days) in light of the matters to be investigated. At their request, the individual will be written to summarising their concern, and setting out how it will be handled along with a timeframe.

Velindre NHS Trust will aim to keep the individual informed of the progress of the investigation and its likely timescale. However, sometimes the need for confidentiality may prevent specific details of the investigation or any disciplinary action from being disclosed. All information about the investigation should be treated as confidential.

If the matter falls more appropriately within the remit of other W&OD policies, the employees should be advised that they should pursue the matter through the relevant policy and that the Procedure for NHS Staff to Raise Concerns will not be followed (see appendix 1).

Velindre NHS Trust does not expect any individual reporting a matter under this procedure to have absolute proof of any misconduct or malpractice that they report, but they will need to be able to show reasons for their concerns, so any evidence that they have such as letters, memos, diary entries etc. will be useful. These will need to be redacted if they contain any patient identifiable information.

If the alleged disclosure is deemed to be serious enough, then Velindre NHS Trust may follow the process laid down in the Disciplinary policy and procedure, where the issues raised could relate to individual misconduct, when considering the most appropriate line of action.

The aim of this procedure is to provide an effective process for serious concerns to be raised. If it is concluded that an individual has deliberately made false allegations maliciously or for personal gain, then Velindre NHS Trust will instigate an investigation into the matter in accordance with the Disciplinary policy and procedure.

Subject to any legal constraints, Velindre NHS Trust will inform the individual(s) who raised the concern, of an outline of any actions taken. However, it may not always be possible to divulge the precise action, e.g. where this would infringe a duty of confidentiality of Velindre NHS Trust towards another party.

Stage 3 – Senior Manager

If an individual is either dissatisfied with a decision to only undertake an informal review, or is dissatisfied with the outcome of stage 2 through the mechanisms outlined previously, they should raise their concerns in writing with the Chief Executive, and/or an appropriate Executive Director. If the concern relates to the Chief Executive or Executive Director, concerns should be raised with the Chair. Exceptionally, an individual should proceed directly to this stage as a "Last Resort Escalation" in the unlikely event that having made every attempt to raise a concern through the mechanisms outlined previously there has been little or no attempt to address the matter.

The Chief Executive or Chair (or a nominated representative not previously involved) will meet the individual within 28 working days. Again, the outcome of this meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Stage 4 - Serious or Continued Concerns and Regulatory/Wider Disclosure

The aim of this procedure is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing/inappropriate practices in the workplace. In most cases individuals should not find it necessary to alert external parties.

However, the law recognises that in some circumstances it may be appropriate to report concerns to an external body. It will very rarely if ever be appropriate to alert the media. It is strongly encouraged that an individual seeks advice before reporting a concern to external parties. The independent charity, Public Concern at Work, operates a confidential helpline to support individuals in determining the appropriate course of action. They also have a list of prescribed regulators for reporting certain types of concern. Public Concern at Work's details are included later in this procedure.

All staff have an individual responsibility to safeguard people from harm or suspected harm, by making known their concerns about abuse. Children and adults with vulnerabilities can be subjected to abuse by those who work with them in any setting; all allegations of abuse must therefore be taken seriously and treated in accordance with the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013. These procedures may dictate that any investigation should be handled by a partner organisation such as Social Services or the Policy which would take precedence over internal procedures, therefore advice from a safeguarding professional should be sought at the earliest opportunity.

If an individual has followed the above procedure to deal with the matter and still has concerns or if they feel that the matter is so serious that they cannot discuss it in any of the ways outlined previously, then in exceptional circumstances they may wish to contact:-

- The National Fraud and Corruption reporting Line on 0800 028 40 60, or alternatively via the on line reporting facility at www.reportnhsfraud.nhs.uk. (if your concern is about financial malpractice)

- Welsh Government

Velindre NHS Trust hopes that this procedure will provide individuals with the reassurances required to raise any matters of concern internally or exceptionally with the organisations referred to above. However, there may be circumstances where individuals are required under their professional regulations to report matters to external bodies such as the appropriate regulatory bodies, including:-

- General Medical Council (www.gmc-uk.org)
- Nursing and Midwifery Council (www.nmc-uk.org)
- Health and Care Professions Council (www.hpc-uk.org)
- General Pharmaceutical Council (www.pharmacyregulation.org)

Velindre NHS Trust would rather the matter is raised with the appropriate regulatory body than not at all. Other regulatory bodies may include;

- Health and Safety Executive
- Health Inspectorate Wales
- Wales Audit Office
- Police

(This list is not exhaustive).

If an individual needs further advice they can contact the charity Public Concern at Work on 020 7404 6609 or by email at helpline@pcaw.co.uk. Public Concern at Work can advise individuals how to go about raising a matter of concern in the appropriate way (www.pcaw.co.uk/law/lawregulators.html). Alternatively, the Department of Health also provide a service for NHS and Social Care employees in England and Wales on 08000 724 725 or by email at enquiries@wbhelpline.org.uk.

Appendix 1

What is whistleblowing?

Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public).

This may include:

- Systematic failings that result in patient safety being endangered, e.g. poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff;
- Poor quality care;
- Acts of violence, discrimination or bullying towards patients or staff;
- Malpractice in the treatment of, or ill treatment or neglect of, a patient or client;
- Disregard of agreed care plans or treatment regimes;
- Inappropriate care of, or behaviour towards, a child /vulnerable adult;
- Welfare of subjects in clinical trials;
- Staff being mistreated by patients;
- Inappropriate relationships between patients and staff;
- Illness that may affect a member of the workforce's ability to practise in a safe manner;
- Substance and alcohol misuse affecting ability to work;
- Negligence;
- Where a criminal offence has been committed / is being committed / or is likely to be committed (or you suspect this to be the case);
- Where fraud or theft is suspected;
- Disregard of legislation, particularly in relation to Health and Safety at Work;
- A breach of financial procedures;
- Undue favour over a contractual matter or to a job applicant has been shown;
- Information on any of the above has been / is being / or is likely to be concealed

This procedure should not be used for complaints relating to your own personal circumstances, such as the way you have been treated at work. In these cases, the Grievance policy or the Dignity at Work policy should be used as appropriate. Please see illustration below:-

Where do I go to raise a concern…?

Informal Mechanisms

If possible, all concerns should be **raised with your line manager** in the first instance. Raising concerns should be a **positive part of our day to day roles** and a way of **improving services** for our patients, carers and each other.

Mediation is used as a first resort in dealing with **Dignity at Work** issues and can be described as an informal, voluntary process, in which a **neutral person (trained mediator)** helps individuals in dispute explore & understand their differences so they can **find their own solution**.

Incident reporting mechanisms should be used for any unintended or unexpected incident which could or did lead to harm for a patient receiving NHS Care. Where available use the new **electronic reporting system** e-Datix (via the intranet or your desktop). You can also talk to a member of the **Patient Safety** Team on 02920 196161 or email HandlingConcernsVelindre@wales.nhs.uk

It is important to develop an **action plan** for all concerns, including those raised

Formal Mechanisms

Raising Concerns Procedure: Use this to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. If you can't talk to your manager contact Human Resources, the Board Secretary or your professional lead.

Dignity at Work Process: Use this if you believe you have not been treated with Dignity and Respect in the workplace. This process emphasises the importance of using informal mechanisms including mediation.

Grievance Policy: Use this if you feel that you need to formally raise and resolve a personal issue, concern or complaint, including issues regarding some aspect of your employment

Counter Fraud: Their role is to investigate all aspects of fraud and corruption in the NHS. If you would like to report any suspicions the local counter fraud team can be contacted on 02920 742725

Putting Things Right: Use these arrangements if you have a concern to raise as a **member of the public**, rather than as a member of staff. Contact the **Concerns Team on 02920 196161 or email Handlingconcernsvelindre@wales.nhs.uk or by post via Velindre NHS Trust, 2 Charnwood Court, Cardiff CF15 7QZ**

Appendix 2

Protection of those making disclosures

It is understandable that individuals raising concerns are sometimes worried about possible repercussions. Velindre NHS Trust aims to encourage openness and will support staff who raise genuine concerns under this procedure, even if they turn out to be mistaken. In addition, there are statutory provisions for individuals who make what are termed “protected disclosures”.

In law individuals must not suffer any detrimental treatment as a result of raising a concern. Detrimental treatment includes dismissal, disciplinary action, threats or other unfavourable treatment connected with raising a concern. If an individual believes that they have suffered any such treatment, they should inform a member of the Workforce and Organisational Development department, immediately. If the matter is not remedied they should raise it formally using the Grievance Procedure.

Those who raise concerns must not be threatened or retaliated against in any way. If an individual is involved in such conduct they may be subject to disciplinary action. [In some cases, the individual raising a concern could have a right to sue for compensation in an employment tribunal.]

Velindre NHS Trust aims to protect and support staff to raise legitimate concerns internally within the organisation where they honestly and reasonably believe that malpractice/wrongdoing has occurred or will be likely to occur. Staff who make what is referred to as a “protected disclosure”, i.e. a disclosure concerning an alleged criminal offence or other wrongdoing, have the legal right not to be dismissed, selected for redundancy or subjected to any other detriment (demotion, forfeiture of opportunities for promotion or training, etc.) for having done so and the protections are set out in law in the Public Interest Disclosure Act 1998.

If an individual is raising a matter of serious or continued concern the same protection applies as for internal disclosure. This is intended to promote accountability in public life and there is no requirement that such concerns should first be raised with the NHS organisation although it is preferred that Velindre NHS Trust should be given an opportunity to resolve the matter first.

If an individual is raising a matter with a regulatory body defined within the Public Interest Disclosure Act 1998 they will be protected where they honestly and reasonably believe that the malpractice/wrongdoing has occurred or is likely to occur

and in addition they honestly and reasonably believe that the information and any allegation contained in it are substantially true. The Public Interest Disclosure (Prescribed Persons) Order 2014 amends the list of prescribed persons and came into force on 1 October 2014 and applies to disclosures made on or after this date. The new list of prescribed persons in respect of matters relating to healthcare services is set out below:-

Relevant matters	**Prescribed person**
Matters relating to the registration and fitness to practice of a member of a profession regulated by the relevant council and any other activities in relation to which the relevant council has functions.	The Nursing and Midwifery Council, Health and Care Professions Council, General Medical Council, General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council.

For healthcare services in Wales (specifically):

Relevant matters	**Prescribed person**
Matters relating to the registration of social care workers under the Care Standards Act 2000.	Care Council for Wales
Matters relating to: • The provision of Part II services as defined in section 8 of the Care Standards Act 2000 and the Children Act 1989. • The inspection and performance assessment of Welsh local authority social services as defined in section 148 of the Health and Social Care (Community Health and Standards) Act 2003. • The review of, and investigation into, the provision of health care by and for Welsh NHS bodies as defined under the Health and Social Care (Community Health and Standards) Act 2003. • The regulation of registered social landlords in accordance with Part 1 of the Housing Act 1996 (as amended by the Housing (Wales) Measure 2011.	Welsh Ministers

If an individual is making a wider disclosure (for example to the police, or an Assembly Member (AM) (other than the Minister for Health and Social Care or a Member of Parliament (MP)) they will be protected only if:

- they meet the above tests for internal and regulatory disclosures;
- they have not made the disclosure for personal gain;
- they have first raised the matter internally or with a prescribed regulatory body unless the matter was exceptionally serious and they reasonably believed they would be victimised if they did so; or
- there is no prescribed regulatory body and it is reasonably believed that there would be a cover up

Public Concern at Work or a Trade Union will be able to advise on the circumstances in which an individual should use this procedure and where they may be able to contact an outside body without losing the protection afforded under the Public Interest Disclosure Act 1998.

Appendix 3 – *Velindre NHS Trust*

Form WB1 – Recording a concern raised under the procedure

Concern raised by (name):				
Designation:				
Ward / Department:				
Confidentiality requested:	yes		No	
Nature of concern raised:	Delivery of care/services to patients			
	Vale for money			
	Health and safety			
	Unlawful conduct			
	Fraud, theft or corruption			
	The cover-up of any of the above			
Details of concern raised: (Continue overleaf is necessary)				

Evidence to support the concern (if available): (Continue overleaf if necessary):		
Any suggestions from employees as to a resolution?:		
How will the matter be handled?:	Informal review	
	Internal investigation	
Concern reported to:		
Contact name:		
Designation:		
Telephone no:		
Signed:		
Date:		
N.B. Once completed, this form should be retained on a case file		

Appendix 4 – *Velindre NHS Trust*

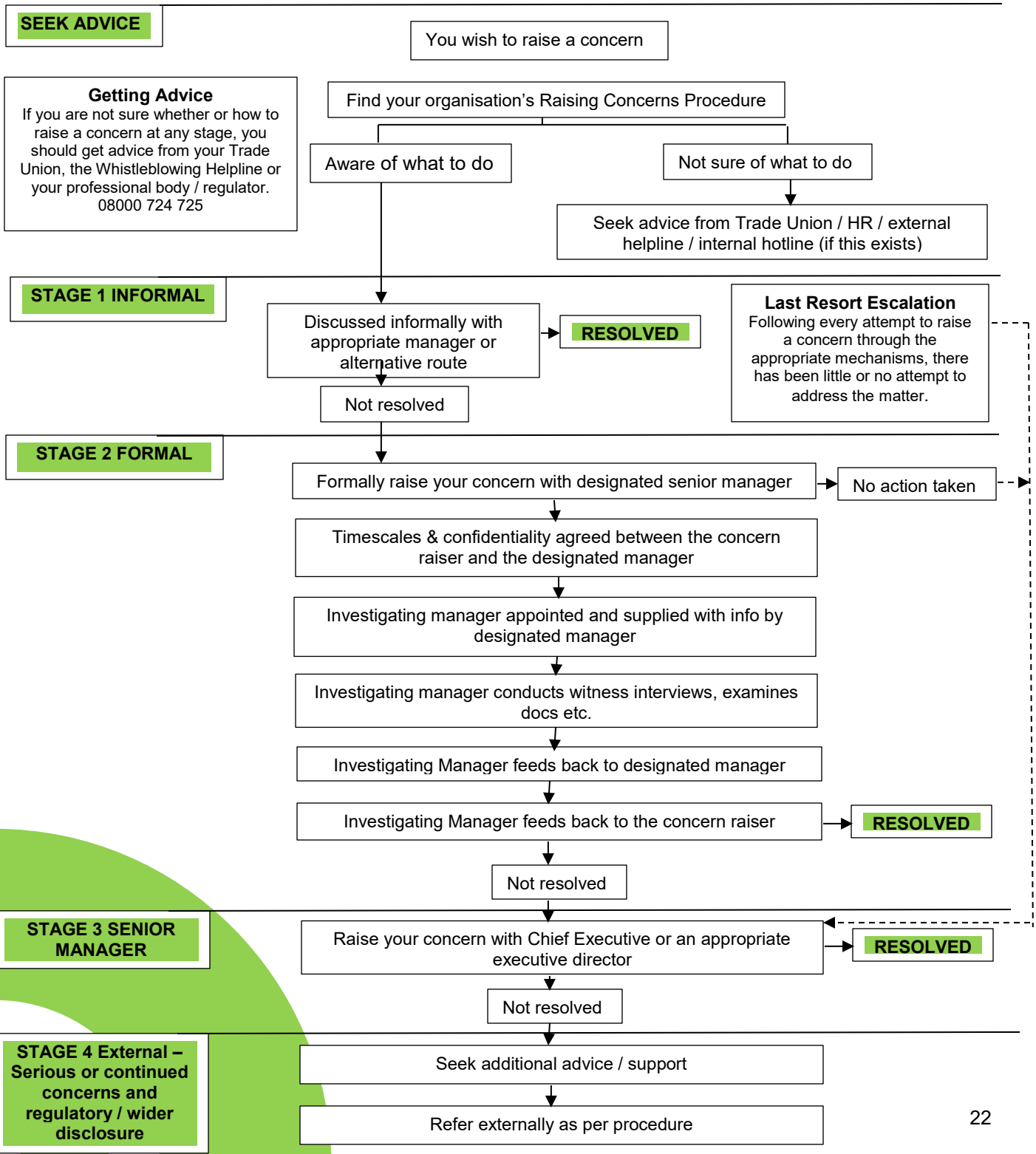
Form WB2 Concerns Raised Under the Procedure: Summary of findings and outcome of investigation

Concern raised by (name):	
Designation:	
Informal review undertaken by:	
Investigation undertaken by:	
Summary of findings of review / investigation: (continue overleaf if necessary):	
Outcome: Action taken: (continue overleaf if necessary):	

No action taken for the following reasons:	
Further action (if appropriate): (e.g. report the matter to Welsh Government / Regulator):	
Name:	
Signed:	
Designation:	
Date:	
N.B. Once completed, this form should be retained on a case file.	

Appendix 5 – Flowchart of Raising Concerns Process

This flowchart sets out the stages in raising a concern and shows the management levels for internal disclosure. In a small organisation, there may not be more than one or two levels of management to whom you can escalate your concerns. In these cases, you should consider escalating your concern to the regulator or other prescribed person at an earlier stage than is shown on the flowchart.



MEETING	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership
DATE	9 April 2019
AGENDA ITEM	6.3
PREPARED BY	Roxann Davies, Compliance Officer
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services
TITLE OF REPORT	NWSSP Counter Fraud Policy

PURPOSE

To provide the Committee with a copy of the NWSSP Counter Fraud Policy, **for information only**, following approval at SMT on 28 February 2019, pursuant to a request from a previous Committee meeting to update overarching Velindre Policy. Appendices 1 and 2 have been redesigned by our Communications Team in order to provide helpful and handy Desktop Guidance for staff to utilise.

The NWSSP Counter Fraud Policy can be accessed at: http://nww.sharedservicespartnership.wales.nhs.uk/our-governance.

Counter Fraud Policy and Response Plan

To provide a framework for response, advice and information on various aspects and implications of an investigation

Version No. V1.0
Status: Effective

Author: Local Counter Fraud Services
Approver: SMT

Date: 28 February 2019
Next Review Date: 28 February 2021

NHS Wales Shared Services Partnership
4-5 Charnwood Court
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Telephone: 01443 848585
www.nwssp.wales.nhs.uk

EXECUTIVE SUMMARY Counter Fraud Policy and Response Plan	
Overview:	One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity, all such offences are hereafter referred to as "fraud", except where the context indicates otherwise. This document sets out NWSSP's policy and response plan for detected or suspected fraud. ***It is essential that all staff are aware of, and are able to access up-to-date, accurate policies to ensure they are aware of current approved practices to help reduce risk.***
Who is the policy intended for:	This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation.
Key Messages included within the policy:	**The three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.** We are absolutely committed to maintaining an honest, open, and well-intentioned atmosphere. It is therefore also committed to the elimination of any fraud within the organisation, and to the rigorous investigation of any such cases. We wish to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also our policy, which will be rigorously enforced; that no employee will suffer in any way as a result of reporting reasonably held suspicions. The flowcharts in section 6.2 describe our intended response to a reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions.
PLEASE NOTE THIS IS ONLY A SUMMARY OF THE POLICY AND SHOULD BE READ IN CONJUNCTION WITH THE FULL POLICY DOCUMENT	

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1.	Introduction
2.	What is Fraud
3.	Public Service Values
4.	Our Policy
5.	Roles and Responsibilities
6.	The Response Plan
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8.	The Law and its Remedies
9.	Interviews
10.	Further Guidance on Fraud
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Appendix 1 – NHS Fraud and Corruption: Do's and Don'ts	
Appendix 2 – NHS Fraud and Corruption Referral Form	

Introduction

One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity, all such offences are hereafter referred to as "fraud", except where the context indicates otherwise. This document sets out our policy and response plan for detected or suspected fraud.

We already have procedures in place that reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and a system of risk assessment. In addition, we try to ensure that a risk (and fraud) awareness culture exists in the organisation.

This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud, or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation. This document is not intended to provide direction on prevention of fraud.

What is Fraud?

2.1 Fraud is defined as:

"*The intentional distortion of financial statements or other records by persons internal or external to the organisation carried out to conceal the misappropriation of assets or otherwise for gain or cause loss to another."*

2.2 Corruption can be defined as:

"The offering, giving, soliciting of an inducement or reward that may influence the actions taken by a body, its members or officers"

Source: The Code of Audit Practice – Audit Commission

Areas where fraud and corruption may occur include:

- Travel and expense claims
- Petty cash vouchers
- Items of Service claims from independent contractors
- Time sheets
- Fraudulent use of authorised leave
- Overpayment of salary/wages
- Fraudulent use of resources
- Working whilst on the sick
- Handling of cash
- Misappropriation of equipment

2.3 Bribery Act 2010

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011.

The Bribery Act 2010 will abolish all existing UK Anti-Bribery Laws and replace them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine.

In addition, the Act introduces a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a stand alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

3 Public Service Values

Source: WHC (2006) 090 'The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006'.

The codes reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.

Accountability: Everything done by those who work in the NHS in Wales must be able to stand the test of scrutiny by the Welsh Government, public judgments on propriety and professional codes of conduct.

Probity: There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of the NHS in Wales's duties.

Openness: There should be sufficient transparency about the NHS in Wales's activities to promote confidence between the NHS body and its staff patients and the public.

4 Our Policy

We are absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. We are therefore also committed to the elimination of any fraud and to the rigorous investigation of any such cases.

NWSSP wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore it is also our policy, which will be rigorously enforced; that no employee will suffer in any way as a result of reporting reasonably held suspicions.

All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are raised maliciously and found to be groundless.

5 Roles and Responsibilities

5.1 Director of Finance and Corporate Services

Responsibility for investigating fraud has been delegated to the Director of Finance and Corporate Services, who is responsible for ensuring that there is a person accredited to investigate fraud. This person is known as a Local Counter Fraud Specialist (LCFS), and will be a senior officer of the organisation, authorised to receive inquiries of staff confidentially and anonymously.

The LCFS is also authorised to decide whether the matter raised needs to be reported to the Director of Finance and Corporate Services.

The LCFS shall also be responsible for informing third parties such as NHS Counter Fraud Service (Wales), NHS Protect, External Audit and/or the Police when appropriate. The LCFS shall inform and consult the Director of Finance and Corporate Services and/or Managing Director, in cases where the incident may lead to adverse publicity.

Where a member of staff is to be interviewed under caution the LCFS shall liaise with the Director of Finance and Corporate Services and Workforce and OD department. Where a member of staff is to be disciplined, the organisation's Disciplinary Policy will be followed with guidance from the Workforce and OD Department

The Director of Workforce and OD shall advise those involved in the investigation in matters of employment law and in other procedural matters, such as disciplinary and complaints procedures, as requested.

Finally, all staff has a duty to protect the assets of the organisation. Assets include information and goodwill as well as property.

5.2 Local Counter Fraud Specialist

Local Counter Fraud Specialists (LCFS) are located in each NHS organisation. The Lead LCFS is nominated appointed by the Director of Finance and Corporate Services and will be responsible for investigating cases of fraud up to £15,000. All investigations involving more than £15,000 and/or Corruption must be referred to the NHS Counter Fraud Service (Wales) Regional Team.

Only individuals who are accredited as Counter Fraud Specialists will be responsible for investigating cases of fraud. The LCFS will be responsible for notifying all cases of fraud to NHS CFS (Wales) in the appropriate manner and via the FIRST Case Management System.

The LCFS shall:

- Report to Director of Finance and Corporate Services.
- Provide a written report at least annually on counter fraud work within NWSSP.
- Be entitled to attend Audit Committee meetings and have a right of access to all Audit Committee members and the Chairman and Managing Director of NWSSP.
- Undertake, as agreed with the Director of Finance and Corporate Services, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall be carried out so as

to complement the detection of potential fraud and/or corruption by auditors in the course of routine audits.

- Proactively seek and report to CFS (Wales) opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption.
- Investigate cases of suspected fraud in accordance with the division of work specified in the Directions as amended and replaced from time to time. Refer to CFS (Wales) all cases appropriate to them.
- Inform CFS (Wales) of all cases of suspected fraud investigated by NWSSP.

5.3 NHS Counter Fraud Service (Wales)

The NHS Counter Fraud Service (CFS) (Wales) will investigate all cases that do not fall within the responsibility of the Local Counter Fraud Specialist.

NHS CFS (Wales) will be responsible for the investigation of cases above £15,000, all corruption cases, and any case at the request of the LCFS, where the CFS (Wales) specialist knowledge and resources could assist with the investigation.

The LCFS will be responsible for maintaining records and data of all cases investigated and reporting to NHS CFS (Wales).

5.4 NHS Protect (formerly Counter Fraud Security Management Service)

NHS Protect was established to counter Fraud and Corruption in the NHS. The Head of Counter Fraud Service (Wales) has overall responsibility for all work to counter fraud and corruption within the NHS in Wales and has the responsibility for ensuring all instances of suspected fraud and corruption are properly investigated.

NHS Protect has the central co-ordinating directing role, revising policy and processes to prevent fraud arising, providing information to target counter fraud action, continuously identifying the nature and scale of the problem of fraud and corruption and setting and monitoring the standards of counter fraud work. The Director has access to Ministers and reports directly to the NHS Chief Executive/Permanent Secretary.

5.5 Management

Managers have a responsibility to ensure that the Local Counter Fraud Specialist or other persons authorised to carry out investigations, has access, as soon as practicable, or within 7 days of a request to premises, records and data and also staff who may have relevant information.

6. The Response Plan

6.1 Introduction

The flowcharts in section 6.2 describe the organisation's intended response to a reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions. Each situation is different; therefore the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 6.3 (Commentary on Flowchart Items).

It should be noted that no unauthorised contact should be made with any representative of the press, TV, radio or any another third party about a suspected fraud without the express authority to do so.

A Memorandum of Understanding currently exists between NHS Protect and the Association of Chief Police Officers (ACPO) which has been agreed and outlines each of their roles. This provides a framework for the exchange of information for the prevention, detection, investigation, and prosecution of matters of fraud and corruption. It is intended to facilitate good working relationships between all parties and develop clear lines of communication.

6.2 Flowcharts

Chart 1 - Reporting Fraud

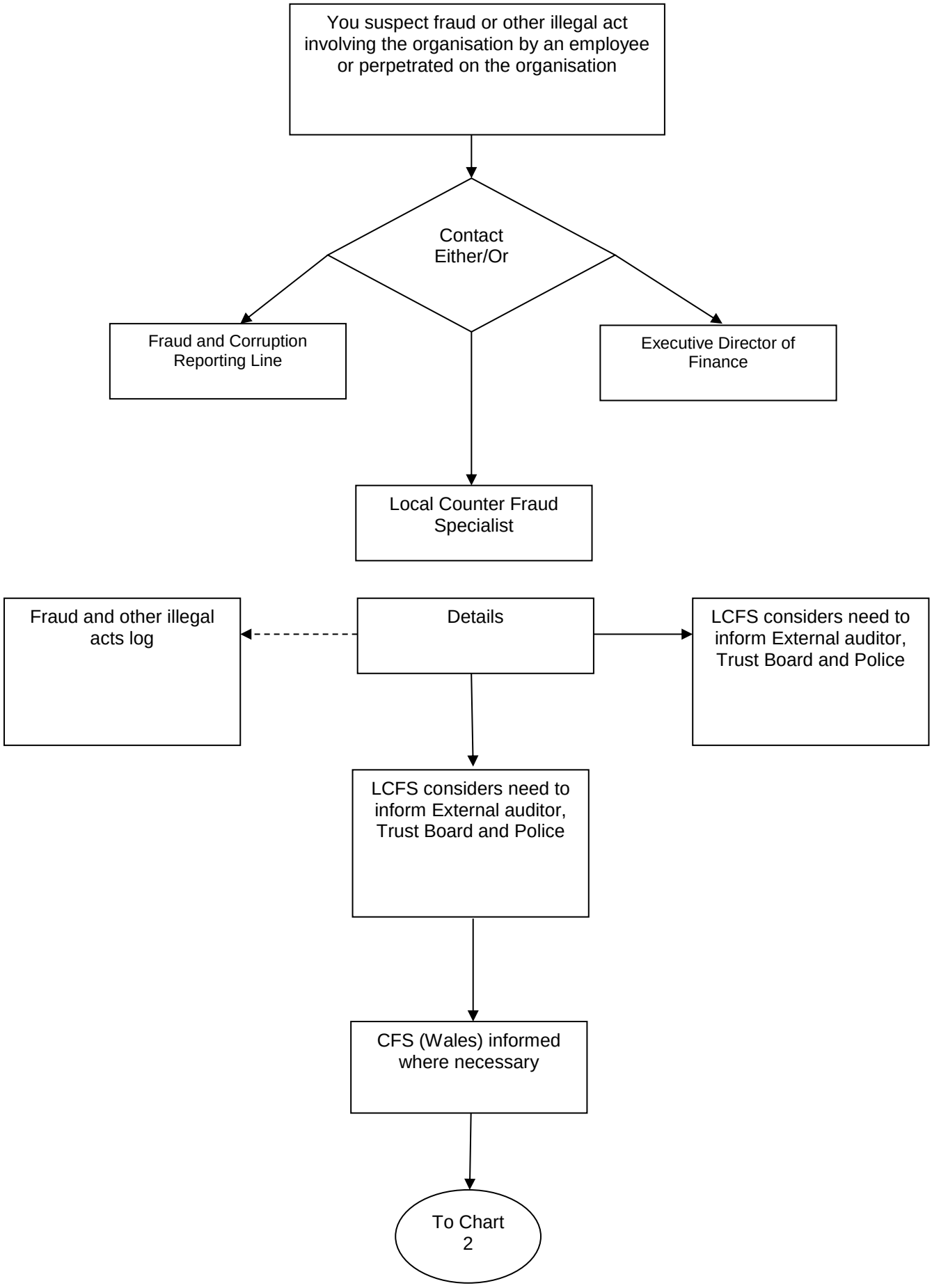


Chart 2 - Managing the Investigation

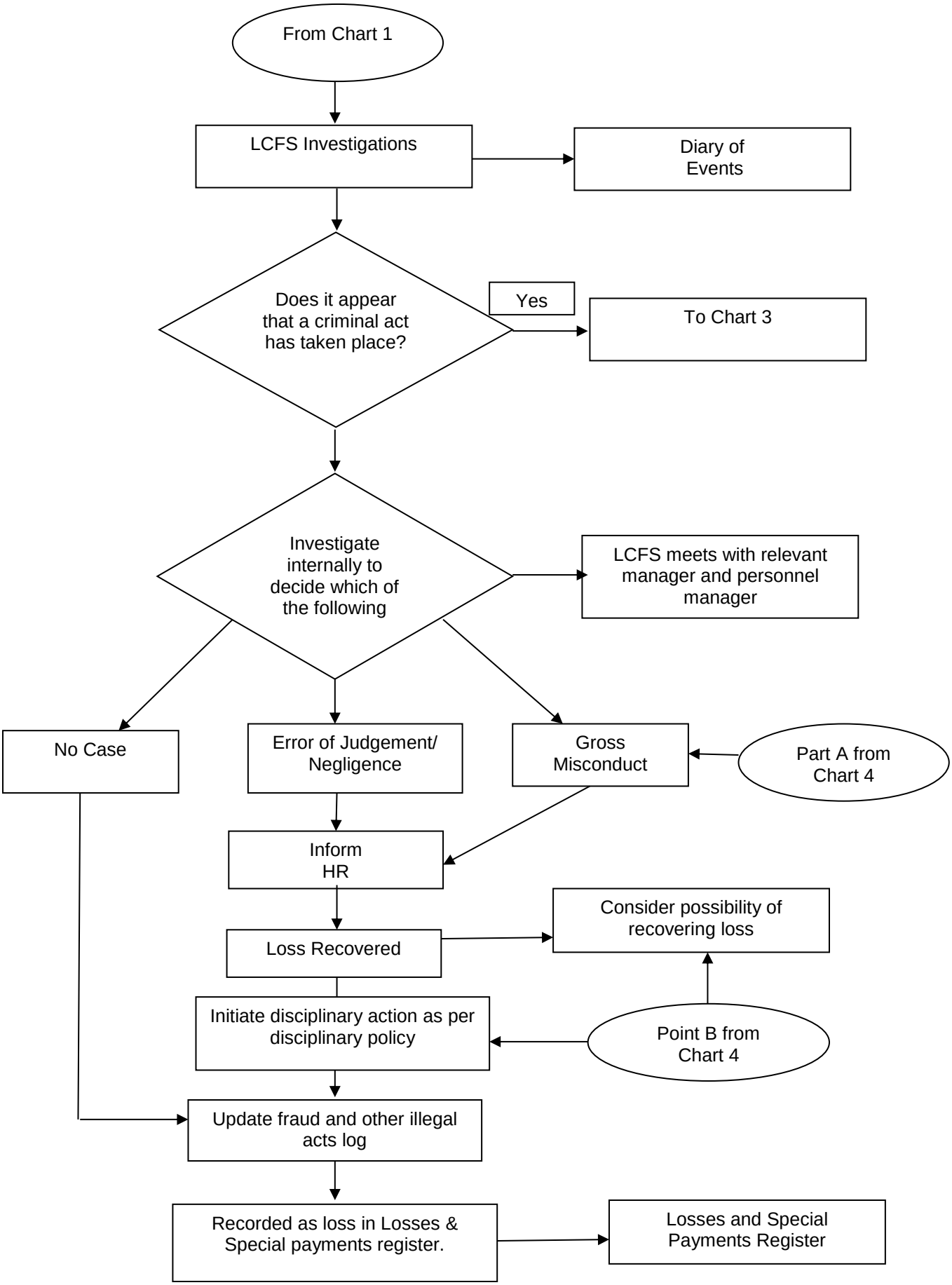


Chart 3 – Gathering Evidence

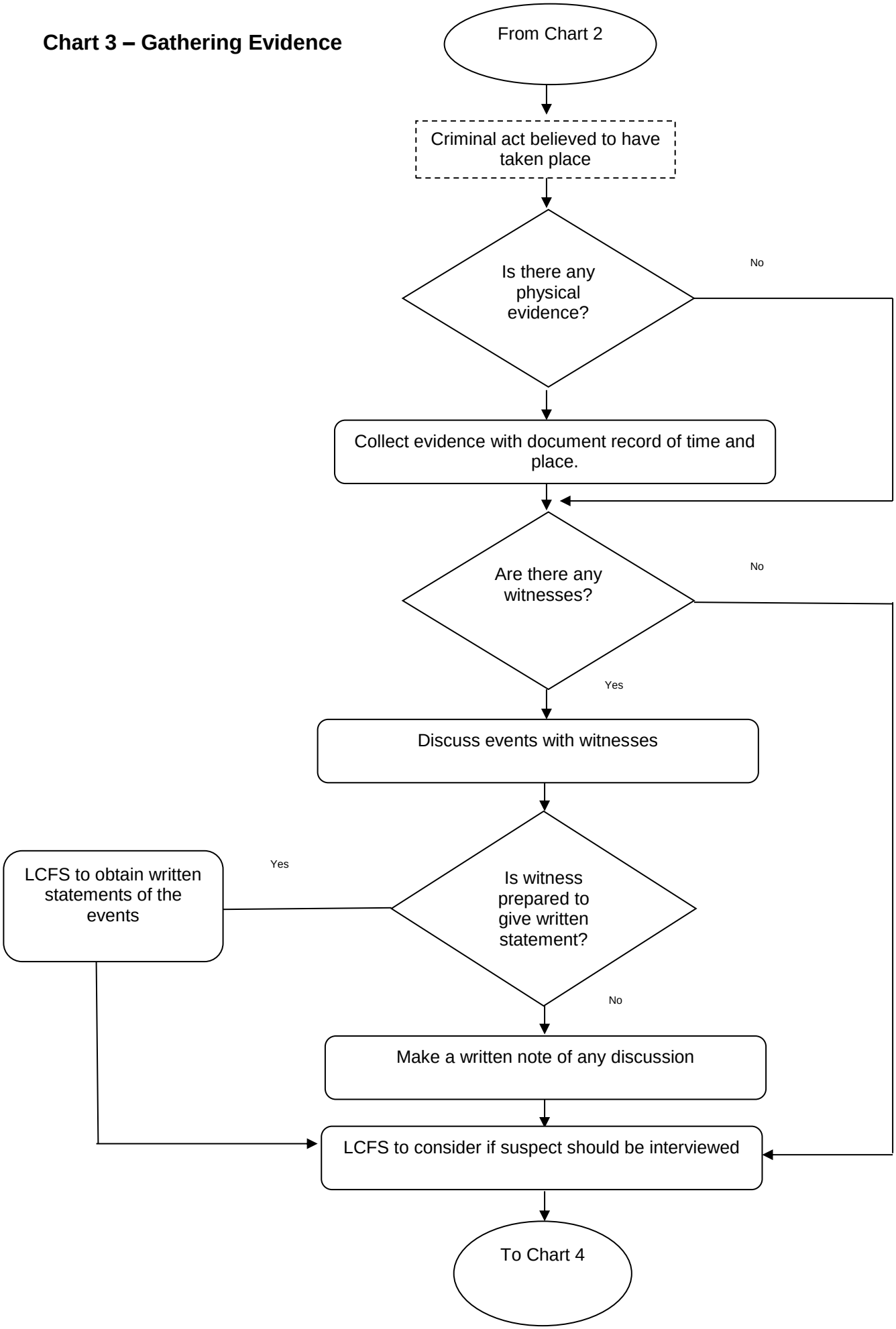
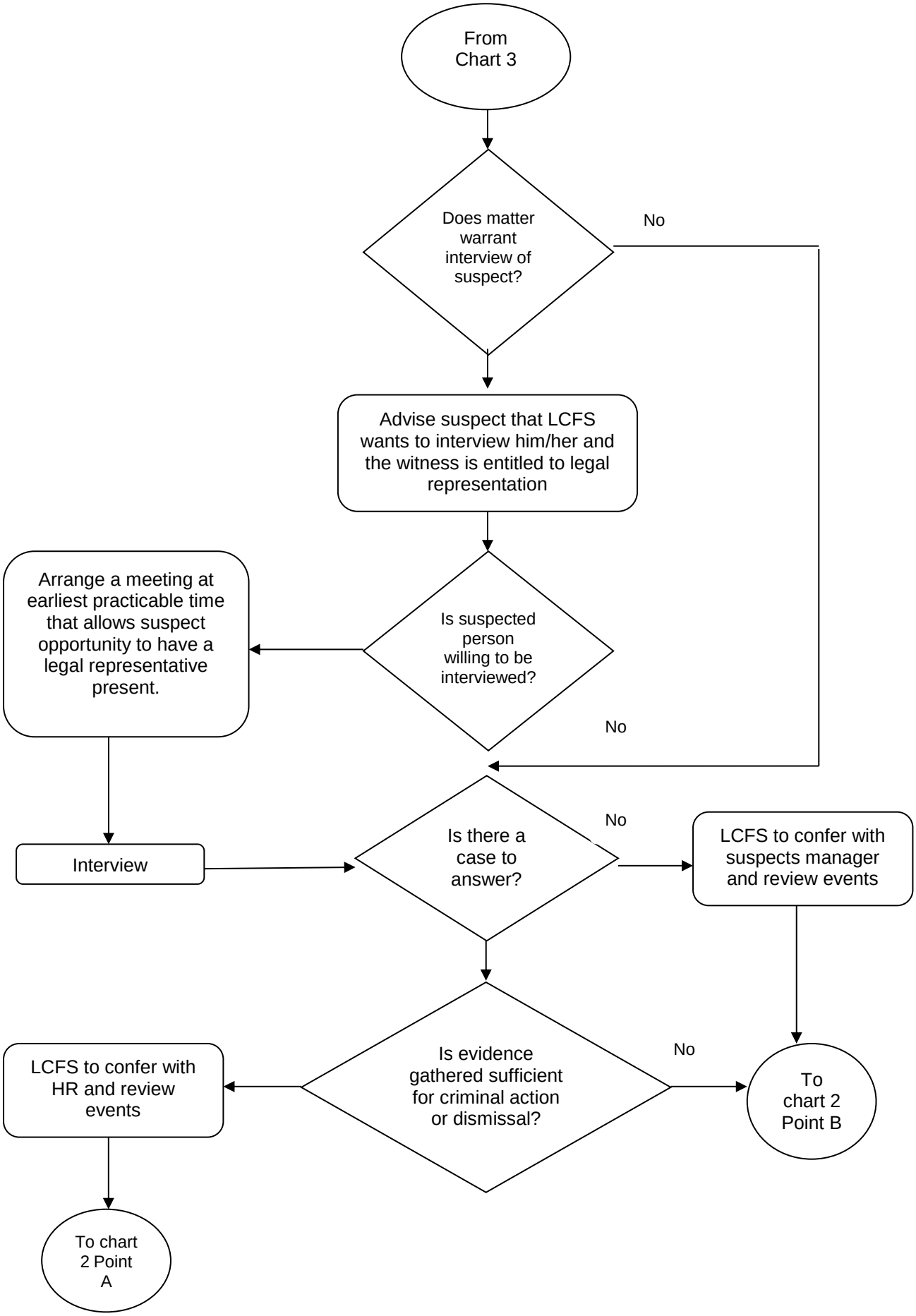


Chart 4 – Interview Procedure



6.3 Commentary on Flowchart Items

Further explanation of many items is also given elsewhere in this document.

- **CHART 1 – REPORTING FRAUD**

6.3.1 The Local Counter Fraud Specialist (LCFS)

The Lead LCFS should be a senior employee, who is authorised to treat inquiries confidentially and anonymously if so requested by the individual making the referral.

The LCFS will receive appropriate skill based training leading to professional accreditation and will be able to respond tactfully and appropriately to concerns raised by staff.

The current Lead LCFS role is provided as part of a Service Level Agreement with Cardiff & Vale University Health Board based on an agreed number of days.

6.3.2 Suspicion of Fraud or Any Irregularities/Anomalies

If any employee has any concerns that a fraud has or is taking place, then he/she should discuss any suspicions in the first instance with the Nominated Lead LCFS on 02920 742725.

However, an employee may choose instead to contact the “NHS Fraud & Corruption Reporting Line” on 0800 028 4060.

Time may be of the utmost importance to prevent further loss to NWSSP.

6.3.2 LCFS Records Details Immediately In a Log

A daily log of any progress of the individual investigations is kept. The log will contain details of all reported suspicions and the progress against each individual case.

6.3.2 Court Action, Adverse Publicity and/or Police Involvement

Where the investigation reaches a stage where the case is likely to end up in a criminal prosecution via the criminal justice system and likely to attract any adverse publicity, then the LCFS must liaise with the Director of Finance and Corporate Services and NWSSP's Communications Dept. Where a fraud is suspected and the need to use the police to carry out an arrest and/or search, then advice will be sought from NHS CFS (Wales) in discussion with the Director of Finance and Corporate Services.

- **CHART 2 - MANAGING THE INVESTIGATION**

6.3.2 Diary of Events

The Local Counter Fraud Specialist in charge of the investigation will keep a diary log of events to record the progress of the investigation.

6.3.2 Does it Appear a Criminal Act Has Taken Place?

In some cases this question may be asked more than once during an investigation. The answer to the question obviously determines if there is to be fraud investigation (or other criminal investigation). In practice it may not be obvious if a criminal act has taken place. If a criminal event is believed to have occurred, the matter will be dealt with by the LCFS/CFS (Wales). If other criminal offences are involved e.g. theft, criminal damage, consideration should be given to reporting the matter, after consultation with the LCFS, to the police.

Section 8 gives further details of the more common offences relevant to fraud.

If, after discussion with the LCFS, it appears a criminal act has not taken place the next step should be an internal review to determine the facts. The review may recommend various courses of action; instigate an investigation under the organisation's Disciplinary Policy and Procedure; establish what can be done to recover a loss and what may need to be done to improve internal control to prevent the event happening again.

In each case the LCFS should consider what can be done to recover any loss and whether anything should be done to improve control to prevent the event happening again.

6.3.7 Recovering a Loss

Where recovering a loss is likely to require a civil action it will probably be necessary to seek legal advice. Where external legal advisors are used the investigation manager must ensure there is coordination between the various parties involved.

6.3.9 Disciplinary Procedures

The organisation's Disciplinary Policy and Procedure has to be followed in any disciplinary action taken by NWSSP towards an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, the results of the investigation (a formal report) and take appropriate action against the employee.

In the event of a disciplinary investigation taking place where a suspicion of fraud exists, then the appointed investigating officer must liaise with the LCFS to agree a way forward.

- **CHART 3 - GATHERING EVIDENCE**

NB. THE CHART CANNOT COVER ALL THE COMPLEXITIES OF GATHERING EVIDENCE. EACH CASE MUST BE TREATED ACCORDING TO THE CIRCUMSTANCES TAKING PROFESSIONAL ADVICE IF NECESSARY.

Section 8.3 gives further brief guidance on gathering evidence.

6.3.10 Witnesses

If a witness to the event is prepared to give a written statement, the LCFS will take a chronological record using the witness's own words. (The witness should be prepared to sign the document as a true record).

6.3.11 Physical Evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time, date, and place it is taken from and by whom, continuity is essential. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record.

6.3.12 LCFS to Consider if Suspect Should be Interviewed

The LCFS, in discussion with the Finance Director, will consider whether or not the suspect should be interviewed under caution.

- **CHART 4 - INTERVIEW PROCEDURE**

6.3.13 Interview

The requirements of the Police and Criminal Evidence Act (PACE) must be considered before any interview with a suspect is performed, since compliance with PACE determines whether evidence is admissible in criminal proceedings

6.3.14 Is the Evidence Gathered Sufficient for Disciplinary Action?

Under UK employment legislation dismissal must be for a 'fair' reason. The manner of dismissal must also be reasonable. It is therefore important that no employee should be dismissed without close consultation with the Director of Workforce and OD. The Director of Workforce and OD should be consulted about the provision of references for employees who have been dismissed or who have resigned following suspicions of a fraud.

6.3.15 Review of Available Evidence

Whether or not the evidence gathered is thought sufficient for dismissal or prosecution, if there is evidence of any another criminal offence, then the Police may be consulted at this stage.

6.3.16 Losses and Compensations Register

All cases of fraud must be reported for inclusion on the register.

6.4 Insurance

The possibility of recovering a loss through insurance should not be overlooked. There may be time limits for making a claim and in certain cases claims may be invalidated if legal action has not been taken.

6.5 More Detailed Investigation

The flowchart covers the basics of reporting fraud, initial evidence gathering, interviewing, and management action. It will be necessary to decide whether further investigation is required, and if so, by what means it should be undertaken. The remainder of this chapter discusses some of the considerations in cases of fraud and corruption, with special regard to the often conflicting objectives of maximising control and minimising cost.

Points of good practice for any investigation include:

- Having an established line of communication with South Wales Police and other police forces;
- Liaison between the LCFS and the person appointed to conduct the disciplinary investigation, who should be independent of the area under investigation;
- Define the objectives;
- Define scope, timing and likely outputs;
- Seek advice where necessary;
- Agree resources required;
- Define responsibilities;
- Monitor resources used (cost and time);
- Monitor progress and inform as required;
- Consider lessons to be learned, e.g. how control can be improved;
- Draw up an action plan based on lessons learned; and
- Keep proper records including a diary of the events.

6.6 Involving the Police

Once a fraud has been identified or suspected, then some managers may mistakenly choose to involve the Police. However, any allegation or suspicion of fraud and/or corruption **must be referred directly to NWSSP's Nominated Lead LCFS on 02920 742725**

7. Investigation Resource

After completion of initial fact finding in accordance with procedures given in the flow charts, the following options for resourcing an investigation are available. These options are not mutually exclusive. In complex cases a number of different parties will need to be involved.

The LCFS is professionally trained and qualified in evidence gathering, investigations, PACE and is therefore equipped to deal with investigations from the outset. This resource should be utilised in all cases of suspected fraud and corruption. The LCFS will also be familiar with the organisation and the investigation will remain within the control of NWSSP.

8 The Law and its Remedies

8.1 Introduction

Criminal action will impose sanctions on the defendant for causing loss to the organisation, while civil action may assist NWSSP to recover any loss.

With any civil action, the method of concealment (in the case of fraud) is unlikely to be a key factor in the value of compensation or the drafting of the statement of claim.

In any criminal action, the nature of the deceit is highly relevant in the framing of charges, but the law is not primarily concerned with restitution or recovery of the proceeds of fraud or theft - although there are statutory powers to award compensation and to order restitution or forfeiture in some circumstances. However, criminal action now requires the financial benefits (to the villain) to be quantified as part of the investigation process. The proceeds direct, and indirect, can now be seized and dealt with by the court of trial.

There is no reason why the criminal prosecution and civil process cannot be taken at the same time if the evidence supports such action. But there are dangers in unilateral un-coordinated action.

8.1.1 Civil Action

The following is a brief description of some of the commoner civil action remedies. It is not comprehensive and legal advice should be sought before action is taken.

8.1.2 Monies Had and Received

The claim will refer to funds of the plaintiff, which have been 'had and received' by the defendant at the plaintiff's expense - and will seek their recovery.

8.1.3 Interest

The plaintiff may be entitled to interest on the amount lost, and there are claims for interest under court rules and statute.

8.1.4 Tracing

Tracing is an equitable remedy for the recovery of assets. Its meaning is that the trail by which assets have been removed must be followed through the hands they pass through after leaving control of the plaintiff.

8.1.5 Proceeds of Crime Act

In some cases a court order can be used to freeze the assets of a person suspected of fraud or a person who has been convicted of a criminal offence in respect of their fraudulent activity. .

8.2 Criminal Law

The following are brief descriptions of some of the criminal offences most relevant in this context. It is not comprehensive, and legal advice should be sought before action is taken.

8.2.1 Theft

The misappropriation of NHS Wales assets for gain or otherwise.

Section 1 Theft Act 1968 defines where …"A person who dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it".

8.2.2 Fraud Act 2006

The Fraud Act came into force on 15th January 2007. The following offences have been repealed:

<u>Theft Act 1968</u>

- Obtain property by deception (section 15)

- Obtain money transfer by deception (section 15A)
- Obtain pecuniary advantage (section 16)
- Procure execution of valuable security (section 20)

Theft Act 1978

- Obtain service by deception (section 1)
- Evade liability (section 2)

The new Act simplifies the original deception offences. There is no need to prove that any person was deceived. The Act now outlines three ways to commit fraud:

- Fraud by False Representation (section 2)
- Fraud by Failing to Disclose Information (section 3)
- Fraud by Abuse of a Position of Trust (section 4)

Many original 'deception' offences will now be covered by section 2 of the Fraud Act 2006 (false representation) which has three main ingredients:

- Dishonesty
- A false representation (no limitations on how this takes place)
- Intention to commit gain or cause loss

Section 3 covers the offence of fraud by failing to disclose information where there is a legal duty to do so.

Section 4 covers the offence of fraud by abuse of position where the defendant is in a privileged position expected to safeguard (not act against) the financial interests of another person.

Section 6 covers the offence of possession of articles for use in fraud. This extends to possession or control of any article, anywhere and includes electronic data.

Section 7 covers the offence of making or supplying articles for use in fraud. It is designed to capture those who supply personal financial details for use in frauds to be carried out by others; or those who manufacture software programmes for generating credit card numbers.

Section 11 of the Fraud Act – "Obtain Services Dishonestly" replaces "Obtain Services by Deception". This offence requires the actual obtaining of a service and must include a dishonest act or false representation.

There are three ways to commit fraud:

- Fraud by false representation (s.2)
- Fraud by failing to disclose information (s.3)
- Fraud by abuse of position (s.6)

All that has to be proved is that the defendant knew their act was dishonest, irrespective of consequential outcome.

8.2.3 Corruption

The definition (in the context of the Prevention of Corruption Acts) is the offering, giving, soliciting, or acceptance of an inducement or reward, which may influence the action of any person.

8.3 Evidence

For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice.

The collection of evidence must be coordinated if several parties are involved in an investigation, e.g. LCFS and internal audit, police and solicitors. Evidence gathering requires skill and experience and professional guidance should be sought where necessary. There is a considerable amount of case law concerning the admissibility of evidence.

Documentary evidence should be properly recorded, it will need to be numbered and include accurate descriptions of when and where it was obtained and by and from whom. In criminal actions evidence on or obtained from electronic media needs a document confirming its accuracy.

9 Interviews

9.1 General

Once it has been decided that a disciplinary investigation is to be carried out, then the investigating officer, whose purpose is to find out the facts, may conduct an interview in the first instance if a crime is not suspected from the outset. This interview should not be under caution. The investigating officer has the right to ask an employee to account for his/her actions in respect of the allegation. For this reason it is important for the LCFS and Human Resources to be involved before interviewing any member of staff. If a crime is suspected, then the matter should be referred immediately to the LCFS, who will then liaise closely with HR and the Line Manager.

As part of the disciplinary process, the person being interviewed does not have the right to refuse to answer questions about his/her actions as an employee. If the employee, knowing the criminal law, refuses to answer on the grounds that he/she might incriminate himself, that is his/her right, and if he/she asks that question he/she should be told so.

If it is decided following liaison between the LCFS and HR that an interview under caution is required, then this should be conducted under PACE.

The Workforce and OD Department should be advised of any interview under caution that is taking place.

9.2 Interview Procedure

Where an interview takes place under caution the following is a summary of the procedure to be followed.

The individual will be written to and advised of the reason for the interview and that he/she is entitled to have a person present at the interview who can act in a legal capacity (i.e. solicitor), but they are not entitled to have a friend, work colleague and/or union representative present at the interview.

The person being interviewed is also to be informed that whilst their attendance at the interview is voluntary, should they not attend, then the matter may be referred to the police which could then result in their subsequent arrest.

The interview under caution will be tape recorded and once the interview has concluded, then the person will be informed as to whether he/she is to be reported for criminal prosecution.

10. References

This policy should be read in conjunction with:

- Standing Orders and Standing Financial Instructions
- Disciplinary Procedures and Dignity at Work Policy
- Standards of Behaviour Framework (including Gifts, Hospitality and Sponsorship declarations, conflicts of interest, procurement and capital/PFI contracts)
- IT Security Policy
- Public Relations and Communications Strategy
- Raising Concerns (Whistleblowing) Policy

11. Further Information

Further information and a copy of the fraud policy and response plan may be obtained from the LCFS or via the staff intranet.

NHS Fraud and Corruption: Desktop Guide

FRAUD is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.

CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- Directly contacting the Local Counter Fraud Specialist;
- Telephoning the free phone NHS Fraud and Corruption Reporting Line; or
- Contacting the Director of Finance.

Do you have concerns about a fraud taking place in the NHS?

If so, any information can be passed to the **NHS Fraud and Corruption Reporting Line:**

0800 028 40 60

All calls will be treated in confidence and investigated by professionally trained staff.

Your nominated **Local Counter Fraud Specialist** is:

Craig Greenstock
02920 742725
craig.greenstock@wales.nhs.uk

If you would like further information about the NHS Counter Fraud Service, please visit www.nhsbsa.nhs.uk/fraud

Do

- **Note your concerns**

Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.

- **Retain evidence**

Retain any evidence that may be destroyed, or make a note and advise your LCFS.

- **Report your suspicion**

Confidentiality will be respected – delays may lead to further financial loss. Complete a fraud report and submit in a sealed envelope marked 'Restricted – Management' and 'Confidential' for the personal attention of the LCFS.

Do not

- **Confront the suspect or convey concerns to anyone other than those authorised**

Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent per son.

- **Try to investigate, or contact the police directly**

Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.

- **Be afraid of raising your concerns**

The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.

- **Do nothing!**

NHS Fraud and Corruption Referral Form

All referrals will be treated in confidence and investigated by professionally trained staff

Please note that referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.

1. Date

2. Anonymous referral

Yes ☐ No ☐ *If 'Yes' go straight to section 6, if 'No' complete sections 3–5*

3. Your name

5. Your contact details

6. Your organisation/profession

6. Suspicion

7. Details of the person to whom the allegation relates

Please provide details including their name, address and date of birth (if known)

8. Possible useful contacts

9. Please include/attach any available additional information

Submit the completed form (in a sealed envelope) marked:

'**Restricted – Management**' and '***Confidential***', for the personal attention of Craig Greenstock, Counter Fraud Manager, Cardiff and Vale University Health Board, 2nd Floor, Monmouth House, University Hospital of Wales, Heath Park, Cardiff, CF14 4XW.