Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee 10th June 2021**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Internal Audit Progress Report - 1st March to 31st May 2021** **Head of Internal Audit Opinion & Annual Report 2020/2021**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton – Board Secretary
Awdur yr Adroddiad **Report Author:**	Dave Harries – Head of Internal Audit
Craffu blaenorol: **Prior Scrutiny:**	The progress report and Head of Internal Audit opinion and annual report has been considered and approved by the Board Secretary.
Atodiadau **Appendices:**	• Appendix 1: Progress Report • Appendix 2: Engagement of Interim Appointments • Appendix 3: Security Compliance • Appendix 4: Statutory compliance - Water management • Appendix 5: Control of Contractors • Appendix 6: Violence and Aggression – Obligatory responses to violence in healthcare • Appendix 7: Head of Internal Audit opinion and annual report for 2020/21

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report; and
- Note and receive the Head of Internal Audit opinion and annual report for 2020/21.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Sefyllfa / Situation:

The progress report is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

The annual report and opinion is produced In accordance with the Public Sector

Internal Audit Standards: Standard 2450 – Overall Opinions.

Cefndir / Background:

The progress report summarises eleven assurance reviews finalised since the last Committee meeting in March 2021, with the recorded assurance as follows:

- Reasonable assurance (yellow) – four;
- Limited assurance (amber) – five; and
- Assurance not applicable (blue) – two.

The report also details:

- Reviews issued at draft reporting stage, work in progress and recommendations subject to follow-up in the period.

In accordance with the Public Sector Internal Audit Standards, the head of internal audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the Health Board's risk management, control and governance processes (i.e. the system of internal control).

The outcomes of these reviews have been shared with management, however at the time of the report, some of these are not yet finalised although the draft report opinion has been used to inform the HIA opinion.

Asesiad / Assessment & Analysis

Strategy Implications

The Internal Audit plan for 2020/21 was approved by the Audit Committee in March 2020, with subsequent amendments at the June and September 2020 meeting.

Financial Implications

The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.

Risk Analysis

The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.

The annual report and opinion for 2020/21 reports the outcome of all risk based reviews completed in the financial year.

Legal and Compliance

The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.5 Reviewing internal audit assignment reports.*

The Head of Internal Audit Opinion and Annual Report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.6 Reviewing the Head of Internal Audit's annual opinion.*

Impact Assessment

The Internal Audit report provides third line independent assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management

arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights beyond what is drawn out specifically in respect of individual audits and is not discriminatory under equality or anti-discrimination legislation.

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st March 2021 to 31st May 2021

NWSSP Audit and Assurance Services

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

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

Disclaimer notice - please note

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues and progress against the Internal Audit (IA) Plan for 2020/21 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the Board Secretary.

2. As a fundamental part of the audit process, agreed actions for limited and no assurance opinion reviews are followed-up to ensure that the control issues identified have been reviewed and addressed as appropriate. The follow-up review, by individual recommendation, is recorded within this report periodically.

Reports Issued

3. A number of reviews have been finalised in conjunction with Health Board management. A summary of these reviews is provided below in Table 1.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
Risk Management – Corporate Risks and Board Assurance Framework Review completed April 2021 with Executive approval May 2021 *We identified the need for the Health Board to be explicit on its strategic objectives as well as minor housekeeping issues.*	Reasonable	-	1	1	The BAF is a key governing document for the Board upon which it identifies risks/opportunity risks in achieving its set strategic objectives – The Health Board has set six strategic priorities. All corporate risks link to the priority risks of the BAF; this allows the Health Board to manage the significant risks that could affect the strategic priorities. The review identified: • Strategic priorities are not overtly explicit in terms of measure or timeframe. • Target risk for some principal risks are above Health Board set risk-appetite. • Unclear that the existing controls and mitigations, coupled with the planned actions, are adequate to impact the current risk assessments that often remain static [Red/Amber]. • Unclear that the 'Key Controls' are correctly stated. • Gaps in controls/assurance are not explicit enabling the Board to reflect on. • Unable to follow the audit trail for a corporate

Title	Assurance Level	High	Medium	Low	Key Messages
					risk process in line with the Risk Management Strategy.
Budgetary Control & Financial Reporting Review completed March 2021 with Executive approval May 2021 *A number of budget holders/managers provided with monthly financial reports are not evidenced as reviewing them. Implications for Officers who have not signed their accountability agreements need to be considered and whether they are fulfilling the requirements of their post.*	Reasonable	1	3	1	The review focused on budgetary responsibility and reporting arrangements. The review identified that: • Audit logs relating to access the 383 monthly budget reports distributed noted an average of 54% were being viewed/reviewed by the budget holders; only 17% of budget holders opened all monthly reports in our sample. • A total of three hundred and twenty one requests made to sign accountability agreements at the time of our review, noting: ○ Accepted - 270, of which: ○ 59 took between 14 and 30 days to sign; ○ 21 took between 30 and 90 days to sign; and ○ 11 took more than 90 days to sign. ○ Outstanding - 47 had not signed the agreement. • For a sample of thirty completed virements since the new electronic system was implemented and identified: ○ There was difficulty in exporting the information from the ICT portal; ○ Delays of over a week were seen in three of the sample of authorised virements; ○ Segregation of duties were not evident within the system where we noted the requestor also authorising the virement on occasions; ○ There is no way to ensure the virements are directed to the correct authoriser, as these are not linked to the individuals assigned cost centre and subjective. ○ We acknowledge that the Head of Financial Reporting had already identified some of these as areas in need of improvement.
Approved Clinicians and	Reasonable	1	1	1	On 3rd November 2008, the Minister for Health and Social Services agreed that the Health

Title	Assurance Level	High	Medium	Low	Key Messages
Section 12(2) approval – Governance Review completed March 2021 with Executive approval April 2021 *Board ratification is required prior to notifying the individuals on their approval; Approvals Team are not responsible for the uptake of Section 12 (2) Doctors/Approved Clinicians, this is the responsibility of operational management.*					Board would act as the central approving body for Approved Clinicians and Section 12(2) doctors on behalf of all Health Boards in Wales. The Board does not ratify approvals on a monthly basis as specified in procedural arrangements. Currently, the Health Board Chief Executive confirms approvals following recommendations made by the All Wales Approval Panel, however the approval decisions are made and communicated to successful applicants prior to Board ratification. For the eleven approvals in our review sample, Board ratification took place between thirty-four (34) and sixty-six (66) days following the approval decision. The Approval Team currently report all-Wales approval activity to the Health Board Mental Health Act Committee in addition to their obligation to report to the Board and to Welsh Government. Reporting to the Mental Health Act Committee is not a requirement of Welsh Government Directions or procedural arrangements and may expose the Approvals Team to issues influencing their objectivity and independence. We reviewed relevant Committee minutes and noted several instances where concern regarding the uptake of Section 12(2) doctors had been raised and discussed. Whilst relevant to service providers and service managers, the Approval Team should not be part of these discussions.
Ablett Unit Project Review completed March 2021 with Executive approval April 2021 *Overall governance was*	Reasonable	-	5	1	Generally robust governance arrangements were observed, however a number of further recommendations have been made at this report to improve the function of the Project Board and Project Team. Recognised project management tools were utilised by management to assist project control. It has been suggested that the costed risk register should be shared with the Project

Title	Assurance Level	High	Medium	Low	Key Messages
as expected, however some enhancements to current arrangements were identified.					Board, to improve transparency and to allow better understanding of risks against contingencies. Whilst the Supply Chain Partner and Project Manager contracts had been completed, management advised that the Cost Adviser contract remained to be completed due to the impact of Covid-19 lockdowns. Positive stakeholder engagement was observed to date, in particular in relation to design development and the design sign-off processes applied. The key risk to the project is the feasibility given the increased capital cost – this will ultimately be scrutinised by both the Health Board and Welsh Government upon conclusion of the Outline Business Case.
Engagement of Interim Appointments Review completed January 2021 with Executive approval April 2021 *The process in place for the engagement of interim appointments was not effective in ensuring compliance with Procurement, Finance or WOD expected controls, coupled with overall compliance with Standing Financial Instructions.*	Limited	3	-	-	The review focused on the Health Board's compliance with Standing Financial Instructions, procurement arrangements and pre-employment checks in respect of appointments made to interim senior roles. Our review has identified that the current Health Board process is not effective or fit for purpose in ensuring the engagements of all interim appointments comply with expected procurement, workforce and financial controls. We identified the following: • No composite register for recording the engagement of interims with different records held by Procurement; Finance and WOD; • Framework governance and approval is not robust or timely; • Incorrect framework details recorded for one engagement that had expired in 2019. No evidence of single tender waiver/tender process. • Establishment Control process has not been followed per the requirements in the Standing Financial Instructions and Finance Procedure approved by Committee;

Title	Assurance Level	High	Medium	Low	Key Messages
					• No competition in the embedded practice of moving interims from existing interim engagements to new engagements; • Evidence to support pre-employment check completion was inconsistent with limited evidence that the agency (supplier) provided this always; • References could not be confirmed for authenticity; • Breach of 'no PO-no pay'; and • Over commitment/receipting against approved purchase order value.
Security Compliance Review completed January 2021 with Executive approval March 2021 *The review identified gaps in achieving the NHS Wales Security Management Framework.*	Limited	2	-	-	The review focused on the requirements set out in the Security Management Framework for NHS Trusts were complied with. The Corporate Health & Safety Department demonstrated compliance within particular areas of the Security Management Framework. However, there are areas to further enhance and strengthen the processes to become fully compliant with the Security Management Framework. We identified the following for consideration: • Health Board does not have a dedicated security manager. • Security, Lone Worker & CCTV polices in draft format. • Discrepancies with regards to roles and responsibilities in the draft policy, to what is currently happening. • No overarching crime prevention plan. • No template root cause analysis being used on incidents. • No specific intranet security website with up to date legislation, guidance and contact details. • No security training currently being provided throughout the Health Board. • No mechanisms in place to measure competency and performance of external security services.

Title	Assurance Level	High	Medium	Low	Key Messages
					• Security Action plan has not been updated since 31st December 2019. All the tasks are highlighted as green and completed, however our findings do support this assertion.
Statutory compliance: Water management Review completed February 2021 with Executive approval April 2021 *The review identified issues concerning Legionella Risk assessments, out of date policy and compliance with elements of the policy.*	Limited	3	1	-	The Health Board has responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulations 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water. Our review identified: • Health Board Policy ES02 – Policy for the Management of Safe Water Systems, is out of date and requires review; post of authorising engineer was vacant; Local Water Management sub-groups are not meeting per frequency identified within the TORs. • Areas of Water Safety Plans were outdated, including Legionella Risk Assessments. • The need for plans for the supply and distribution of alternative safe water including annual testing as per policy ES02 – Policy for the Management of Safe Water Systems.
Control of Contractors Review completed February 2021 with Executive approval April 2021 *The control of contractors requires effective control to ensure the Health Board meets its Statutory obligations. Limited progress*	Limited	2	1	-	The system in place for the control of external contractors had been the subject of a paper produced by the Occupational Health & Safety (H&S) Team in September 2019 which we referred to as part of our review. The Contractor's Safety Guidance document is extensive concerning contractors' on-site work and code of conduct, but there is little regarding the Health Board's responsibilities. The documentation does not address the contractor appointment process, management whilst on site or the post-completion review/checking process of contractors. In addition, individual departmental responsibilities are not specified. There has been limited progress to date in addressing the findings of the Occupational

Title	Assurance Level	High	Medium	Low	Key Messages
made since 2019 on the Health & Safety gap analysis.					Health and Safety Gap Analysis Report, presented to the Strategic Occupational Health and Safety Group on the 29th August 2019. Whilst recognising the impact COVID-19 pandemic has had, the volume of contractors engaged during this period to support the Health Board in delivering changes to the fabric of buildings etc. has been significant.
Violence and Aggression – Obligatory responses to violence in healthcare Review completed March 2021 with Executive approval May 2021 *The requirements expected within the Obligatory Response are not being complied with in full.*	Limited	3	2	-	Our findings within the report identify that the Health Board is not complying in full with the requirements of the Obligatory Response. To deliver on all requirements will require a shift in focus and increased resource enabling a wider V&A team to deliver on all requirements but most importantly, prevent incidents of V&A happening to staff through: refreshed risk assessments; ensuring staff groups are identified for relevant training; support and liaison with the victim; liaising with the Police; supporting the manager in the investigation; and embedding lessons learnt in refreshed risk assessments so incidents do not happen in the future. There is no available training needs analysis, with the exception of Mental Health & Learning Disabilities Division (MHLD), to identify all staff who require All Wales Violence and Aggression Training Passport Module B and Module C sessions. Underpinning the training needs analysis should be updated V&A risk assessments and it is unclear whether operational management have completed these as part of wider health and safety processes. Further, there is no central repository to help/support local managers compile ward/department specific V&A risk assessments. The MHLD model for training has identified the training needs of its staff and has updated its training packages. Of the 1,123 incidents closed, all had lessons learnt recorded. However, we found varying

Title	Assurance Level	High	Medium	Low	Key Messages
					quality regarding the recorded lessons learnt and whether management had actually completed what they said they were going to action. We noted one that merely stated what the expected process should be which undermines the whole process and confidence in reporting incidents. In addition we identified two RIDDOR reported incidents for the same ward, in the space of two months where the same recorded lesson was noted, indicating that the learning from the first incident had not been embedded in revised process/pathway.
IM&T Control and risk assessment Review completed January 2021 with Executive approval May 2021 *The risk assessment has identified areas for consideration.*	Not applicable	-	-	-	This review has been conducted pan-NHS Wales and sought to establish the processes and mechanisms in place for management of Information Governance/ Informatics within the organisation. The review sought to provide a baseline picture of the Health Board's status and provides suggestions for areas of improvement or future development. There are thirty-eight risk areas for consideration identified within the assessment that have been agreed with both Information Governance and Informatics.
Patient monies and property Review completed January 2021 with Executive approval March 2021 *The review has identified the need to reinforce Health Board process with staff.*	Not applicable	-	-	-	We received a request from the Interim Deputy Director for Mental Health and Learning Disabilities due to concerns regarding the security of mental health (MH) patient monies following a spate of recorded thefts. No recommendations were made although we identified the following actions for consideration: • Re-inforce the Finance procedure across the whole Division and re-issue [subject to update] the Division specific poster and guidance issued in May 2018 Lessons Learned - Patient Money May 2018 (wales.nhs.uk). Finance Directorate staff be consulted to support the exercise. • Ensure Disclaimer Notices are located in all MH public and ward areas.

Title	Assurance Level	High	Medium	Low	Key Messages
					• Localised operational procedures are updated to ensure dedicated secure safe storage is available for patient monies/property on every MH ward. Safe storage should have one key access with a dedicated key holder for each shift (Nurse in Charge). Any movement of the key between staff or access to the safe storage must be logged, along with the time, date, reason for access and the name of the person accessing/requesting – Any duplicate key is retained by the respective General Office.

Work in Progress Summary

4. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Welsh Risk Pool Claims Management Standard	Draft report issued and meeting held to discuss the findings.	10th May 2021
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Awaiting management response.	14th April & 7th May 2021
HASCAS & Ockenden external reports: Recommendation progress and reporting	Draft report issued.	24th May 2021
Health & Safety	Draft report issued.	19th May 2021
Performance measure reporting to the Board: Accuracy of information	Draft report issued.	18th May 2021
Capital systems	Draft report issued.	24th May 2021

Fieldwork

5. The following reviews are currently in progress:

- Temporary Hospitals – Follow-up of KPMG recommendations – The brief has been agreed with the Executive Director of Finance, however due to timelines for implementing agreed recommendations this review has yet to commence and report in full.

- Follow up of previous Healthcare Inspectorate Wales reports has been delayed due to our confirmation of reporting arrangements and identification of a sample; we have focused on the 2020/21 financial reporting period to identify the sample.
- Security Payments Review (21/22) – This review has been requested by the Executive Director of Finance; the audit brief has been agreed and data for the 20/21 financial year obtained, review has only just started.

Follow Up

6. Follow up reviews remain in progress as and when actions are noted as 'Implemented – Final Client Approved' for limited and no assurance internal audit reviews only. The follow-up is based solely upon the evidence and narrative included within TeamCentral which supports final approval by the relevant executive lead.

7. Table 3 details the follow-up review(s) of individual recommendations undertaken in the period and whether they have been implemented (Closed – Verified) or rejected (with supporting narrative).

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Executive responsibilities and update of Escalation policy and Schemes of Reservation and Delegation	Closed – Verified
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Nurse Staffing Levels and Escalation Plan and Recording of breaches on Safecare	Closed – Verified
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Reporting to the Board and QSE	Closed – Verified
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Quarterly reporting of Harms and Breaches of the Nurse Staffing Levels	Closed – Verified
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Safecare Training and Operational guidance for Nurse staffing levels	Closed – Verified
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Nurse staffing levels and shift times	Closed – Verified
Corporate Legislative Compliance - Nurse	Populating Safecare and Datix Incident reporting	Closed – Verified

Review Title	Recommendation Title	Follow-up status
Staffing Levels (Wales) Act 2016		
Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016	Funding and Staffing Strategy	Closed – Verified

Contingency/Organisational Support/Advice

8. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.

9. During the period, the following review/advice/guidance/support has been provided:

   - Attendance at the Health Board Symphony/National WEDS Project Board.
   - Supporting the NHS Wales Finance Academy Finance Business Continuity Project.

Delivering the Plan

10. The additional support provided to the Health Board with focused reviews is channelled through contingency.

11. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high level risks.

12. The impact of COVID-19 (C-19) on the Health Board has been one that has necessitated on-going discussion with Board Secretary, Deputy Board Secretary and Director of Finance with subsequent dialogue with the Executive Team.

13. The following tables detail the planned performance indicators (Table 4) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 5) with the assurance provided.

14. Table 4 is reporting a positive status across all indicators with management response to draft reports increasing 1% to 76% over the previous quarter.

15. We have experienced delays in receiving information/evidence to support our reviews which has had a direct impact on our ability to complete reviews in a timely manner. We continue to escalate issues concerning receipt of information and turnaround times for management response and work through the Board Secretary/Deputy Board Secretary per the Charter.

Table 4 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Green	76%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 5 – Core Plan 2020-21

Planned output	Outline timing	Status	Assurance
Corporate governance, risk and regulatory compliance			
Annual Governance Statement	Q1	Complete – Head of internal audit annual report.	Assurance not applicable
Welsh Risk Pool Claims Management Standard	Q4	Draft report issued.	
Risk Management	Q4	Final report issued.	Reasonable
Health and Safety	Q4	Draft report issued.	
Security	Q2	Final report issued.	Limited
Violence and Aggression – Obligatory responses to violence in healthcare	Q3	Final report issued.	Limited
Engagement of interim appointments	Q2	Final report issued.	Limited
Temporary Hospitals – Follow-up of KPMG recommendations	Q2	Deferred to 21/22.	Deferred to 21/22 due to agreed implementation timelines.
Decision making during COVID-19 – Advisory review	Q2	Final report issued.	Advisory Review
Mental Health & Learning Disabilities Division – Governance arrangements	Q2	Final report issued.	Limited
Strategic planning, performance management and reporting			
Performance measure reporting to the Board – Accuracy of information	Q2	Draft report issued.	
Improvement Groups	Q3		Recommended for deferral by Committee.
Advisory Review: Preparations for EU exit (Brexit)	Q3	Final report issued.	Advisory Review

Planned output	Outline timing	Status	Assurance
Financial governance and management			
Delivery of Savings – Ysbyty Glan Clwyd Hospital	Q1	Final report issued.	Limited
Budgetary Control & Financial Reporting	Q2-3	Final report issued.	Reasonable
Financial Governance Cell - Consultancy	Q1-2	Final advisory paper on capital expenditure issued.	Advisory Review
Quality and Safety			
Annual Quality Statement	Q2	Final report issued.	Reasonable
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q2-4	On-going review as and when evidence is received.	Assurance not applicable
Clinical Audit	Q4		Recommended for deferral by Committee.
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices	Q2	Draft report issued.	
Follow up of previous Healthcare Inspectorate Wales reports	Q2-4	On-going review as and when evidence is received.	Deferred to 21/22 following review of sample.
Information governance and security			
IM&T Control and risk assessment	Q2	Final report issued.	Assurance not applicable
Caldicott Principles into Practice (CPiP)	Q2	Final report issued.	Substantial
Disaster Recovery/Business Continuity Plan - Informatics	Q2-3	Final report issued.	Limited
Digital Strategy	Q3		Recommended for deferral by Committee.
Operational service and functional management			
Programme Management Office (PMO)	Q2-3		Recommended for deferral by Committee.
Patient monies and property	Q3/4	Final report issued.	Assurance not applicable
Approved Clinicians and Section 12(2) approval - Governance	Q4	Final report issued.	Reasonable
Workforce management			
Roster Management	Q1	Final report issued.	Limited
Recruitment – Employment of locum doctors	Q2-3	Draft brief issued.	Recommended for deferral by Committee.

Planned output	Outline timing	Status	Assurance
Sickness management – Recording reason for the sickness episode	Q3		Recommended for deferral by Committee.
Establishment control – Leaver management	Q2-3	Draft brief issued.	Recommended for deferral by Committee.
On-Call arrangements	Q3		Recommended for deferral by Committee.
Capital and estates management			
Environmental sustainability report	Q2	Final report issued.	Substantial
Control of Contractors	Q2-3	Final report issued.	Limited
Statutory Compliance: Water Safety	Q2	Final report issued.	Limited
Capital Systems	Q2	Draft report issued.	
Integrated Audit and Assurance Plan(s): • Ablett Unit	Q1-4	Final report issued.	Reasonable

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.

Assurance not applicable is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Local Health Board

Head of Internal Audit Opinion & Annual Report 2020/2021

May 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Report status: Final
Draft report issued: 5th May 2021
Final report issued: 27th May 2021
Author: Head of Internal Audit
Executive Clearance: Board Secretary
Audit Committee: 10th June 2021

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

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

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

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2020/21 is that:

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

1.3 Delivery of the Audit Plan

Due to the considerable impact of COVID-19 on the Health Board, the internal audit plan has needed to be agile and responsive to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. In addition, regular audit progress reports have been submitted to the Audit Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for 2020/21 year was initially presented to the Audit Committee in March 2020, however as a result of the impact of the pandemic a revised version of the plan was prepared, with this version receiving approval at the Committee in June 2020. This Annual Report and Opinion is primarily based on the delivery of the June 2020 version of the annual plan, including the subsequent updates made to the plan that are reported the Audit Committee at each meeting.

There are, as in previous years, audits undertaken at NWSSP, NWIS, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see Section 3).

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

1.4 Summary of Audit Assignments

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

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

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in figure 1 overleaf.

Where we have given either Limited or No Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, and in part reflecting the impact of COVID-19, we also undertook a number of advisory and non-opinion reviews to support our overall opinion.

Figure 1 – Summary of audit results

Substantial Assurance	Reasonable Assurance
• Caldicott Principles into Practice (CPiP) • Environmental sustainability report	• Risk Management

- Welsh Risk Pool Claims Management Standard
- Budgetary Control & Financial Reporting
- Annual Quality Statement
- HASCAS & Ockenden external reports – Recommendation progress and reporting
- Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices
- Approved Clinicians and Section 12(2) approval - Governance
- Capital Systems
- Capital assurance - Ablett Unit
- Performance Reporting

Limited Assurance

- Security
- Violence and Aggression – Obligatory responses to violence in healthcare
- Engagement of interim appointments
- Mental Health & Learning Disabilities Division – Governance arrangements
- Delivery of Savings – Ysbyty Glan Clwyd Hospital
- Disaster Recovery/Business Continuity Plan – Informatics
- Roster Management
- Control of Contractors
- Statutory Compliance: Water Safety

Advisory/Assurance not applicable

- Annual Governance Statement
- Health and Safety
- Decision making during COVID-19 – Advisory review
- Financial Governance Cell – Consultancy
- Advisory Review: Preparations for EU exit (Brexit)
- IM&T Control and risk assessment
- Patient monies and property

No Assurance

- No reviews

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

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

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

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

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

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

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

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

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

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Betsi Cadwaladr University Local Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

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

The overall opinion by the Head of Internal Audit on governance, risk management and control 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.

2.3 Assurance Rating System for the Head of Internal Audit

Opinion

For 2020/21, the assurance rating framework for expressing the overall Head of Internal Audit annual opinion that was agreed in 2013/14 has been amended to formally remove the eight assurance 'domains based' approach to forming the opinion for Health Boards. The domains approach has been removed to ensure that work in 2020/21 reflected the significant change in the risk profile for NHS Wales' organisations due to the impact of COVID-19. There are no changes to the approach to forming the opinion for Trusts and other Health Bodies. The professional judgement of the Head of Internal Audit also remains key in determining the appropriate overall opinion. This change does not impact upon our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2013/14 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

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

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2 and **Appendix B**). We will consider whether changes need to be made to how we present our findings in this report for the 2021/22 Head of Internal Audit Opinion.

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

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

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

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any Limited Assurance reports issued during the year and the significance of the recommendations made (of which there were three audits in 2020/21).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2020/21 and reported to the Audit Committee has been aggregated at **Appendix B**.

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

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including: cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of ad hoc work and support provided; liaison with other assurance providers and regulators; and research. Cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified that a small majority of reviews during the year concluded positively with robust control arrangements operating in some areas. However, there were nine limited assurance reviews and action has been identified in a number of key areas.

From the reports issued during the year, three were allocated Substantial Assurance, nine were allocated Reasonable Assurance and nine were allocated Limited Assurance. No reports were allocated no assurance. In addition, seven Assurance not applicable/Advisory reports were also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited or no assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings in each of the domains as per the structure of the plan for 20/21, is shown below, whilst noting the overall opinion for the Health Board is based on an overall aggregated position.

Corporate Governance, Risk Management and Regulatory Compliance

Our review of the *Annual Governance Statement* was fulfilled and reported on within the Head of Internal Audit's annual report – assurance not applicable.

Our review relating to *Welsh Risk Pool Claims Management Standard* recorded substantial assurance (Draft).

Risk Management: Corporate Risk Register and Board Assurance Framework recorded reasonable assurance, where some compliance issues with expected controls were identified.

The *Decision making during COVID-19 – Advisory review* (assurance not applicable) presented a positive picture of arrangements, highlighting that the temporary governance arrangements operated effectively during the peak of the pandemic and overall complied with the guidance and the principles issued by Welsh Government.

The *Health and Safety* review, focusing on progress made against the 2019 gap analysis has identified progress against some areas and less so in others – assurance not applicable (Draft).

The *Security Compliance* review identified limited assurance concerning the Health Board's achievement against the 2005 Security Management Framework for NHS Trusts in Wales (extant) as well as delivering against its own security action plan where limited progress had been made.

The *Violence and Aggression – Obligatory responses to violence in healthcare* review identified limited evidence that the Obligatory Response was complied with in full. We also found investigation officers recording of lessons learnt were of varying quality, with a lack of training needs identified for the training of all staff – limited assurance.

The *Engagement of interim appointments* review reported that the current Health Board process was not effective or fit for purpose in ensuring that the engagements of all interim appointments complied with expected procurement, workforce and financial controls – limited assurance.

The *Mental Health & Learning Disabilities Division – Governance arrangements* review reported limited progress since the previous internal audit report in addressing governance issues. The Together for Mental Health Strategy project plan has not been maintained and has lost direction due to elapsed tasks, with Psychological Therapy services not subject to the same focus and support – limited assurance.

The *follow-up review of the KPMG recommendations relating to the Temporary Hospitals*, has been started but deferred to 2021/2022 as not all the actions are set for completion; we are using the evidence in the Audit Committee tracker to identify implementation and this review will report as the hospitals are decommissioned.

Strategic Planning, Performance Management & Reporting

Performance measure reporting to the Board – Accuracy of information review reported reasonable assurance. Whilst no issues of significance have been identified in relation to data accuracy concerning Urology, we have highlighted some weakness in reporting for consideration. We have been unable to test prioritisation of patients waiting as the process has not been fully implemented (Draft).

The *Advisory Review: Preparations for EU exit (Brexit)* sought to support management in identifying whether key elements of the NHS Confederation guidance document 'Preparing your NHS Organisation for the end of the EU Exit Transition Period' could be evidenced as being considered – assurance not applicable.

A review was deferred form the original plan due to the impact of the pandemic in this domain relating to *Improvement Groups*.

Financial Governance and Management

The *Delivery of Savings – Ysbyty Glan Clwyd Hospital* review was limited assurance as only one saving scheme in our sample achieved its planned target, raising concern over the robustness of the planning and proposals made coupled with how realistic delivery of each scheme was.

Budgetary Control & Financial Reporting review was reasonable assurance where we identified automation of the virement process should continue, however governance improvements need considering. Evidence was noted where budget holders/managers were not reviewing their monthly reports (Draft).

Financial Governance Cell – Consultancy paper undertook a review of capital expenditure relating to COVID-19 as part of the self-assessment commissioned by the Executive Director of Finance – assurance not applicable.

Quality & Safety

Annual Quality Statement (AQS) review identified the consistency of data reported to Members and published in the AQS/performance measures (IQPR) needed to be clearly identified/agreed at the outset of AQS compilation – reasonable assurance.

HASCAS & Ockenden external reports – Recommendation progress and reporting involved following-up the evidence of eight agreed actions where management have recorded recommendations for closure. We reviewed two areas, end of life planning and those which were directed at the Office of the Board Secretary where we were able to corroborate this with supporting evidence – reasonable assurance (Draft).

Patient Safety Notices/Alerts/Medical Device Alerts/Field Safety Notices review identified issues surrounding the process embedded in the Health Board is not underpinned by a current operational procedure articulating roles, responsibilities and process to be followed upon receipt of and obtaining a response from operational areas advising of actions taken – reasonable assurance (Draft).

Follow up of previous Healthcare Inspectorate Wales reports has been started but deferred to 2021/2022 as we have been agreeing the sample period and obtaining details from Datix following the transfer from a manual system.

A review was deferred form the original plan due to the impact of the pandemic in this domain relating to *Clinical Audit*.

Information Governance & Security

IM&T Control and risk assessment review identified areas for improvement including managed projects, managed operations and managed security – assurance not applicable.

Caldicott Principles into Practice (CPiP) review identified there were a small number of areas where the narrative/score did not fully reflect the Health Board's position – substantial assurance.

Business Continuity Plan – Informatics review noted that business continuity plans had not been tested and in some cases were not evident as having been updated for a significant period of time. Informatics attendance at the Health Board's Civil Contingencies/ Business Continuity Groups was not evident – limited assurance.

A review was deferred form the original plan due to the impact of the pandemic in this domain relating to *Digital Strategy*.

Operational Service and Functional Management

Patient monies and property was an advisory review requested by the Mental Health and Learning Disabilities Division following a series of incidents within a small number of locations – assurance not applicable.

Approved Clinicians and Section 12(2) approval – Governance review noted there was robust governance in place as the Health Board is the central approving body for Approved Clinicians and Section 12(2) doctors on behalf of all Health Boards in Wales but we did identify some housekeeping issues for consideration – reasonable assurance.

A review was deferred form the original plan due to the impact of the pandemic in this domain relating to *Programme Management Office (PMO)*.

Workforce Management

Our review of *Roster Management* identified limited engagement from external providers as we were unable to fulfil the scope of this review due to COVID-19 restrictions and could not verify that all shifts the Health Board paid for were undertaken – limited assurance.

A number of reviews were deferred from the original plan due to the impact of the pandemic in this domain including *Recruitment – Employment of locum doctors*; *Sickness management – Recording reason for the sickness episode*; *Establishment control – Leaver management*; and *On-Call arrangements*.

Capital & Estates Management

Environmental sustainability report review noted there remains a lack of any explicit detail concerning an overarching corporate environmental strategy – substantial assurance.

Control of Contractors review identified limited progress to date in addressing the findings of the Occupational Health and Safety Gap Analysis Report, presented to

the Strategic Occupational Health and Safety Group on the 29th August 2019 – limited assurance.

Statutory Compliance: Water Safety review identified that the water safety plan and policy require updating – limited assurance.

Capital Systems review identified minor issues surrounding the expected compliance with Health Board procedure – reasonable assurance (Draft).

Ablett Unit Project was limited in scope to project governance arrangements and identified a small number of issues for consideration as the project moves forward – reasonable assurance.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited or No Assurance.

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

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

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

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

2.4.4 Limitations to the Audit Opinion

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

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

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

2.4.5 Period covered by the Opinion

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

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

The majority of audit reviews will relate to the systems and processes in operation during 2020/21 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

The audit of Environmental Sustainability Reporting contained with the 2020/21 Internal Audit plan related to the Health Board's report produced in respect of the 2019/20 year.

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

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

2.5 Required Work

There are a number of pieces of work that Welsh Government has required previously that Internal Audit has reviewed each, where applicable. These pieces cover aspects of:

- Health & Care Standards, including the Governance, Leadership and Accountability standard;
- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report; and
- Welsh Risk Pool.

Where appropriate, our work is reported in Section 5 – Risk based Audit Assignments and at **Appendix B**.

Please note that following discussions with Welsh Government we are not being mandated to audit these areas from 2021/22. Future work in these areas will be determined on the basis of risk or specific requests from the Health Board.

2.6 Statement of Conformance

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

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

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Betsi Cadwaladr University Health Board in conformance with the Public Sector Internal Audit Standards for 2020/21.

Our conformance statement for 2020/21 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2020/21 which will be reported formally in the Summer of 2021; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A,** the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2020/21 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

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

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Health & Safety, Local Counter-Fraud, Post Payment Verification, and Risk Management;
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and

- Reviews completed by external regulation and inspection bodies including the Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

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

- NHS Wales Shared Services Partnership;
- NHS Wales Informatics Service;
- Welsh Health Specialised Services Committee; and
- Emergency Ambulance Services Committee.

Please note that, in response to COVID-19, we have altered our approach this year and undertaken additional testing on a number of the national NWSSP run systems and produced separate reports for each NHS Wales organisation where appropriate.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Comments
Accounts Payable	Reasonable	A summary report will be produced for the health board
Payroll	Reasonable	A summary report will be produced for the health board
Primary Care Services – Medical (GMS), Pharmaceutical (GPS), Dental (GDS), and Ophthalmic (GOS) Services	Substantial (*draft*)	A summary report will be produced for the health board
Welsh Risk Pool	WIP	-
New PCS payment system – data migration & project management	N/A	Advisory support work on the implementation of the new PCS payment system.
Covid-19 financial governance	N/A	-

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

The reports on Accounts Payable, Payroll, and Primary Care Services are also included in the table at Appendix B (as they have been in previous years).

NHS Wales Informatics Service (NWIS)

As part of the internal audit programme at NHS Wales Informatics Service (NWIS), a hosted body of Velindre University NHS Trust in 2020/21, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Comments
IT Cyber Security	Substantial	-
GDPR Follow-Up	Substantial	-
Operational Resilience	Reasonable	-
Supplier Management Follow-Up	Reasonable	-

Please note that other audits of NWIS activities are undertaken as part of the overall NWIS internal audit programme. All reports are received by the Velindre University NHS Trust Audit Committee. No formal Head of Internal Audit Opinion is currently given for the work at NWIS.

For 2020/21, NWIS will become a Special Health Authority under the name of Digital Health and Care Wales and will have a separate Audit Committee, Internal Audit plan and annual Head of Internal Audit Opinion.

Welsh Health Specialised Services Committee (WHSSC) and **Emergency Ambulance Services Committee (EASC)**

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Comments
WHSSC - Women and Children Directorate	Substantial	-
WHSSC – financial systems	Substantial	-
EASC - Recruitment review	Reasonable	-

While these audits do not form part of the annual plan for Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. NWIS audits are summarised in the

Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported and reflected within this Annual Report will be reported alongside audits from the 2021/22 operational audit plan.

The audit plan approved by the Audit Committee in March 2020 contained thirty-two planned reviews. During the year changes have been made to the plan with six reviews added, ten removed/deferred, with us therefore planning to deliver twenty-eight reviews.

The assignment status summary is reported at section 5 and **Appendix B**.

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

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. The key performance indicators are summarised in **Appendix C**.

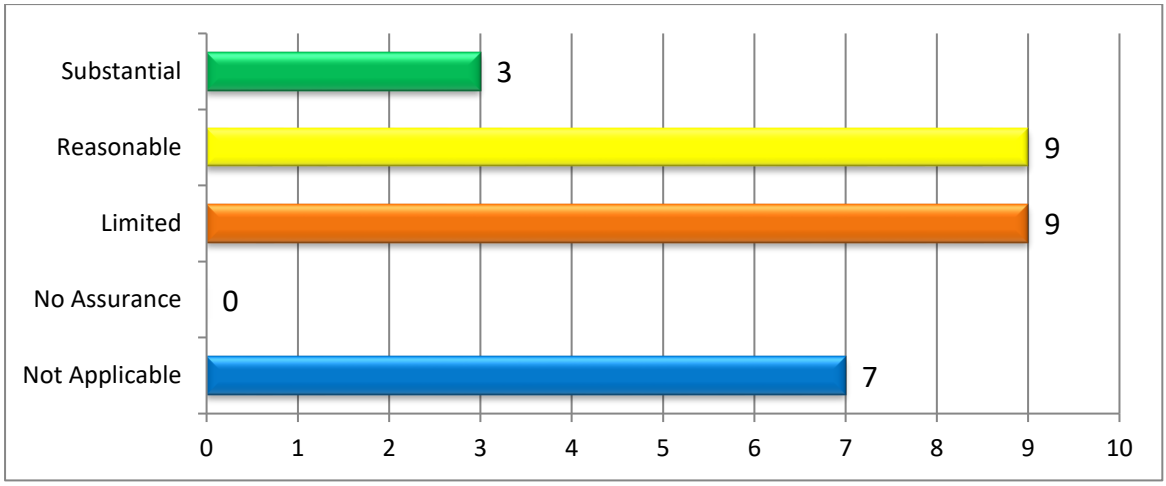
5. RISK BASED AUDIT ASSIGNMENTS

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

5.1 Overall summary of results

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

Figure 2 Summary of audit ratings



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

In addition to the above, there were twelve reviews which did not proceed following preliminary planning and agreement with management, as it was recognised that there was action required to address issues/risks already known to management and an audit review at that time would not add additional value.

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

5.2 Substantial Assurance (Green)

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

Review Title	Objective
Welsh Risk Pool Claims Management Standard (Draft)	To establish whether there is a robust control environment in place within the Health Board to manage and support claims reimbursements from the Welsh Risk Pool.
Caldicott Principles into Practice (C-PIP)	To review the Health Board's processes for completion of the C-PIP assessment and the collation of appropriate evidence to support the assessed score.

Review Title	Objective
Environmental sustainability report	To assess the adequacy of management arrangements for the production of the Sustainability Report within the Annual Report.

5.3 Reasonable Assurance (Yellow)

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

Review Title	Objective
Risk Management – Corporate Risks and Board Assurance Framework	To ensure the Health Board has an effective system in place in which identifying and managing risk is a continuous process.
Performance measure reporting to the Board – Accuracy of information (Draft)	To validate the reporting of a sample of Performance Measure (s) going back to source data to confirm the integrity, accuracy and controls in place.
Budgetary Control & Financial Reporting (Draft)	To assess the effectiveness key financial controls and compliance in accordance with Finance policies/procedures.
Annual Quality Statement	To review the consistency of information published within the AQS with organisational data previously reported to the Board and its Committees.
Patient Safety Notices/Alerts/ Medical Device Alerts/Field Safety Notices (Draft)	To review the process operated in the Health Board for the receipt of a sample of notices to ensure they are disseminated to the right people in a timely way.
Approved Clinicians and Section 12(2) approval - Governance	To establish whether, within the Health Board, there is robust control and governance arrangements in place to ensure that applications for approval and re-approval, meet the professional requirements to undertake the functions of an Approved Clinician and Section 12(2) Doctor.

Review Title	Objective
HASCAS & Ockenden external reports – Recommendation progress and reporting (Draft – *based upon the review of eleven recommendations received to date*) (Draft)	To review the evidence supporting the eleven recommendations noted as completed to the Health Board at its meeting of the 5th September 2019.
Capital Systems (Draft)	To evaluate the systems and controls in place within the Health Board, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.
Ablett Unit	To evaluate the systems and controls in place within the Health Board, with a view to delivering assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.

5.4 Limited Assurance (Amber)

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

Review Title	Objective
Security	To ensure the requirements set out in the Security Management Framework for NHS Trusts are being complied with.
Violence and Aggression – Obligatory responses to violence in healthcare	To ensure robust arrangements are in place relating to Violence & Aggression.
Engagement of interim appointments	To review the Health Board's compliance with Standing Financial Instructions, procurement arrangements and pre-employment checks in respect of appointments made to interim senior roles.

Review Title	Objective
Mental Health & Learning Disabilities Division – Governance arrangements	To review the governance arrangements in place for Mental Health and Learning Disabilities Division (MH&LD) in line with the previous internal audit review undertaken in February 2019 and follow-up on previous agreed management actions.
Delivery of Savings – Ysbyty Glan Clwyd Hospital	To establish whether there is a robust control environment in place within the Health Board to support the delivery of the Health Board savings plan.
Business Continuity - Informatics	To establish whether there is a robust control environment in place within the Health Board to ensure that effective business continuity measures are in place and comply with relevant policies, legislation, and best practice.
Roster Management	To ensure the Health Board was not paying for agency services it had not received due to a lack of internal control at ward level.
Control of Contractors	To evaluate the systems and controls in place within the Health Board, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.
Statutory Compliance: Water Safety	To determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Blue)

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

Review Title	Objective
Annual Governance Statement	To review the completion of the Statement in compliance with the Manual for Accounts requirements.
Health and Safety (Draft)	To review the current status of the gap analysis undertaken in 2019 and ascertain whether the milestones for set actions have been achieved.
Governance Arrangements during the Covid-19 Pandemic	To assess the adjusted financial and overall governance arrangements that were put in place to enable Betsi Cadwaladr University Health Board to maintain appropriate governance whilst enabling its senior leadership team to respond to the rapidly developing emergency.
Advisory Review: Preparations for EU exit (Brexit)	To ensure the adequacy and effectiveness of the arrangements in place to prepare the Health Board for the end of the transition period on 31st December 2020.
Financial Governance Cell – Consultancy: COVID-19 Capital Expenditure	To review discretionary capital expenditure relating to COVID-19 with a view to providing assurance to the Health Board that risks material to the objectives of the areas of coverage are appropriately managed.
IM&T Control and Risk Assessment	To establish the processes and mechanisms in place for management of IG/ ICT within the organisation. The review sought to provide a baseline picture of the organisation's status and provides suggestions for areas of improvement or future development.
Mental Health and Learning Disabilities - Review of Patient Monies	To provide the MH Division with assurance that there are adequate and effective arrangements in place for the management and safeguarding of patients monies at Wrexham and Ysbyty Glan Clwyd.

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for deferment
Temporary Hospitals – Follow-up of KPMG recommendations	Due to the pending decommission of the three hospitals, some recommendations will not be complete until later in 2021. Recommendations will be followed up per the Audit Committee tracker responses.
Improvement Groups	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Clinical Audit	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Digital Strategy	The document presented to the Board in December 2019 was the last version presented prior to COVID-19. Following discussion with the Executive Medical Director, the Acting Board Secretary and the Chief Information Officer no further progress had been made with plans in place to refresh the strategy in 21/22.
Programme Management Office (PMO)	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Recruitment – Employment of locum doctors	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Sickness management – Recording reason for the sickness episode	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Establishment control – Leaver management	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
On-Call arrangements	Per the Committee's request, plan was revisited following the second wave of the pandemic and anticipated winter pressures.
Integrated Audit and Assurance Plans: • Ablett Unit • North Denbighshire • Wrexham Maelor Hospital - Backlog maintenance requirements	Continuing pressures and the status of delivery programmes for the major projects/ programmes across NHS Wales, it was recognised that these schemes were subject to approval delay and therefore no internal audit review would be prudent.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2020/21 plan.

Dave Harries CMIIA QiCA
Pennaeth yr Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
May 2021

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

	based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's

	framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN

Assurance domain	Audit Count	Overall rating	Not rated	No assurance	Limited assurance	Reasonable assurance	Substantial assurance
Quality and Safety	3					●●●	
Corporate Governance, Risk and Regulatory Compliance	9		●●●		●●●●	●	●
Financial Governance and Management*	7		●		●	●	■■■■
Strategic Planning, Performance Management and Reporting	2		●			●	
Information Governance and Security	3		●		●		●
Operational Service and Functional Management	2		●			●	
Workforce Management	1				●		
Capital and Estates Management	5				●●	●●	●

Key to symbols:

● Audit undertaken within the annual Internal Audit plan including those issued as draft.

■ * This domain outcome also includes the four financial system audits undertaken through the audit of NWSSP as they include transactions processed on behalf of the Health Board (please see section 3 for details).

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	Mar 2020	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2020/21	G	93%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [20 working days]	G	76%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.
Assurance not applicable	 - + Blue	Reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Confidentiality

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

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

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

Audit

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

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

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

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

Responsibilities

Responsibilities of management and Internal Auditors:

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

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

Betsi Cadwaladr University Health Board

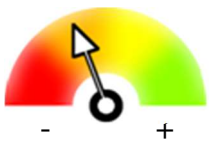
Engagement of Interim Appointments

Final Internal Audit Report

BCU 2020/21

April 2021

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating N/A

Contents **Page**

Review reference:	BCU-2021-38
Report status:	Final Internal Audit Report
Fieldwork commencement:	8th September 2020
Fieldwork completion:	28th January 2021
Discussion draft report issued:	29th January 2021
Discussion draft report meeting:	10th February 2021
Additional evidence provided:	2nd March 2021
Revised draft report issued:	4th March 2021
Further additional evidence provided:	8th April 2021
Revised draft report issued:	12th April 2021
Management response received:	22nd April 2021
Final report issued:	23rd April 2021
Auditor/s:	Audit Manager Head of Internal Audit Director of Audit & Assurance
Executive sign off:	Director of Finance
Distribution:	Board Secretary Director of Workforce & OD Deputy Board Secretary
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

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

1. Introduction and Background

This review was formally requested by the Director of Finance to assess the Health Board's compliance with Standing Financial Instructions (SFIs) and procurement arrangements in respect of appointments to Senior Interim roles.

Assurance in respect of interim appointments was the subject of a report by Audit Wales, "Arrangements for Interim Senior Staff Appointments – Betsi Cadwaladr University Health Board", published in March 2020. As noted in the following extract from the report, the focus was the appointment to five senior staff appointed on an interim basis between February and October 2019.

> *"Our review examined the process followed by Betsi Cadwaladr University Health Board in appointing five interim senior staff between February and October 2019, including the Interim Recovery Director. The significant cost of that appointment has attracted attention in the media and amongst Assembly members and our review was centred on this role". (p3)*

Our review built on and expanded the work undertaken by Audit Wales to review an extended sample for which we assessed a number of key controls.

2. Scope and Objectives

The overall objective was to review the Health Board's compliance with Standing Financial Instructions, procurement arrangements and pre-employment checks in respect of appointments made to interim senior roles.

The scope of this was to identify a list of appointments made in a defined time period and for a sample of these:

- Assessed compliance with Standing Financial Instructions and the requisite Procurement policies/regulations; and
- Reviewed the pre-employment checks undertaken, ensuring compliance with Health Board Procedures.

We did not evaluate compliance with IR35 Legislation - Intermediaries Legislation which is a set of rules designed to ensure that individuals contracted to work for a client through an intermediary e.g. their own limited company, partnership or personal service company, have the right rate of Income Tax and National Insurance deducted. When deciding if IR35 applies to a contract the employment status of the worker must be established as if the intermediary did not exist.

3. Associated Risks

The following risks were identified at the outset:

- Health Board is in breach of SFIs and/or competitive tendering regulations;
- Not achieving value for money when making appointments due to procurement model followed; and
- Employing senior staff without completing the necessary pre-employment checks, so not ensuring the suitability of appointments.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the **Engagement of Interim Appointments** review is limited assurance.

RATING	INDICATOR	DEFINITION
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.

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.

5. Assurance Summary

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

Assurance Summary					
1	Compliance with Standing Financial Instructions and the requisite Procurement policies/regulations		✓		
2	Pre-employment checks undertaken, ensuring compliance with Health Board Procedures.		✓		

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

Design of Systems/Controls

The findings from the review have highlighted a number of issues that are classified as weakness in the system control/design for Engagement of Interim Appointments.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the currently designed system/control for Engagement of Interim Appointments, one being specific to an engagement to one specific post.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided by Procurement Services [a part of NHS Wales Shared Services Partnership (NWSSP)] and a Corporate Accountant, Senior Accountant and a Head of Workforce & OD from the Health Board. We would like to express our gratitude for their input during the undertaking of the review.

We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

We found it difficult to identify a composite list of interim engagements and had to use lists held by Procurement[1]; Finance; and Workforce & Organisational Development, all of which had elements of different engagements.

To address this we consolidated the several lists provided to us by Procurement and Finance and further verified this by access to Oracle with assistance from the Systems team. At the same time, we approached Workforce for their list of engagements. By a triangulation of data, we established there was a potential sample of twenty-five interim engagements, excluding prior year appointments. However, we cannot confirm that this is the complete number of appointments.

We identified a risk based sample size of twelve from within the time period upon which to review process.

This review has taken longer than anticipated due to difficulties in obtaining supporting documentation. Following issue of the discussion draft report, we were advised that additional evidence would be provided by the end of February 2021 – We received some additional evidence on the 2nd March 2021 from Workforce & Organisational Development and revised our findings accordingly.

On issuing the revised draft report on the 4th March 2021, we requested the management response for the 12th March 2021. We followed this up on the 16th March 2021 advising the Board Secretary that we needed to escalate as the response had not been received. The Board Secretary advised that they would raise with the Directors' of Finance and Workforce & OD respectively.

We received confirmation on the 30th March 2021 that additional evidence would

[1] Procurement maintain a register of interim appointments as and when they receive documentation and requests for framework access by the Health Board.

be received on the 31st March 2021 and received this from Workforce & OD on the 8th April 2021.

We recognise that the impact of COVID-19 and the need to engage external support, at the height of the Health Board's pandemic response, may have resulted in some stages of the process not being adhered to as intended. However, we also note that some of the appointments in our sample were engaged after the Health Board returned to a form of business as usual, albeit with the continued pressures of a second wave of the pandemic; Test Trace Protect (TTP) programme; and mass vaccination programme.

Compliance with Standing Financial Instructions and the requisite Procurement policies/regulations

At the outset, we sought to ensure we undertook the review in accordance with the current operational procedure in use in the Health Board and clarified this with both Workforce & Organisational Development (WOD) and Finance Directorates.

WOD provided us with the *F18 - Interim Appointment and Intermediaries Legislation (IR35) Procedure* [approved by the Finance & Performance Committee 12th February 2020]. WOD advised that some gaps/changes needed applying to the procedure but had yet to be discussed with Finance; further we were told that WOD were developing a draft agency appointment procedure but this is yet to be formalised.

Using *F18* procedure, the role of the manager recorded *"The manager should obtain authorisation for the engagement through the Establishment Control process."*[2]

We requested a list of all posts subject to establishment control from WOD to verify our sample against the list. We were advised that the report had been produced but was waiting approval for issue to us. We requested the information and received a response on the 24th November 2020 advising the following:

> *"The Intermediaries Legislation (IR35) Procedure was agreed in February 2020. The timing of the procedure immediately pre the pandemic, meant that it was quickly realised that Establishment Control was not an appropriate vehicle for interim appointments because interim support was required extremely quickly in the majority of cases.*
>
> *It was therefore agreed that the procedure would be that the requirement would be agreed by key executives, with WOD then advising or managing the process. WOD are then responsible for management of contract negotiation and ensuring that checks are done etc."*

Whilst acknowledging the response, it did not directly address our request for a copy of the report detailing a list of all posts subject to establishment control. We followed this up on the 25th November 2020 requesting sight of the report that, as advised, had been produced by WOD colleagues. Further, we also asked for minuted evidence where the decision not to follow the finance procedure was taken – at the time of compiling this report, we have not received a reply or the

[2] Extract from F18 – Role of Manager

evidence requested.

On the 8th April 2021, we received a copy of the Workforce & OD Workstream Decision Log pertaining to the COVID-19 emergency planning arrangements.

Decision ID WF23, 26th March 2020 notes the following:

Description of decision	Decision made by	Decision to be communicated elsewhere? If so where?	Action complete	Notes	Rationale for decision	Required escalation to Gold	Required escalation to Board
Implementation of Fast-Track Establishment Control Processes.	SRO	All managers via daily briefing	Yes	Covers all staff/ contracts/ contractors	to increase speed of recruitment	No	No

Whilst recognising the above decision taken by the Workstream SRO, it is worth noting that no formal changes were made to the Scheme of Reservation and Delegation during the pandemic.

In reviewing the noted controls/steps within the procedure, a summary of our findings is provided as following:

- F18 procedure references reporting to the Audit and Risk Assurance Committee, but the Health Board does not have a so named Committee;
- Establishment control approval process was not undertaken for any of the posts engaged by interim appointments/finders fees paid to agencies;
- Audit Committee has not received, within the quarterly conformance report, details of "…..*all IR35 assessments carried out to provide assurance that the Health Board is compliant with the Intermediaries legislation"*; and
- Procurement advised that they were not always involved in the process concerning interim appointments.

Whilst the F18 procedure covered a number of elements, we sought to ensure wider procurement and establishment controls were in situ and sought the following evidence:

- Details of agencies contacted per individual post;
- Copy of procurement framework call-off order form;
- References received [advised by WOD that two references is the standard]; and
- We reviewed the procurement system to confirm the date and value of the purchase order issued per post.

We were advised by WOD where RM6160 Framework is used, Section 5 advises that pre-employment checks are the responsibility of the supplier. Section 5 states:

5. Temporary Worker Compliance Requirements

Pre-Employment Check Standards

5.1. The Supplier shall undertake employment checking which seeks to verify that all Temporary Workers meet the preconditions of the role they are applying for. All Temporary Workers must be fully compliant prior to the commencement of the role.

5.2. The Supplier shall have a dedicated compliance manager who will ensure that all checks have been undertaken correctly prior to the appointment of a Temporary Worker.

The Health Board also undertook pre-employment checks and we recognise this as a positive additional control. However, we found limited evidence in our sample that agencies provided the Health Board with assurance that this was undertaken.

Based on the evidence we received from WOD and subsequent correspondence from other officers, table 1 below summarises our findings.

Table 1 – Summary of findings by interim post reviewed

Interim post	Findings based on evidence provided	Gap in control
Post 1	Framework document signed by agency and Health Board. Five agencies were contacted and twelve CVs received. Two references received, one of which was on an Agency headed document and was not signed to confirm authenticity. We received partial evidence to support that pre-employment check (PEC) [copy of passport] was completed however this is undated and unclear if it was undertaken prior to the individual starting. The purchase order requisition for this post [finder's fee - £17,290.38] was not completed or approved until after the invoice date which is a breach of the Health Board's 'no PO no pay' process.	Inconsistent application of PEC – Assurance from the agency that pre-employment checks were completed not evident.
Post 2	Framework document signed by agency and Health Board although some sections remained as template narrative. Four agencies contacted per the WOD spreadsheet. Email	PEC was received/ completed after the recorded contract start date.

Interim post	Findings based on evidence provided	Gap in control
	provided to us latterly with copies of CVs attached. One reference was received however the referee's surname was the same as the candidate but different per the footer. PEC were completed on the 1st July 2020 with the noted start date per the framework order form as "w/c 22/6/20". The original requisition was raised in advance of the invoice but the engagement has been extended on the same order number. The first requisition was for £56,875 and the second for £56,900 in October 2020, but the invoice was dated 30th September 2020 which is a breach of the Health Board's 'no PO no pay' process.	
Post 3	Framework document signed by Health Board. Nine agencies contacted per the WOD spreadsheet. Copies of CVs were not initially provided to us but latterly these have been forthcoming. PEC was not evidenced as being undertaken by the Health Board but we did see Certified PEC from the Agency dated 4th August 2020, however we note this was provided to the Health Board on the 3rd November 2020. Two references observed both undated however and we cannot verify when received as no audit trail evident. Purchase order raised in advance of the first invoice [£37,800 for 5th August to 30th October 2020. Extension noted for 2nd November to 31st December 2020 order raised for £25,200]. We were advised that the individual contractor has moved to another role in WOD from	Inconsistent application of PEC. No PO No Pay process not adhered to.

Interim post	Findings based on evidence provided	Gap in control
	November 2020 to June 2021 per a further purchase order for £85,000 – we noted the requisition and approval were made after the invoice was received which is a breach of the Health Board's 'no PO no pay' process.	
Post 4	We were provided with an ESPO Framework Agreement 664-17 Consultancy Services for this post. We contacted Procurement and were advised the incorrect form had been used; they also advised that from the description *'nmnc framework run by Crown Commercial services'* the Health Board may have intended to utilise the CCS RM971 framework which has now expired (expired 30th June 2019) – We confirmed that neither agency or firm used were on this framework. On the 2nd March 2021, we received correspondence advising that no framework was used. We contacted Procurement services who confirmed that no tender or waiver has been sought for this supplier. We have received a copy of an assignment confirmation note signed by the Agency but not the Health Board. We have not received any evidence of CVs or whether PEC have been completed.	Framework not used and no evidence of appropriate tender/waiver - Breach of Standing Financial Instructions. No PEC evident.
Post 5	Framework document signed by Health Board 27th July 2020 and covered two interim appointments, however start date listed as 6th July 2020; two references were recorded through the TRAC system for one appointment. Copies of further two references provided to us latterly, noting however one of these was dated 24th July 2020	Framework contract approved after the actual start date. PEC was received/ completed after the recorded contract start date. No PO No Pay process not adhered to. Not evident Standing

Interim post	Findings based on evidence provided	Gap in control
	which was after the reported start date of 6th July 2020. We received evidence that PEC were completed in respect of two copies of passports, these were provided to us latterly with further evidence received noting PEC were recorded in TRAC on the 23rd July 2020 as being completed. Our review of the purchase order process identified an invoice was received and dated the 1st July 2020 but the requisition was approved on the 2nd October 2020, which is a breach of the Health Board's 'no PO no pay' process. In addition, we identified that the order for this was approved at £19,500 but has been over-receipted/committed by £5,200 (Total paid £24,700). This does not comply with the requirements of Standing Financial Instruction (SFI) 14.6.1i [Duties of Budget Holders and Managers].	Financial Instructions were complied with.
Post 6	Framework document signed by Health Board after the recorded start date. Four agencies contacted and CVs received. Two references received on agency headed documentation but not signed to confirm authenticity. Latterly provided with evidence to show PEC completed. Enhanced DBS viewed. Framework contract signed by Health Board after start date.	-
Post 7	Framework contract signed before start date with deliverables detailed. Eight agencies contacted and eleven CVs received.	Breach of no PO no Pay process.

Interim post	Findings based on evidence provided	Gap in control
	Three references received on agency headed documentation but not signed to confirm authenticity. Evidence that PEC was completed prior to the individual starting. Purchase order requisition not approved until 2nd November 2020 with the actual start date noted on the framework contract as 28th September 2020 which is a breach of the Health Board's 'no PO no pay' process.	
Post 8	Framework contract schedule signed by Health Board but undated. Three agencies contacted per WOD spreadsheet. Three CVs and two references dated 13th October 2020 provided to us latterly. The framework document stated that DBS check was to be carried out by the Health Board but no evidence that this was completed. We have seen no evidence that the Health Board received confirmation from the agency of PEC.	No PEC evident.
Post 9	No contract details are available for this post as we were advised this post was recruited through the Bank system, although we were also told this was unusual for such a senior post. We were told that this post was required to address an urgent issue in Ysbyty Glan Clwyd (YGC). On the 8th April 2021, we received further evidence from WOD: • Three agencies were contacted, with two responding and providing a cv each. • The individual appointed	Recruitment and agreement of salary is unclear.

Interim post	Findings based on evidence provided	Gap in control
	submitted a cv directly to the Health Board; we are unclear by who and how the individual was approached. • PEC were recorded in TRAC as being completed on the 27th October 2020. • Two references were received on the 22nd and 30th October 2020. • Timesheets were to be signed by an officer in the division. We have ascertained from Payroll Services that the individual was paid an hourly rate of £83.33 per hour plus on-costs and was paid: • £3,958.33 in November 2020 • £16,624.99 in December 2020 • £10,291.66 in January 2021. Correspondence received from WOD on 2nd March 2021 states: *"Day rate adjusted to £750 per day following WOD review to align to band 9.* *Appointment approved by Executive Director. Given urgent issues in YGC, it was agreed that bringing in a known individual was the best approach."* Following discussion with Payroll Services on the 4th March 2021 we confirmed that the individual's annual salary is £162,946.25 (£750 per 9-hour day). Top of Band 9 salary is £104,927, at £53.66 per hour.	
Post 10	Framework document signed by Health Board after the recorded start date [Finder's fee £13,640.51]. Eleven agencies contacted per WOD spreadsheet. References as provided are in the form of Survey Monkey questionnaires that appear to	-

Interim post	Findings based on evidence provided	Gap in control
	have originated from the contractor engaged by the agency. We received evidence that PEC [copy of passport] was completed and subsequently also the TRAC record noted them as being undertaken on the 9th October 2020.	
Post 11	A former Hospital Managing Director (MD) completed this engagement. We received correspondence showing a request from the MD to raise a purchase order for the initial engagement from the 30th March to 30th September 2020 along with the Agency's assignment confirmation note that was not signed by the Health Board. We did not receive evidence that PEC were completed prior to the individual starting in March 2020 or that the engagement was subject to competition or references sought. We were advised that this contract was extended and were provided with a copy of the Framework contract signed by the Health Board on the 30th November 2020 after the extension start date of 30th September [to 31st December 2020]. We saw email correspondence showing a breach of the Health Board's 'no PO no pay' process with the Agency advising on the 1st December 2020 that no purchase order had been issued for the new contract period and that a total of £43,362 was due for the 29th September to 30th November 2020 inclusive.	Completed framework document for the initial engagement and evidence that PEC were completed prior to individual taking up role on 31st March 2020.
Post 12	We noted that this was a contract extension; on the 8th April 2021 we received the	One framework contract was not signed by an Executive Director.

Interim post	Findings based on evidence provided	Gap in control
	following evidence to support the engagement: • Framework contract call off order for 1st April to 31st July 2020 [post] signed by the Agency (12th March 2020) and Health Board (1st April 2020). • Framework contract call off order for 1st August to 31st October 2020 [Post] signed by the Agency (22nd July 2020) and Health Board (24th July 2020). This was signed by an Associate Director. • Framework contract call off order for 1st November 2020 to 31st March 2021 [Post] signed by the Agency (9th October 2020) and Health Board (26th October 2020). No competition is evident as being sought and the individual has retained the same daily rate as that for the previous post. In addition, we identified that the two purchase orders completed in 2020/21 were approved with order values of £76,440 and £59,150 respectively. Both purchase orders have been over-receipted/committed by £7,735 and £10,920 respectively (Total paid to date £154,245). This does not comply with the requirements of Standing Financial Instruction (SFI) 14.6.1i [Duties of Budget Holders and Managers]. In reviewing the invoices paid, we could not identify the approver for one invoice totalling £20,020 plus VAT – The timesheet (September 2020) had not been approved by an Executive Director and we have been unable to confirm who	

Interim post	Findings based on evidence provided	Gap in control
	authorised the timesheet for payment (£20,020 & VAT). Correspondence from WOD received on the 2nd March 2021 notes *"A call off order was not completed for [post holder] transfer into TTP. This would need to be retrospective."*	

Pre-employment checks (PEC) undertaken, ensuring compliance with Health Board Procedures

Part of our review focused on ensuring all interim appointments were subject to the same checks as those of substantive appointments. Table 1 details our findings per post of the twelve we sampled.

We sought evidence that PEC had been completed per the notes made on the WOD spreadsheet as noted under the *'PEC Status'* column.

A summary of the findings, based on additional evidence received on the 8th April 2021, from Table 1 note the following:

- Eight posts have had PEC completed, with two being completed after the start date;
- One post was an extension and transfer to a new interim position;
- For three posts we have been unable to confirm PEC were completed.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – Interim Appointment governance (Operating effectiveness)	Risk
Our review has identified that the current Health Board process is not effective or fit for purpose in ensuring the engagements of all interim appointments comply with expected procurement, workforce and financial controls. We have identified: • No composite register for recording the engagement of interims with different records held by Procurement; Finance and WOD; • Framework governance and approval is not robust or timely; • Incorrect framework details recorded for one engagement (Post 4) that had expired in 2019. No evidence of single tender waiver/tender process.	Standing Financial Instructions are not complied with.
Recommendation	**Priority level**
Using available Office365 applications to apply control and automate workflow steps, a full system review is undertaken to govern the recruitment of all interim appointments, thus removing the ability of individuals to engage interim staff without procurement, finance and workforce processes completed.	**High**
Management Response	**Responsible Officer/ Deadline**
Use of Office 365 is not appropriate for these purposes. However, an electronic process has been developed to support workflow, audit and reporting. Revised Standard Operating Procedure developed and subject to review and approval by Executive Team. Communication sent to agencies confirming the process and indicating payment of invoices will not be made if process not followed.	Director of Workforce & OD/Director of Finance 31st May 2021

Finding - ISS.2 – Interim Appointment governance (Operating effectiveness)	Risk
Our review has identified that the current Health Board process is not effective or fit for purpose in ensuring interim appointments comply with expected procurement, workforce and financial controls. We have identified: • Establishment Control process has not been followed per the requirements in the Standing Financial Instructions and Finance Procedure approved by Committee; • No competition in the embedded practice of moving interims from existing interim engagements to new engagements; • Evidence to support pre-employment check completion was inconsistent with limited evidence that the agency (supplier) provided this always; • References could not be confirmed for authenticity; • Breach of 'no PO-no pay'; and • Over commitment/receipting against approved purchase order value (Post 5 & 12).	Individuals have not been subject to pre-employment checks. Standing Financial Instructions are not complied with. Value for money not evident through lack of competition for posts.
Recommendation	**Priority level**
Using available Office365 applications to apply control and automate steps, a full system review is undertaken to govern the recruitment of all interim appointments, thus removing the ability of individuals to engage interim staff without establishment control, procurement, finance and workforce processes complied with.	**High**

All engaging officers ensure they comply with the Standing Financial Instructions.	
Management Response	**Responsible Officer/ Deadline**
Use of Office 365 is not appropriate for these purposes. However, an electronic process has been developed to support workflow, audit and reporting. Revised Standard Operating Procedure developed and subject to review and approval by Executive Team. Communication sent to agencies confirming the process and indicating payment of invoices will not be made if process not followed. Once the post has been approved, a purchase order will be raised prior to the engagement of the individual in order to comply with SFIs and appropriate guidance, together with the process will be issued across the organisation. A reminder to all staff about no purchase order, no pay will be issued by the end of April 2021. In addition, it has been agreed that a regular report will be submitted to RATS detailing engagement of senior interims against this process and compliance with the process.	Director of Workforce & OD/Director of Finance 31st May 2021 Director of Finance End April 2021 Ongoing but starting from July 2021

Finding - ISS.3 – Interim appointment review (Operating effectiveness)	Risk
We cannot confirm that the engagement to Post 9 has followed due process.	Openness and transparency in the recruitment to this post is not assured.
Recommendation	**Priority level**
The Executive Director of Finance considers whether the engagement to the post requires further investigation (Post 9) to determine whether the process followed was robust and delivered value for money.	**High**
Management Response	**Responsible Officer/ Deadline**
The Executive Director of Workforce has undertaken a review of the engagement of the post (post 9) to examine the recruitment process and outcomes delivered. The findings have been shared with Internal Audit and the Executive Director of Finance. The findings from this review have informed policy development already in-train regarding appointment to interim positions and the Executive Director of Finance will consider whether the post requires any further investigation.	Director of Workforce & OD/Director of Finance 30 April 2021

Appendix B - Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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.

Betsi Cadwaladr University Health Board

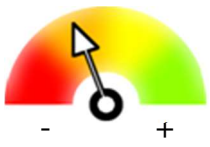
Security Compliance

Draft Internal Audit Report

BCU 2020/21

March 2021

NHS Wales Shared Services Partnership

Limited Assurance

Previous review rating N/A

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Final report issued:	30th March 2021
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Executive Director Workforce & Organisational Development
Distribution:	Associate Director Of Health, Safety & Equality, Head of Health & Safety, Board Secretary, Assistant Director – Deputy Board Secretary Head of Governance & Statutory, and Compliance, Governance & Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Security focuses on actions to protect property, people and assets from harm. Breaches of security against the Health Board diverts resources from their proper use and has the potential to affect the ability of the Health Board to meet the needs of the public.

Security involves all groups of staff at all levels and to be effective it is important to establish the support of everyone within the Health Board. The Health Board has a responsibility to have effective security measures in place to provide a safe environment for its patients, staff and visitors, through the reduction of security hazards and minimisation of crime on the premises under its control.

In July 2005, an all Wales security task and finish group produced the Security Management Framework for NHS Trusts in Wales. This was developed with the purpose of introducing revised security standards for NHS Wales, as well as providing guidance on their implementation.

A Health Board security review conducted between July and August 2019 developed an action plan to ensure compliance with the Welsh Government Security Management Framework and was presented to the Quality, Safety & Experience Committee 19thNovember 2019 (extract below).

Quality, Safety & Experience Committee 19 November 2019.

QS19.178c H&S Security Action Plan

Quality, Safety and Experience (QSE) Committee Minutes of the Meeting Held in public on 19.11.19

QS19/178.1

In terms of the security action plan, which was set out in an appendix to the report, it was noted that this would need to be revised in light of the gap analysis, which would require a longer timescale. [Director] indicated there was a risk in that the Board did not have the basic expected levels for security arrangements in place within some areas.

2. Scope and Objectives

Working in partnership with the Head of Health and Safety, the objective of this review will be to ensure the requirements set out in the Security Management Framework for NHS Trusts are being complied with.

We recognise that since the publication of the framework, Health Boards have been established, however the Framework remains extant.

The scope of this review was limited to:

- Using the thirteen (13) categorised areas for assessment within the Security Management Framework, we identified whether the four (4) key themes of accountability, process, capability and outcomes had been implemented.
- We cross-referenced the actions within the Health Board's security action plan to the Security Management Framework to determine Health Board compliance and identify, if any, gaps in control and assurance to the Board.

3. Associated Risks

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

- Non-compliance with the Security Management Framework for Wales.
- Damage/loss to Health Board owned property.
- Lack of pro-security culture amongst staff.
- Inadequate procedures and policies that protect staff, patients and visitors.
- Failure to comply with legislative for example the Data Protection Act and Health & Safety at Work etc. Act 1974.
- Unclear roles and responsibilities of staff within the Health Board.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

RATING	INDICATOR	DEFINITION
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.

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.

5. Assurance Summary

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

Assurance Summary					
1	2005 Security Management Framework for NHS Trusts in Wales compliance		✓		
2	Health Board Action Plan		✓		

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Security Compliance.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Security Compliance.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Security

This report is based upon the information provided by the Associate Director of Health, Safety & Equality, Head of Health and Safety and Security & Violence and Aggression Advisor. We would like to express our gratitude for their input and support in completing the review.

We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

Current situation

At the time of this review, security for the Health Board is split into two areas concerning accountability; Estates and Facilities have responsibility for the asset management (property and assets) whilst Health & Safety have overall responsibility for patients, staff and visitors.

From the 30th March 2020, all district hospitals and field hospitals now have 24/7 cover provided by an external security provider - The officers are located within the ED departments. Responsibility for the external security company lies with the Hospital Management Team as per contract agreement.

2005 Security Management Framework for NHS Trusts in Wales

Below are our findings from each assessment point.

1. Accountability

All trusts must nominate an Executive Director with responsibility for security. This role must be clearly defined with clear lines of accountability for security matters throughout the organisation, leading to the Board.

1. Finding

The Executive Director of Workforce and Organisational Development is the nominee who has responsibility for security regarding responsibility for patients, staff and visitors, as referenced in the Draft Security Policy, section 4. Roles and Responsibilities.

Direct responsibility for key tasks have been delegated within the draft policy where it identifies within section four (Roles and Responsibilities) clear lines of responsibility for security matters through the Health Board.

2. Accountability

All Trusts must have a dedicated Security Manager or an individual with specific operational responsibility for Trust security matters. This post holder should be adequately trained and demonstrate knowledge and expertise.

2. Finding

Currently the Health Board does not have a dedicated security manager; at the time of this review the role is a joint role undertaken by the Violence & Aggression Case Manager/Security Manager supported by the Head of Health & Safety referenced as follows:

Quality Safety and Experience Committee 28th August 2020

QS20/173 Occupational Health and Safety Annual Report 1st April 2019 to 31st March 2020 and Quarter 1 Report

15.1 Violence and Aggression

The Violence & Aggression Case Manager has also undertaken a Security Management function during Q1 following interim arrangements with Corporate Health & Safety team.

Having been provided with the draft Security policy the above differs to the Roles and Responsibilities within the draft policy:

Draft Security Policy - 4.Roles and Responsibilities

Head of Health, Safety and Security

The Head of Health, Safety and Security is responsible for the overall delivery of the security strategy

BCU HEALTH BOARD Security Management Service. (Under development)

The Head of Health Safety and Security will authorise suitable persons to conduct security management and advisory responsibilities under the Security Management Service. This service will be responsible for supplying advice and direction to all services, departments and managers within BCUHEALTH BOARD.

Within the Security Management Framework for NHS Trusts in Wales it states:

2.2 Area for Assessment 2 – Accountability at operational level

In larger Trusts there is an expectation that an appropriately trained Security Manager will be appointed who will normally work for a senior manager reporting directly to the Executive Director with overall accountability for security.

Although there is not a dedicated security manager within the Health Board, the Head of Health & Safety, as an Accredited Security Management Specialist (NHS Protect) supports a Health Board internal Security Management Service (SMS). This service currently consists of the Violence and Aggression Case Manager/Security Manager [0.8 WTE] and the Security/Violence and Aggression advisor presently employed on the bank [full time] as of the 26th October 2020.

3. Accountability

There is a Board approved security policy and strategy that has been communicated throughout the organisation and is supported by an agreed plan.

3. Finding

At the time of writing this report, the Security Policy was in draft format and had not been ratified.

4. Process

A crime prevention programme is developed, utilising relevant risk assessments, implemented and maintained throughout the organisation. In addition, specific crime prevention plans should be developed for sensitive /high risk areas such as A&E, Ambulance, Mental Health, Paediatrics, Maternity and Lone working.

4. Finding

Currently there is no overarching crime prevention programme, however specific Crime prevention programmes have been developed which include:

- CCTV - there is currently a root and branch review of CCTV ongoing, an external consultancy firm who have specialist knowledge is undertaking this.
- WEDFAN - is the Welsh Emergency Department Frequent Attenders Network (WEDFAN) who are multi-agency and together look at addressing as well as providing a holistic management package for service users.
- Checking of Staff ID badges – the aim being to introduce a pro security culture in the organisation whilst also at the same time limiting the opportunities for individuals to commit crime on our premises.
- The Security Management Service undertakes security risk assessments when a specific issue or incident arises; risk assessments appears to be reactive rather than proactive.

5. Processes

There is proper and timely response to security incidents in accordance with appropriate response plans.

5. Finding

The Security Management Service use the Datix incident reporting system to identify and respond to security incidents that have been reported within the Health Board. We reviewed security incidents (not including staff records) within the Datix system and it was identified that incidents are accessed by the SMS on a daily basis.

An example of this provided to us as evidence was of a general ward that was reporting an excessive amount of assaults on their staff; arrangements were made with the ward managers to attend and undertake an assessment. As part of a response plan, SMS were able to identify common denominators in the incident patterns and provide advice to mitigate the issues.

6. Processes

Security hazards and incidents are reported and analysed in accordance with the processes contained in the Incident and Hazard Reporting Standard (Standard 3).

6. Finding

As with the previous area for assessment (point 5), the Datix incident reporting system is used to report and analyse any security incidents.

We were informed that there is no root-cause analysis (RCA) standard template used for the security incidents that require further investigation, instead the analysis is currently undertaken through emails and meetings.

7. Processes

The risk management process contained within the Risk Management Policy and Strategy standard (Standard 1), and Risk Assessment and Treatment standard (Standard 2) is applied to security risks.

7. Finding

Security sits on the risk register Tier 1 as a very high risk (20) and is also on the Board Assurance Framework as a significant risk to the organisation achieving its strategic Objectives of a 'safe and secure environment'.

Quality, Safety & Experience Committee 28 August 2020

QS20/173 Occupational Health and Safety Annual Report 1st April 2019 to 31st March 2020 and Quarter 1 Report

Risk Analysis

The significant risks have been escalated to Tier 1 on the risk register and were previously agreed by QSE. These include Leadership of OHS, Security, Contractor Management and Control, Asbestos, Legionella and Fire Safety. All risks have mitigation plans, but require investment. A business compliance case has been produced to support the implementation of the control measures. The risks are scored as 20. Additional risks identified since COVID-19 pandemic include:-

- *Security compliance limited with staffing available within the Team*

8. Capability

The organisation has access to up-to-date security-related legislation and guidance.

8. Finding

The Head of Health & Safety and the SMS have access to the internet allowing them to keep up to date with any security related legislation and guidance.

The Health & Safety Department have their own internal intranet page for staff, which contains basic security guidance and Covid-19 security information.

9. Capability

All employees receive security training/awareness that is commensurate with risks in their work area.

9. Finding

All staff undertake e-learning Modules A & B of the Violence & Aggression Passport, these sections are completed once and do not have to be repeated in the future.

The Framework notes, in area for assessment 9 – capability guidance, the following:

Special security training will most likely need to be provided for certain staff, for example in maternity, A&E and children's services, mental health, ambulance, and for lone workers where there is known to be heightened risk at the point of care.

The passport does contain some information on lone working, risk assessments and personal safety training all of which could be considered security related, however there is no specific security related training available to staff.

10. Capability

The competency and performance of security personnel, whether employed internally or out-sourced, is monitored.

10. Finding

Health Board staff have their competency and performance monitored through their annual PADR. The Head of Health & Safety and the Violence & Aggression Case Manager/Security Manager have both received their annual PADR. The Health Board has only recently employed the Security/Violence and Aggression advisor on the 26th October 2020.

The Security Industry Authority (SIA) is the statutory organisation responsible for regulating the private security industry in the UK, working without a valid SIA Licence is a criminal offence.

We were informed that all staff are SIA licenced as part of the external contract but we have not been able to corroborate this. The Health Board currently has no mechanisms in place to monitor the competency and performance of the company.

During the review we were cited on email correspondence highlighting contractual issues between the Health Board and contractor due to ongoing contractual issues involving payment of invoices.

11. Outcomes

Key indicators capable of showing improvements in security management, and the management of associated risks, are used at all levels of the organisation, including the Board, and the efficacy and usefulness of the indicators is reviewed regularly in association with the Risk Management Committee.

11. Finding

There are currently no key indicators formally adopted specifically to security management that demonstrate the improvement in services relating to security management. However it should be noted that some recommended in the Framework do get reported in a wider assurance report to the Quality, Safety and Experience Committee [Committee meeting 15th January 2021, Agenda item: QS21/8 Health & Safety Q3 Report – Para. 7].

Below is the Framework recommendations for KPIs:

The organisation should monitor the key indicators developed for this standard as follows:

- *Level of compliance with this standard.*
- *RIDDOR - security reports.*
- *NPSA - Number of physical assaults on patient broken down by perpetrator.*
- *Performance against training needs analysis for security training.*
- *Number of incidents of non-physical assault to staff.*
- *Number of assaults on staff (EFPMS).*
- *Number of physical assaults.*
- *Number of physical assaults requiring attendance of police.*
- *Number of physical assaults resulting in prosecution of assailant.*
- *Number of security incidents reported (EFPMS).*
- *Number of security incidents requiring police attendance (EFPMS).*
- *Number of security incidents resulting in prosecution.*
- *Number of thefts.*
- *Number of rehearsals testing the suspected abduction of baby policy.*

12. Monitoring and review

The system in place for managing security is monitored and reviewed by management and the Board in order to make improvements to the system.

12. Finding

It is important to note that the impact of COVID has impacted significantly on the frequency of meetings.

Although there is no assurance reporting process identified within the draft security policy, the assurance reporting is noted within the HS01 - Occupational Health and Safety Policy.

The Security Management group reports into the Strategic Occupational Health & Safety Group (SOHSG) which reports into the Quality, Safety and Experience Committee (QSE).

Security Management Group

We were provided with a set of minutes for the first security management meeting which took place on the 11th March 2020 (the only meeting to have taken place due to COVID pandemic). No issues of significance for escalation were reported in the meeting.

We were also provided with the draft Terms of Reference (TOR) and have been unable to determine if the TOR have been formally agreed. TOR highlight that they were written by the Head of Health, Safety at the time but does contain an approval date, review date and signature.

Strategic Occupational Health & Safety Group

We were provided with the minutes for the meetings held on the 1st November 2019, 10th January 2020 and 21st October 2020 (frequency affected by COVID). Agenda points within all the three sets of minutes have security as a discussion topic.

Strategic Occupational Health and Safety Group 1st November 2019

6. H&S Action Plan/Manual Handling, Security Review Action Plan

Strategic Occupational Health and Safety Group 10th January 2020

5. Quarter 3 Security Report / Update, CCTV & Security Policies

5.1 XX informed the group that Security and CCTV Policies are in draft form but still need work to amend them following the feedback received after they went out for consultation. They should then be ready for ratification….

Strategic Occupational Health and Safety Group 21st October 2020

21/10:9 Minutes and Triple A report (alert, assurance, achievement) from Sub-groups

9.5 Security Management Sub-group – this group has not met during the pandemic.

XX advised….security contract ends April 2021 and a group led at Executive level have met to discuss the future contract and what type of provision will be employed going forward considering the financial position and risks…. It has been recognised that BCHUB have less security staff than other Health Boards and temporary staff are being employed until the business case is agreed. The community model needs to be reviewed and the possibility of establishing a contact centre is being considered. The pros and cons of this were discussed.

Quality, Safety and Experience Committee (QSE).

We reviewed the QSE minutes from January 2020 to January 2021 – Table 1 details the Committee meetings and notes where security related matters are reported for assurance.

Table 1 – QSE meeting dates and internal audit findings

Committee	Date	Findings
QSE	28th January 2020	Occupational Health & Safety Report Q3 Section 10 Security Report – contains update on security.
	17th March 2020	Nothing reported (due to COVID)
	5th May 2020	Nothing reported (due to COVID)
	3rd July 2020	Nothing reported (due to COVID)
	29th July 2020	QS20/133 Health and Safety Briefing – Contains report on security.
	28 August 2020	QS20/173 Occupational Health and Safety Annual Report 1st April 2019 to 31st March

		2020 and Quarter 1 Report – contains the progress made on security and future plans.
	3rd November 2020	QS20/210 Health & Safety Q2 Update - contains update on security.
	15th January 2021	QS21/8 Health & Safety Q3 Report – contains update on security.

Although no issues of significance are highlighted with the SOHSG, security matters can be seen being frequently discussed within the reports provided to the QSE.

The overall common theme within the reports is the challenge of implementing the security provision.

13. Audit

The Internal Audit function, aided as necessary by relevant security specialists, carries out periodic audits to provide assurance to the Board that a system of security management is in place that conforms to the requirements of this standard.

13. Finding

This is the first assessment undertaken by the Internal Audit Department against the 2005 Security Management Framework for NHS Trusts in Wales. Internal Audit reviews are risk based and security was identified as a key risk in the 2020/21 financial year.

Security Action Plan

The gap analysis undertaken in June 2019 and the Health Board Security review conducted between July and August 2019 identified significant areas of concern requiring management action. Using the findings from the gap analysis, Corporate Health & Safety Team developed action plans to identify and mitigate the risks identified; the action plans included security as a key area of risk.

We cross-referenced the actions within the Health Board's security action plan to the 2005 Security Management Framework for NHS Trusts in Wales, to determine Health Board compliance and identify gaps, if any, in control and assurance to the Board.

The Health Board action plan does reference [to an extent] what is required within the 2005 Security Management Framework for NHS Trusts in Wales. However, we note that all 12-action points within the action plan are marked green as completed.

The action plan has not been reviewed since the 31st December 2019

Table 2 below records the recorded planned actions from the security plan and our observations/findings against each, based upon the evidence shared and provided to us.

Table 2 – Health Board security plan actions with Internal Audit findings

Action	Actions form security plan	Findings
1	Compose and complete fit for purpose Security Management Policy (Including The Prevention and Control of Violence and Aggression through 'Obligatory Responses to Vioence in Healthcare'). Stipulating all security roles and responsibilities of General Users, Key Staff and Management.	Currently in draft.
2	Compose and complete CCTV Management Policy including use of body worn camera's with the policy to include; a. Positioning of Camera's b. Quality of Images c. Recording and Retention of Images d. Access to and Disclosure of Images to Third Parties e. Access to Images by Individuals and Enforcement.	At the time of review, the draft CCTV policy has now been submitted to the Strategic Occupational Health and Safety group for review.
3	Identify and review posts and positions of health board employees within the estates function currently conducting security related work activities with view to adopt into H&S/Security function.	Discussions have been held but no further progress is evident.
4	Conduct training needs analysis to establish levels of competence and/or gaps in personnel both external and internal within the security function of the health board.	No progress was evident at the time of this review.
5	Identify, promote and communicate dedicated security head/lead for the organisation as required under Security Framework document for NHS Trusts in Wales.	The Executive Director of Workforce and Organisational Development is the nominee who has Executive responsibility for security. No dedicated security manager, however we noted that the Health & Safety annual report presented on the 28th August 2020 to the QSE Committee recorded that the Violence & Aggression Case Manager has also undertaken a Security Management function supported by the Head of Health and Safety as an Accredited Security Management Specialist.

Action	Actions form security plan	Findings
6	Develop and establish security service standards including training of both external security contractor and Health Board staff who conduct security related work activities.	Once the security structure has been fully developed and there is clarity on the roles and responsibilities, then standards and training needs can be introduced.
7	Amend the role and responsibilities of Violence and Aggression Case Manager to include security responsibilities. (Current post holder has evolved with security elements to role that need to be adopted into JD).	We received the original job description of the Violence and Aggression case Manager which does not include security responsibilities. The job description will need to be amended to reflect the additional accountability or review whether this is model will deliver the requirements of the Framework.
8	Review post and role of seconded North Wales Police Demand Reduction Inspector with view to dissolve and replace with Health Board Security/V&A Officer.	Security/Violence and Aggression advisor presently employed on the bank full time who was appointed on the 26th October 2020 – The contract with North Wales Police was not renewed.
9	Establish Security/V&A Officers in each regions of the organisation with additional officer specific to MH & LD function.	A business case has been developed which identifies those areas of concern and proposes new roles.
10	Review, revise and re-scope current scope/specification of third party security provider based on findings of the security review.	An external provider currently delivers security services and we were advised the contract which is due to be reviewed in early 2021. This should take into consideration the split responsibilities between property and other services.
11	Review and, where appropriate, amend current Lone Worker Policy stipulating roles and responsibilities of general users, key staff and management. Including monitoring devices and the use of, home visits, office based lone working and managers checklists.	At the time of writing the review the policy was currently in draft format.
12	Establish appropriate Security related committee.	The first security management meeting which took place on the 11th March 2020, however due to the COVID situation this is the only meeting to have taken place, although we note that the Health Board reintroduced business as usual in July 2020.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – 2005 Security Management Framework for NHS Trusts in Wales compliance. (Operating effectiveness)	Risk
The Corporate Health & Safety department demonstrated compliance within particular areas of the Security Management Framework. However, there are areas to further enhance and strengthen the processes to become fully compliant with the Security Management Framework. We identified the following for consideration: • Health Board does not have a dedicated security manager. • Security, Lone Worker & CCTV polices in draft format. • Discrepancies with regards to roles and responsibilities in the draft policy, to what is currently happening. • Out of date job description of Violence & Aggression case manager due to increased duties. • No overarching crime prevention plan. • No template root cause analysis being used on incidents. • No specific intranet security website with up to date legislation, guidance and contact details. • No security training currently being provided throughout the Health Board. • No mechanisms in place to measure competency and performance of external security services. • No KPIs to support the improvement of the service. • Governance process in place however significantly impacted by COVID 19	Health Board in non-compliant with Security Management Framework for NHS Trusts in Wales.

Recommendation	Priority level
Corporate Health & Safety Management and Security Manager review the implementation of the Framework and align with the security plan, combining all gaps into one overarching implementation project/plan.	High
Management Response	**Responsible Officer/ Deadline**
The security action plan has been reviewed and is currently under amendment. Checks against the Welsh Government Security Management Framework identified elements that were not included and additional actions are being written to ensure the action plan is comprehensive. The final action plan will be completed 01.04.21	Head of Health and Safety, 01.04.21

Finding - ISS.2 – Security Action Plan (Operating effectiveness)	Risk
Security Action plan has not been updated since 31st December 2019. All the tasks are highlighted as green and completed, however our findings do support this assertion.	Action Plan no longer be fit for purpose and may have lost its direction, which in turn affects the compliance with the Security Management Framework.
Recommendation	**Priority level**
See Recommendation 1 ensuring gaps in implementation of the security action plan are embedded within the requirements of the Framework, including but not exhaustive the following: • Crime prevention programme; • Access to guidance; • Competency and performance; and • KPIs development and reporting.	**High**
Management Response	**Responsible Officer/ Deadline**
The security action plan has been reviewed and is currently under amendment. Checks against the Welsh Government Security Management Framework identified elements that were not included and additional actions are being	Head of Health and Safety, 01.04.21

written to ensure the action plan is comprehensive. The final action plan will be completed 01.04.21	

Appendix B - Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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.

Betsi Cadwaladr University Health Board

Violence and Aggression – Obligatory responses to violence in healthcare

Final Internal Audit Report

BCU 2020/21

May 2021

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-2021-06
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Auditor/s:	Head of Internal Audit Audit Manager
Executive sign off:	Director of Workforce & OD
Distribution:	Associate Director of Health, Safety & Equality Head of Health and Safety Violence & Aggression Case Manager/Security Manager Board Secretary Deputy Board Secretary Statutory Compliance, Governance & Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

1. Introduction and Background

The Obligatory Responses to Violence in Healthcare in Wales took effect on the 21st November 2018 and was signed by the Chief Executive, NHS Wales along with the four Welsh Police forces and the Crown Prosecution Service.

The Health Board is committed to promoting the creation of a safe and secure environment for all, so that the highest standards of clinical care can be made available to patients. The Health Board has a legal duty of care under the Health and Safety at Work etc Act 1974, to ensure, so far as it is reasonably practicable, the health, safety and welfare at work of their employees and others affected by their work activity.

The Health Board issued *HS02 Procedure and Guidance Protecting Employers from Violence and Aggression* in April 2014 clearly outlining what form violent and aggressive incidents could form:

> *"Any incidents where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge to their safety, well-being or health. This can incorporate some behaviours identified in harassment and bullying, for example verbal violence. (All Wales Violence & Aggression training Passport & Information Scheme 2004)".*

As part of the Procedure, the Health Board recognises the All Wales NHS Violence and Aggression Training Passport and Information Schemes and the good practice in the field of management of Violence and Aggression the document represents.

The Health Board also received a high level review *"Managing Reductions of Violence & Aggression against Staff"* presented to the Quality, Safety and Experience Committee on the 7th November 2017 by Professor Lepping that identified key areas of work to be addressed and recommendations.

The document seeks *"….to bring effective and efficient communication across partners, including the exchange of information at all levels; a clear understanding of the respective roles, responsibilities, processes and legal constraints; and a clear statement on prosecution policy which will help NHS staff to understand the criminal justice system, and have confidence in it."*[1] Overseeing the implementation and monitoring of compliance rests with the NHS Wales Anti Violence Collaborative working together with key stakeholders across NHS Wales, Welsh Government, CPS, the Police and Trade Unions.

2. Scope and Objectives

The objective of the review was to ensure robust arrangements are in place relating to Violence & Aggression.

The scope of the review focused on the following key areas:

- Policies and Procedures have been approved and implemented with roles

[1] Source - Press Release: National agreement document launched to protect violence against staff in NHS Wales - An updated agreement entitled 'Obligatory Responses to Violence in Healthcare' with regards to violence and aggression towards NHS Wales staff, has been launched.

and responsibilities clearly defined and formally assigned within the Health Board;

- Implementation/compliance of Health Board responsibilities in respect to The Obligatory Responses to Violence in Healthcare and expected reporting to the Anti Violence Collaborative;
- Reporting of incidents are appropriately categorised;
- Lessons learned by the Health Board are identified and effectively reported; and
- Training responsibilities have been identified in respect of Violence and Aggression management within BCUHB and is update.

3. Associated Risks

The risks considered at the outset of the review were:

- Incidents are not being reported by staff resulting inability of Health Board management to support staff;
- Incidents are not being effectively reported and communicated in accordance with the Health Board Procedure;
- Actions are not being taken, or are ineffective, in response to incidents reported resulting in staff not being effectively supported resulting in increased staff stress levels, stress related absences and staff welfare;
- Policies, procedures, roles and responsibilities are not clearly defined and understood;
- The Health Board is not identifying and communicating lessons learned resulting in Health Board staff remaining exposed to similar violent and aggressive acts in the future;
- Management Training is not up to date;
- Staff suffer work related stress or associated mental health conditions as a result of violence in the workplace; and
- Prosecution, fines, reputation damage for non-compliance with the Health and Safety at Work etc Act 1974.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Violence and Aggression – Obligatory responses to violence in healthcare review is limited assurance.

RATING	INDICATOR	DEFINITION
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.

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.

5. Assurance Summary

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

Assurance Summary					
1	Policies and Procedures/Roles and responsibilities clearly defined			✓	
2	The Obligatory Responses to Violence in Healthcare		✓		
3	Reporting of incidents are appropriately categorised			✓	
4	Lessons learned are identified and effectively reported		✓		
5	Training responsibilities have been identified		✓		

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

Design of Systems/Controls

The findings from the review have highlighted one issue that is classified as a weakness in the system control/design for Violence and Aggression – Obligatory responses to violence in healthcare.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Violence and Aggression – Obligatory responses to violence in healthcare.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

Policies and Procedures/Roles and responsibilities clearly defined

The Health Board has two key policies/procedures that outline its responsibilities concerning compliance with all aspects of the Health and Safety at Work etc Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007.

HS01 Occupational Health and Safety Policy was approved on the 9th December 2020 and recorded as live on the 21st January 2021. Section six of the policy has definitive statements relating to roles and responsibilities; Statements concerning violence and aggression (V&A) roles within HS01 are noted in table 1.

Table 1: Role and responsibilities detailed within HS01 Occupational Health and Safety Policy relating to V&A

Role	Responsibility specifically has V&A recorded
Manual Handling Manager/Team	• Provide support to the Head of Health & Safety to ensure the provision of effective training programmes in violence & aggression including de-escalation, personal safety and breakaway techniques to the majority within BCUHB, with the exception of MH&LD directorate. • The Dementia and Violence & Aggression Link within the Team supports staff with the patient centered behavioral support plan and provides the support needed following training to staff dealing with complex patients or situations.
Violence and Aggression Case Manager	• Providing support, information and advice for BCUHB staff victims of work related crime including violence/aggression taking forward prosecutions in partnership with stakeholders within the NHS and external organisations such as the Police and the Crown Prosecution Service.

Role	Responsibility specifically has V&A recorded
	• Providing support, information and advice for BCUHB victims of work related violence/aggression and untoward workplace security incidents.

We have not sought to review individual job descriptions to triangulate policy statements and vice versa.

HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is available on the intranet but is out of date [scheduled for review in April 2018] and refers to roles no longer in the Organisational structure – We have been advised that a revised document is currently progressing through the governance approval process.

Section six of the procedure has definitive statements relating to roles and responsibilities; Statements concerning violence and aggression (V&A) roles within HS02 are noted in table 2.

Table 2: Role and responsibilities detailed within HS02 Procedure and Guidance Protecting Employers from Violence and Aggression relating to V&A

Role	Responsibility specifically has V&A recorded
Board Director	Operational strategic responsibility for violence and aggression issues is led by the Director of Governance and Communications.
Duties of Chief of Staff (COS) and Line Managers	• Actively promote the reporting of all incidents of violence and aggression and to provide feedback of reported incidents to the individual(s) involved. • Review reported incidents of violence & aggression within their sphere of responsibility and refer serious incidents to the V&A Case Manager. • They will ensure that risk assessments required under the Management of Health and Safety at Work Regulations (1999) take account of the risk of violence to staff, they will prioritise the defects in the system which require addressing, determine any associated costs, report their findings as necessary to the Director of Governance and Communications and take action as necessary to meet the requirements in order to eliminate all defects in the system. Where possible risk assessments should be undertaken in a collaborative manner with staff and safety representatives.

Role	Responsibility specifically has V&A recorded
	• They will ensure that where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity and where that risk cannot be avoided, that local procedures and safe systems of work are devised and followed in order to reduce that risk and are made easily assessable to staff.
Violence & Aggression Case Manager	Assist managers with investigation of incidents of violence/ aggression in which BCUHB staff are adversely affected.

The Health Board has clearly outlined all roles with responsibilities relating to V&A, albeit HS02 is out of date and refers to roles no longer accountable for V&A through structure changes.

The Obligatory Responses to Violence in Healthcare (OR)

The OR agreement came into effect on the 21st November 2018 and has set out specific responsibilities for the Health Board.

The OR has five key stages and we have noted the following:

- **Prevent (Prevent assaults using effective risk management procedures)**

  We found V&A risk assessments dating back to 2014/2015 on the intranet. We were also advised there is no central repository of all V&A risk assessments for the Health Board that should drive the training needs analysis for all employees.

- **Capture (Incident report (Datix) completed; Manager or Victim contacts NHS V&A Case Manager or equivalent in Primary Care NHS)**

  Datix is used by the Health Board to record all V&A incidents.

- **Investigate (V&A Case Manager Investigates (Supports NHS Manager to investigate) - Contacts Police via 101 promptly. Also scope for online crime reporting, Shares information with Police)**

  We were advised that the Case Manager is the Single Point of Contact and is not always advised of cases, and is often only told once the case is due for Court to support the individual. The Case Manager would support an investigation if requested.

- **Prosecute (NHS V&A Case Manager facilitates information sharing, supports victim)**

  The V&A Case Manager, when advised, supports individuals and has attended Court when individuals provide evidence.

- **Deter (Health Body provides Director Level Service Impact statements and Victim statements in conjunction with Police; NHS reflect & refine preventative risk management)**

There is no evidence to support management revisit V&A risk assessments following a prosecution. We have been unable to identify any Director impact statement for two recently reported prosecutions (Emergency Department, Ysbyty Glan Clwyd [14th January 2021] and Ysbyty Gwynedd respectively [4th September 2020])[2].

Further review of the OR has identified that:

- No six monthly report was sent to the Anti-Violence Collaborative in 2019/20 or 2020/21 [to date] although we were advised that a draft version had been developed and sent to a former Head of Health & Safety who is no longer in post - we have not been provided with a copy of this draft and cannot corroborate this assertion.
- It is unclear who leads on V&A in Primary Care or whether the Health Board reports/supports contractors.
- All health bodies in Wales have a Board-level violence and aggression lead – The OR recorded lead is the Associate Director of Quality Assurance, however responsibility now rests with the Director of Workforce & OD.
- Whilst we note that the Case Manager publicises reference to the OR in their email signature, there is a Health Board wide lack of publicity surrounding the agreement. The OR also has a number of publicity materials and posters that are not evident across the Health Board. We have also not seen reference to it within the weekly bulletin.
- Whilst the Health Board and lead Director will determine what is reported and when, the OR does state that the Case Manager *"Report comprehensively on a monthly basis to their lead Director for violence and aggression the numbers of assaults by patients, Police attendances and completed and pending criminal prosecutions*". We found reports to Quality Safety and Experience Committee were made quarterly but did not include this information. Similarly, reports to the Strategic Occupational Health and Safety Group are undertaken bi-monthly but we could not evidence that this information is reported.

Reporting of incidents are appropriately categorised

We obtained from the Datix system, for the period 1st April 2020 to the 9th February 2021, data recording V&A on staff.

There are 1,227 incidents recorded as 'abuse etc of staff by patients' with 204 wards/Departments recording incidents. Table 3 details total incidents recorded by health economy and table 4 details the twenty wards/departments, by number, having recorded incidents against staff by patients.

Table 3 – Incidents of patients against staff by health economy

[2] Patient broke nurse's cheekbone and assaulted guard in 'appalling' hospital attack - North Wales Live (dailypost.co.uk) Abusive patient called top North Wales hospital doctor a 'prostitute' - North Wales Live (dailypost.co.uk)

Health economy	Major	Moderate	Minor	Negligible	Total
BCUHB Central	1	29	75	220	**325**
BCUHB East		29	69	253	**351**
BCUHB West	1	25	116	409	**551**
Total	**2**	**83**	**260**	**882**	**1,227**

Source: Datix extract report

Table 4 – Top 20 Wards/Departments by recorded incidents

Ward/Department	Major	Moderate	Minor	Negligible	Total
Gwion Ward, Ty Llywelyn			2	69	**71**
Mesen Fach, BYN		1	21	43	**65**
Cemlyn A, Cefni (MH&LDS)			26	39	**65**
Emergency Department (secondary care)		9	5	42	**56**
Taliesin, Hergest			5	43	**48**
Foelas, Villa 15, BYN		1	18	17	**36**
Bryn Hesketh Unit		2	13	17	**32**
ECRS			14	18	**32**
Dyfrdwy Ward		2	4	25	**31**
Hydref Ward		1	13	14	**28**
Gwanwyn Ward		1		26	**27**
Cybi, Penrhos Stanley (Area)		2	6	18	**26**
Tegid Ward - Ablett		3	4	17	**24**
Reception			3	19	**22**
Clywedog Ward			3	18	**21**
Buckley Health Centre		1	1	18	**20**
Dinas Male Ward		1		18	**19**
Glaslyn, YG (secondary care)		7	3	8	**18**
Tryfan, YG (secondary care)	1		2	15	**18**
Wards, Ysbyty Alltwen (Area)		2	6	9	**17**

Source: Datix extract report

To ascertain whether reporting was part of the day to day process, we sought to identify that the incident at Ysbyty Gwynedd Emergency Department, as reported in the Press, had been recorded in Datix and could find no record for the incident occurring on the 4th July 2020.

The number of incidents in our reporting period indicates that recording and

categorisation is known across the Health Board but we are unclear whether this is a complete record.

Lessons learned are identified and effectively reported

The review of the lessons learnt information from the 1,227 incidents recorded for the period 1st April 2020 to 9th February 2021 identified:

- 1,123 incidents have been closed;
- 87 incidents noted as under investigation; and
- 17 incidents noted as rejected.

Of the 1,123 incidents closed, all had lessons learnt recorded. However, we found varying quality regarding the recorded lessons learnt, a sample of which is detailed in table 5 below.

Table 5 – Recorded lessons learnt for a sample of incidents

Example of recorded lessons learnt in Datix
no lessons to be learnt this was a staff member assault
No lessons learnt. The incident will be addressed by team manager and support by risk management if necessary.
as above risk assessment in place
Staff awareness raised in relation to patients risk of physical aggression.
Review Lone worker policy Double manned visits Notify line manager Notify violence and aggression manager Engage with patientEngage with family and carersConsider GP interventionVerbal de-escalationConsider notifying North Wales PoliceConsider a formal staff statement to support legal prosecutionReview environment risk assessmentsReview mental capacity assessment where appropriateConsider psychiatric review where appropriateIf children involved, consider Social Services referralIf children involved, consider Health Visitor referralConsider Legal and Risk EngagementConsider safeguarding referralDocument evidence within the care recordsComplete a DATIX Incident [sic]
All appropriate action was taken.
reminded staff to not place fingers in the patients mouths.
Ward Manager and Matron to liaise with North Wales Police to ensure any future incidents are managed co-operatively.
Importance of generating the datix as a means of alerting the organisation that this is not an isolated case. [sic]

Source: Datix extract report

The review of RIDDOR reported patient against staff incidents for the period 1st April 2020 to 9th February 2021 recorded nine incidents. We identified two of these incidents related to the same ward at Ysbyty Glan Clwyd [Ward 12] in June and August 2020 respectively, both recording the same learning points:

- June 2020*: "Patients with dementia should not be transferred late evening due to sun downing causing distress and potential harm to patients and staff."*
- August 2020: *"Aim not to transfer patients with dementia during the night continue to maintain dementia pathways for all dementia patients To involve patients relatives in patients care highlight and discuss in ward safety brief".*

Training responsibilities have been identified

The All Wales Violence and Aggression Training Passport is overseen by the All Wales Violence and Aggression Advisory Group and sets out the required training that NHS staff should receive in relation to Violence and Aggression.

Training is framed around four modules, detailed as follows:

- Module A - Induction & Awareness raising (e-learning for all NHS Wales staff);
- Module B - Theory of Personal Safety and De-escalation;
- Module C - Breakaway; and
- Module D - Restrictive Physical Intervention (RPI) is solely for Adult Mental Health Services.

Section 6.12 of the HS01 Occupational Health and Safety Policy states the Manual Handling Manager/Team:

- *Provide support to the Head of Health & Safety to ensure the provision of effective training programmes in violence & aggression including de-escalation, personal safety and breakaway techniques to the majority within BCUHB, with the exception of MH&LD directorate.*
- *The Dementia and Violence & Aggression Link within the Team supports staff with the patient centred behavioural support plan and provides the support needed following training to staff dealing with complex patients or situations.*

We obtained training data from Workforce & OD (WOD) to ascertain the numbers of staff and compliance rates relating to V&A training; the details are provided in table 6.

Table 6: V&A training figures and compliance rate

Course	Number of staff completed course 1st April 2020 to 31st January 2021	Health Board compliance rate as at 31st March 2020
000 NHS Wales - Violence and Aggression A (no specified renewal)	888	95.45%
000 NHS Wales - Violence and Aggression B – 2 years	3014	64.92%
050 BCUHB Violence & Aggression Mod. A&B (Mandatory Trg days only)	822	N/K
050 BCUHB Violence & Aggression Mod. A,B&C (Classroom sessions only)	1	N/K
Grand Total	**4,725**	

Source: WOD

For the Health Board as a whole, we were advised that there is no active V&A training for staff except for the mandatory Module A through e-learning. We note however that there has been additional resource allocated to V&A albeit non-

recurring at the time of this review.

The Mental Health and Learning Disabilities Division (MHLD) maintain records and deliver their own training to MHLD staff.

The Positive Interventions Clinical Support Service (PICSS) within MHLD provide focused training on Modules B, C & D.

As Module D is specific to MHLD, table 7 details relevant training information that indicates 16% of staff are yet to receive training and 26% will be out of date as at April 2021.

Table 7: MHLD Module D training information

Area	Total staff	Vacancies	Not Trained	Out of date April 2021- 1 or 2 days		In date until end 2021	In date until March 2022
				1	**2**		
West	121	7	25	13	24	26	21
Ty Llewelyn	74	8	3	9	5	19	30
Central	111	3	16	5	12	62	9
East	148	8	30	20	29	31	29
				47	**70**		
Totals	**454**	**26**	**74**	**117**		**138**	**89**
%		**8%**	**16%**	**26%**		**30%**	**18%**

Source: Positive Interventions Clinical Lead, 29th January 2021

We noted that MHLD also devised a business case to in order to address delays in delivering training due to the pandemic that required revenue investment for a 12 month period – we are unclear whether MHLD management has approved the business case.

For the Health Board to deliver on its statutory obligations in relations to Statute and the OR [surrounding focused training for Module B to D inclusive], we sought to confirm Health Board wide funding in place.

Whilst MHLD has a well-established and funded PICSS department, the wider Health Board has less capacity and resource to deliver everything required to meet its V&A obligations. Table 8 details the funding and resources in the Health Board.

Table 8: Funded establishment for V&A

Cost Centre	WTE/Budget (£)	Non-pay (£)	Total
T451 Violence and Aggression Case Manager (WOD)	0.84 wte £40,535	£800 travel	£41,335
D008-A - Aggression Management Team (MHLD)	4.00 wte £188,768	£4,079 travel	£192,847

Source: Finance Directorate

In reviewing the funding for both cost centres, there is no evident non-staff/equipment funding allocated that would be needed to underpin class-based learning.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**2**	**0**	**5**

Finding - ISS.1 - Provision of Violence and Aggression (V&A) Training (Control design)	Risk
There is no available training needs analysis, with the exception of Mental Health & Learning Disabilities Division (MHLD), to identify all staff who require All Wales Violence and Aggression Training Passport Module B and Module C sessions. Underpinning the training needs analysis should be updated V&A risk assessments and it is unclear whether operational management have completed these as part of wider health and safety processes. Further, there is no central repository to help/support local managers compile ward/department specific V&A risk assessments. The MHLD model for training has identified the training needs of its staff and has updated its training packages.	Health Board has not identified all staff who require Module B and/or C training.
Recommendation	**Priority level**
The Health Board standardise delivery of all V&A training, through an adequately resourced service, ensuring all Health Board staff receive Module B & C training where a risk assessment and subsequent training needs analysis determines. To deliver training in a cost-effective way, consideration should be given to taking the training 'on the road' where the training package allows, thus reducing lost time for front-line staff.	**High**
Management Response	**Responsible Officer/ Deadline**
1.1 Training Needs Analysis to be completed for mandatory training — 31.07.21	Head of Health and Safety 31st July 2021

1.2	Finalise the training package in line with the All Wales NHS V&A Training and Information Scheme	31.05.21		
1.3	Review and update all V&A templates	30.06.21		
1.4	Upload V&A risk assessment templates on the intranet and update intranet pages	30.06.21		
1.5	Implement a process to monitor risk assessments completed through Corporate health and Safety reviews and Self Assessments returned to the H&S team	31.05.21		
1.6	SBAR to be completed to escalate the resource required to deliver training for Module C	31.05.21		

Finding - ISS.2 - Obligatory response to violence in healthcare (Operating effectiveness)	**Risk**
Our findings within the report identify that the Health Board is not complying in full with the requirements of the Obligatory Response. To deliver on all requirements will require a shift in focus and increased resource enabling a wider V&A team to deliver on all requirements but most importantly, prevent incidents of V&A happening to staff through: refreshed risk assessments; ensuring staff groups are identified for relevant training; support and liaison with the victim; liaising with the Police; supporting the manager in the investigation;	Obligatory response is not embedded and does not support staff in reducing the risk to violence and aggression.

<table>
<tr><td colspan="3">and embedding lessons learnt in refreshed risk assessments so incidents do not happen in the future.
We understand there is a possibility the Obligatory Response could be issued under a Welsh Health Circular in the near future.</td><td></td></tr>
<tr><td colspan="3">Recommendation</td><td>Priority level</td></tr>
<tr><td colspan="3">The Health Board must fulfil all its duties in delivering and actively promoting the Obligatory Response.</td><td>High</td></tr>
<tr><td colspan="3">Management Response</td><td>Responsible Officer/ Deadline</td></tr>
<tr><td>2.1</td><td>Training schedule for department/ ward visits/ Teams meetings to be compiled</td><td>31.05.21</td><td rowspan="8">Head of Health and Safety
31st July 2021</td></tr>
<tr><td>2.2</td><td>ORV to be captured in all H&S training slides delivered by the Team</td><td>30.06.21</td></tr>
<tr><td>2.3</td><td>Explore options for promotion through the internal staff intranet</td><td>31.05.21</td></tr>
<tr><td>2.4</td><td>Consultation with TU partners/ H&S leads</td><td>31.05.21</td></tr>
<tr><td>2.5</td><td>Complete the schedule of police education training sessions</td><td>31.05.21</td></tr>
<tr><td>2.6</td><td>Education session to be arranged for Occupational Health following staff referrals due to V&A incidents</td><td>31.05.21</td></tr>
<tr><td>2.7</td><td>SBAR to be completed to update the Executives</td><td>31.05.21</td></tr>
</table>

2.8	Engage with the National campaign for promotional material once this has been established	31.07.21		
2.9	Promote via the staff app/ staff bulletins/ H&S newsletter	30.06.21		

Finding - ISS.3 - Lessons Learnt (Operating effectiveness)	Risk
Of the 1,123 incidents closed, all had lessons learnt recorded. However, we found varying quality regarding the recorded lessons learnt and whether management had actually completed what they said they were going to action. We noted one that merely stated what the expected process should be which undermines the whole process and confidence in reporting incidents. In addition we identified two RIDDOR reported incidents for the same ward, in the space of two months where the same recorded lesson was noted, indicating that the learning from the first incident had not been embedded in revised process/pathway.	The Health Board is unable to actively manage the risk associated with V&A.
Recommendation	**Priority level**
The role of documenting lessons learnt rests with the investigating officer/line manager who should ensure lessons learnt are clear, concise and deliverable. The V&A Team should scrutinise lessons learnt and identify broader learning for sharing Health Board wide to reduce the risk of similar V&A incidents happening to staff.	**High**

Management Response			Responsible Officer/ Deadline
3.1	Lessons learnt is a specific section on datix, a review of this will be undertaken to identify key elements of training required for staff, supportive guidance documents and risk assessment templates	30.06.21	Head of Health and Safety 30th June 2021
3.2	Protecting staff from Violence and Aggression/ Managers actions course to be written and implemented	30.06.21	
3.3	RCA's for RIDDORs are reviewed and reported to the SOHSG. A RIDDOR review group is to be established	30.06.21	

Finding - ISS.4 - HS02 Procedure and Guidance Protecting Employers from Violence and Aggression (Operating effectiveness)	Risk
HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is available on the intranet but is out of date [scheduled for review in April 2018] and refers to roles no longer in the Organisational structure – We have been advised that a revised document is currently progressing through the governance approval process.	Roles and responsibilities for V&A are not reflective of the organisational structure.
Recommendation	**Priority level**

HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is approved and issued as soon as practically possible.	**Medium**
Management Response	**Responsible Officer/ Deadline**
4.1 HS02 Guidance Protecting Employees from Violence and Aggression to be ratified at the Strategic Occupational Health and Safety Group 25.05.21 — 31.05.21	Head of Health and Safety 31st May 2021

Finding - ISS.5 – Reporting of incidents (Operating effectiveness)	**Risk**
The Health Board places reliance on staff to report incidents through Datix however we noted one incident reported in the Press but we were unable to identify that the incident had been recorded in Datix. The number of incidents in our reporting period indicates that recording and categorisation is known across the Health Board but we are unclear whether this is a complete record.	Under-reporting of incidents of V&A by patients against staff.
Recommendation	**Priority level**
All staff are reminded to report incidents of V&A.	**Medium**
Management Response	**Responsible Officer/ Deadline**

5.1	HS02 Guidance for Protecting Employees from Violence and Aggression details the process to report through Datix. Promotion of this further will be via the educational sessions and communications detailed in section 2	31.07.21		Head of Health and Safety 31st July 2021

Appendix B - Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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.

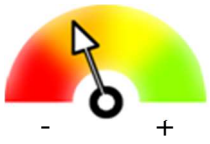
Betsi Cadwaladr University Health Board

Water Management: Statutory Compliance

Internal Audit Report

BCU 2020/21

April 2021

Limited Assurance

Previous review rating N/A

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-2021-32
Report status:	Internal Audit Report
Fieldwork commencement:	15th December 2020
Fieldwork completion:	24th February 2021
Draft report issued:	24th February & 16th March 2021
Management response received:	15th April 2021
Final report issued:	16th April 2021
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Director Of Estates And Facilities
Distribution:	Executive Director Of Planning And Performance Board Secretary, Assistant Director – Deputy Board Secretary Head of Governance & Statutory, and Compliance, Governance & Policy Manager
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The Health Board has responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulations 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water (i.e. with regard to Legionella, Pseudomonas aeruginosa and other water borne pathogens) to patients, visitors, staff and other persons working at or using its premises.

The Welsh Health Technical Memorandum (WHTM) 04-01 gives comprehensive advice and guidance to healthcare management, design engineers, estate managers, operations managers, contractors and the supply chain on the legal requirements, design applications, maintenance and operation of hot and cold water supply, storage and distribution systems in all types of healthcare premises.

The Health Board is committed to reducing the risks associated with water borne pathogens and ensuring compliance with WHTM 04-01 by providing arrangements to ensure effective practice, through the Policy for the Management of Safe Water Systems (ES02).

2. Scope and Objectives

The objective of this review was to determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The scope of this review was limited to:

Governance arrangements

Whether an appropriate policy is in place to address water safety issues, with defined allocation of responsibilities, clear lines of communication and reporting and approval processes.

Reviewing minutes from the Local Area Water Management Control Team (LAWMCT) to the Water Safety Group (WSG) and identify any matters of significance that are reported to Strategic Infection Prevention Group (SIPG).

Implementation Arrangements and Monitoring

Reviewing the following implementation arrangements:

- Water Safety Plan WSP – A collective term for a number of documents.
- Operational Procedures Document – An Area document for developing, implementing and monitoring compliance.
- Routine Water Testing (Clear Water Portal).
- Contingency Requirements.
- Appropriate use of Thermostatic Vales (TMVs).

Risk management

Establishing that the Health Board performed suitable and sufficient assessment of risk as well being appropriately managed.

3. Associated Risks

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

- Patient Safety;
- Adverse publicity;
- Breach of regulations / approved code of practice;
- Fines and defence costs;
- Ineffective / inappropriate governance arrangements; and
- Ineffective risk control.

OPINION AND KEY FINDINGS

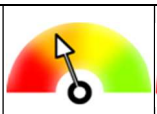
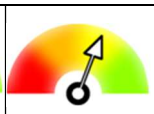
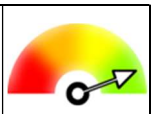
4. Overall Assurance Opinion

RATING	INDICATOR	DEFINITION
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.

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.

5. Assurance Summary

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

Assurance Summary					
1.	Governance		✓		
2.	Implementation Arrangements and Monitoring			✓	
3.	Risk management		✓		

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Statutory Compliance: Water Safety

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weakness in the operation of the designed system/control for Statutory Compliance: Water Safety.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided by the Interim Head of Operational Estates and Estates Officers East, Central and West. We would like to express our gratitude for their input during the undertaking of the review.

We have relied solely on the documents, information and explanations provided and except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

Governance Structure

Policy

Governance requirements for water compliance is defined within the ES02 – Policy for the Management of Safe Water Systems.

At the time of writing this report, the last reviewed date of the Policy was June 2017; elements of the Policy require a review in particular Roles, Responsibilities, Appendix C - Contact Details, and Key Appointed Roles (at the time of writing this review the post of authorising engineer was vacant).

It is noted that within the minutes of Infection Prevention Sub Group (IPSG) 18th January 2021:

> *IPSG 21/03.6 Estates and Facilities Alert Assurance Achievement (AAA) Report*
>
> *4.6 Estates and Facilities – Policy updates*
>
> *Policy for the Management of Water Systems to be presented to IPSG in February 2021.*

Local Water Management Sub-Groups

We reviewed minutes from the Local Area Water Management Control Team (LAWMCT) to the WSG to identify any matters of significance that are reporting to Infection Prevention Group (IPG).

East

A Terms of Reference (TOR) is written within the minutes of 19th June 2019 meeting, however we are unable to confirm these have been ratified.

We received the last three sets of minutes (8th March 2018, 11th May 2018 & 19th June 2019). Meetings are required to be bi-monthly; from our findings, only one meeting took place in 2019 and no meetings in 2020.

All three sets of minutes had different templates; actions from the WSG can be seen feeding into the meetings of 8th March 2018 and 11th May 2018 as agenda items. Issues of significance (IOS) to the WSG is evidenced within the minutes of 11th May 2018.

Central

We received the last three sets of minutes, which have taken place (7th May 2019, 24th September 2019 and 11th February 2020). Meetings are required to be monthly with three taken place since May 2019.

Issues of Significance for Escalation to WSG are raised within all three sets of minutes and a standard template is used for all three meetings with the TOR provided and noted as reviewed on the 11th February 2020, however we are unable to confirm these have been ratified.

West

We received the last three sets of minutes that have taken place (27th March 2019, 2nd May 2019 & 6th September 2019). No meetings have taken place in 2020 and no TOR was provided, however we were informed the frequency of meetings is every three months.

Issues of Significance for Escalation to WSG were noted within all three sets of minutes and a standard template is used for all three meetings.

Water Safety Group

We were provided with a draft TOR dated January 2020 - currently there are names next to the titles within the membership section, of which some will require updating. Meetings are noted to be quarterly, however we note the Health Board stood down a number of meetings due to the COVID-19 pandemic which will have a direct impact on the WSG meeting its TOR.

We received the last three sets of minutes (23rd January 2020, 20th August 2020 and 24th November 2020.

Although only one Local Water Management Sub-Group meeting had taken place in 2020, evidence of reporting from the areas into the WSG minutes can be evidenced within the following agenda items:

- Agenda point 6 - BCUHB Pseudomonas aeruginosa Sampling/Testing update.
- Agenda point 7 - legionella management updates. and
- Agenda point 9 - Issues of Significance from Local Area Management Control Teams.

We sought to follow issues of significance from the WSG meeting of the 24th November 2020 as escalated to the Infection Prevention Group:

Water Safety Group (WSG) 24th November 2020

Matters for escalation to the Infection Prevention Sub Group:

- *No NWSSP-SES in place for North Wales*
- *Ice machines throughout the HB*
- *SOP for POU filters*

We were able to confirm the issues of significance being raised at the Infection prevention sub-group meetings of the 8th December 2020, and at the 18th January 2021 meeting where an Alert Assurance Achievement report was presented by the Director of Estates and Facilities.

Infection Prevention Sub-Group (IPSG)

The TOR for the IPSG identifies the WSG (section 8 Reporting) as a sub-group and reporting to it.

We reviewed three consecutive sets of minutes (10th November 2020, 8th December 2020 and 18th January 2021). Per the cycle of business provided, a quarterly report is to be presented by the WSG at the meeting of the 10th November 2020 however we were unable to confirm the report being presented within the minutes.

Previously we were able to establish the IOS from the WSG being raised at the ISPG meetings for the 8th December 2020 and the 18th January 2021. However we have not been able to verify within the minutes discussion taking place on the IOS raised.

Patient Safety Quality Group (PSQG)

Chairs assurance reports from the ISPG were being presented to the Patient Safety Quality Group meetings of the 13th November 2020, 11th December 2020 and 16th February 2021.

No issues of significance for escalation to the PSQG regarding water management were recorded within the minutes of the ISPG meetings during this period.

Implementation Arrangements and Monitoring

Water Safety Plan (WSP)/operational procedure documents

ES02 – Policy for the Management of Safe Water Systems

The WSP is a holistic approach to manage water for all uses (including diagnostics and treatment purposes) so that it is safe for all users including those most at risk of water borne infections as a consequence of their illness or treatment.

The WSP is a collective term for a number of documents; we have obtained various operational documents, minutes of meetings, including the policy for the Management of Safe Water Systems (ES02), all of which contribute to the WSP.

Areas of the WSP need to be updated, including Policy, Risk Assessments and training.

We were informed that once the new external contract for water management is awarded in April 2021, the development of a full plan will form part of the agreement.

Our review of specific items is detailed below.

Routine Water Testing.

An external company monitors all sentinel outlets (a water outlet chosen to have its temperature monitored so that risk from Legionella can be controlled) as well as servicing Thermostatic Valves (TMVs) across the Health Board bi-annually. All the information is uploaded to a portal where the Estates Department are able to monitor any issue of non-compliance.

The portal provides access to:

- All areas that have been tested;
- Risk assessments of the areas tested;
- Method statements;
- Water Tanks inspections;
- Expansion Vessels;
- Fail safety tests; and
- TMVs checks.

Legionella Pneumonia Testing

We were provided with spreadsheets from all three areas, which evidences routine testing taking place on a six-month programmed cycle.

Samples collected by the Estates Department are sent to laboratories at Ysbyty Gwynedd. Certificates are then issued from the laboratories to Estates identifying if anything has/has not been detected.

We noted test results being recorded per minutes of the WSG as an agenda item.

Water Safety Group (WSG) 23rd January 2020, 20th August 2020 and 24th November 2020

Agenda point 6.0 BCUHB Pseudomonas Aeroginosa Sampling/Testing update

Expansion Vessels

Expansion vessels play a very important role in the function of a pressurised heating system. Without one, the system cannot allow cold water to expand as it is heated and therefore a system can become dangerous.

We were provided Excel spreadsheet asset list from East, Central and West with all infrequently used outlets identified on a live document.

Expansion vessels are serviced in house on a six-monthly basis, however several dates within the West indicated that the last flushed test date was in 2019.

Flushing list of Outlets

Infrequently used flushing outlet documents have been provided to us for all three areas. These are to be flushed twice weekly – We received documentation completed by Estates and Facilities department, below are our findings.

Central

Evidence provided to us shows the flushing list for Ysbyty Glan Clwyd and community being checked twice weekly including signatures. From the list, three

of the locations had not been checked as they had been identified as COVID areas, two other locations had no signature or date and written within the signature section was "no information".

West

Evidence provided to us shows the flushing list for Ysbyty Gwynedd, Penrhos Stanley and Bryn Y Neuadd being checked twice weekly including dates and signatures.

East

Evidence provided to us shows the flushing list for Ysbyty Wrexham Maelor and community sites being checked twice weekly including dates and signatures. Sections of the community list were incomplete however we were informed that the outlets had been removed from the sites but had not been removed from the lists.

Building Management System (BMS) East, Central & West.

In acute sites, BMS monitors the water temperatures of water heaters, at the entrance to departments and at the furthest point, if these are out of temperature parameters this will notify individuals (electronically) on shift for further investigation.

Appropriate use of Thermostatic Vales (TMVs).

All TMVs are subject to risk assessment before being installed as from a water safety perspective it is preferable not to have thermostatic valves. Currently the external contractors undertake twice yearly checks on the TMV's; evidence of this has been provided from the external contractor portal including method statements.

We were advised of the following:

East

Contractor commenced TMV servicing in September 2020 with Estates Department only having an asset list for the acute site. By March 2021 it is hoped all TMV across East will have been serviced and a detailed asset list will have been created in readiness to move into the new service contract in April 2021.

Central

Contractor undertakes twice-yearly checks with Estates attending a faulty TMV. There is no pre-planned maintenance as the contractor undertake all the temperature checks, failsafe tests and filter strip downs.

West

Contractor undertakes twice yearly checks on the TMV's with Estates undertaking a two yearly strip down and full service. Evidence provided shows that the last internal pre-planned maintenance was undertaken in 2017; no pre-planned maintenance occurred in 2019. We were informed that pre-planned maintenance is to be completed later this year 2021.

Contingency Requirements.

Welsh Health Technical Memorandum 04-01 – Safe water in healthcare premises Part B

6.72 Contingency plans should be available in the event of the following:

b. A water supply failure that could last beyond the period for the designed storage capacity.

Note:

The WSG should ensure that plans are in place for the supply and distribution of alternative safe water for drinking to vulnerable patients and those unable to collect supplies from distribution points within the healthcare facility. This will include the use of sterile water if appropriate.

We asked what contingency plans were in place for the three areas; we were advised that Central and West have facilities for a tanker connection should a water supply fail. However, we have not been provided with any documentation/plans (including annual tests) to corroborate this. East informed us that there were no contingency plans in place.

Training

Welsh Health Technical Memorandum 04-01 – Safe water in healthcare premises Part B

6.29 Individuals to whom tasks have been allocated (supervisors and managers as well as operatives) need to have received adequate training in respect of water hygiene and microbiological control appropriate to the task they are responsible for conducting.

Currently there is no water hygiene awareness training being undertaken within the Health Board for staff. We were informed that once the new contract for water management is awarded in April 2021, training would be requested as part of the contract.

Previously staff have addressed this within their 'Legionella hot and cold water' training although it is unknown if this syllabus meets the requirements of WHTM 04-01.

The three Responsible Officers for East, Central and West provided us with up to date certificates for Legionella control – The role of the responsible person.

Risk management

In order for the Health Board to comply with their legal duties and in accordance with the Health and Safety Executive (HSE) Approved Code of Practice L8, a risk assessment in relation to legionella must be carried out, reviewed regularly and specifically whenever there is reason to suspect that the current assessment is no longer valid.

We received evidence of risk assessments from East, Central and West, below is a table of our findings.

Table 1: Legionella risk assessments by area

Area	No of risk Assessments	In Date	Out of Date
East	75	1	74
Central	*81	65	16
West	39	2	37

*11 taken out from the Central as HB not the duty holder.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**1**	**0**	**4**

Finding - ISS.1 – Governance (Operating effectiveness)	Risk
In reviewing governance and accountability arrangements recorded in Health Board Policy ES02 – Policy for the Management of Safe Water Systems, the review has identified: • Policy is out of date and requires review; • at the time of writing this review the post of authorising engineer was vacant; and • Local Water Management sub-groups are not meeting per frequency identified within the TORs.	Governance and assurance is not effective.
Recommendation	**Priority level**
Policy requires a full review in respect of Roles, Responsibilities, Contact Details, and Key Appointed Roles. Reinstatement of Local Water Management sub-groups in accordance with TORs.	**High**
Management Response	**Responsible Officer/ Deadline**
Recommendation 1	The Director of Estates and Facilities through the Head of Operational Estates will action the following recommendations by:

Operational Estates are updating the Policy for the Management of Safe Water Systems (ES02) following internal audit recommendations and Corporate Health & Safety Audit review. Recommendation 2 The Health Board in line with HTM compliance has appointed an Authorising Engineer – Water Safety. This role is provided through NHS Wales Shared Services – Specialist Estates Services Pan Wales. Specialist Estates Services are currently recruiting to this role following the departure of the current post holder. Recommendation 3 In line with ES02 Terms of Reference for Local Water Safety Sub-Groups are in place. The frequency and attendance and escalation will be reviewed as part of the updated Policy for the Management of Water System.	Recommendation 1 30th June 2021 Recommendation 2 31st May 2021 (subject to SES recruitment process) Recommendation 3 30st June 2021

Finding - ISS.2 – Water Safety Plan (Operating effectiveness)	Risk
Areas of Water Safety Plan outdated:- • Training; • Policy; • Legionella Risk Assessments; and • Local Water Management Sub-Groups.	Non-compliance with Regulations and Approved Codes of Practice. Risk to staff, patients, visitors and public.
Recommendation	**Priority level**
Water Safety Plan requires a full review to identify weaknesses as well as to ensure that control measures are in place to conform with the Welsh Health Technical Memorandum (WHTM) 04-01 and HSG274.	**High**
Management Response	**Responsible Officer/ Deadline**
Operational Estates have appointed external consultants from Clearwater Technology Ltd to update the current Health Board Water Safety Plan to include the risks identified – Policy, Training and Risk Assessments. In compliance with WHTM 04-01 and HSG274	The Director of Estates and Facilities through the Head of Operational Estates will action the following recommendations by: 30th June 2021

Finding - ISS.3 – Training (Operating effectiveness)	Risk
Currently no water hygiene awareness training taking place for relevant staff.	Non-compliance with regulations and approved codes of practice.
Recommendation	**Priority level**
Complete a training needs analysis to ensure all relevant staff who require Water Hygiene' training and other appropriate training have been identified.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As part of Operational Estates PADR Programme, a bespoke training matrix has been developed for staff identified as requiring specific Water Hygiene Training.	The Director of Estates and Facilities through the Head of Operational Estates will action the following recommendation by: 31st April 2021

Finding - ISS.4 – Contingency Plan (Operating effectiveness)	Risk
We were advised that two of the three areas have facilities for a tanker connection but have not seen evidence to corroborate this. We have not received any evidence that the East area have similar contingency arrangements.	Non-compliance with the Welsh Health Technical Memorandum (WHTM) 04-01.
Recommendation	**Priority level**
Ensure that plans are in place for the supply and distribution of alternative safe water including annual testing as per policy ES02 – Policy for the Management of Safe Water Systems.	**High**
Management Response	**Responsible Officer/ Deadline**
Operational Estates have reviewed the water supply contingency planning arrangements for all three acute sites. Ysbyty Glan Clwyd – Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority (Welsh Water / Dwr Cymru). The infrastructure is tested annual as part of the a programme of tests incorporated within the Fire Hydrant testing schedule. Ysbyty Gwynedd - Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority (Welsh Water / Dwr Cymru). A Planned Preventative Maintenance programme will be developed to ensure annual testing of outlet will be carried out. Wrexham Maelor Hospital - Water distribution has been designed to accommodate on-site replenishment via the local statutory water authority	The Director of Estates and Facilities through the Head of Operational Estates will action the following recommendations by: 31st April 2021

(Hafen Dyfrdwy) the fill point is located adjacent the main water storage. Planned Preventative Maintenance programme will be developed to ensure annual testing of outlet will be carried out.	

Appendix B - Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Betsi Cadwaladr University Health Board

Control of Contractors

Final Internal Audit Report

BCU 2020/21

April 2021

NHS Wales Shared Services Partnership

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Executive sign off:	Director of Estates and Facilities
Distribution:	Chief Information Officer Board Secretary Head of Operational Estates Data Communications Manager Deputy Board Secretary
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standar validated through the external quality assessment undertaken by the Institute of Int Auditors.

ACKNOWLEDGEMENT

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

Disclaimer notice - Please note:

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

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The Control of Contractors review sought to evaluate the processes and procedures that support the management and control of contractors working for the Health Board. The audit forms a part of the 2020/21 internal audit plan.

Both the Health Board and its appointed contractors have responsibilities under health and safety law, to ensure appropriate precautions are taken to reduce the risks of dangers to patients, employees, visitors and contractors themselves. Applicable legislation includes the Health and Safety at Work etc. Act 1974, Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002 and the Control of Asbestos Regulations 2012, amongst others.

The Health & Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including "Managing Contractors" (HSG 159), and the "Using Contractors – a Brief Guide." The audit will assess compliance with the requirements of this guidance.

2. Scope and Objectives

The scope of the review was to determine the adequacy of, and operational compliance with, the systems and procedures of the Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

The objective of the review was to evaluate the systems and controls in place within the Health Board, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.

Accordingly, the scope and remit of the audit included:

- **Governance –** To ensure that the Health Board has adequate arrangements in place to support the control of contractors and compliance with regulations and guidance. Including:
  - that an appropriate policy and procedural documents are in place to manage the control of contractors, in line with HSE requirements; and
  - that policy requirements encompass all relevant departments, including Estates, IT, Medical Equipment etc. and that requirements have been effectively communicated.
- **Appointment of Contractors -** To ensure potential contractors are appropriately checked to establish compliance with HSE requirements and the Health Board's required standards for health and safety, including confirmation that contractors:
  - have sufficient skills, knowledge, experience and the ability to implement appropriate health & safety systems;
  - have undertaken an appropriate risk assessment in relation to the specific work they are to undertake; and
  - have a reasonable track record of occupational health and safety

performance at work of a similar nature.

- **Management of work on site –** To ensure appropriate arrangements are in place to manage contractors working on Health Board premises, including:
  - controls over access to site;
  - appropriate site induction arrangements;
  - risk assessments, safe systems of work etc., are in place;
  - operation of Permits to Work where appropriate; and
  - the regular monitoring of contractors on site, to ensure compliance with required practices.
- **Monitoring & Reporting –** To ensure ongoing monitoring and review of contractors / contractor-related incidents, in order to maintain the required standards of health and safety and to improve existing processes, including:
  - appropriate arrangements are in place for the monitoring, review and reporting (both internal and external (e.g. RIDDOR requirements) of any contractor-related incidents, including the feedback of lessons learnt to contractors and to inform Health Board procedures; and
  - Monitoring of compliance with the Health Board's requirements, both within Works & Estates and in other areas across the Health Board.

Other – Review of any other issues relevant to the general objectives above which may arise during the review.

3. Associated Risks

The potential risks considered in the review are as follows:

- Patient, Staff, Contractor & Public safety;
- Damage to Health Board property;
- Adverse publicity/reputational damage;
- Breach of HSE regulations and potential financial penalties; and
- Prosecution / criminal negligence.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the **Control of Contractors** review is limited assurance.

RATING	INDICATOR	DEFINITION
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.

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.

5. Assurance Summary

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

Assurance Summary					
1	Governance		✓		
2	Appointment of Contractors		✓		
3	Management of work on site		✓		
4	Monitoring & Reporting		✓		

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

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Control of Contractors.

Operation of System/Controls

The findings from the review have highlighted three issues that are classified as weakness in the operation of the designed system/control for Control of Contractors.

6. Summary of Audit Findings

This report is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.

The original scope for this review encompassed controls in place in respect of contractors appointed by and for Operational Estates, Informatics and EBME. However, following a discussion with EBME, we noted that the contractors they use do not undertake work that affects the fabric of the building and therefore we did not pursue any further testing in relation to their service provision, focusing instead on Informatics and Operational Estates.

Early on in the review, we noted that the system in place for the control of external contractors had been the subject of a paper produced by the Occupational Health & Safety (H&S) Team in September 2019. Following this we understand that discussions were undertaken to prepare action plans to address the issues identified in this paper. However, the COVID-19 pandemic has severely affected this work.

Similarly, in completing this review we have not been able to undertake the on-site testing that would have been undertaken. However, noting the appraisal offered by Senior Management within Operational Estates, H&S and Informatics concerning the current situation and that it does not differ markedly from that in place 12 months earlier, we have taken note of the H&S recommendations and reflected progress against these in our findings and conclusions.

Governance

The Health Board does not possess its own in-house policy regarding the management of contractors, instead there is a document entitled Contractor's Safety Guidance Document.

This is extensive regarding a contractor's on-site work and code of conduct, but there is little concerning this from the Health Board perspective. The documentation does not address the contractor appointment process, management whilst on site or the post-completion review/checking process of contractors.

From discussions with Senior Managers from both Operational Estates and Informatics we understand that historically Informatics managed the user requesting, and procurement aspects whilst Estates colleagues would manage the Data Cabling contractors whilst on site, ensuring that the RAMS, CDM, asbestos, and fire-stopping requirements are fully met and adhered to agreed standards. This however is an interim process and there were variations in working practice across the three geographical areas of BCUHB. We note though the newly agreed collaborative working arrangement between Estates and ICT, which formalises the agreement for Estates to manage Contractors whilst working 'On Site'.

The Contractor's Safety Guidance Document was found to be available on the Health Board's intranet site, but did not appear on the public facing internet site.

Appointment of Contractors

Whilst there is the Contractors Safety Guidance Document, the H&S Gap analysis work undertaken and the limitations of conducting field-testing during the pandemic, we have not verified that Contractors are provided with a copy of the document detailing H&S standards.

Within the limited testing we were able to complete, it was identified that a contractor used extensively by Informatics to undertake network-cabling installation had not ensured its staff were up to date with Asbestos training with 2/6 named staff having certificates that expired in 2018. It is understood however that Cabling Contractors are usually given a copy of the asbestos report for the site/area they are working on.

It is noted however that whilst good practice to undertake refresher training every 12 months, the Health and Safety Executive (HSE) website details that: *"Information instruction and training on asbestos awareness is merely intended to help workers avoid carrying out work that will disturb asbestos. There is no legal requirement to repeat an entire formal awareness refresher-training course every 12 months. However some form of refresher should be given, as necessary, to help ensure knowledge of asbestos awareness is maintained."* [1]

The H&S Gap Analysis report noted, "*There was limited evidence that contractors are inducted and provided with information regarding the exposure to asbestos"*. [2]

Management of Work on-site

Following discussion with the Acting Head of Operational Estates, we were advised that there are measures in place to manage the presence on site of external contractors at the main acute hospital sites at Bangor, Bodelwyddan and Wrexham. This covers the period Monday to Friday 8am to 5pm.

However, this is not operational at the majority of the Health Boards' estate. The H&S Gap Analysis Report, presented to the Strategic Occupational Health & Safety Group on the 29th August 2019, identified this and reported, *"There was no system in community hospitals to sign contractors in and issue them with an identification badge".*

As reported in Appointment of Contractors above, we noted the issue of contractor staff not having their asbestos training updated; the risk this presents is compounded by the findings of the H&S Gap Analysis that found *"The overall view of asbestos was that the system was fragmented and inconsistently managed. There is a policy on the intranet that was due to be reviewed in January 2019".*

As part of this review, we confirmed that, as at January 2021, the Asbestos policy is still overdue for review as detailed in the H&S report.

The Occupational Health & Safety Gap Analysis report noted the following in relation to the induction and management of external contractor staff

- *"A permit to work system in specific areas in relation to asbestos related work is required; one has been drafted but not approved".*

[1] HSE website - Asbestos information, instruction and training.

[2] Occupational Health and Safety Gap Analysis Report June 17th –July 31st 2019.

- *"A permit to work system and clear policy on working at height is required with specific guidance risk assessment and training for all staff involved in high risk activities".*
- *"Weaknesses are in site induction and site monitoring of contractors".*
- *"The management of contractor's policy describes the role of the Fire Officer is to provide induction to all contractors visiting the site the evidence was that this hadn't taken place at the premises for 5 years. There was evidence of contractors starting work with no consultation with site* occupiers".

We have not been provided with evidence to support that these have been addressed. We note that a paper was presented by the Director of Estates and Facilities to the Strategic Occupational Health and Safety Group on the 2nd February 2021 that details actions being implemented to mitigate a number of the recommendations of the Gap Analysis report, eighteen months since the gap analysis was published.

However, the same paper does also note, "*the Business Case currently has not been approved and as a result, many of the risks identified in the Gap analysis require funding to mitigate the risks and improve compliance to achieve the target risk score on the Corporate Risk Register, which is within the Health Boards risk appetite".*

Monitoring & Reporting

We requested a report from Datix of incidents involving external contractors whilst on Health Board premises for the period 1st April 2018 to 31st March 2020.

We identified ten incidents that fitted the criteria involving external contractor staff. All recorded negligible to moderate in severity and narrative was included to support that an investigation had taken place to review the events. However it is unclear where the conduct and performance of contractors is reviewed/reported, when this has been found wanting.

This issue was also identified in the Health & Safety Gap Analysis paper that identified there *"had been a number of incidents of poor contractor behaviour, management and safety issues".*

It is unclear that these incidents are taken into account when renewing contracts or employing the services of contractors for future schemes. Similarly we are not aware of any forums at which the performance of contractors is routinely reviewed and reported following completion of work undertaken.,

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

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

Finding - ISS.1 – Contractor's Safety Guidance	Risk
The Contractor's Safety Guidance document is extensive concerning contractors' on-site work and code of conduct, but there is little regarding the Health Board's responsibilities. The documentation does not address the contractor appointment process, management whilst on site or the post-completion review/checking process of contractors. In addition, individual departmental responsibilities are not specified. Following discussions with Informatics, it was noted that they would use the Contractor's Safety Guidance policy if required, but typically, they would have passed over the control of contractors' aspect to Operational Estates.	Health Board personnel not aware of the Policy and are not applying the correct and appropriate processes with regards to the Control of Contractors.
Recommendation	**Priority level**
A Health Board Standard Operating Procedure and should be developed to encompass the management of external contractors, this would state the relevant responsibilities of BCUHB personnel, including the differing departments who would be able to use contractors.	**High**
Management Response	**Responsible Officer/ Deadline**

Estates and Facilities have a divisional Contractor's Safety Guidance Document (Standard Operating Procedure). This SOP was implemented in 2018 and following the audit review the SOP will be updated to include the actions contained within the recommendations of this audit. The Contractors safety Guidance Document (SOP) is available through the intranet under the Estates and Facilities section.	The Director of Estates and Facilities through the Head of Operational Estates will update the SOP by: 30th June 2021

Finding - ISS.2 –Health & Safety Gap Analysis	**Risk**
There has been limited progress to date in addressing the findings of the Occupational Health and Safety Gap Analysis Report, presented to the Strategic Occupational Health and Safety Group on the 29th August 2019. Whilst recognising the impact COVID-19 pandemic has had, the volume of contractors engaged during this period to support the Health Board in delivering changes to the fabric of buildings etc. has been significant.	Enforcement action, prosecution and fines from breaches of Health and Safety Regulations.
Recommendation	**Priority level**
Operational Estates and Informatics ensure that required management actions to the H&S Gap Analysis Report, concerning the Control of Contractors are addressed.	**High**
Management Response	**Responsible Officer/ Deadline**

Operational Estates and Informatics have developed a 2 stage operational procedure to ensure that management of contractors is compliant during the installation of data cabling. Phase 1 Implementation of an interim management procedure between Operational Estates and Informatics for the management of IMT Data cabling. Phase 2 As part of Estates and Facilities (Health and Safety and Statutory Compliance Resources Business Case), funding has been requested to progress the interim arrangement to permanent based on resource requirement. (The Business Case has been submitted as part of Estates and Facilities cost pressures for financial planning 2021-2022	The Director of Estates and Facilities / Chief Information Officer through the Head of Operational Estates and Data Communications Manager have agreed the following actions: Phase 1 – Completion by 30th April 2021 Phase 2 – Completion by 31st May 2021 (Subject to 2021-2022 budget setting process)

Finding - ISS.3 – Monitoring and reporting of Contractors	Risk
From Datix we identified ten incidents concerning external contractor staff. All deemed negligible to moderate in severity. However we are not clear on where the conduct and performance of contractors is reviewed/reported when this has been found wanting. It is similarly unclear where the performance of Contractors is evaluated and reported to ensure that this is a factor in appointing for future work.	Contractor performance or issues of Health & Safety compliance not identified when selecting contractors for future engagements.
Recommendation	**Priority level**
Formalise monitoring and reporting of contractor performance, noting satisfaction with delivery of work including any breaches of Health & Safety or other issues recorded on Datix.	**Medium**
Management Response	**Responsible Officer/ Deadline**
As part of the review of the Contractors Safety Guidance Document (SOP) an addition section will be include to address monitoring and reporting of contractor performance (KPI's). This will be taken from the NHS Shared Services Procurement tender documentation.	The Director of Estates and Facilities through the Head of Operational Estates will update the SOP by: 30th June 2021

Appendix B - Assurance opinion and action plan risk rating

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 can take **no assurance** that arrangements in place 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.

 **Assurance not applicable** is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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.