Bundle Audit & Risk Assurance Committee 25 June 2019

2.2 Table of Actions

Presenter: Chair

Table Of Actions Audit Risk Assurance Committee 29 May 2019

AC(18)246 - Final Insolvency note to minimise and manage potential risks

HDdUHB Cleaning Standards Internal Audit 2018-19 Final Report (Updated Management Response)

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 29th May 2019

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(18)246	**11/12/2018**	**Women & Children's Phase 2 Updated Management Response**	To take forward the possibility of devising a Code of Best Practice around supply chain partners across Wales.	SC/HT	Feb 2019	*A briefing paper outlining good practice has been shared with the HB, by the Specialist Services Team from Audit & Assurance Services. The opportunity to share this more widely across NHS Wales is currently being explored.* See attached briefing paper.
AC(18)247	**11/12/2018**	**Procurement and Disposal of IT Assets Follow-Up (Reasonable Assurance)**	To take forward concerns around the lack of an adequate asset register.	HT	~~Feb~~ June 2019	*Internal Audit brief agreed. Advisory project to be undertaken. Project which will entail a review of the current system in place and how it operates, a review of good practice in operation at a number of other NHS Wales bodies and a proposal to take this forward.*

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						Internal Audit report being presented to 25th June 2019 meeting.
AC(19)06	**19/02/2019**	**Feedback from the Targeted Intervention Meeting held on 8th February 2019**	To undertake work through the Finance Committee to ensure the Health Board is in a position to understand the underlying deficit, and provide assurance by the next meeting that this work had progressed.	HT	~~April~~ July 2019	*This will be taken through Finance Committee. The Health Board is working with Welsh Government colleagues on the engagement of external support to develop a better understanding of the underlying deficit.* Invitations to tender have been issued, project to commence end June 2019.
AC(19)44	**23/04/2019**	**Annual Review of the Committee's Self-Assessment of Effectiveness**	To provide for the above report information around monitoring and review mechanisms for Internal Audit.	SC	~~May~~ ~~June~~ August 2019	*Monitoring and review mechanisms are included in the annual Quality Assurance and Improvement Programme report which will be available in draft for the June 2019 meeting.* Report needs to be finalised via NWSSP processes. Forward

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						planned for 27th August 2019 meeting.
AC(19)46	**23/04/2019**	**Wales Audit Office Update Report**	To share, when available, the proposed scope for the Clinical Equipment review.	AB	~~June~~ October 2019	The Clinical Equipment review is scheduled for quarter 3 of 2019-20. The draft scope will be shared at that time.
AC(19)49	**23/04/2019**	**WAO Clinical Coding Follow-up Review**	• To discuss Clinical Coding and Medical Records with Mr Joe Teape and suggest that Mrs Miles leads on these matters and takes them to Executive Team for further discussion;	KM	October 2019	Discussion held. The Director of Planning, Performance and Commissioning will oversee the implementation of recommendations contained within the WAO review; however the Director of Operations will retain Executive Accountability for Medical Records.
			• To speak to Dr Philip Kloer regarding clinical engagement;	KM	October 2019	To be discussed as part of the implementation plan for the WAO review.
			• To provide an update at the next meeting to provide assurance that this matter had been raised at Executive Team.	KM	June 2019	A paper was submitted to and considered at the Executive Team meeting on 10th June 2019.
			• To discuss outside the meeting whether there	JW	June 2019	To be reviewed as part of ongoing

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			are areas similar to Cleaning and Water Safety which should be considered for inclusion in the IA Plan;			discussions with Head of Internal Audit throughout the year.
AC(19)57	**23/04/2019**	**Welsh Risk Pool Claims (Substantial Assurance)**	To share with Mr Huw Thomas any examples of good practice relating to WRP Claims from other Health Boards.	SC/JJ	~~June~~ August 2019	*IA is currently looking to obtain the required information in order to provide an update for the June 2019 meeting.* The information required has been determined as wider than that in the Internal Audit report across the Health Boards, so a request will need to be made to NWSSP for the wider information on good practice.
AC(19)64	**23/04/2019**	**National Standards for Cleaning Follow-up (Limited Assurance)**	To update/revise the management response in the SMART format;	RE	June 2019	See attached update.
AC(19)67	**23/04/2019**	**Primary & Community Care Pipeline Projects – Aberaeron Integrated Care Centre**	To include within a future iteration of the Financial Assurance Report information on management of supply chain partners.	HT	June 2019	Completed.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
		(Substantial Assurance)				
AC(19)86	**23/04/2019**	**Audit & Risk Assurance Committee Work Programme 2019/20**	To make the agreed amendments.	CM	June 2019	Completed. Included in ARAC Workplan.
AC(19)101	**07/05/2019**	**Draft Annual Accounts 2018/19**	To undertake retrospective analysis of previous years' WRP projections to assess whether these were realistic;	HT	~~June~~ August 2019	Report will be prepared for the 27th August 2019 ARAC meeting.
AC(19)107	**29/05/2019**	**Table of Actions: AC(18)247 – Procurement and Disposal of IT Assets Follow-Up (Reasonable Assurance)**	• To provide an update at the next meeting;	HT	June 2019	Internal Audit report being presented to 25th June 2019 meeting.
		Table of Actions: AC(19)53 – Concerns (Reasonable Assurance) Update	• To discuss inclusion of the full-year figures relating to Concerns in the Annual Report;	JW/AF	June 2019	Completed. Communications team will ensure this is incorporated within the report.
		Table of Actions: AC(19)68 – Cardigan Integrated Care Centre (Reasonable Assurance)	• To provide information regarding timescales for legal action to Mrs Karen Miles.	JW	June 2019	Completed. ARAC minutes shared with Mrs Miles.
AC(19)114	**29/05/2019**	**Accountability Report**	To amend the description of Mr Mike Lewis on page 92, to	JW	May 2019	Completed.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			read 'Independent Member – Finance'.			
AC(19)117	**29/05/2019**	**Final Accounts for 2018/19**	To undertake retrospective analysis of previous years' CHC claims to assess whether projections are realistic.	HT	August 2019	Report will be prepared for the 27th August 2019 ARAC meeting.
AC(19)119	**29/05/2019**	**Integrated Care Fund Follow-up (Reasonable Assurance)**	To amend 'Intermediate Care Fund' to read 'Integrated Care Fund'.	JJ	June 2019	The references in the report have been updated and the revised version issued.
AC(19)122	**29/05/2019**	**Preparedness & Compliance with the Nurse Staffing Act (Substantial Assurance)**	• To clarify, with regard to Objective 4, figures and percentages in relation to the need for temporary staff, in order to gauge potential risk;	JJ	June 2019	The assurance was given based on the adequacy of the systems in place to manage the ongoing risks around this, with each of the five wards requiring the regular use of temporary staff. If further detail was required, additional work would be needed and further information requested from the wards visited. This could be done when the further testing is undertaken.
			• To schedule a re-audit in 6 months.	JJ	December 2019	Further testing will be undertaken in late 2019.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(19)126	**29/05/2019**	**Review of PADR Process (Limited Assurance)**	• To schedule a re-audit in 2020;	JJ	June 2020	A follow up audit will be undertaken during early 2020. This will be formally added to the IA Plan when reviewed half way through the year.
			• To feed back to those who conducted the fieldwork ARAC's praise regarding the format, content and quality of the report, in particular the methodology utilised during the audit.	JJ	June 2019	The comments from ARAC have been passed on to the relevant Internal Audit team members.

Practical Advice:

Potential Contractor

Insolvency and/or Liquidation

Hywel Dda University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

1. Context

Following a discussion at the December 2018 ARAC meeting, the Director of Finance requested practical advice to aid the UHB in the management of on-going risks relating to the potential insolvency and/or liquidation of contractors at the UHB capital projects.

This paper was prepared in advance of the recent pre-pack administration of a major contractor; a supplementary update has therefore been included.

The same is circulated for information of Members.

2. Background

Recently there has been significant focus in the press on the risk of insolvency and liquidation of major UK contractors.

Insolvency of contractors is relatively common due to the low margins that they typically operate with, the high level of turnover and relatively low liquidity.

Liquidation is less common than administration in the construction industry. In the case of Carillion in 2018, it is thought that liquidation was chosen as there was insufficient remaining funds to appoint an administrator.

In any event, contractually, the consequences are often the same.

The RICS '*Termination of contract, corporate recovery and insolvency'* guidance note should be accessed as a best practice guide.

Below we summarise key actions recommended for Health Boards/Trusts:

3. Monitoring

It is important, as an informed client, that appropriate arrangements are put in place to effectively monitor the risk of a contractor failing:

- Ensure that Contracts, Insurances and Collateral Warranties are appropriately completed.
- Ensure that comprehensive records are retained of key activities undertaken to meet statutory obligations; for example, Building Regulations, CDM Regulations, designs etc.
- Ensure that an appropriate Site Supervisor has been appointed to monitor site progress and maintain detailed records. The Supervisor should be mindful of:
    - evidence of slow-down in the programme and on-site performance;
    - a lack of materials or plant on site;
    - a reduction in labour engaged on site; and
    - the frequency and quantum of defective work increasing.
- Ensure that the externally appointed Cost Adviser is particularly diligent in ensuring that payments are based on actual activities performed, rather than programmed activities i.e. ensuring there is minimal overpayment risk.
- Ensure timely payment of SCP by the UHB/Trust, so as not to contribute to cash flow pressures.
- Obtain confirmation that sub-contractors are being paid on a timely basis.

- Regularly check the financial standing of the contractor – including potential commissioning of in-depth review(s) as appropriate.
- Maintain a Payments Register – detailing payments made and retentions withheld.

4. Pro-active action

Whilst monitoring the ongoing performance, the UHB/Trust should be mindful of requirements in the event of a potential liquidation/ insolvency:

- Familiarise itself with the contractual requirements and provisions for termination on insolvency – most contracts would require a notification to be served. Also, identify the specific 'step-in' arrangements.
- Ensure that the site can be secured in a timely manner and that it is appropriately insured in the event of insolvency.
- Undertake an assessment of all plant, equipment and materials and to take protective measures to ensure items cannot be removed from site.
- Identify and record details of all on-site and off-site assets.

5. Upon notification

Upon notification of the contractor liquidation/ insolvency, the UHB/Trust should:

- **Utilise the RICS guidance on insolvency.**

  Key actions will include - Securing the site and ensuring appropriate insurances are in place (noting contractor insurances will have lapsed).

6. Other Considerations

Some other considerations include:

- Obtaining legal advice on the implications of introducing direct payment from the UHB to sub-contractors – ensuring they are reimbursed in a timely manner.
- Project Bank Accounts (PBA) – the intention being that SMEs working on government projects receive payment in five days or less from the due date. Major programmes such as Crossrail have already implemented PBA.
- Performance Bonds - provide protection for the employer under a contract by transferring the risk of contractor's default to a third party. It guarantees to pay the direct loss suffered if a legal or contractual obligation has been breached. Usually, this breach occurs if the party responsible for these obligations becomes insolvent.

  This will, however, involve a premium set by the market.

7. Year End

Health Boards and Trusts should be mindful of the above guidance in high risk situations and ensure appropriate prudent action is taken at all times, including periods close to financial year ends.

Update Post the recent Pre-pack administration.

NWSSP, on behalf of NHS Wales, has arranged increased financial vetting of high risk contractors. Additionally, relevant entities have been subject to bulletins and recommendations from the Cabinet Office. NWSSP has circulated results to Health Boards and Trusts at frequent intervals.

Cabinet Office has encouraged public sector entities to adopt best practice payment terms so that the public sector does not negatively contribute to cash flow problems.

Steps to Consider upon a Supplier Entering into a Pre-Pack Administration

1. Financial vetting bulletins should continue to be monitored and appraised by relevant Directors of Finance on a regular basis.
2. Services should, in theory, continue to be provided at the levels agreed in respective contracts. However, it is possible there may be significant personnel changes, therefore it is appropriate this should be monitored to ensure potential negative implications are appropriately managed.
3. Health Boards/Trusts should:
    - ensure an exit management plan is in place. This should consider a strategic partner back-up plan, alternative firms that can be approached, allow for succession planning gaps etc.;
    - meet with senior management within the first 30 days. Obtain assurances that key personnel remain in the service delivery team, review the supplier's contingency plans etc.;
    - arrange weekly performance meetings for the first 12 weeks, reducing frequency thereafter, as appropriate; and
    - request quarterly management accounts to be provided within 60 days of each quarter end.

8. Conclusion

The newly formed entity post Pre-pack administration has been reported to be in good financial shape now that it has shed much of the debts of its former entity. It is however, good practice to monitor this on an ongoing basis until reasonable assurance has been derived.

Hywel Dda University Health Board

National Standards for Cleaning in NHS Wales

FINAL Internal Audit Report

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit & Assurance Services

Limited Assurance

Previous Audit Rating Reasonable

Contents **Page**

Review reference:	HDUHB-1819-34
Report status:	FINAL Internal Audit Report
Fieldwork commencement:	27th September 2018
Fieldwork completion:	10th January 2019
Draft report issued:	17th January 2019
Management response received:	Updated 5th April 2019
Final report issued:	11th April 2019
Auditor/s:	Ceri-Ann Corcoran
Executive sign off:	Joe Teape - Director of Operations/Deputy Chief Executive
Distribution:	Joe Teape - Director of Operations/Deputy Chief Executive; Heather Williams - Operations Manager East; Stephen John – Operations Manager West
Committee:	Audit & Risk Assurance Committee

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 assignment originates from the risk based Internal Audit plan for 2018/19 agreed by the Audit & Risk Assurance Committee, and the subsequent report will be submitted to the Executive Director and the Audit & Risk Assurance Committee.

The relevant lead Executive Director for the assignment is the Director of Operations/Deputy Chief Executive.

The responsibility of the Health Board is to ensure that healthcare premises are clean and that risks from inadequate or inappropriate cleaning have been reduced to the lowest possible level. All cleaning related risks should be identified and managed on a consistent long-term basis, irrespective of where the responsibility for providing cleaning services lies.

The National Standards for Cleaning in NHS Wales were originally published in July 2003. These have now been revised and new standards were published in December 2009. This revision occurred following the publication of "Free to Lead, Free to Care" (2008) and the introduction of Health Care Standards (2005). They also reflect the advice and guidance within "Healthcare Associated Infections – A Strategy for Hospitals in Wales" (2004).

The Standards provide a framework which outlines how the Health Board can demonstrate the achievement of minimum levels of cleanliness and the method of assessment, rather than how services should be provided.

The Standards apply to all NHS premises and the document sets out:

- The principles of cleanliness to be applied by the Health Board;
- The standards and their requirements;
- Guidance on meeting the requirements of the standards;
- The application of outcome and risk based analysis; and
- Measures of performance evaluation to monitor cleaning outcomes.

As part of the implementation plan the Health Board adopted the Credits for Cleaning system (C4C). The use of C4C is mandated within the National Standards of Cleanliness.

C4C facilitates cooperation between facilities, nursing, housekeeping and estates staff. Initially rolled out to all major hospitals, the system is now required to be used to monitor standards of cleanliness across all NHS healthcare sites. It requires the ward sister/charge nurse to 'sign off'

audit results, enabling greater levels of consistency of monitoring. It allows for more meaningful comparisons to be made, not just between wards and departments but between hospitals and Health Boards/Trusts. The tool should also enable accurate data to be recorded over time making it possible to demonstrate continuous improvement and the maintenance of the highest standards of environmental cleanliness. Across the UHB there are one hundred and forty one functional areas required a cleaning audit.

2. Scope and Objectives

The scope of the review is to identify how the Health Board is meeting its requirements in relation to the National Standards for Cleaning in NHS Wales. This review is limited to reviewing Standard VII - Monitoring of Cleaning Outcomes – of the National Standards and concentrates on Internal Technical Audits.

The overall objective of the review is to establish whether there are effective management arrangements in place to demonstrate compliance with the Standard.

The main areas included within the review are:

- Standard VII Monitoring of Cleaning Outcomes has been implemented within the Health Board in accordance with the National Standards for Cleaning in NHS Wales;
- There are measures of performance, evaluation and follow-up to monitor cleaning; and
- Identifying the governance arrangements in place to ensure the Health Board is meeting Standard VII.

3. Associated Risks

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

- Risk of infection for patients;
- Poor public image for the Health Board;
- A health and safety risk for the public and staff; and
- The risk of the Health Board providing poor value for money.

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 established controls within the **National Standards for Cleaning in NHS Wales** 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*			
Audit Scope					
1	Standard VII – Monitoring of Cleaning Outcomes		✔		
2	Measures of Performance, Evaluation and Follow-Up		✔		
3	Governance Arrangements				✔

** 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 **0** issues that are classified as weakness in the system control/design for National Standards for Cleaning in NHS Wales.

These would be identified in the Management Action Plan as (D).

Operation of System/Controls

The findings from the review have highlighted **5** issues that are classified as weakness in the operation of the designed system/control for National Standards for Cleaning in NHS Wales.

These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Audit Scope 1: Standard VII – Monitoring of Cleaning Outcomes

Audit & Assurance testing was undertaken to ensure cleaning service providers for healthcare facilities undertake regular audits of cleanliness to monitor standards and managers, supervisors and infection control teams have a key role in ensuring corrective action is taken where standards fall short of what is expected.

A sample of very high and high risk area audits was attended and observed as outlined in the table below. Across the UHB there are one hundred and forty one functional areas required a cleaning audit. The frequency of the audits was noted to see if this aligned with the risk category of the facility.

Functional Area	**Risk**	**Date of Technical Audit**	**Staff Present during the Audit**	**Scores C=Domestic Staff N=Nursing Staff N/C=Nurse Cleaning E=Estates Staff O=Overall**	**Dates of audit during period July – Sept/Oct 2018**	**Additional Comments by Internal Audit**
GGH A&E	Very High	28/9/18	Domestic Supervisor + Sister	C: N: E: O: *Audit score sheet not available at the time of the audit for any month due to IT access problems.*	25/4/18 17/5/18 13/6/18 28/9/18	Audit not undertaken in July or August due to there not being a Domestic Supervisor. The Standard notes that the audits should be carried out no less than monthly. The audit observed on 28/9/18 was uploaded on the same day.

						Audit done on paper, rather than iPad.
GGH Cilgerran	High	9/10/18	Domestic Supervisor	C: N: E: O: *Audit score sheet not available for any month due to IT access problem.*	17/4/18 30/5/18 14/6/18 24/7/18 These dates above are from actions required (ie date of upload) therefore date of audit can't be verified. 09/10/18	Audit not done in August or September due to staff absences. Audit was observed on 9/10/18 but it was not uploaded until 13/10/18. Audit done on paper, rather than on iPad. Not all failures input when uploaded on 13/10/18.
PPH Oncology/Chemo/Ward 7/Lymphoe-dema	Very High	26/9/18	Domestic Supervisor *We were informed that Estates do not attend this early audit as they are unavailable before 9am.*	C: 93.26% N: 57.14% E: 70% O: 87.04%	30/7/18 30/8/18 02/9/18 26/9/18 23/10/18	Audit is undertaken before patients arrive.
PPH Mynydd Mawr Rehab Unit	High	26/9/18	Domestic Supervisor + Estates Rep	C: 96.83% N: 96.92% E: 59.09% O: 93.95%	22/7/18 02/09/18 (in lieu August) 26/9/18	No matters arising
WGH PACU	High	26/10/18	Domestic Supervisor	C: 98.71% N: 77.78% E: 85.71% O: 92.83%	10/7/18 9/9/18 1/10/18 26/10/18	August audit not undertaken
WGH Ward 3 (Surgical)	Very High	26/10/18	Domestic Supervisor + Sister at beginning and end of audit	C: 93.07% N: 100% E: 64.52% O: 91.99%	4/7/18 8/8/18 28/9/18 26/10/18	Not all failures were input when the results were input. Audit

						undertaken on 26/10/18 but not uploaded until 29/10/18.
BGH HSDU	Very High	15/10/18	Domestic Supervisor + Estates + HSDU staff for parts of the audit	C: 97.92% N: 100% E: 93.33% O: 96.32%	27/7/18 31/8/18 27/9/18 15/10/18	No matters arising
BGH Meurig	Very High	15/10/18	Domestic Supervisor + Estates + Sister for part of the audit	C: 90.76% N: 84% E: 16.67% * O: 81.29%	23/7/18 30/8/18 30/9/18 15/10/18	No matters arising
Llandovery Hospital	High	3/10/18	Domestic Supervisor + Sister liaised with at the end of the audit	C: 94.48% N: 96.15% N/C:78.57% E: 38.24% O: 83.54%	16/8/18 3/10/18	October audit not uploaded until 7/11/18. Audit done on paper.

* Previous Scores for Estates:-

4/4/18 – 61.59%
4/5/18 – 98.99%
5/6/18 – 70.59%
23/7/18 – 62.50%
30/8/18 – 42.86%
30/9/18 – 57.14%

Unresolved Estates and Cleaning Fails

For each cleaning audit observed by internal audit the previous reports and scores were obtained and reviewed and it was found that many of the same fails are repeated month after month for both Cleaning and Estates issues. For example at WGH a Ward 3 comparison of the July and August reports revealed the same cleaning fails which suggests that issues are not being fully addressed.

At PPH the same Estates issues were being brought up month after month for Oncology and Mynydd Mawr, however it is acknowledged that this is a reflection of difficulties in obtaining money to address the remedial work

and it is problematic accessing patient areas that are permanently occupied.

A recommendation regarding the above has been made in Appendix A.

Audit Scope 2: Measures of Performance, Evaluation and Follow up

The Standard requires that there are measures of performance, evaluation and follow-up to monitor cleaning.

Regular comprehensive cleaning audits that cover multiple elements and functional areas are scored in accordance with the monitoring schedule provided by the All-Wales Monitoring Tool and comply with the auditing process outlined in Part 2 of the National Standards for Cleaning in NHS Wales - "Performance Measurement - The Auditing Process".

The score will be reported to the Board through the Standards for Cleaning Group and recorded centrally through the All-Wales Monitoring Tool, submitted with Estates, Facilities and Performance Measurement System data as required, and will contribute to the overall assessment of the Health Board's performance.

Input/Attendance at Audits

The Cleaning audit team is discussed under the audit process in Standard VII. The standard states that the composition of the cleaning audit team is very important and indicates the staff groups who could attend. Lack of input from the various staff groups may increase the likelihood of issues not being addressed.

Officers in attendance at the cleaning audits observed by Audit & Assurance were noted – see table under Audit Scope 1.

Frequency of Audits

It was found that due to sickness and staffing problems there were instances of some audits being missed. No audit was completed at A&E GGH during July or August and Cilgerran was missed in August and September. The PACU audit at WGH was not completed during August.

A recommendation regarding the above has been made in Appendix A.

Uploading of Data and Scoring

C4C audits are not always uploaded to the MICAD pms (property management software) website on the same day as the checks are undertaken. The 'audit date' shown on the C4C audit score sheet and the 'monitored on' date on the Actions Required from C4C Cleaning Audits reports are the date the data is uploaded not the date the physical checks were carried out.

The two audits observed at GGH had been uploaded and the actions required reports provided to audit but the audit scores were not provided and could not be obtained despite several requests. This is especially concerning for A&E as a number of issues were identified in the cleaning audit and audit were unable to ascertain if the score was a fair reflection of the very many fails found during the audit. Furthermore some areas audited eg sluice room don't exist as a monitored element on the Actions Required from C4C Cleaning Audits report. This report could not be compared to the Audits 49 Audit Score Sheet to see if the score was a fair reflection of issues observed during the audit as it was not available for Internal Audit to review at the time of the audit.

A recommendation regarding the above has been made in Appendix A.

IPads usage

IPads are not always used to complete audits at WGH and they are never used at GGH during an area visit. In these instances pen and paper is used to note any findings with the intention of inputting the information on to the iPad at a later time.

This duplicates time and effort as effectively the audit is being worked through twice. The risk of issues being missed increases because the Domestic Supervisor does not have the rooms and elements to mark against as they check the functional area. It also increases the likelihood of a delay between carrying out the checks and getting the information onto C4C.

Several instances were noted by internal audit at WGH and GGH of failures seen on the wards but these failures not appearing on the audit score sheet and actions required report.

A recommendation regarding the above has been made in Appendix A.

Audits at Peripheral Sites

Although some progress has been made, the introduction of monthly audits at Llandovery Hospital, South Pembs Hospital and Tenby Resource Centre as agreed after last year's internal audit review is not yet fully underway. Audits were done at Llandovery on 16/8/18 and 3/10/18 using pen and paper. The audit on 3/10/18 was later input onto an iPad at Glangwili but not uploaded onto the C4C system until 7/11/18. At the time of the audit in October, the Domestic Supervisor for Llandovery had still not yet been issued with her own iPad. Internal audit noted a greater amount of outstanding Estates issues at Llandovery Hospital and this is reflected in the C4C score of 38% for Estates.

Audits have commenced in South Pembs but problems have been encountered with the use of iPads and in particular, access to the Cloud. A C4C audit was undertaken for Sunderland Ward, South Pembs on 19/7/18, the first and only one so far, and successfully uploaded and audit score grids and actions required reports successfully produced. No audits have been completed since this date however.

Tenby audits have not yet commenced due to Cloud access issues. These issues have been discussed at the HB and local IP&C meetings and attempts are being made to resolve the situation with support from the supervisory team at WGH.

A recommendation regarding the above has been made in Appendix A.

Audit Scope 3: Governance Arrangements

The Governance Arrangements in place to ensure the Health Board is meeting Standard VII were identified and noted as follows.

Since the last audit monthly Operations Delivery Meetings have been set up at each site for hard and soft Facilities Management. Reports which include a section on performance of the C4C system are presented at these meetings.

Operational reporting for Credits for Cleaning Scores takes place at the 4 Locality Team Infection Prevention Group meetings which are held every one to two months. Departmental scores and exception reports for each local hospital site are presented at these meetings.

The Whole Health Board Healthcare Facility scores and exception reports are presented at the quarterly Hywel Dda UHB Infection Prevention Control group meeting.

Infection Prevention and Control feeds to the Quality, Safety and Experience Assurance Committee (via Acute QSEAC) via an annual report. QSEAC is a statutory committee to the Board.

Audit & Assurance ascertained the frequency of meetings and obtained agendas and minutes. It was confirmed that C4C was discussed and/or reports presented at the meetings noted above. However the minutes for the Bronglais local IP&C could not be reviewed as these were not received from the Infection Prevention Nurse.

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	**4**	**1**	**0**	**5**

Finding - ISS.1 – Unresolved Cleaning and Estates Fails (O)	Risk
For each cleaning audit observed by internal audit the previous reports and scores were obtained and reviewed and it was found that many of the same fails are repeated month after month for both Estates and Cleaning issues.	Cleaning and Estates issues, although being reported upon are not actually being resolved.
Recommendation	**Priority level**
It should be ensured that Cleaning fails are resolved as soon as practicable after the audit and Estates fails are addressed where possible to reduce the likelihood of the same issues being raised repeatedly.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
• • Detailed review of C4C Estates and cleaning results report tabled at these meetings of preceding month. Report includes feedback and actions taken. • Evidence is provided to show specific information on each C4C "fail" so that targeted action can be identified. • Limited repetitive cleaning fails are experienced. All cleaning fails are	*Stephen John - West* *Heather Williams – East*

Deleted: Operational Performance meetings are held on a monthly basis on each of the 4 areas of the Health Board Estate. At each of these meetings the Agenda will included a detailed review of both Estates and Cleaning C4C results for the preceding month. Evidence is provided to show specific information on each C4C "fail" so that targeted action can be identified.¶
¶
Cleaning – We are identifying very few repetitive cleaning "fails" in our audit reviews. We acknowledge on the small sample taken the report references one example of this occurring but our evidence will confirm these incidences are very limited.¶
¶
Estates – We fully acknowledge on the Estates audits we see far more frequent repeat "fails" in the same areas. We do however identify these at each performance review and where possible undertake associated works to correct the item. This is often challenging due to restrictions on access and Capital Funding. (Noting the condition of our Estate and backlog figures recorded elsewhere).¶
...

Deleted: ***Actioned-Monitored in the Monthly delivery team meetings held on each acute site***

discussed with supervisory staff and fully cascaded to teams. • Estates audits experience far more repeat fails, due to funding shortage and available access. These are identified at each performance review and where possible associated works to correct the item is planned. There is limited funding within the DCP, the list of schemes/works are agreed and prioritised jointly between Hard FM team and the site general manager (GM). Current estates and backlog figures show an estimate of £65m backlog across the HB estate. • All approved works are programmed with the site GM and completed in year. Areas have improved their score significantly following release of funding and appropriate access.	In place In place January 2019 (Completed) January 2019 (Completed) Awaiting release of capital and infrastructure funding to agree a programme of works with general managers.

	Process in place

Finding - ISS.2 – Frequency of Internal Technical Audits (O)	Risk
It was found that due to sickness and staffing problems there were instances of some audits being missed. No audit was completed at A&E GGH during July or August and Cilgerran was missed in August and September. The PACU audit at WGH was not been completed during August.	Standards of cleanliness will not be monitored and areas that fall short of the expected standards will be not be identified and corrected if Internal Technical Audits (Cleaning for Credits) are not undertaken.
Recommendation	**Priority level**
C4C technical audits should be undertaken monthly for very high and high risk areas, as per the Standard VII guidelines. The good practice of using plans and rotas as used in some localities may reduce the risk of audits being missed.	**HIGH**
Management Response	**Responsible Officer/ Deadline**

• High levels of sickness and absence have now been addressed. 766 of actual audits out of 835 possible audits were completed in this sample period. This evidenced that 92% of all audits were successfully completed.
• Supervisors have subsequently been instructed to ensure that all Very High risk (VHR) audits are completed every month.
  • If any VHR audits are missed, Supervisors must notify the local Soft FM management team, who will reschedule staffing as appropriate.
  • Any high risk audits missed reported to the local soft FM team for resolution.
  • Total number of audits completed for VHR and HR risk is recorded in monthly Ops performance and delivery meetings.
• Rotas for audits will be completed for all 4 sites by July 2019.
	January 2019 (Completed)
	January 2019 (Completed)
	July 2019

Finding - ISS.3 – Uploading of Data and Scoring (O)	**Risk**

Deleted: As discussed with the Audit Team, the Facilities Team experienced significant sickness levels/vacancies during the time of the Audit, which led to a number of missed audits. Supervisors have subsequently been instructed to ensure that all Very High Risk areas are undertaken without fail on a monthly basis. If any High risk areas are omitted for any reason then this must be escalated to the local Soft FM Managers, who will reschedule staffing as appropriate. ¶
Any very high/high risk audits missed must be escalated to the Assistant Operations Manager for re-prioritisation of work load.¶

Deleted: *Stephen John-West*¶
Heather Williams-East¶
Actioned ¶

Deleted: ¶

C4C audits are not always uploaded to the pms website on the same day as the checks are undertaken. The 'audit date' shown on the C4C audit score sheet and the 'monitored on' date on the Actions Required from C4C Cleaning Audits reports are the date the data is uploaded not the date the physical checks were carried out. The two audits observed at GGH had been uploaded and the actions required reports provided to audit but the audit scores were not and could not be obtained despite several requests.	By the time the information is reported upon it will already be out of date. Also it is not straightforward to ascertain if audits are carried out on a timely basis if the reports are showing the date the audit is uploaded rather than the date it was performed. Progress made between audits cannot be assessed if the audit score sheets can't be obtained from the system.
Recommendation	**Priority level**
Audits should be uploaded to the pms system on the same day they are undertaken or within a timescale agreed by Management, to ensure the information is not out of date by the time it is distributed.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Audits should be uploaded as promptly as possible (ipad on same day), due to shift patterns and audits being completed out of hours , this may take up to 48 hours to be actioned (eg, manual audits undertaken on a Friday) • Memo has been issued to all hotel services supervisors in January 2019 reminding them to ensure of uploading audits within the 48hr window.	*Stephen John – West* *Heather Williams – East* ***January 2019 (Completed)***

Deleted: ***Actioned***

• Continuing communications between soft FM supervisory staff and ward staff will improve the content of the audit. Any areas of non-compliance or missed audits will be escalated through the soft FM management structure. • This will be tracked and monitored via monthly operational performance meetings from July 2019.	***In place*** ***July 2019***

Finding - ISS.4 – IPad Usage (O)	**Risk**
IPads are not always used to complete audits at WGH and they are never used at GGH during an area visit. In these instances pen and paper is used to note any findings with the intention of inputting the information on to the iPad at a later time. A few instances were noted by Internal Audit at WGH and GGH of failures seen on the wards but these failures not appearing on the audit score sheet and actions required report.	This duplicates time and effort as effectively the audit is being worked through twice. The risk of issues being missed increases because the Domestic Supervisor does not have the rooms and elements to mark against as they check the functional area. It also increases the likelihood of a delay between carrying out the checks and getting the information onto C4C.
Recommendation	**Priority level**
The C4C monitoring tool should be fully utilised to increase the efficiency and effectiveness of the process to ensure the scores are accurate and actions required are addressed. Any problems that may be discouraging staff from using the iPads should be addressed.	**HIGH**

Management Response	Responsible Officer/ Deadline
• IPads are now being used for all audits on the acute sites. Paper audits will only be completed in extreme circumstances and the reason escalated to the relevant operational manager. • Mental health areas may deviate from this for technical and/or safety grounds. However, we will continue to monitor for full compliance and uploading of data within 48 hours window via the monthly Operational Delivery and Performance meetings. • Community hospitals may experience difficulty due to cloud coverage. • If manual audits are undertaken, this will be indicated on the dashboard and communicated to the relevant operational manager. All manual audits will be uploaded into the system within 48 hours.	*Stephen John – West* *Heather Williams – East* *January 2019 (Completed)*

Finding - ISS.5 – Audits at Peripheral Sites (O)	Risk
Although some progress has been made, the introduction of monthly audits at Llandovery Hospital, South Pembs Hospital and Tenby Resource Centre as agreed after last year's audit review is not yet fully underway. Audits were completed at	Standards of cleanliness will not be monitored and areas that fall short of the expected standards will be not be

Deleted: In terms of iPad usage this point is acknowledged. There are a number of reasons for this including cloud coverage and a general culture challenge around modern technology. ¶
¶
This has improved markedly and we are looking to have 100% iPad usage (where cloud is available) by the end of the first quarter of the new financial year.¶
¶
We will, for operational reasons, in Mental Health areas need to be mindful of clients approaching our staff when using an iPad which may mean we have to return to a paper audit in these specific circumstances. This has been raised as a concern by several of our staff in these areas.¶
¶
We will shortly be introducing a modified dashboard at our monthly Operational Performance Reviews to indicate which of our 141 operational areas are undertaken by iPad/pen and paper.¶

Deleted: ***Actioned*** ¶

Llandovery on 16/8/18 and 3/10/18 using pen and paper. The audit on 3/10/18 was later input onto an iPad at Glangwili but not uploaded onto the C4C system until 7/11/18. At the time of the audit in October, the Domestic Supervisor for Llandovery had still not yet been issued with her own iPad. Internal audit noted a greater amount of outstanding Estates issues at Llandovery Hospital and this is reflected in the C4C score of 38% for Estates. Audits have commenced in South Pembs but problems have been encountered with the use of iPads and in particular, access to the Cloud. A C4C audit was undertaken for Sunderland Ward, South Pembs on 19/7/18 and successfully uploaded and audit score grids and actions required reports successfully produced. No audits have been completed since this date however. Tenby audits have not yet commenced due to Cloud access issues. These issues have been discussed at the HB and local IP&C meetings and attempts are being made to resolve the situation with support from the supervisory team at WGH.	identified and corrected if Internal Technical Audits (Cleaning for Credits) are not undertaken. If audits are not undertaken or scored correctly and regularly there will be inadequate objective relative assessment of the cleanliness of the healthcare facility and no ongoing measurement of the effectiveness of the cleaning process.
Recommendation	**Priority level**
The Cleaning audit team should undertake regular comprehensive internal technical audits in accordance with the All-Wales Monitoring Tool and these should be scored at both Acute and Community sites.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
• Community in-patient area audits are continuing to be implemented, manually if	*Stephen John – West* *Heather Williams – East*

Deleted: The community in-patient area audits were instructed last year but have not been fully implemented. We have been and are continuing to await additional and replacement iPads for some community sites.¶
¶
This has been the case at Llandovery, however, whilst paper audits have been undertaken, they were not uploaded in a timely fashion. All Supervisors have now been advised of the agreed timescale for uploading the audit results. With regard to Llandovery an IPad unit from GGH has been provided and audits are now in place.¶
¶
South Pembs hospital has had little, if any Wi-fi availability. This has now been addressed and audits are being undertaken.¶

Deleted: The current work plan is to deliver monthly audits on all Community In-Patient facilities by the end of the first quarter 2019/20. ¶
¶
Any roll out of this C4C process to other Health Board premises (without In-Patient accommodation) will be reviewed on our basis of our ability to undertake this with current resource levels. We envisage this report to be available by the en...

Deleted: ***Actioned***

appropriate. As previously noted all manual audits will be uploaded within 48 hours window. • Awaiting additional IPad's for community sites. The provision of these is being actively pursued with IT. • Community facilities which are within the VHR or HR categories will be added to the monthly operational performance meeting agenda.	***January 2019 (completed)*** ***June 2019*** ***July 2019***

Appendix B - Assurance opinion and action plan risk rating

2018/19 Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

National Standards for Cleaning in NHS Wales

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Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership
Audit and Assurance Services