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| **Meeting Date** | **31st July 2018** | **Agenda Item** | **4a (ii)** |
| **Report Title** | **Audit & Assurance Assignment Summary Report** | | |
| **Report Author** | Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A<br>Huw Richards, Deputy Director, NWSSP A&A (SSu) | | |
| **Report Sponsor** | Paula O'Connor, Head of Internal Audit, NWSSP A&A | | |
| **Presented by** | Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A<br>Huw Richards, Deputy Director, NWSSP A&A (SSu) | | |
| **Freedom of Information** | Open | | |
| **Purpose of the Report** | To advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports. | | |
| **Key Issues** | Eleven reports have been finalised with Executive leads since the last meeting (including 2017/18 reports indicated as "draft" in the Head of Internal Audit Opinion & Annual Report issued in May 2018). Their outcomes are summarised for information and discussion as appropriate.<br><br>The assurance levels derived can be summarised:<br>• 4 *Reasonable*<br>• 4 *Limited*<br>• 2 No ratings applied<br>• 1 No revised rating applied (*Limited* previously)<br>The Report indicates the timescales for completion of actions agreed with management for each. | | |
| **Specific Action Required** ***(please ✓one only)*** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | ✓ | |
| **Recommendations** | Members are asked to:<br>• Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management.<br>• Consider any further action required in respect of the subjects reported. | | |

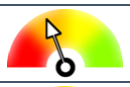
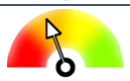
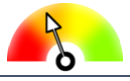
**AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT**

## 1. PURPOSE

The purpose of this report is to advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.

## 2. REPORTS ISSUED

Since the last meeting the following audit reports have been finalised:

| Subject | Rating[1] |
|---|---|
| **Internal Audit** | |
| Annual Planning: Engagement & Integration (ABM-1718-011) |  |
| Medical Devices: Home Maintenance Payments (ABM-1718-017) | **No rating assigned** |
| Non Pay Expenditure: Goods Receipting (ABM-1718-018) |  |
| IT Infrastructure Assets (ABM-1718-029) |  |
| EWTD: Portering Services (ABM-1718-046) |  |
| Regulatory Compliance: Fire Safety (Follow Up) (ABM-1718-109) |  |
| Medical Devices & Equipment Maintenance (Follow Up) (ABM-1718-113) | **No rating revision** |
| Charitable Funds: Part 1 (Ward Donations) (ABM-1819-016a) | **No Rating (Interim Report)** |
| **Specialist Services Unit (SSU)** | |
| Follow Up - Capital (SSU_ABMU_1718_01) |  |
| Capital Systems – Equipment Replacement Programme (SSU_ABMU_1718_06) |  |
| Follow up – Estates Assurance (SSU_ABMU_1718_10) |  |

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

[1] Definitions of assurance ratings are included within Appendix A to this report. Explanations for reports without ratings are set out in the main body of the report.

Audit report findings and conclusions are summarised below in Section 3. Full copies of the reports can be made available to Audit Committee members on request.

Actions have been agreed with Executive Directors in respect of audit recommendations made for Final reports issued. Progress against agreed actions is input into an online database by lead officers and visible to Executive Officers for monitoring. The Head of Accounting & Governance analyses and summarises the status for Audit Committee meetings as a matter of routine.

Audit & Assurance undertake follow-up reviews on key issues within areas deriving limited assurance ratings as part of its agreed plan of work for subsequent years. Additional follow up reviews may be undertaken at the request of the Audit Committee. The timing of follow up work is planned in liaison with Executive Officers.

## 3. INTERNAL AUDIT FINAL REPORT SUMMARY

### 3.1 ANNUAL PLANNING: ENGAGEMENT & INTEGRATION (ABM-1718-011)

Board Lead: Director of Strategy

#### 3.1.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

The Health Board did not have an approved IMTP (Integrated Medium Term Plan) for 2017/18-2019/20. It was unable to align its service and financial plans and produce a plan that delivered both financial balance and the performance targets set by Welsh Government, so adopted instead an annual plan for 2017/18. Recognising that there was more work to do to close the financial gap, it was agreed that the planning process for 2018/19 and beyond would begin with developing an annual plan for 2018/19, following which work would commence on the next three-year IMTP.

At an event hosted by the NHS Confederation in October 2017, Deloitte presented their learning following reviews of financial governance within NHS Wales organisations. Amongst the common areas they highlighted were:

- A lack of coherency in strategy – IMTP versus financial plan versus clinical strategy versus longer-term strategy.
- Silo-working across executive portfolios – lack of multi-disciplinary working – finance/operations/workforce/quality.
- Lack of Board engagement in the planning process.

Following engagement with the Director of Finance and Director of Strategy this audit of the development of the Annual Plan 2018/19 considered arrangements in place to foster integration, with particular

respect to the planning, finance, recovery & sustainability and workforce functions.

The overall objective of this audit was to review the approach taken by management to ensure the engagement and integration of key functions of the Health Board during the development of the Health Board's annual plan for 2018/19.

The audit scope included:

- Identifying in discussion with management the corporate meeting structures and mechanisms that have contributed to the development of the plan, and those which that have undertaken any quality assurance of Unit and corporate directorate submissions and of the plan itself;
- Assessment of the membership of those meetings for appropriate representation and review of attendance for compliance;
- Review of mechanisms in place for engagement with Service Delivery Units and any other key internal stakeholders;
- Review of opportunities taken for consideration of the plan by the Executive Team as a whole, during its development and prior to consideration by the Board.

### 3.1.2. Overall Opinion

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

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review scope & objectives and should therefore be considered in that context. This audit has not reviewed the wider aspects of project management associated with production of the annual plan, or assessed the content of the annual plan itself, and so these are outside the scope of the assurance reported.

A number of key groups of significance to the planning process were highlighted to us at the outset of the audit: the Core Team, the Executive Steering Group, Joint Workshops, the Executive Team (and joint meetings with Service Directors) and the Recovery & Sustainability Board. The audit has reviewed notes and papers for each of these groups / events in order to identify the actions taken to ensure engagement and integration within the planning process. The assurance reported is based on our review of those papers.

Overall, there was good evidence of action taken to engage Units and corporate leads in the planning process and several measures within the approach taken that promoted the production of an integrated plan. Initially through workshops, and later at the re-structured Recovery & Sustainability Programme Board (RSPB), Executives and Units have been

brought together to develop plans. Planning guidance and template documentation, later supplemented by programme documentation (including project outline documents), have been used to promote the presentation of plans in a consistent way in order to support challenge and to consider impacts and dependencies across the Health Board. Attendance at joint groups was good.

Whilst the above is noted, weaknesses within record keeping have reduced to some extent the assurance we are able to report in respect of some arrangements:

- The Workshops did not record actual attendance. We have considered records of those accepting invitations as an indicative measure and taken some assurance from that, supplemented with discussion with a small number of staff.
- Action notes provided demonstrated that an Executive IMTP Steering group brought Directors/senior management from Strategy, Finance and Workforce together for direction and coordination of activities. However, there were gaps in the records made of meetings held.

Additionally, the late agreement of quality & safety priorities for 2018/19 meant that Units were asked to plan using the 2017/18 priorities. New priorities were addressed within the final health board annual plan in time for its approval, and linked to targeted intervention performance priorities, but their earlier agreement would have made for a more integrated planning process within Units. Noting that the health board Quality Strategy was to be reviewed shortly and priorities possibly re-assessed for future years, we recommended that timescales for that be aligned with the wider planning cycle.

Action has been agreed with the Director of Strategy to be completed by the beginning of October 2018.

## 3.2 MEDICAL DEVICES: HOME MAINTENANCE PAYMENTS (ABM-1718-017)

***No rating assigned***

Board Lead: Director of Finance

### 3.2.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

Medical devices are used throughout the Health Board, from large MRI scanners to portable infusion devices. Many of these devices require periodic maintenance or repair and for some this is undertaken by external companies.

Following issues highlighted in NHS England in respect of payments to external companies for the servicing of dialysis equipment in patients' homes, this limited scope audit set out to assess the risk exposure within ABMU Health Board with a view to reviewing the controls in place to manage it.

The overall objective of this limited scope audit was to review the risks and controls with respect to the probity of payments to external companies for the maintenance of equipment in patients' homes.

The scope did not include contact with any patient or with the equipment within their home. Internal Audit assessed the extent to which the maintenance of equipment was contracted to external companies and the value of payments made. We liaised with the Head of Counter Fraud throughout the audit, sharing the detail in the scope and audit testing.

### 3.2.2 Overall Opinion

The Medical Equipment maintenance database was reviewed by Internal Audit to identify equipment located in patients' homes. No records were noted where home equipment had an external maintenance supplier assigned.

Expenditure transactions over ten months coded to medical equipment maintenance were sourced from the Oracle system to identify if any could be linked to activity carried out at patients' homes. Analysis of the data resulted in identification of only four payments, associated with the installation or removal of dialysis equipment. The financial costs associated with this activity were noted to be negligible. No other payments were noted for on-going maintenance of equipment located within patients' homes.

The findings of this limited scope audit review of the medical equipment database and Oracle payments have confirmed that there is no significant risk exposure that would require a further in-depth audit. (Recognising that the audit did not proceed to full systems review, we have not allocated the associated assurance rating).

The findings have been communicated to the Head of Counter Fraud for ABMU Health Board. No recommendations were raised.

## 3.3 NON PAY EXPENDITURE: GOODS RECEIPTING (ABM-1718-018)

Board Lead: Director of Finance

### 3.3.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

The Health Board is supported in its management of non-pay expenditure by the systems of the NWSSP Procurement and Accounts Payable functions. Creditor payments are processed via the Oracle financial system, and for most categories of expenditure the authorisation to pay is either enforced through electronic order approval hierarchies built into the purchasing module of Oracle, or checked and processed by NWSSP

Accounts Payable staff following confirmation that invoices that are not supported by purchase orders are authorised by appropriate individuals in accordance with approved signatory lists.

In previous years, increasing numbers of invoices on hold (IOH) and difficulties achieving Public Sector Payment Policy targets, gave rise to the formation of an Accounts Payable group comprising members from both the Health Board and NWSSP to review data, analyse problems and agree action and the partner responsible for taking it.

Progress was monitored by the Assistant Director of Finance. Following a gap of some months, the group reconvened in February 2018 to continue this work. In the meantime, there appeared to be issues to be addressed by management relating to receipting of goods and services within some Health Board service areas. Notable in respect of invoices on hold arising from unreceipted goods were delivery points relating to:

- Support Services (Morriston and POW catering functions)
- Theatres (NPT and POW)
- Diabetic Services (NPT and Morriston)

This audit reviewed arrangements in place within these areas for the effective receipting of goods. In undertaking the audit fieldwork Health Board staff raised some operational issues that were outside the scope of this review. These have been relayed to the Head of NWSSP Procurement and/or Health Board Finance management team as appropriate.

The overall objective of this audit was to review the systems in place to effectively account for goods received and engage actively with suppliers to resolve issues and facilitate the timely payment of invoices received.

The audit scope has included a review of arrangements in place to ensure that:

- Staff responsible for receipting goods are trained with respect to the requirements of the role
- Goods are receipted within the financial system promptly after being received
- Invoices on hold due to receipting issues are investigated promptly and addressed appropriately

We considered the information available in receipting areas relating to outstanding orders to support receipting and the adequacy of record-keeping in respect of the above.

### 3.3.2 Overall Opinion

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.

Our review of Invoice on Hold (IOH) reports indicated that where delays were highlighted many were cleared within subsequent reports or reasons were given as to why not. However, we identified issues in each area reviewed that contribute to delays within the receipting process. Collectively these present potential to improve performance in the prompt payment of invoices:

- At both Neath Port Talbot and Princess of Wales Theatres, the receipting of items used from Theatre "loan kits" and the adjustment of order values to enable payment of invoices, was performed only when prompted by the receipt of invoice information from NWSSP, rather than the earlier point at which items used were known.
- The majority of the long-standing IOH in our sample for Morriston Catering were caused by non-submission of delivery notes from the satellite Llwyneryr site. Management note they have now put in place arrangements to monitor and escalate this.
- Many of the long-standing IOH relating to POW catering related to the non-receipt of delivery notes from the satellite site of Ewenni. Management note that following discussions with the auditor they have introduced twice-weekly collections of documentation from that site.
- Within the Diabetic departments at Neath Port Talbot and Morriston hospitals, payments are made for healthcare items delivered directly to patients in the community. Staff responsible for receipting items waited to be prompted by NWSSP at which point they would receipt as instructed from invoice details provided against a single call-off order (one order per department). We have been informed that individual orders have now been put in place for all patients (making comparison of usage with expectation clearer) and one receipter indicated she would receipt from the Supplier's monthly sales reports that list deliveries, instead of waiting to be prompted.

The Assistant Director of Finance had established an Accounts Payable Group, comprising Health Board Finance officers and NWSSP representatives aimed at addressing prompt payment issues and those at the interface between the two organisations. The meeting frequency has been affected by key management absence; as a result SDU managers have not been receiving information on outstanding IOH to address with their receipters. This is due to be addressed following the finalisation of the annual accounts in May 2018.

Within Theatres and Diabetic Services it was clear that the processes required to receipt the items purchased could not follow the standard processes laid down in FCP and guidance. Following agreement of appropriate variations for these areas we recommend that procedures and guidelines are revised accordingly.

The assurance rating above reflects the position as found during the audit. As noted above, some staff indicated that they would revise their process following the discussion with Internal Audit. Those actions were incorporated alongside recommendations within the management action plan following the audit to facilitate follow up review in due course. Actions have been agreed by senior management within service areas to address all issues raised by the end of August 2018. The final report and consolidated action plan has been agreed with the Director of Finance.

## 3.4 IT INFRASTRUCTURE ASSETS (ABM-1718-029)

Board Lead: Medical Director (Chief Information Officer)

### 3.4.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

Information technology hardware is a key asset used by the Health Board to support the effective delivery of clinical services and management processes. The information technology infrastructure underpins all Health Board business critical systems and must be procured, supported, maintained, and disposed of accordingly.

Effective management, administration, and controls over the asset life cycle, from procurement through to disposal, are important to the ongoing success of the Health Board.

The overall objective of this audit was to review compliance with the Health Board's agreed procedures and systems for the management of IT infrastructure assets, taking into account relevant government directions.

The audit scope focused on hardware assets and considered the following:

- Policy and procedures
- IT equipment asset register maintenance
- IT hardware physical security
- Losses and disposals

### 3.4.2 Overall Opinion

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. We noted a number of positive arrangements in place in respect of IT asset management. The Health Board has invested in Microsoft System Centre Configuration Manager (SCCM) and the SNOW asset management software. Procurement is governed via an ICT Procurement Policy and disposal under the Information Security Policy. For new devices there are

processes in place to assign users upon allocation and arrangements are in place for secure disposal and recording of obsolete equipment. The physical security of stocks held in IT Departments was adequate.

However, the following key issues have been highlighted for attention:

- The Information Technology Asset Management (ITAM) maturity assessment conducted in January 2017 by Trustmarque identified a number of findings that required addressing. During this review we noted some progress against the recommendations raised in the report, such as the creation of an ITAM Improvement Plan and the updating of existing policies to include ITAM requirements. However, a review of the action plan provided at the close of the audit indicated that there was slippage against most areas. Management have indicated that this has been due to a lack of resource which they are addressing currently through the appointment of an ITAM Manager. We have recommended that the target dates be re-assessed and that the revised plan and timescales, and subsequent progress against them, be monitored by the senior management team.
- Whilst SNOW records frequent users of many of the assets it has captured, there are no complete records of asset 'owners' currently (persons ultimately responsible for the hardware assets). As noted above, recent purchases are allocated to users via the Workflow system.
- We also noted there was no programme to review the accuracy and completeness of disposed and active asset information on the register. (However, we were informed that work is currently being undertaken between the IT and Security Department Teams to establish a review programme.)

Action has been agreed with the Executive Medical Director (Chief Information Officer) to address issues by the end of July 2018.

## 3.5 EUROPEAN WORKING TIME DIRECTIVE: PORTERING SERVICES (ABM-1718-046)

Board Lead: Director of Workforce & OD

### 3.5.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

The Working Time Regulations 1998 (WTR) apply across the UK. The regulations affect the number of hours that an employee can work per week and the rest breaks the employee is entitled to – including breaks between shifts, annual leave and days off. The key aim of the regulations is to ensure standards of health and safety in the workplace.

Assurance in respect of compliance with WTR is not reported to the Board or its Committees currently. Review of other Health Boards' papers in the public domain suggests that ABMU Health Board is not an outlier in this

respect. This audit has set out to identify areas of potential risk of non-compliance and review arrangements in place to manage the risk and monitor compliance with a view to highlighting issues and recommendations for consideration more widely.

The overall objective of this audit was to review the processes adopted to ensure compliance with Working Time Regulations (WTR).

Noting recent years' audit work on nurse rostering and the management of junior doctor bandings, each of which examined controls which support monitoring of compliance with WTR, and each of which are proposed for follow up in 2018/19, these staff groups were not included in this review.

Following an analytical review of overtime worked by staff over a six month period, we selected the Portering Service for review. The focus was on arrangements in place within Morriston.

The audit has reviewed arrangements in place to ensure that:

- Policy and/or procedures are clear in respect of the requirement to comply with European Working Time Directive (EWTD).
- Work is allocated in compliance with the Regulations.
- Records of attendance are approved appropriately and record sufficient detail to support the demonstration of compliance with rest break requirements.
- Staff working hours in excess of the 48 hour weekly limit have signed formal declarations opting out of this element of the Regulations.
- Compliance with the Regulations is monitored by management.

Additionally, we reviewed the consideration given to individual staff sickness levels when allocating additional work to staff.

### 3.5.2 Overall Opinion

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.

The following key findings were identified which require management attention:

- The Health Board does not currently have clear documentation in place that outlines responsibilities in respect of European Working Time Directive regulations.
- For the Morriston Hospital Portering Service, the Health Board was not complying with the European Working Time Directive with some

members of staff exceeding an average 48 hours working limit with no 'opt out' form or letter on file or an outdated form on file.

- Rostering practices at Morriston Portering Services acknowledge EWTD requirements but a total of 564 (3856.5 hours) overtime shifts were rostered for the period 31st December 2017 to 24th March 2018 which impacts on EWTD compliance and incurs increased staffing costs.

Action has been agreed with the Director of Strategy to address issues raised by December 2018.

## 3.6 FIRE SAFETY (FOLLOW UP) (ABM-1718-109)

Board Lead: Director of Strategy

### 3.6.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

In the first Quarter of 2017/18 we undertook a review of the Health Board's Fire Safety management arrangements, reporting *limited assurance* in July 2017. The overall objective of that audit was to assess the adequacy of arrangements operating within the Health Board for the management of fire safety, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. The audit reviewed corporate arrangements for ensuring fire risks are identified, assessed and managed, focusing on selected elements of the Fire Policy. Delivery Unit processes and structures for managing fire safety were not within the scope of the review, but the audit considered the outcome of risk assessments undertaken within wards and departments and the mechanisms in place to monitor corporately the action taken to address issues & risks arising.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the earlier 2017/18 audit review of Regulatory Compliance: Fire Safety (ABM-1718-010).

This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.

### 3.6.2 Overall Opinion

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.

Whilst the above level of assurance has been derived and action remains to be taken to address issues & risks, we would note the priority given by management in the period since the last report towards addressing one of the Health Board's key fire risk areas and an area of high priority reported previously – the ward areas at Singleton Hospital.

The previous audit made eleven recommendations, of which four were classed as high priority and seven were medium priority. Concluding testing, we can confirm that four recommendations had been addressed, one was partially addressed, five were not addressed and one required no further testing.

The following key findings were identified which require management attention:

- The completion of action required by ward / department staff is not monitored corporately;
- High risk action plans are not copied to Service Directors, or their nominated officers;
- The Health & Safety Committee and the Quality & Safety Committee are not receiving comprehensive assurance on action to address all known risks, or those remaining open.

Action has been agreed by the Director of Strategy to address issues raised with target completion date of October 2018.

### 3.7 MEDICAL DEVICES & EQUIPMENT MAINTENANCE (FOLLOW UP) (ABM-1718-113)

***No revision to rating***

Board Lead: Medical Director

#### 3.7.1 Introduction, Scope and Objectives

This assignment was requested by the Executive Medical Director and approved by the Audit Committee for addition to the audit plan 2017/18.

In October 2017, an internal audit report was issued on this subject, recording a *limited* level of assurance, and incorporating an action plan agreed with management to address issues raised. In December 2017, the Medical Director requested that we make arrangements to undertake a follow up review of progress.

The overall objective of this audit was to review progress made against actions agreed to address issues raised at the last audit. The previous audit focused on the management of the medical equipment register, the timely servicing of equipment and associated monitoring arrangements.

This scope of this audit has been restricted to a review of actions taken to address issued previously highlighted only.

### 3.7.2 Overall Opinion

The level of assurance previously given as to the effectiveness of the system of internal control in place to manage the maintenance of medical devices was *Limited Assurance* at the last audit.

At this follow up review, progress was noted against all areas recommended following the original audit:

| Number of previous recommendations followed up | Number Addressed | Number Partially Addressed | Number not started |
|---|---|---|---|
| 10 | 4 | 6 | 0 |

Recognising the early timing of this revisit, action was ongoing in a number of areas – in particular, a new approach to escalating equipment not made available for servicing had been piloted in Morriston. We were informed at the close of work that teams on other sites had been asked to implement the same. Consequently this review reflects positively on action taken so far, but there are some areas for which action was required to provide assurance regarding the management of all medical devices. We have reflected this in a revised action plan and made additional observations and recommendations where relevant.

Whilst positive progress was being made to address the issues highlighted previously, we have not reported a revised rating. Instead, we proposed that we agree time within the 2018/19 plan to revisit this area following wider rollout and the embedding of action, and to review the rating again at that time.

Action has been agreed with the Deputy Medical Director to address all issues by September 2018. Internal Audit has agreed to meet with him and the Head of the Medical Equipment Management Service to discuss progress then and bring back a proposal to re-audit subject to management assurance that all issues are addressed.

## 3.8 FUNDS HELD ON TRUST: PART I (ABM-1819-016A)

***Rating to be assigned at completion of Part II. Current indication is limited assurance.***

Board Lead: Director of Finance

### 3.8.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

In agreement with the Director of Finance the review of charitable funds has been planned in two parts, undertaking the first whilst the Finance

department prepared the annual accounts. This report focuses only on ward safe inspections and receipting of donations at wards and Hospital General Office.

The second part will be completed in early Quarter 2 following finalisation of the Health Board Annual Accounts and will focus on expenditure and corporate systems. It is underway currently and an additional report will be issued for that final part of the audit review.

The overall objective of this part of the review was to ensure that charitable donations were being identified and properly safeguarded, recorded and accounted for, in accordance with the requirements of the donors, relevant legislation, and the Charity Commission.

Testing of income included:
- Inspection of Ward safes;
- Ward donation receipt book completion;
- Receipting at General Offices.

### 3.8.2 Overall Opinion

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Funds Held on Trust will be assessed and reported following completion of part 2 of the review in Quarter 2. However, audit would highlight that the key findings in this review are likely to result in *limited assurance* overall.

We visited 23 wards across Morriston, Singleton, Neath Port Talbot and Princess of Wales sites and spoke with staff regarding donation records. At eight, staff informed us that they did not have or were unable to provide ward donation receipt books for review.

At the Neath Port Talbot Unit these arrangements were well established – staff receiving donations there are required to take them directly to General Office for receipting. At one ward (Ward C) the Ward Sister expressed a desire to have a donations receipt book. At another (Ward D), the Ward sister said she was not confident that donations received were used for the purpose intended.

Three wards out of five visited at the POW Unit could not provide donations receipt books for review (Wards 4, 19 & 20). At two of these we were informed that cash donations were not banked at General Office but retained on the ward as staff were not confident that funds would be spent as intended or considered this the most efficient way of accessing funds.

At Morriston Unit there were no books available on four wards (one of which was Ward M, managed by Singleton) and at one ward at Morriston (Ward J) we were informed that cash was retained locally without receipting as the process for accessing funds was too slow. Fewer issues

were apparent at the Singleton Unit, though there was no book at Ward 1 Pre Assessment (this service is managed by Morriston).

At the wards highlighted above we cannot provide assurance that all donations received have been banked promptly or completely, and it would be difficult to give any independent assurance regarding how donations have been spent, as there is no documentary trail.

Additionally, we noted instances whereby the Treasurer of an external charity supporting Ty Olwen (managed by Singleton) had collected cash recorded in the Unit, without it having been receipted within the Morriston Hospital Cash Office firstly. The Health Board has an agreed arrangement with this charity in respect of the collection of donations intended for use within Ty Olwen – however, the release of cash for collection as above did not comply with financial control procedure requirements. This was brought to the attention of the Finance & Business Partner and Director of Finance and steps have been taken to address this.

Action has been agreed with the Director of Finance to address issues raised by September 2018.

## 3.9 Follow Up – Capital [SSU_ABMU_1718_01]

Lead: Director of Strategy

### 3.9.1 Introduction, Scope and objectives

The objective of the audit was to evaluate the actions taken by the Health Board to address previously agreed recommendations. This process was progressed through obtaining evidence in support of each recommendation relating to the following audits:

| Audit | Prior Rating | Date issued |
|---|---|---|
| Catheter Laboratory B | Reasonable Assurance | June 2017 |
| Capital Systems | Reasonable Assurance | June 2017 |
| Follow up of outstanding capital recommendations | Reasonable Assurance | June 2017 |
| *containing:* | | |
| *Phase 1b Main Entrance follow up report* | *Limited Assurance* | *November 2015* |
| *RMHSS Phase 8 Glanrhyd LSU* | *Reasonable Assurance* | *December 2015* |
| *Emergency Medical Retrieval and Transfer Service* | *Reasonable Assurance* | *June 2016* |
| *Clinical Support Accommodation – HVS Phase 1B Scheme 2* | *Limited Assurance* | *June 2016* |
| *Existing Medical School – HVS Phase 1B* | *Limited Assurance* | *June 2016* |

| | | |
|---|---|---|
| *Cardiac Intensive Therapy Unit* | *Reasonable Assurance* | *November 2016* |

### 3.9.2 Overall Opinion

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.

There were a total of 18 recommendations made at the two 2017 audits, together with a further 13 outstanding from prior audits (total = 31). Status of the recommendations can be summarised as follows:

| Priority | H | M | L | Total |
|---|---|---|---|---|
| **Number of recommendations** | **7** | **18** | **6** | **31** |
| Implemented / closed | 3 | 12 | 2 | 17 |
| Partially implemented | 3 | 5 | 4 | 12 |
| Future | 1 | 1 | - | 2 |

Noting the above, the finalisation of the current review of Capital Projects Control Manual, for subsequent approval by the Audit Committee will address the 3 high priority recommendations.

Action has been agreed by management to address the remaining outstanding issues arising from the review.

## 3.10 Capital Systems (Equipment Replacement Programme) [SSU_ABMU_1718_06]

Lead: Director of Strategy

### 3.10.1 Introduction, Scope and objectives

The objective of the audit was to evaluate the systems and controls in place within the University 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.

The audit sample [15 procurement exercises – total purchase cost £4,184,113] was selected from the Capital Programme to appropriately review procurement procedures, covering a range of procurement methodologies for replacement capital equipment.

The focus of the audit was directed to the following areas:

***Strategy***

- Ensure that an appropriate equipment procurement strategy and policies exist; which align with departmental / board wide clinical strategies;
- The equipment replacement strategy sufficiently addressed the equipment lifecycle and replacement costs.

***Procurement Programme***

- The purchasing department was afforded sufficient time to procure equipment which have a long lead time.
- Equipment was procured and delivered in accordance with the user's programme requirements.

***Capital Planning and Approval***

- The funding process was appropriately defined, documented and applied.
- The funding proposition (including benefits, and both capital, ancillary / acquisition, lifecycle and revenue costs) was appropriately defined, evaluated and approved utilising objective criteria.
- Any changes were subject to re-evaluation and approval.
- Appropriate arrangements were in place for streamlined approval processes required for additional / end-of-year funding with reference to procurement lead times.

***Tendering and Quotations***

- Tendering and quotation exercises undertaken to procure equipment were undertaken in accordance with Health Board / EU procedural requirements.
- Tenders and quotations were appropriately evaluated to guarantee value for money and to minimise potential additional costs.
- Single tenders were assessed to demonstrate value for money and are appropriately authorised / reported.
- Equipment maintenance costs were adequately considered.
- Ensure appropriate declaration of interests were recorded.

### 3.10.2 Overall Opinion

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.

Noting the above, the following key findings were identified which required management action:

- The need to review and financial control procedures (refs 5 & 15) and the Capital Projects Control manual to reflect best practice requirements; and

- To update the Discretionary Capital Bid form to indicate where alternative procurement options are / are not available; as well as inclusion of additional objective and comparable information, thereby aiding prioritisation of respective bids.

Action has been agreed by management to address the issues arising from the review.

## 3.11 Follow Up – Estates Assurance [SSU_ABMU_1718_11]

Lead: Director of Strategy

### 3.11.1 Introduction, Scope and objectives

The objective of the audit was to evaluate the actions taken by the University Health Board to address previously agreed Estates Assurance recommendations. This process was progressed through obtaining evidence in support of each recommendation relating to the following audits:

| Audit | Prior Rating | Date issued |
|---|---|---|
| Backlog Maintenance | Limited Assurance | October 2017 |
| Health & Safety – Primary Care Estates | Reasonable Assurance | March 2017 |
| Property & Lease Management | Reasonable Assurance | January 2017 |
| Neath Port Talbot Operational PFI | Reasonable Assurance | July 2017 |
| Follow up of outstanding recommendations | Reasonable Assurance | July 2017 |
| *containing:* | | |
| *Legionella Management* | *Limited Assurance* | *November 2014* |
| *Energy & Water Management* | *Reasonable Assurance* | *July 2014* |
| *Disability Discrimination Capital Follow Up* | *Reasonable Assurance* | *March 2015* |

### 3.11.2 Overall Opinion

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.

There were a total of 19 recommendations made at the four 2017 audits, together with a further 13 outstanding from prior audits (total = 32).

The status of the recommendations can be summarised as follows:

| Priority | H | M | L | Total |
|---|---|---|---|---|

| **Number of recommendations** | **1** | **28** | **3** | **32** |
|---|---|---|---|---|
| Implemented / closed | - | 10 | 1 | 11 |
| Partially implemented | - | 3 | 1 | 4 |
| Outstanding / Action not evidenced | 1 | 14 | 1 | 16 |
| Future | - | 1 | - | 1 |

Whilst management stated that appropriate action had been taken to address the issue(s), at 16 previously agreed audit recommendations above, appropriate supporting information had not been provided to substantiate the actions.

The one high priority recommendation relates to the formulation of the estates strategy, identifying the longer term direction of the UHB how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed.

## 4. RECOMMENDATION

**4.1 The Audit Committee is asked to <u>note</u> the summarised findings and conclusions presented by Audit & Assurance, and the exposure to risk pending completion of action by management.**

**4.2 The Audit Committee is asked to <u>consider</u> any further action required in respect of subjects reported**.

**APPENDIX A**

## 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. |