Meeting Date	**15th November 2018**	**Agenda Item**	**4a.**
Report Title	**Internal Audit Progress Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A 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 Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	The main purpose of this report is to report progress in delivering agreed audit work.		
Key Issues	The report presents: • Progress in respect of the planning & delivery of assignments agreed within the annual operational audit plan 2018/19. • The audit assurance ratings of finalised reports.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Recommendations	**Members are asked to:** • **Note the progress of the internal audit programme of work.** • **Approve proposed changes to plan**			

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

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Private & Confidential

INTERNAL AUDIT PROGRESS REPORT

ABM University Health Board
Audit Committee
15th November 2018

NHS Wales Shared Services Partnership

Audit and Assurance Services

1 INTRODUCTION

1.1 The main purpose of this report is to report on the progress of work within the agreed 2018/19 audit plan.

Additionally, it reflects on support provided to management and Board members and updates the Committee on developments within the internal audit service.

1.2 The report records progress of general (section 2) and specialist (section 3) internal audit work at the end of October 2018.

2 GENERAL INTERNAL AUDIT SERVICES

2.1 PROGRESS OF THE 2018/19 (GENERAL) INTERNAL AUDIT PLAN

2.1.1 We continue to report to the Executive Team on matters arising from audit work and progress against the plan. The most recent report was presented at the 10th October meeting.

2.1.2 Since the last meeting of the Audit Committee, we have finalised the following reports:

Ref	Subject	Rating[1]	Executive Officer Recipient(s)	Receiving C'ttee(s)
1819 -017	Golau (Follow up)		DOF	AC CFC
1819 -025	Mortality Reviews (Follow up)		Interim EMD	AC QSC
1819 -028	Delayed follow ups		COO Cc DOPH	AC QSC
1819 -030	Business Continuity & Disaster Recovery		DOS	AC
1819 -037	Morriston Hospital Service Delivery Unit		COO	AC QSC
1819 -038	Strategy & Planning Directorate		DOS	AC
1819 -045	Sickness and absence (Follow up)	N/A	DOWOD	AC W&OD
1819 -047	Third Sector Commissioning (Follow up)		DOS	AC

[1] Definitions of assurance ratings are included within Appendix B to this report.

2.1.3 In addition to the above, we have issued Draft reports on the following:

- 004 Corporate Legislative Compliance: Wellbeing of Future Generations (Wales) Act
- 008 Health & Safety (Follow Up)
- 009 Fire Safety (Follow Up)
- 024 Pressure Ulcers (Follow up)
- 027 Nurse Quality Assurance

2.1.4 Work is in progress in respect of:

- 005 Corporate Governance: Code Compliance
- 007 Partnership Governance: ARCH
- 010 Annual Plan: Delivery Framework*
- 032 GDPR

* This audit has commenced but was paused during the auditor's paternity leave (he has now returned) and will report in November.

2.1.5 A number of audit briefs have been issued for assignments to be undertaken before the end of December 2018 in respect of:

- General Ledger (agreed)
- Payroll – local controls (agreed)
- Medical Staff Revalidation
- IT Cyber Security

Additionally, we have brought forward and agreed a brief for a review of *Welsh Risk Pool Claims.* Work commences shortly.

2.1.6 The 2018/19 Internal Audit Plan was agreed by the Audit Committee in March 2018. It remains flexible and we are continuing to work with Executive Directors to ensure that audit work is appropriately focused and timed.

We have a follow up review of *Medical Locum Expenditure* scheduled to start in November. Early in 2017/18 senior management indicated that actions to address the report would be progress via the implementation of electronic systems. Discussion with the Director of Workforce & OD has indicated that procurement of the electronic solution identified to address this (*"Locum on Duty"*) is being taken forward currently, but it is not yet implemented. She has prepared a separate paper to apprise the Committee in more detail. In view of the action reported to address this area we are requesting that the Audit Committee consider deferral of the follow up audit of *Medical Agency Locums* for inclusion within the audit plan for 2019/20, to follow the implementation of *Locum on Duty* software.

Noting the vacancies within our team we have arranged for colleagues within our specialist IT Audit team to undertake the reviews of *Cyber Security* and *IT*

Applications. The first will commence in December and report in January as planned, but we have re-scheduled the second audit to commence in January and report in February in line with their available capacity. Work is in had to scope the latter.

A qualified accountant has been contracted from an external agency to join the team in November to undertake the audit review of *Financial Ledger*. Following this we aim to use that resource or the audit of *Budgetary Control & Financial Reporting* also. Timings within the audit schedule have been adjusted to reflect this.

We are scoping potential internal audit work on *Discharge Planning* arrangements in discussion with management, considering action taken following the Wales Audit Office review and the contents of a recently issued Delivery Unit report.

Progress against plan is detailed at Appendix A.

2.2 ADDITIONAL WORK: FOLLOW UP, ADVICE, PROJECTS & ADDED VALUE

There are contingency days set aside within our Plan to provide for advice to individuals and groups, follow up work in response to audits reported in-year and other ad hoc tasks.

2.2.1 Advice

The Head of Internal Audit provides advice as a critical friend on the forthcoming Bridgend boundary change Governance work-stream and continues to attend meetings of the management-led review of governance arrangements within the Bridgend Private Clinic.

2.2.2 Added Value

Providing an insightful, pro-active, future-focused internal audit service that promotes improvement within the Health Board, is central to the core principles of our service. In addition to planned assignments and responses to direct requests, we "scan the horizon" for good practice publications, national thematic audit reviews and emerging developments, to share with Executives and senior managers to promote improvement and the management of risk. Most recently this has included the following:

- NAO July 2018: *The health and social care interface* (COO)
- NAO June 2018: *Developing new care models through NHS vanguards* (COO)
- Policy Forum Wales July 2018: *Next steps for primary care in Wales: priorities for Primary Care Clusters, resourcing and preparing for the new Health and Social Care Plan* (2xQSC NOMs)

- CQC Oct 2018: *Social care in prisons in England and Wales: A thematic report* (DON&PE & SD PCS)
- HIW 2018: *Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018* (COO)

2.2.3 Board Engagement

The Head of Internal Audit has continued to meet with members of the Board. Since the last meeting:

- Chairman
- Director of Corporate Governance
- Chief Operating Officer

Additionally, the Deputy Head of Internal Audit has presented the latest update on audit outcomes and progress against the plan at the October meeting of the Executive Board. Following feedback already disseminated via the Director of Corporate Governance, the meeting also discussed Audit Committee concerns in relation to progress in addressing long-standing audit recommendations. The Chief Executive was supportive of Executive attendance at Audit Committee to report on progress and noted she was monitoring progress via one-to-one meetings with her Executive Director colleagues.

3 SPECIALIST SERVICES UNIT

3.1 PROGRESS OF THE 2018/19 CAPITAL AND ESTATES DOMAIN

3.1.1 Since the last meeting, fieldwork has been completed, debrief meetings held and draft reports are currently being prepared for issue in respect of the following:

- Estates Assurance: Control of Substances Hazardous to Health; and
- Estates Assurance: Water Safety

3.1.2 Fieldwork is substantially complete in respect of the Capital Projects: Environmental / Infrastructure Modernisation Programme audit. A debrief meeting with management is currently scheduled for 8th November 2018

3.1.3 Fieldwork is also currently being progressed in respect of the following assignments:

- Capital Systems; and
- Major Strategic Investment Programmes: ARCH Programme.

3.1.4 The following audit briefs have been issued and are awaiting management agreement:

- Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity; and
- Informatics Modernisation Programme (Installation of Wireless Network Infrastructure).

3.1.5 The audit brief for the Capital Projects: Primary and Community Care Infrastructure Projects assignment is currently being prepared for issue.

3.1.6 Further details including changes to timings are available at Appendix A as applicable.

4 DEVELOPMENTS

4.1 Staff Changes

We reported to the September 2018 Audit Committee that our longest-standing Principal Auditor took up post in another team at the start of September. We were unable to appoint to this post as there were a limited number of applications. Hence we are currently back out to advertisement.

The BSc Accounting graduate from Swansea University has started work with the Team and settling in well having completed his first audit.

On 5th November 2018 we will be joined by an external Agency Support who has NHS experience working for many months in another Welsh Health Board. It is the intention to use Agency for a small number of audit assignments pending appointment to the vacant Principal Auditor post.

5 ACTION

5.1 The Audit Committee is asked to note progress against the 2018/19 audit plan.

5.2 The Audit Committee is asked to consider and approve the deferral of the audit of *Medical Locum Expenditure* for inclusion in the 2019/20 plan.

INTERNAL AUDIT PROGRESS AGAINST PLAN — APPENDIX A

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Corporate governance, risk and regulatory compliance domain			
Governance, leadership and accountability (incorporating Health & Care Standards)	Mar 19	May 19	DOCG
Annual Governance Statement	Apr 19	May 19	DOCG
Risk Management & Assurance	Nov 18	Jan 18	DON&PE
Corporate Legislative Compliance – Wellbeing of Future Generations (Wales) Act	Draft report issued October 2018		DOCG[2]
Corporate Governance – Code Compliance *(deferred 17/18)*	Work in progress	Nov 18	DOCG
Board Assurance Framework *(deferred 17/18)*	Jan 19	Feb 19	DOCG
Partnership Governance: ARCH *(deferred 16/17 & 17/18)*	Work in progress	Dec 18	DOCG
Health & Safety (follow up)	Draft report issued October 2018		DOS
Fire Safety (follow up)	Draft report issued October 2018		DOS
Strategic planning, performance management and reporting domain			
Annual Plan (in absence of IMTP)	Work in progress	~~Oct~~ Nov 18	DOS
Performance management and reporting	Dec 18	Jan 19	DOS
Vaccination and Immunisation	Final report issued Aug 2018		DOPH
Third Sector Commissioning (follow up)	Final report issued Oct 2018		DOS
Financial governance and management domain			
Budgetary control & financial reporting	~~Oct~~ Nov 18	~~Nov~~ Jan 19	DOF
General Ledger	Audit brief issued	Nov 18	DOF
Welsh Risk Pool Claims	~~Dec~~ Nov 18	~~Feb~~ Dec 18	DON&PE
Charitable Funds – Part 1 Charitable Funds – Part 2	Final report (I+II) Sep 2018		DOF
Charitable Fund: Golau Governance (follow up)	Final report issued Oct 18		DOF
Payroll – local controls	Brief Approved	~~Sep~~ Nov 18	DOF
Clinical governance, quality & safety domain			
Annual Quality Statement	Final report issued Aug 2018		DON&PE[3]
Putting Things Right *(deferred 17/18))*	Final report issued Aug 2018		DON&PE
Patient Reported Outcome Measures *(deferred 17/18)*	Nov 18	Dec 18	EMD
Clinical Audit & Assurance *(deferred 17/18)*	Nov 18	Jan 19	EMD
Discharge Planning *(deferred 17/18)*	Scoping	Dec 18	DON&PE
Pressure Ulcers (follow up)	Draft report issued September 2018		DON&PE
Mortality Reviews (follow up)	Final report issued Oct 18		EMD

[2] With support of DOCG
[3] With support of EMD and DOTH&HS

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
POVA (DoLS) (follow up)	 Final report issued Sep 2018		DON&PE
Nursing Quality Assurance / Matron Checks	Draft report issued October 2018		DON&PE
Information governance & security			
Outpatient Delayed Follow Ups	Draft report issued Aug 2018		COO
IT / Cyber Security	Audit brief issued	Jan 19	CIO/DOCG
Business Continuity & Disaster Recovery	 Final report issued October 2018		DOS
Health Records Management (Physical notes)	 Final report issued Jul 2018		EMD
GDPR	Work started	Dec 18	DOCG
IT Application	~~Oct~~ Jan 19	~~Dec~~ Feb 19	CIO/DOCG
Operational service and functional management domain			
HR&OD Directorate (follow up) *(deferred 17/18)*	Jan 19	Feb 19	DOWOD
GP Managed Practice: *Cymmer Health Centre* *(deferred 17/18)*	 Final report issued Sep 2018		COO
Princess of Wales Service Delivery Unit	 Final report issued Aug 2018		COO
Morriston Hospital Service Delivery Unit	 Final report issued Oct 2018		COO
Strategy and Planning Directorate	 Final report issued Oct 2018		DOS
Workforce management domain			
Medical Staff Revalidation *(deferred 17/18)*	Audit brief issued	Nov 18	EMD
Organisational Change Policy/Contractual Changes *(deferred 17/18)*	Jan 19	Mar 19	DOWOD
Nurse Rostering (follow up) *(deferred 17/18)*	Dec 18	Feb 19	DON&PE
Junior Doctor Bandings (follow up) *(deferred 17/18)*	Jan 19	Mar 19	DOWOD
Staff Performance Management & appraisal (follow up)	Dec 18	Jan 19	DOWOD
Statutory and Mandatory Training (follow up)	Jan 19	Feb 19	DOWOD
Sickness absence Management (follow up)	Final report issued October 2018		DOWOD
Medical Locum Cover (follow up)	Request made for deferral to AC		EMD
Capital and Estates domain			
Equipment Replacement *c/fwd 17/18*	 Final report issued July 2018		DOS
Follow up (Estates Assurance) *c/fwd 17/18*	 Final report issued July 2018		DOS
Follow up (Capital) *c/fwd 17/18*	 Final report issued July 2018		DOS
Environmental Sustainability Report	Final briefing paper issued 4th September 2018		DOS
Carbon Reduction Commitment	Final briefing paper issued 4th September 2018		DOS
Capital Systems	Jun 18	~~Aug~~ Nov 18[4]	DOS

[4] Note: Completion of fieldwork has been put on hold to recognise current UHB review of risk management processes.

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Major Strategic Investment Programmes: ARCH Programme	End Sep 18	Dec 18	DOS
Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity	~~Oct~~ Dec 18	~~Dec~~ Mar 19	DOS
Capital Projects: Primary and Community Care Infrastructure Projects	Dec 18	Mar 19	DOS
Capital Projects: Environmental / Infrastructure Modernisation Programme	Aug 18	~~Oct~~ Nov 18	DOS
Informatics Modernisation Programme	~~Nov~~ Dec 18	~~Jan~~ Mar 19	EMD
Estates Assurance: Control of Substances Hazardous to Health *c/fwd 17/18*	Aug 18	~~Oct~~ Nov 18	DOS
Estates Assurance: Water Management	Aug 18	~~Oct~~ Nov 18	DOS
Follow up (Estates Assurance)	Feb 19	Mar 19	DOS
Follow Up (Capital)	Feb 19	Mar 19	DOS

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ASSURANCE RATINGS

APPENDIX B

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.

Meeting Date	**15th November 2018**	**Agenda Item**	**4a**
Report Title	**Audit & Assurance Assignment Summary Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A 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 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 Audits.		
Key Issues	Eight reports have been finalised with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised: • 3 *Reasonable* • 4 *Limited* • 1 No ratings applied		

Specific Action Required ***(please ✓ one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management. • Consider any further action required in respect of the subjects reported.

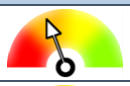
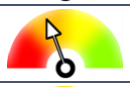
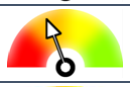
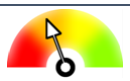
AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

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	
Golau Governance (Follow up) (ABM-1819-017)	
Mortality Reviews (Follow up) (ABM-1819-025)	
Delayed Follow Ups (ABM-1819-028)	
Business Continuity and Disaster Recovery (ABM-1819-030)	
Morriston Unit Governance (ABM-1819-037)	
Strategy and Planning Directorate Governance (ABM-1819-038)	
Sickness and Absence Management (Follow up) (ABM-1819-045)	**No rating assigned**
Third Sector Commissioning (Follow up) (ABM-1819-047)	

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.

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

[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.

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 GOLAU GOVERNANCE REVIEW (FOLLOW UP) (ABM-1819-017)

Board Lead: Director of Finance

3.1.1 Introduction, Scope and Objectives

An audit review in 2017/18, requested by the Charitable Funds Committee, identified major concerns with the way that Golau Charitable funds were operating. In addition, the audit highlighted the absence of a Health Board wide strategy. As a result, *limited* assurance was reported.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the last audit.

Audit work considered information presented to the Charitable Funds Committee to support review of progress against the original audit actions and schedule of actions within the Golau Business Plan 2017/18.

The outcome of this review may contribute to the organisation's assessment of its achievements in respect of the Governance, Leadership and Accountability standard of the Health and Care Standards (2015).

3.1.2. 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 minutes of the Charitable Funds Committee for March and June 2018 evidence an increase in scrutiny with regard to progress made by the Service Unit to action Internal Audit recommendations from the 5th

February 2018 reported review. Although some progress has been made there are a number of key areas that are yet to be finalised.

Since the issue of the previous Internal Audit report, there is now a Golau Fundraising Manager in post. The Fundraising Manager has attended the Charitable Funds Committee to provide updates both at the March and June 2018 meetings.
It is clear from the minutes that the Charitable Funds Committee are concerned with progress made and the Chair and another Member of the Committee will be meeting with the Unit Service Director in September 2018 to discuss this further.

Whilst progress is ongoing the key documentation that will promote sound governance is yet to be finalised.

Internal Audit would note that a number of findings and recommendations in this report are interim assurance measures as the overarching Health Board wide charitable funds strategy is yet to be produced. A comprehensive strategy encompassing all endowment funds both large and small would negate the need for the development of a separate policy and strategy and standardise processes in the management of these funds.

Action has been agreed with the Director of Finance to be completed by the beginning of April 2019.

3.2 MORTALITY REVIEWS (FOLLOW UP) (ABM-1819-025)

Board Lead: Interim Executive Medical Director

3.2.1 Introduction, Scope and Objectives

This assignment has been undertaken as part of our 2018/19 audit plan agreed by the Audit Committee in March 2018.
The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the internal audit report issued in February 2017 (Reference ABM-1617-020) (noting that this was a follow up of an audit report issued in 2014).

This is a follow up audit and as such the audit scope focused on progress against the high and medium priority actions contained in the previous internal audit report only.

3.2.2. 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 some action has been taken against recommendations previously raised, it has not been completed consistently or effectively across all areas.

The following key findings have been identified which require management attention:

- Reporting of performance in respect of Stage 2 reviews was not evident at all Unit quality & safety groups.
- Information on the outcomes of mortality reviews was limited across Unit quality & safety groups.
- Action had been taken to improve performance information in respect of stage 2 review completion presented to the Quality & Safety Committee; however, it is still not clear on the total number of reviews outstanding. Additionally, the new format of reporting has changed for October 2018 and does not include this information. Assurances on performance have been given verbally by Executives at meetings.
- The Annual Clinical Audit report has presented some assurance in respect of the outcomes of mortality reviews completed, but the detail in respect of action taken for those requiring it was limited.

We are aware that the Director of Corporate Governance and Deputy Medical Director have begun a process of review to improve the governance of Clinical Audit and that Mortality Reviews will feature as part of this. We recommend that this include consideration of Unit and corporate roles & responsibilities, expected processes, and the reporting requirements of Units and corporate team in order to ensure effective assurance is provided to the Quality & Safety Committee. We would recommend that agreed arrangements are documented in a policy / procedural documentation as a clear point of reference for all involved.

Action has been agreed with the Interim Executive Medical Director to be completed by the end of December 2018. Actions & timescales may be subject to review by the substantive Executive Medical Director following his start in post.

3.3 DELAYED FOLLOW UPS (ABM-1819-028)

Board Lead: Chief Operating Officer

3.3.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan and agreed by the Audit Committee in March 2018.

The Outpatient Departments see more patients each year than any other hospital department. A follow-up appointment is an attendance to an outpatient department following an initial or first attendance and make up the largest part of all outpatient activity. The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date is identified as a key delivery measure within the NHS Outcomes Framework 2017-20.

The Wales Audit Office (WAO) undertook a review of follow-up outpatients across all seven Health Boards in Wales in 2015. A subsequent follow up report was published by the WAO in February 2018 noting the progress made in addressing the recommendations raised in the original report. Their work generated recommendations in respect of data quality and performance monitoring, both of which are informed are being processed via the Health Board's Outpatient Improvement Group. This audit has looked at the progress made in relation to the WAO recommendations.

The overall objective of this audit was to review action taken to reduce outpatient follow-up delays and to improve the quality of information reported to the Board and Welsh Government.

The scope of the audit was restricted to a review of evidence demonstrating progress against WAO recommendations identified in the *Follow-up Outpatient Appointments: Update on Progress ABMU Health Board* report, with particular consideration to how this is managed and monitored via the Outpatient Improvement Group.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Information Governance and Communication Technology (3.4)* standard of the Health and Care Standards 2015 and the *Delivering Excellent Patient Outcomes, Experiences and Access* corporate objective.

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.

Concluding this review, three key findings were identified.

- Whilst we noted the development of Delivery Unit plans for 2018/19, there continues to be an absence of identified clinical risks recorded in these plans.

- There continues to be a lack of an overarching mechanism to capture and share lessons learned from service changes implemented within specialties and delivery units. Whilst we noted a proposal within the project outline document to mitigate this risk, there continues to be no system in place to share lessons learned.
- The WAO follow-up report issued in February 2018 noted that the POW Hospital Unit outlined the clinical validation that is being undertaken, with no reference to how they planned to identify and prioritise high-risk patients. Following fieldwork, this issue continues to remain in place.

Action has been agreed with the Chief Operating Officer to be completed by the end of February 2019.

3.4 BUSINESS CONTINUITY AND DISASTER RECOVERY (ABM-1819-030)

Board Lead: Director of Strategy

3.4.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan and agreed by the Audit Committee in March 2018.

Business continuity planning enables an organisation to help ensure that business processes can continue during a time of emergency or disaster, whilst a disaster recovery plan is a documented process or set of procedures to aid the recovery of returning an organisation to a state of normality after the occurrence of a disastrous event.

In November 2016, the Wales Audit Office (WAO) issued a *Communications Technology Audits* report that provided an update on progress against previous communication technology audits including IT Disaster Recovery and Business Continuity.

The overall objective of this audit was to confirm that action have been taken to address issues highlighted in the Wales Audit Office reviews for business continuity arrangements.

The scope of this audit was limited to a review of management action to address the issues raised in the Wales Audit Office report *Communications Technology Audits* report issued in November 2016 and also the entries in the corporate risk register.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Information Governance and Communication Technology (3.4)* standard of the Health and Care Standards 2015.

3.4.2 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 objectives and should therefore be considered in that context.

Concluding this review, no key findings were identified. However the following have been identified for further action.

- We confirm that a progress report on the development/review of the business continuity plans for cross-cutting services was reported to the EPRR Strategy Group in July 2018, with a further request that each Unit and cross cutting service provide an updated at the September 2018 meeting. However, no deadlines or timescales were evident in progress reports or updates provided to the group.
- Of the four Executive Directors listed as members of the EPRR Strategy Group, only once did an Executive Director attend a meeting in May and July 2018.
- The EPRR Strategy Group terms of reference also notes one of their key responsibilities as "Receiving and approving emergency response plans". However, given the poor attendance of Executive Directors and the lack of a defined quorum in the EPRR Strategy Group terms of reference, we would recommend that the responsibility for the approval of organisation-wide plans and procedures should be allocated to the Executive Team.

Action has been agreed with the Director of Strategy to be completed by the end of November 2018.

3.5 MORRISTON HOSPITAL DELIVERY UNIT GOVERNANCE REVIEW (ABM-1819-037)

Board Lead: Chief Operating Officer

3.5.1 Introduction, Scope and Objectives

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

The Morriston Hospital Delivery Unit was established as a managed unit in October 2015. The Unit's senior leadership team is made up of a Unit Service Director, Unit Nurse Director and Unit Medical Director, with support in maintaining & developing governance arrangements from a Head of Quality & Safety. The framework of unit groups was subject to a

high level audit review shortly after its formation, but this is the first audit to consider the operation of some of the key groups within the structure. Since the original audit there has been a change of person occupying the Unit Medical Director role and revision to group structure (and this audit has been undertaken at a time of transition).

The objective of this review was to confirm the Unit governance structures follow the principles set out in the Health Board's current system of assurance, and support the management of key risks and the achievement of the Unit's objectives.

The approach taken was a desktop review of the terms of reference, work plans/programmes, agendas, minutes & action logs relating to key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.

3.5.2 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 objectives and should therefore be considered in that context.

The key issues identified during this audit were:

- The Morriston Management Board does not regularly receive the risk register. When a report was included in April 2018 papers it did not include an extract of the register due to the need for cleansing of duplicates and other administrative concerns.
- The Unit risk register at the time of testing held 190 risks which were overdue for review.

While the above are noted, we would highlight that work is currently underway with Service Groups, led by the Unit Medical Director and Unit Nurse Director, to remedy this situation.

In addition to the above, a number of additional observations and recommendations have been made to maintain the documentation of supporting group administration and operation.

Action has been agreed with Morriston Unit Service Director to be completed by the end of December 2018.

3.6 STRATEGY AND PLANNING DIRECTORATE GOVERNANCE (ABM-1819-038)

Board Lead: Director of Strategy

3.6.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan agreed by the Audit Committee in March 2018.

The Director of Strategy has a varied portfolio of responsibilities, incorporating:

- Strategic Service Planning & Commissioning
- Partnerships & Engagement
- Business Planning & Performance (including Health & Safety)
- Capital Planning
- Estates
- Facilities Management

The overall objective of this audit was to review the governance arrangements in place within the Directorate.

Consideration was also given to the review of policies and procedures in place, but it was determined that noting the disparate functions within the Directorate, imminent changes to the Director of Strategy portfolio and organisational structure, we have not reviewed current procedures in place.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Governance, Leadership and Accountability* and *Workforce (7.1)* standards of the Health and Care Standards 2015.

3.6.2 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 objectives and should therefore be considered in that context.

Concluding this review, one key finding was identified.

- The financial limits for two staff on the Directorate authorised signatory register exceeded the Health Board's Standing Orders Scheme of Delegation limits. Some additional inconsistencies have been highlighted between this register and the limits set within Oracle.

In addition, the following have also been identified for further action.

- Sample testing, we noted one instance when an individual with a financial limit of £120k had approved an invoice for £174k. Six others had approved non purchase order invoices in excess of their limits on the authorised signatory register, but five of these were within the limits ascribed in the electronic Oracle purchasing hierarchy; the email approving payment for the sixth copied in the approver's manager (who had an appropriate limit).
- The Strategy & Planning Directorate does not have a risk register. No local registers are maintained for the Partnership & Engagement and Business Planning & Performance functions either.
- The objectives received for Estates managers were old (dated 2015/16 and 2016/17).
- Job descriptions were not provided for two posts reviewed: the Head of Strategy & Values and the Strategic Planning Manager.

Action has been agreed with Director of Strategy to be completed by the end of December 2018.

3.7 SICKNESS AND ABSENCE MANAGEMENT (FOLLOW UP) (ABM-1819-045)

No rating assigned

Board Lead: Director of Workforce and OD

3.7.1 Introduction, Scope and Objectives

In accordance with the 2018/19 audit plan agreed with the Audit Committee in March 2018, a follow up review has been undertaken in respect of sickness absence management.

A previous follow up audit reported in October 2017 (ref ABM-1718-103) a *Limited* assurance rating, identifying two high priority issues remaining for management action in respect of project governance supporting Occupational Health service improvements.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during previous audits.

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

3.7.2 Overall 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. The last audit review of this area derived a *limited* assurance rating.

Since that audit there has been continued change amongst the Executive Team, including the appointment of a new Director of Workforce & OD. She commenced in post in April 2018.

We have noted that the previous action assigned to the Senior HR Manager within the Primary Care & Community Services Unit had been completed. However, the actions relating to the Occupational Health Transformation Project, requiring Executive decision, had not been completed prior to the commencement of the new Director and had not yet been brought to her attention. Immediate action was agreed with the operational management lead and the Director and steps have since been taken to facilitate completion of remaining points.

In view of the above, we have not applied a revised audit rating within this report currently. However, subject to management completion of remaining actions now in hand, it is anticipated that further improvement may be demonstrable in a relatively short time and before the end of the year.

The last audit made three recommendations, of which two were high priority and one medium. Progress can be summarised as follows:

- One has been addressed (1 x medium priority);
- Two have not been addressed (2 x high priority).

Action remains to review the Occupational Health Transformation Project and obtain Executive Sponsor decision in respect of its continuation and content. There are also considerations in respect of the governance arrangements a revised project may require if approved.

Action was agreed with the Director of Workforce and OD to be completed by the end of October 2018.

3.8 THIRD SECTOR COMMISSIONING (FOLLOW UP) (ABM-1819-047)

Board Lead: Director of Strategy

3.8.1 Introduction, Scope and Objectives

An audit was undertaken previously in June 2017 (ref ABM-1718-013) to review the arrangements adopted for the management of services provided to the Health Board by the third sector. The audit was undertaken following the Board's receipt of a paper on the development of the Health Board's *Strategic Framework for Voluntary Sector* and derived a reasonable assurance rating. At the conclusion of that review, actions were agreed to address issues raised and monitor the Framework's implementation.

The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified during the 2017/18 review of the effectiveness of the system of

internal control in place to manage the risks associated with third sector commissioning.

The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.

3.8.2 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 overarching key finding was the delay in the development and implementation of the Voluntary Sector Strategic Framework following the paper received by the Board in March 2017. The need to revise timescales was reported to the Board in January 2018, but no detail has been presented in respect of revised timescales. Nothing has been received at the Strategic Planning & Commissioning Group between October 2017 and July 2018. It is appreciated that there are developments within the Health Board that may impact further on progress and senior management capacity. For the moment, the lack of clarity within reporting to Board and Executive Team in respect of revised timescales, or when these will be agreed, reduces the assurance that can be reported at this follow up review. Addressing timescales and clarity in respect of monitoring arrangements would provide greater assurance.

The previous audit made seven recommendations. Concluding testing, we can confirm that one recommendation had been addressed, three were partially addressed and three were not yet addressed.

Action has been agreed with the Director of Strategy to be completed by the end of January 2019.

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.