Meeting Date	**15th July 2019**	**Agenda Item**	**3a**
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 Audit and Specialist Service Unit reports.		
Key Issues	Five reports have been finalised with Executive leads since the last meeting (including 2018/19 reports not previously reported to the Committee). Their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised: • *5 Reasonable* • *1 Limited* • *2 No ratings applied* 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: • 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.

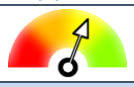
AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

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

This report summarises the outcomes of the following finalised assignments:

Subject	Rating[1]
Internal Audit 2018/19	
Payroll Local: Radiology Overtime (ABM-1819-018)	
Estates MRI Planet IT Application System (ABM-1819-033)	
Internal Audit 2019/20	
Human Tissue Act: Mortuary (Interim)(SBU-1920-005)	No rating applied
Annual Quality Statement (SBU-1920-017)	No rating applied
Medicines Management (SBU-1920-024)	
Specialist Services Unit (SSU)	
Safe Water Management	
Informatics Modernisation Programme	
Environmental Infrastructure Modernisation Programme	

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 PAYROLL LOCAL: RADIOLOGY OVERTIME (ABM-1819-018)

Board Lead: Director of Finance
Cc Chief Operating Officer

3.1.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

Variable pay costs present a significant risk to the achievement of financial balance. The Board were informed in September 2018 that the Month 5 variable pay costs were above the average for 2017/18 and the highest level of variable pay spend in 2018/19. Effective control of variable pay costs would make a key contribution to the achievement of year end targets.

The overall objective of the audit was to review key financial controls with respect payroll expenditure.

An analytical review of data within the ESR system over a 15 month period had identified staff overtime as a significant source of payroll costs, and the following areas were proposed for review based on high gross cost and/or high mean cost per member of staff:

Cost Centre	Description	Gross Cost £	Units Worked	Number of EE's	Average £
130J601	Laboratory Medicine	483,179	19,982	231	2091.68
130A423	MN Theatres	401,505	16,805	211	1902.87
130D616	MN Radiology	207,006	8,788	78	2653.92
130D612	SN Radiology	133,425	5,710	33	4043.19

During fieldwork, the complexity of rostering arrangements within Radiology indicated a higher level of potential risk that resulted in refocusing of audit activity within this service. Work within other areas has been deferred for future audit.

The audit sought to confirm that:

- There are adequate records recording hours worked;
- Controls ensure that the hours paid are additional to core contract hours;
- There is effective control over time worked in lieu;
- Overtime is authorized in advance, or certified by an independent, senior officer with knowledge of service needs and monitored by the budget holder;
- Overtime costs are monitored via Unit Governance structures.

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 objectives and should therefore be considered in that context.

There were no key issues arising from the review with a material impact. However, we noted that rostering arrangements were complex and time-consuming in nature and some of our findings indicated the presence of some risk. We have recommended that consideration be given to rostering arrangements as part of the ongoing wide work within the Health Board Workforce Redesign workstream.

Action has been agreed by the Radiology Services Manager, Director of Finance and Chief Operating Officer to be completed by the end of June 2020. This target date recognises the other priorities within the service for its new manager during the organisation's transitional year and the likelihood that it may be preceded by reconfiguration of the service subsequently.

3.2 ESTATES MRI PLANET IT SYSTEM (ABM-1819-033)

Board Lead: Chief Operating Officer

3.2.1 Introduction, Scope and Objectives

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

MRI Planet facilities management software is designed to offer comprehensive financial, health and safety, resource and work management functionality to support efficient estates/facilities

management. Its supplier indicates that it provides functionality to enable estates/facilities management to:

- Schedule planned and reactive maintenance work in accordance with shift patterns.
- Plan jobs in such a way as to optimise workloads across the workforce.
- Assign jobs to staff (either individuals or groups of people) or contractors.
- Send details of jobs and allow engineers to record that they have been completed by a variety of methods (i.e. mobile devices, email, paper, web portal).
- Record breakdown of costs for each job and track against budgets.
- Manage health and safety requirements.

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the Estates MRI Planet system, in order to provide assurance to the organisation's Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The specific purpose of the review was to provide assurance that data held within the Estates MRI Planet system is accurate, secure from unauthorised access and loss, and that the system is used fully.

The main areas that we sought to provide assurance on were:

- An appropriate governance process is in place for the system;
- Appropriate control is maintained over the database;
- All input is authorised, complete, accurate, timely and input once only;
- Proper control is exercised over access to application systems;
- Controls ensure the accuracy, completeness, confidentiality and timeliness of output, reports and interfaces;
- A complete audit trail is maintained which allows an item to be traced from input through to its final resting place;
- Appropriate business continuity arrangements are in place which include backing up copies of data and programs, storing and retaining them securely, and recovering applications in the event of failure.

3.2.2 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.

- The database version being used is SQL Server 2014 Service Pack 1. This does have some vulnerabilities and support for this service pack ended in October 2017, with the current Service Pack being number 3. In addition the end of mainstream support for SQL Server 2014 is in July 2019, with only extended support running to 2024.
- The review highlighted a number of issues relating to database and system access:
  - Password controls are not enforced with no minimum length of password nor regular forced change of password.
  - There are high privilege generic accounts used within the database and system.
  - There is an orphan account still active within the database.
  - The Assistant Director of Operations has administrator access to the system.
- There are a large number of calls on the system without a work order (2128) and these are spread across the year from January 2018. A review of these indicated that a number of these have been completed under other calls, however the processes for reviewing and clearing these off are not working.
- The introduction of tablets has the possibility to impact on the continuity of the department.
  - The continuity arrangements for the loss of the system rely on the use of the paper documentation, however once all staff are using the tablets then this paper documentation will not be required and the department may not therefore retain a supply.
  - The move to the tablets has not been accompanied by a full change of procedures and there are some aspects which were done in the paper based system, but are not carried out in the electronic system e.g. supervisors checking of weekly timesheets.
- Although the backups have been tested by restore / rollback etc., this is on an ad hoc basis and there is no formal process for periodic testing of the backups to ensure their validity / integrity.
- Although a contract has been paid for licencing of the system, the UHB (Estates and Procurement departments) has not been able to provide a copy of the contract details for support and maintenance of the system. As such there is no information on what support is available or the level to which updates are expected. In addition, there is no process in place to monitor performance of the supplier and ensure it meets the contractual requirements.

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

3.3 HUMAN TISSUE ACT: MORTUARY (INTERIM REPORT) (SBU-1920-005)

No Rating Assigned

Board Lead: Chief Operating Officer

3.3.1 Introduction & Background

An internal audit review of Human Tissue Act compliance at the Health Board's mortuaries has been agreed with the Audit Committee as part of the 2019/20 internal audit plan.

The Executive Director of Therapies & Health Sciences is the Board Director with lead responsibility for Human Tissue Act compliance. This interim report was prepared for his attention and that of his Deputy Director of Therapies & Health Sciences who oversees arrangements to ensure compliance.

The Human Tissue Act 2004 (*"The Act"*) came into force on 1st September 2006. The aim of the Act is to provide a legal framework regulating the storage and use of human tissue from the living and the removal storage and use of tissue from the deceased. It introduces regulation of other activities such as post mortem examinations, and the storage of human material for education, training and research. It is intended to achieve a balance between the rights and expectations of individuals and families, and broader considerations, such as the importance of research, education, training, pathology and public health surveillance to the population as a whole.

In response to critical reports published by the Human Tissue Authority following inspections at mortuaries managed by other organisations in NHS Wales, the Deputy Director of Therapies & Health Sciences indicated to the Health Board Quality & Safety Forum in January 2019 that an internal management review would be undertaken against the recommendations made.

Staff within the mortuaries have since compiled a self-assessment against the HTA *Post Mortem Examination: Standards & Guidance*. Whilst the mortuary management leads indicate some of the self-assessment remains to be completed, it has been provided to the Deputy Director and shared with Internal Audit to assist with planning of the audit review.

Following preliminary audit planning, including a review of the self-assessment completed to date, we propose to delay any further work but instead issue an interim report for immediate management consideration and action as appropriate.

3.3.2 Assessment of Current Position

The overall objective of the audit of *Human Tissue Act: Mortuary* within the Audit Plan for 2019/20 is to review arrangements in place to ensure compliance with legislation.

The self-assessment presents management's view of compliance against each of the areas in the HTA guidance as they relate to each of the sites managed by Swansea Bay UHB under the Morriston Hospital HTA licence 30015, including the mortuary it manages at Princess of Wales Hospital.

The assessment indicates that there is a limited level of management assurance currently. Whilst compliance is noted in some areas, there are several key areas of non-compliance and many more indicated as requiring improvement or further review. Some of these are in areas the HTA have considered critical or major at other establishments.

Internal Audit had been asked to consider undertaking an audit of this subject early in 2019/20. However, in view of management's own findings, we do not consider it an appropriate time for an internal audit review, but recommend that the audit be delayed until later in the year to allow mortuary management to make the improvements they have identified as required. Whilst this is the case, we have made a number of observations and recommendations for consideration by the Deputy Director in the next section of this report.

Amongst the revised (and previous) HTA requirements is the expectation for an establishment's governance arrangements to have a schedule of audits that include review of compliance with documented procedures, records (for completeness), traceability and tissues held. They require that actions to address issues arising, and the target dates for their completion, be documented.

The self-assessment indicates that such a schedule is not in place currently. Internal Audit review of the current terms of reference for the HTA Oversight Group has highlighted that they are not explicit on the requirement to receive a schedule of audits for consideration, receive the outcomes of audits undertaken, or monitor the completion of actions agreed in response to them. Our recommendations in the next section address this.

3.3.3 Recommendations

The completion of a management self-assessment is the first positive step to ensuring compliance with the revised guidance. The following actions are recommended to assist in making the necessary improvements at pace:

1) We recommend that the remaining areas of the self-assessment be completed quickly.

2) Actions should be agreed to address all areas for improvement. They should be prioritised so that those presenting the greatest risk of non-compliance with the Act, and/or potential for external inspection criticism and reputational damage, are targeted for early action and completion where possible. Actions should be scheduled within a documented improvement plan accordingly.

Whilst inspections elsewhere are not necessarily an indicator of all areas considered that may be considered critical at future visits within this Health Board, we would recommend that management consider those areas highlighted as *Critical* and *Major* at recent visits to Cardiff & Vale UHB and Cwm Taf UHB when assigning the prioritising tasks within Swansea Bay UHB.

3) Officers responsible for completing actions should be assigned. Where responsibility sits outside of the mortuary for actions, this should be communicated and agreed with senior management in those areas.

Where the Health Board is reliant upon management within another organisation eg Cwm Taf UHB, to address issues, this needs to be communicated and agreed similarly. Expectations of both organisations will need to be documented in service level agreements. The responsibility for ensuring this is achieved should be included within the action plan.

4) Having agreed an action plan, the Designated Individual (DI) should meet with mortuary staff regularly to monitor progress against it (we would recommend a fortnightly update). Notes be made of meetings, of actions agreed and completed – these may support assurance in respect of governance processes at a future inspection. The DI should report into the HTA Governance Group on progress against the prioritised plan, and highlight any slippage and/or issues arising.

5) The HTA Oversight Group should monitor progress at every meeting. The terms of reference for this group currently indicate that it meets only twice a year. This will not be adequate to ensure effective oversight of the highest priority improvements required. Until substantial progress can be demonstrated in the highest priority areas, the meetings should be held more regularly – we would recommend monthly.

6) The current position and any action agreed to address it should be summarised appropriately for reporting to the Quality & Safety Forum, in order that the appropriate risks & assurances can be communicated in turn to the Quality & Safety Committee.

7) To ensure the ongoing operation of effective oversight, we would recommend that the terms of reference for the HTA Oversight Group be amended to include the requirements:

- To receive and agree a schedule of audits for each year that indicates the meetings at which the outcomes will be available;
- To receive the outcomes from those audits; and
- To monitor action taken to address issues arising.

The schedule should be received at each meeting in order that the group can be assured that audits are undertaken and reported as planned. The meeting action log should be used to ensure that action required following audits and assurance that it is completed is brought back to future meetings.

8) Lastly, we would recommend that a revised target date be agreed for the commencement of an internal audit review. In considering a suitable date, the Health Board should consider the timescales within the improvement plan, and the point at which it is anticipated management's own self-assessment will provide a substantial level of assurance regarding arrangements in place. This would be subject to independent review within the scope of the internal audit.

The Deputy Director of Therapies & Health Science has confirmed that action is being taken on these recommendations and updates will be provided to the Executive Team, Quality & Safety Forum and Quality & Safety Committee. (To that end we note that the draft version of this report was included on the agenda for the Quality & Safety Forum scheduled for 21st May 2019, though the meeting was cancelled due to operational pressures within the Health Board.)

3.4 ANNUAL QUALITY STATEMENT (SBU-1920-017)

No Rating Assigned

Board Lead: Director of Nursing & Patient Experience

3.4.1 Introduction & Background

This assignment originates from the 2019/20 internal audit plan.

The Board is required to publish an Annual Quality Statement (AQS) for 2018/19. In doing so, the Board must assure itself that the information published in the Statement presents an accurate and representative picture of the quality of services and improvements it is committing to make prior to the deadline for its publication on 31st May 2019.

3.4.2 Scope & Objectives

The overall objective of this audit was to assist the Health Board with accuracy checking and triangulation of data and evidence before publication of the AQS.

The scope was limited to verifying that the AQS is consistent with information already published and/or reported to the Board and its committees over the period. It did not include a review of the internal controls over data quality within the underlying information systems generating the data reported.

During the audit consideration was given to the consistency of the AQS content with Welsh Government requirements and the potential impact that any gaps in information may have on the representativeness of the AQS with respect to the quality of the Health Board services. These were highlighted during fieldwork for management consideration and action if appropriate.

While performing the review, consideration was given to the process adopted to develop the AQS in order to advise management, if appropriate, on potential areas for future improvement.

We did not undertake to provide an assurance opinion in respect of the final AQS; however, by making audit recommendations and comments directly to management ahead of publication, we have provided opportunities to improve the AQS content, which if addressed may support management assurance in respect of the same.

3.4.3 Audit Approach

The Welsh Government (WG) deadline for publication of the Annual Quality Statement was 31st May 2019. Directions for its production were set down within Welsh Health Circular WHC (2019)007.

As recommended previously, management documented a timeline for the development of the 2019/20 AQS, indicating key milestones and points of engagement along the way, in order to achieve the WG deadline.

As part of this timeline, Internal Audit was to be provided with a copy of the Draft AQS on 7th May 2019. At the request of management in response to software issues, we delayed the review by two days, but mitigated this by providing some early feedback following review of a preliminary draft of the AQS that had been shared in advance. In addition to this, auditors attended a meeting of the Editorial Board and were provided with papers for others.

Following review and clearance on the 8th May, the Deputy Director of Nursing provided a copy of the draft AQS in order that the audit review could commence on the 9th May. It was that version upon which audit observations were made and shared with management. The following work was undertaken:

- We reviewed the draft AQS format against the structure required by the Welsh Health Circular (WHC).
- We sought to confirm that commentary had been provided in respect of the commitments made in the previous year's AQS.
- Using the cumulative audit knowledge gained over the course of the year, we reviewed the draft AQS content for any significant information gaps that we considered could impact upon the representativeness of the picture presented within the statement.
- We considered the consistency of the draft AQS content with messages presented within the Health Board's draft Accountability Report.
- We undertook a sample review of data presented within the draft AQS against data previously presented within the public domain via Board and/or Committee papers, or reported internally at Executive-led groups.

Finally, whilst it was not a core objective of the audit to proof read the document text, comments have been shared with management to address

some typographic, spelling and punctuation errors and to enhance clarity, where opportunities were evident in the draft provided.

3.4.4 Key Findings: AQS Content

We met with the Deputy Director of Nursing & Patient Experience on 10/05/2019 to discuss the key findings. Further findings aimed at enhancing clarity and presentation were sent on 13/05/2019 for consideration alongside those shared previously.

The key areas recommended for further consideration and action in respect of accuracy and representativeness were:

- Improve consistency in the use of reporting periods for performance information. Recognising the challenge presented by the earlier publication deadline this year, the WHC gave direction on the presentation of performance data where a full financial year's data was not yet available. There were some inconsistencies in how this had been applied; and in some cases there was more up to date information available which would enable a more positive picture to be presented appropriately e.g. infection control, never events.
- Enhance staffing information, including greater balance on NHS staff survey outcomes.
- Improve clarity in respect of outcomes of two of the 2018/19 year's quality priorities presented in the *Looking Back* section of the draft AQS.
- Look to address differences between draft AQS data and figures previously reported within the public domain for some subject areas: friends & family, formal complaints, pressure ulcers, cancer performance targets.
- Add information to the *Timely Care* section to reflect targeted intervention performance: Stroke, Referral to Treatment, Accident & Emergency waiting times.
- The *Dignified Care* section was based almost entirely upon patient stories, without an evaluation of how the Health Board has performed overall. Look to enhance the section to reflect a wider assessment of performance.
- Review and develop the *Looking Forward* section to improve clarity and alignment with the Health Board's top priorities for the year ahead.

The detail supporting the above and other findings has been provided directly to the Deputy Director of Nursing & Patient Experience, in order that she and the Director can make the changes they consider appropriate within the timescale and provide management assurance to the Board in this respect. She has noted that the AQS will continue to develop over the coming weeks leading up to the presentation at Board at the end of May 2019.

At the Audit Committee on 16/05/2019 members received the draft AQS and made some additional observations. The Director of Nursing & Patient Experience undertook to provide assurance that comments will have been

addressed when the revised statement is presented to the Board for approval at the end of May.

3.4.5 Key Findings: AQS Process

Whilst this audit has not sought to test the process for production of the AQS in detail, we have made a number of observations as a result of our discussions with management, attendance at Editorial Board (and access to meeting papers) and review of the AQS itself and supporting information. They indicate some areas of good practice and others for improvement when preparing next year's statement:

Good Practice
A timeline was prepared to guide the production of the AQS. This included time for internal audit input. It also identified dates at which Committees of the Board could be engaged to comment on draft versions – the Quality & Safety Committee on 18/04/2019 and the Audit Committee on 16/05/2019. There is a meeting of the Executive-led Quality & Safety Forum scheduled to receive the final AQS on 28/05/2019 ahead of the Board on 30/05/2019.

The Head of Engagement was a member of the Editorial Board, stakeholder engagement was scheduled as part of the timeline and views were received for consideration at the April 2019 meeting. Data was evident in the draft AQS reviewed by Audit for some stakeholder request areas (eg sepsis intervention performance), though it was not clear for some others (eg waiting times, stroke timeliness).

Representatives from WHSSC attended the Editorial Group and provided positive input to discussions. They remarked that this was the first Health Board to engage with them directly during AQS development.

Suggested Areas for Improvement
Following review of last year's AQS (2017/18), management indicated that Editorial Board meetings would include a representative of the Communications Team. The WHC indicates that *Organisational communications leads will need to work closely with their quality and safety colleagues to ensure that the content and format of the statement is as would be expected of a public-facing report*. Whilst we identified that representation was included within the terms of reference for the group and papers were circulated accordingly, there was no representation at the meetings. We suggested that the draft AQS when revised be circulated to the Head of Communications for comment prior to publication this year in order to gain some benefit of her expertise.

One of last year's agreed recommendations was to identify in advance, information already submitted to committees of the Board as possible sources of information for the AQS for 2018/19, rather than rely upon many individuals. The January Editorial Board meeting considered recommendations following the last internal audit review and agreed action for this year. Whilst this is the case, we have noted that data has continued to be provided by individuals for some of the reported measures and some

figures in the draft AQS differed from those reported to Committees/Board. Opportunities exist to improve consistency of information and the efficiency of AQS production by using Board and Committee information already within the public domain.

This year we highlighted some gaps in content and potential to improve the balance between patient stories and a wider Health Board assessment of performance (highlighted earlier and already shared with management).

3.4.6 Conclusions & Recommendations

We did not undertake to provide an assurance opinion in respect of the final AQS as part of this audit assignment. Instead, by making audit recommendations and comments directly to management ahead of publication, we have provided opportunities to improve the AQS content, which if addressed may support management assurance in respect of the same.

Detailed findings in respect of draft AQS content have been shared separately with the Deputy Director of Nursing & Patient Experience so that early action can be taken where necessary.

As part of this process, we have identified potential areas for improvement in approaching the development of next year's AQS.

The 2019/20 year is the first year of existence of the new Swansea Bay University Health Board. It provides an opportunity re-think, structure and plan the message and presentation of the Annual Quality Statement. The following should be considered:

a) We would recommend starting with a new template. Whilst retaining the high-level Health & Care Standard-led structure for the AQS as laid down in the WHC directions, think afresh what core content the new Health Board wishes to include.

   In particular, we would recommend identifying in advance a core of performance information that the Health Board considers will demonstrate achievements and challenges in its priority areas under the Health & Care Standard headings. Being important measures they should already be reported to the Board or one of its Committees in some form already. If they are not already reported, then we recommend that this should be addressed in Board / Committee level reporting too, or reconsidered.

   In planning the information required, consider the guidance within the WHC on suggested content to ensure that the breadth of the Health Board's services are represented.

   Ensure the views of stakeholder groups are taken on board early in the year and included within the identification of information required.

We would recommend that an indicative plan of core information encompassing the above is agreed within the first six months of the year.

b) We would recommend that management identify the Board and Committee meetings within the Health Board's calendar from which data will be sought for inclusion in the AQS at the end of the year. Use the papers from these meetings in due course as the source of the core data for inclusion, in the knowledge that the figures used will already have been submitted for scrutiny by Board Committees and published in the public domain.

c) Management should ensure that progress against the quality priorities indicated in the *Looking Forward* section is monitored during the year to demonstrate effective stewardship and promote the achievement of positive outcomes for reporting in next year's AQS. Reports on progress against all of the quality priorities should be received by the Board or its Committees.

d) There will continue to be a need to share patient stories and tell the broader narrative story of quality improvement within the Health Board as part of the statement, alongside performance data. Welsh Government guidance is clear that organisational communications leads will need to work closely with their quality and safety colleagues to ensure that the content and format of the statement is as would be expected of a public-facing report.

The Health Board should ensure that the expertise of its Communications Team is core to the development of the next AQS. Consideration should be given to allocating leadership for its development to the Head of Communications, with support from corporate quality & safety colleagues.

Action has been agreed with the Deputy Director of Nursing & Patient Experience to address issues by the end of October 2019, in preparation for the next year's AQS.

3.5 MEDICINES MANAGEMENT (SBU-1920-024)

Board Lead: Executive Medical Director

3.5.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

The Executive Medical Director is the Board Director with lead responsibility for Medicines Management. The senior management lead is the Clinical Director (Integrated Pharmacy & Medicines Management) (IPMM) who reports administratively via the Neath Port Talbot Delivery Unit to the Chief Operating Officer. The Clinical Director also occupies the separate role of

Accountable Officer for Controlled Drugs, as required by the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008.

Medicines management encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to produce informed and desired outcomes of patient care.

The Medicines Management Strategic Board is responsible for setting the direction and determining strategy to ensure the Health Board delivers clinically and cost effective drug treatment. Its role includes ensuring compliance in relation to use of medicines in accordance with the Health & Care (H&C) standards with a particular focus on:

- *Health & Care standard 2.6: Medicines management*

  People receive medication for the correct reason, the right medication at the right dose and at the right time.

- *H&C standard 3.1: Safe and clinically effective care*

  Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.

- *H&C standard 3.3: Quality improvement, research and innovation*

  Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and effectiveness of services.

It is supported by a Medicines Management Operational Board and a number of sub-groups.

The overall objective of this audit was to review the role and effectiveness of the Medicines Management Strategic Board in providing strategic oversight for all aspects of prescribing & medicines management.

The audit has reviewed arrangements in place to ensure that the Medicines Management Strategic Board, its supporting Medicines Management Operational Board and sub-groups, were operating effectively in order to provide assurance on medicines management strategy and objectives within the Health Board.

The audit scope considered the following:

- Roles and responsibilities for Medicine Management Strategic Board, Medicines Management Operational Board and supporting sub-groups are clearly documented
- The boards/groups meet regularly in accordance with their terms of reference
- The boards/groups are well-attended and quorate
- The meetings of the boards/groups are adequately documented and in accordance with the requirements of their terms of reference.

- The information the boards/groups require in order to deliver their objectives are established comprehensively within the meeting business cycles / work programmes and arrangements are in place to ensure that the information is provided as required
- Arrangements are in place to ensure that the additional information needs of the Boards and the sub-groups and actions agreed are addressed in a timely way (*Action logs)*
- The groups report to their parent group/board on key matters in a timely way.

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.

All groups have terms of reference and most met as frequently as required – exceptions have been highlighted. Meetings of the three groups we reviewed in more detail were on the whole quorate (one exception identified), but there is scope to improve engagement from the wider membership.

The key issue identified was that there has been no formal reporting from sub-groups to their parent groups.

Action has been agreed with the Clinical Director of Medicines Management to address issues raised by the beginning of August 2019.

3.6 SAFE WATER MANAGEMENT (ABM-1819-S09)

Board Lead: Director of Nursing & Patient Experience

3.6.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

The Water Safety Management audit was commissioned in order to evaluate the associated processes and procedures that support its management and control. The audit assessed compliance with relevant legislation and guidance to manage and minimise the risks to health including clinical risks, microbial and chemical contamination and changes to the water system. There was also emphasis on related staff competencies and implementation of water hygiene awareness training.

Accordingly, the focus of the audit was directed to the following areas:

- Procedures - to ensure that management were implementing applicable procedures (both internal and external requirements).
- Governance – that the UHB had adequate arrangements in place to support the implementation of the approved code of practice. Also, that an appropriate policy was in place to address water safety issues, there were defined allocation of responsibilities, clear lines of communication and approval processes.
- Monitoring and Reporting - to ensure that the UHB had effective monitoring procedures in place across the estate e.g. the establishment of appropriate Water Safety Groups (WSGs) etc; also that there was appropriate record retention and dissemination of information through to the Executive team and Board.
- Management - assurance that relevant staff received appropriate training, appropriate resources allocated and an appropriate inspection / detection regime was operating.
- Risk Management - assurance that the UHB performed a suitable and sufficient assessment of risks; and that risks were appropriately managed.

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 system was found to benefit from several key controls including revised procedures, and a risk assessment refresh. Water temperature testing was directed by an automated system, with associated reporting of outcomes and remedial actions. However, key issues included:

- The Water Safety Policy and Plan (procedures) were recently updated to accord with HTM 04-01 and approved by the Quality and Safety Committee in May 2018. However at the time of the audit fieldwork, the updated procedures had not been widely circulated.
- The lack of assurance relating to Legionella testing (including non-compliance with the testing regimes determined within the UHB's Water Safety Plan) i.e.
    - infrastructure risk assessments were out of date and were not being referenced to determine testing regimes; and
    - noting the lapse of the testing contract, the audit did not evidence legionella testing in accordance with the Water Safety Plan requirements.

- The need to update procedures to detail assurance reporting requirements relating to Pseudomonas Aeruginosa testing and cleaning regimes in appropriate areas e.g. taps, and sink drainage outlets (with associated monitoring and reporting arrangements).
- Assurance relating to the flushing of infrequently/unused outlets was not identified.
- While a Water Safety Group had been established, which reported to the Health and Safety Committee. The group did not meet with appropriate frequency or attendance (as determined within the procedures/HTM04), including the need to ensure advice by a micro-biologist.
- The need for more effective monitoring and reporting regimes e.g.
    - there was a focus was on in-month reporting of work performed / not undertaken (testing/rectification etc.). However, outlets with on-going / cumulative issues, or outstanding actions (backlog) across time-periods were not featured;
    - while Statutory and Planned Preventative Maintenance was reported, this did not separately identify closure of water related maintenance issues etc; and
    - Planned temperature control checks had an 81.5% compliance rate at the time of the audit (but with variability from 58% to 100% between the sites). While these matters were advised to the Water Safety Group, no exception reporting relating to such results or anomalies was identified to the appropriate (superior) committees.
- There was a need for improved training in the operation of water management systems.

All of the recommendations raised at the report have been agreed by management.

3.7 ENVIRONMENTAL INFRASTRUCTURE MODERNISATION PROGRAMME (ABM-1819-S05)

Board Lead: Director of Strategy

3.7.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

This audit focused on the delivery of the first in a series of projects forming the Environmental Infrastructure Modernisation Programme.

Business Justification Case 1 (BJC1) consisted of 11 separate schemes across the Morriston, Singleton and Princess of Wales hospital sites, aimed at addressing the redevelopment and modernisation of the University Health Board's estate, in accordance with HSE requirements, Building Standards and other statutory compliance requirements.

Accordingly, the focus of the audit was directed to the following areas:

- **Project Delivery** – determine whether there were any relevant issues that limited the successful delivery of the projects e.g.:
  - Procurement approach;
  - Project management e.g. activity schedules, site issues, performance control issues (including advisors performance);
  - Time and cost e.g. delays, variations, cost escalation;
  - Quality e.g. defects;
  - Effectiveness of project reporting and approvals; and
  - User satisfaction feedback.
- **PPE Procedures & Lessons Learned –** assurance that the Health Board's requirements for post project evaluation were appropriately applied, with appropriate arrangements in place to ensure lessons learnt from the delivered schemes were applied, in practice, to the future planned infrastructure projects.
- **Benefits Realisation -** assurance that the identified benefits from the delivered schemes had been achieved.
- **Other –** identification and assessment of any additional post completion issues arising.

3.7.2 Overall Opinion

The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under audit, 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 review noted the following positive aspects of project delivery:

- BJC1 was delivered within reasonable parameters of the approved budget and delivery programme, further noting that an additional scheme was also accommodated within the original budget.

  The project outturn cost was reported at £22k over the approved budget allocation of £7.768m: to be funded from discretionary capital; and
- Project governance arrangements, as observed at BJC1, were generally robust.

However, recommendations were raised, aimed at improving the project control environment, e.g.

- enhancements to the current project management arrangements have been recommended, including the appropriate assignment of the Project Director role, consistent use of key performance indicators, and a clear audit trail to document approvals;

- whilst noting the delivery of BJC1 within reasonable budget/time parameters, significant variances in both cost and time performance, were observed at individual schemes;
- there is a need for the wider consideration of the lessons learned from the BJC1 project, including an assessment of procurement value for money and associated time and cost performance etc.; and
- the need for a formal benefits realisation assessment in line with the requirements of the approved business cases.

A recommendation was also made aimed at enhancing future Programme Business Case submissions (thereby enhancing associated monitoring and reporting arrangements.

All of the recommendations raised at the report have been agreed by management.

3.8 INFORMATICS MODERNISATION PROGRAMME (WIRELESS NETWORK INFRASTRUCTURE PROJECT) (ABM-1819-S06)

Board Lead: Chief Operating Officer

3.8.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan.

The aim of the project was to install wireless infrastructure within Singleton Hospital, Maesteg Hospital, Gorseinon Hospital, Suites in Tonna and Angleton Clinic. The project was identified as a key infrastructure enabler in the Informatics Strategic Outline Plan. Welsh Government approval to the project was provided in December 2016 (£3.462 million).

The project will provide an equitable Wireless Infrastructure to the rest of the UHB's larger hospital sites. The project was split over three years:

- Year 1 (16/17) Procurement of all the Wireless equipment.
- Year 2 (17/18) Installation of all cabling and infrastructure, and some end user devices.
- Year 3 (18/19) Procurement and the installation of the remaining end user devices.

Accordingly, the focus of the audit was directed to the following areas:

- **Project Governance:** an appraisal of organisational and governance arrangements to provide assurance that appropriate scrutiny and decision mechanisms operated at the project; and assurance that appropriate contractual arrangements operated at the project.
- **Reporting and Approvals:** assurance that appropriate reporting and approval mechanisms operated at the project; and that funding was appropriately approved and applied.

- **Project Management:** an assessment of the project management tools utilised including risk management, cost control and project planning and performance monitoring undertaken.
- **Procurement / Installation:** an assessment of the procurement and installation arrangements applied at the project; and assurance that best value was attained in the procurement / installation methodologies applied.
- **Commissioning:** assurance that arrangements were in place to ensure the identified key deliverables and benefits were achieved.

3.8.2 Overall Opinion

The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under audit, 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.

Compliance was noted with the established control frameworks in each of the objective areas sampled, particularly procurement and commissioning.

Noting the project is now complete, recommendations were made aimed at enhancing the project governance and management arrangements at future IM&T projects e.g:

- formal acceptance of key project roles;
- review and updating of Project Board terms of reference; and
- improved frequency and minuting of project meetings.

All of the recommendations raised at the report have been agreed by management.

4. RECOMMENDATIONS

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.