Meeting Date	**21st March 2019**	**Agenda Item**	**3a.**
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. • Draft 2019/20 Internal Audit Plan		
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
21st March 2019

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 and present changes to plan for approval where required.

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 start of March 2019.

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 has been submitted for consideration at the 13th March 2019 Executive Board 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 -003	Risk Management & Assurance		DON&PE Cc DOCG	AC
1819 -006	Board Assurance Framework		DOCG	AC
1819 -010	Annual Plan: Delivery Framework		DOS Cc COO	AC
1819 -013	Budgetary Control & Financial Reporting		DOF	AC
1819 -027	Nursing Quality Assurance		DON&PE	AC, QSC
1819 -029	IT / Cyber Security		DOCG Cc ADOI	AC
1819 -039	Medical Appraisal for Revalidation		EMD	AC
1819 -044	Statutory & Mandatory Training (Follow Up)		DOWOD	AC, WODC

[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:

- 018 Payroll (Local Controls): Radiology Overtime (Proposed Final issued)
- 022 Clinical Audit & Assurance
- 043 Staff Performance Management & Appraisal (Follow Up)
- 046 Medical Locum Cover (Interim Follow Up)

Responses have been received to two of the above already and we are in discussion to clarify actions and agree final action plans.

2.1.4 Work is in progress in respect of:

- 011 Performance Management & Reporting
- 033 IT Application System: Planet FM (Estates System)
- 040 Contractual Band Changes[2]
- 041 Nurse Rostering
- 042 Junior Doctor Bandings

Fieldwork on *Partnership Governance: ARCH* was paused following an initial set up meeting with the agreement of the Director of Corporate Governance and Health Board Chairman. It has resumed in March 2019.

2.1.5 A meeting has been arranged to discuss internal audit work on *Discharge Planning* with the Director of Nursing & Patient Experience in March. It may be necessary to refocus this work and possibly undertake it as part of next year's audit programme. An entry has been included in our Draft audit plan for next year to cover this possibility. We will update the Committee following discussion with the Director of Nursing & Patient Experience.

2.1.6 We agreed to delay audits under the Workforce heading of our 2018/19 plan to the end of the year to allow for action under the direction of the Director of Workforce & OD following her commencement in the Health Board this year. Most are now complete or in progress and due to report in March.

In respect of the planned HR&OD Directorate follow up review, we have suggested to the Director of Workforce & OD that a straight-forward follow up of the audit undertaken in 2015 may not be of great value now, and that a fresh audit of the function may be more appropriate. She has indicated she will be undertaking a fundamental review of her Directorate structure and capacity following completion of the Bridgend transfer and we note she has updated the Workforce & OD Committee in this respect. We have therefore agreed with her to propose a deferral of a full review of the Workforce Directorate into 2019/20, the exact timing to be agreed so that it may provide independent assurance on the arrangements put in place. This has been included prospectively within our draft audit plan for 2019/20.

[2] Indicated within the plan at Appendix A as *Organisational Change Policy/Contractual Changes*

The Audit Committee is asked to approve deferral of this subject for inclusion in the audit plan for 2019/20.

2.1.7 Early contact has been made with the Directors of Nursing & Patient Experience and Corporate Governance ahead of year end to consider the approach that the Health Board will take to its self-assessment against the *Health & Care Standards*, and *Governance Leadership & Accountability* arrangements in support of the *Annual Governance Statement*. Internal Audit will consider and comment on these areas within our Annual Report – the approach we take will be discussed with the Directors of Nursing & Patient Experience and Corporate Governance when the Health Board approach and timescales are confirmed.

2.1.8 Progress against plan is detailed at Appendix A. In addition, whilst the Head of Internal Audit opinion is yet to be finalised, pending completion of remaining work, we have included a summary table of those audit reports issued in final and draft (*italics*) form along with their assurance ratings at Appendix C.

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 has continued to provide advice as a critical friend on the forthcoming Bridgend boundary change Governance work-stream.

Additionally, we have provided an analysis of questionnaire responses from members of the Mental Health Legislative Committee to support its annual self-assessment.

2.2.2 Added Value

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 sharing the following:

- Information on the *Getting It Right First Time* programme
- CQC report critical of staffing issues at an English health organisation
- International Public Sector Fraud Forum: A Guide to Managing Fraud for Public Bodies
- CIPFA Counter Fraud Centre: Fighting Fraud and Corruption Locally

2.2.3 Board Engagement

The Head of Internal Audit continues to meet and/or maintain ongoing correspondence/discussion with Board members. Since the last meeting:

- Chairman
- Director of Corporate Governance

3 SPECIALIST SERVICES UNIT

3.1 PROGRESS OF THE 2018/19 CAPITAL AND ESTATES DOMAIN

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

Ref	Subject	Rating[3]	Executive Officer Recipient(s)	Receiving C'ttee(s)
1819 -S12	Estates Assurance: Control of Substances Hazardous to Health.		COO	AC QSC

3.1.2 Management comments, are currently awaited in respect of the draft reports issued on the following:

- Capital Projects: Infrastructure Modernisation Programme;
- Capital Systems; and
- Estates Assurance: Water Safety.

3.1.3 Fieldwork is currently being progressed on the following:

- Informatics Modernisation Programme (Installation of Wireless Network Infrastructure);
- Follow Up (Capital); and
- Follow Up (Estates Assurance).

3.1.4 Fieldwork in respect of the ARCH Programme has been placed on hold (subject to ongoing discussions and the investigation taking place within Swansea University).

3.1.5 The following audit briefs have agreed by management agreement

- Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity; and
- Capital Projects: Primary and Community Care Infrastructure Projects.

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

Noting the above, we have been requested to defer the commencement of the Primary and Community Care Infrastructure Projects audit until June 2019 (to enable the review of two projects commencing on site in Spring 2019).

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

4 DEVELOPMENTS

4.1 Health Board Boundary Change

As noted earlier, the Head of Internal Audit continues to attend the Bridgend boundary change Governance work-stream.

4.2 Draft Internal Audit Plan 2019/20

Following a period of risk assessment, planning and engagement, the Head of Internal Audit has drafted a risk-based plan for 2019/20 for consideration and approval by the Audit Committee.

The draft audit plan was submitted to the meeting of the Executive Board on 13th March for consideration and endorsement. More detail on the approach taken to its preparation and the draft audit plan itself are included within a separate paper for the Committee's consideration at this meeting.

5 ACTION

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

5.2 The Audit Committee is asked to approve deferral of an audit of the Workforce Directorate to the 2019/20 audit plan.

5.3 The Audit Committee is asked to consider and approve deferral of the commencement of the Primary and Community Care Infrastructure Projects audit until June 2019.

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	 Final report issued Mar 2019		DON&PE
Corporate Legislative Compliance – Wellbeing of Future Generations (Wales) Act	 Final report issued Nov 2018		DOS[4]
Corporate Governance – Code Compliance *(deferred 17/18)*	 Final report issued Dec 2018		DOCG
Board Assurance Framework *(deferred 17/18)*	 Final report issued Mar 2019		DOCG
Partnership Governance: ARCH *(deferred 16/17 & 17/18)*	Work restarting March 19	Apr 19	DOCG
Health & Safety (follow up)	 Final report issued Nov 2018		DOS
Fire Safety (follow up)	 Final report issued Nov 2018		DOS
Strategic planning, performance management and reporting domain			
Annual Plan (in absence of IMTP)	 Final report issued Mar 2019		DOS
Performance management and reporting	Work closing	Feb 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	 Final report issued Mar 2019		DOF
General Ledger	 Final report issued Jan 2019		DOF
Welsh Risk Pool Claims	 Final report issued Dec 2018		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	Proposed Final report issued for Management consideration		DOF
Clinical governance, quality & safety domain			
Annual Quality Statement	Final report issued Aug 2018		DON&PE[5]
Putting Things Right *(deferred 17/18))*	 Final report issued Aug 2018		DON&PE
Patient Reported Outcome Measures *(deferred 17/18)*	AC approved removal in Jan 2019		EMD

[4] With support of DOCG
[5] With support of EMD and DOTH&HS

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Clinical Audit & Assurance *(deferred 17/18)*	Draft report issued Feb 2019		EMD
Discharge Planning *(deferred 17/18)*	Meeting with DON&PE to discuss		DON&PE
Pressure Ulcers (follow up)	Final report issued Nov 2018		DON&PE
Mortality Reviews (follow up)	Final report issued Oct 2018		EMD
POVA (DoLS) (follow up)	Final report issued Sep 2018		DON&PE
Nursing Quality Assurance / Matron Checks	Final report issued Mar 2019		DON&PE
Information governance & security			
Outpatient Delayed Follow Ups	Final report issued Oct 2018		COO
IT / Cyber Security	Final report issued Mar 2019		CIO/DOCG
Business Continuity & Disaster Recovery	Final report issued Oct 2018		DOS
Health Records Management (Physical notes)	Final report issued Jul 2018		EMD
GDPR	Final report issued Dec 2018		DOCG
IT Application	Work in progress	~~Feb~~ Mar 19	CIO/DOCG
Operational service and functional management domain			
HR&OD Directorate (follow up) *(deferred 17/18)*	Deferral to 2019/20 proposed		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)*	Final report issued Mar 2019		EMD
Organisational Change Policy/Contractual Changes *(deferred 17/18)*	Work started	Mar 19	DOWOD
Nurse Rostering (follow up) *(deferred 17/18)*	QA stage	Feb 19	DON&PE
Junior Doctor Bandings (follow up) *(deferred 17/18)*	Work closing	Mar 19	DOWOD
Staff Performance Management & appraisal (follow up)	Draft report issued Feb 2019		DOWOD
Statutory and Mandatory Training (follow up)	Final report issued Mar 2019		DOWOD
Sickness absence Management (follow up)	Final report issued October 2018		DOWOD
Medical Locum Cover (follow up)	Draft report issued Feb 2019		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

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Environmental Sustainability Report	Final briefing paper issued 4th September 2018		DOS
Carbon Reduction Commitment	Final briefing paper issued 4th September 2018		DOS
Capital Systems	Draft report issued Jan 2019		DOS/COO/ DOCG
Major Strategic Investment Programmes: ARCH Programme	End Sep 18	TBC[6]	DOS
Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity	Mar 19	May 19	DOS
Capital Projects: Primary and Community Care Infrastructure Projects	June 19	August 19	DOS
Capital Projects: Environmental / Infrastructure Modernisation Programme	Draft report issued Jan 2019		DOS
Informatics Modernisation Programme	Work in progress	Mar 19	EMD
Estates Assurance: Control of Substances Hazardous to Health *c/fwd 17/18*	 Final report issued Feb 19		COO
Estates Assurance: Water Management	Draft report issued Jan 2019		COO
Follow up (Estates Assurance)	Work in progress	Mar 19	COO
Follow Up (Capital)	Work in progress	Mar 19	DOS

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[6] Fieldwork has been placed on holding pending ongoing discussions and the investigation taking place within Swansea University

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.

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN (End of February 2019 Position)

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Clinical Governance, Quality and Safety		tbc	● Annual Quality Statement		● Mortality Reviews – Follow up review ● Nursing Quality Assurance ● POVA (DoLS) – Follow up review ● *Clinical Audit & Assurance*	● Pressure Ulcers – Follow up review ● Putting Things Right	
Corporate Governance, Risk and Regulatory Compliance		Tbc			● Fire Safety – follow up review ● *Board Assurance Framework*	● Corporate Legislative Compliance: WFG Act ● Health & Safety – Follow up ● Risk Management & Assurance	● Corporate Governance: Code Compliance
Financial Governance and Management		Tbc			● Charitable Fund Golau Governance: Follow up review ● Charitable Fund: Wards (Parts I & II)	● *Payroll (Local Controls): Radiology Overtime*	● Budgetary Control & Financial Reporting ● Financial Ledger ● Welsh Risk

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
							Pool Claims
Strategic Planning, Performance Management and Reporting		Tbc			● Vaccination & Immunisation ● Annual Plan: Delivery Framework ● 3rd Sector Commissioning – Follow Up		
Information Governance and Security		Tbc			● Outpatient Delayed Follow Ups	● Business Continuity & Disaster Recovery ● Health Records Management (Physical notes) ● IT/Cyber Security	● General Data Protection Regulations

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Operational Service and Functional Management		Tbc			● Princess of Wales Service Delivery Unit	● Morriston Hospital Service Delivery Unit ● GP Managed Practice ● Strategy & Planning Directorate	
Workforce Management		Tbc	● Sickness Absence Management – Follow up review		● *Staff Performance Management & Appraisal* ● *Medical Locum Cover (Follow Up)*	● Medical Appraisal for Revalidation ● Statutory & Mandatory Training – Follow up review	
Capital and Estates		Tbc	● Environmental Sustainability Report ● Carbon Reduction Commitment		● Estates Assurance: Control of Substances Hazardous to Health ● *Estates Assurance: Water Management* ● *Systems (Risk Management/ Declarations of*	● Equipment Replacement ● Follow up (Estates Assurance) ● Follow up (Capital)	

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
					Interest) ● *Environmental / Infrastructure Modernisation Programme*		

Draft reports are presented in *italics*.

Meeting Date	**21st March 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 Audits.		
Key Issues	Nine 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: • *1 Substantial* • *4 Reasonable* • *4 Limited*		

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.

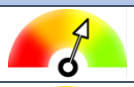
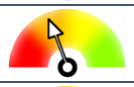
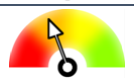
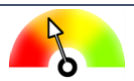
AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

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	
Risk Management & Assurance (ABM-1819-003)	
Board Assurance Framework (ABM-1819-006)	
Annual Plan: Delivery Framework (ABM-1819-010)	
Budgetary Control & Financial Reporting (ABM-1819-013)	
Nursing Quality Assurance (ABM-1819-027)	
IT / Cyber Security (ABM-1819-029)	
Medical Appraisal to Support Revalidation (ABM-1819-039)	
Statutory & Mandatory Training (ABM-1819-044)	
Specialist Services Unit (SSU)	
Estates Assurance: Control of Substances Hazardous to Health (ABM-1819-S12)	

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.

[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.

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

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

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 RISK MANAGEMENT AND ASSURANCE (ABM-1819-003)

Board Lead: Director of Nursing and Patient Experience
cc Director of Corporate Governance

3.1.1 Introduction, Scope and Objectives

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

The Director of Nursing & Patient Experience is delegated responsibility for Risk Management. In its extant Risk Management Strategy the Health Board recognises that all health service activity carries risk, including harm to patients, which needs to be managed through a systematic framework.

During 2017/18, external reports from Wales Audit Office (WAO) and the Welsh Government Delivery Unit (DU) highlighted improvements required to risk management arrangements. The Health Board is in the process of implementing revised arrangements currently. In the *Strategic Risk Report* presented to the Audit Committee in November 2018, it was noted that the Corporate Risk Register template had been revised and content was being revised so that the refreshed register would be in place for December 2018. Assurance had been given that recommendations raised in the WAO 2017-18 Structured Assessment had been largely addressed, with one remaining for completion in January 2019 (the quarterly reporting of risks to the Board Committees to which they are aligned).

This audit scope was designed in recognition of the ongoing process of review & revision reported to the Audit Committee. As such it has not been a full review of risk management arrangements but instead was intended to provide assurance on the approach taken and progress so far.

The overall objective of this audit was to review the process that has been adopted to establish a robust risk management and assurance

framework across all activities of the Health Board. In particular, it considered the effectiveness of arrangements to ensure the escalation and review of significant risks recorded within Units/Directorates.

The audit considered the following:

- The Risk Management Strategy and Policy have been reviewed and include clear roles and responsibilities across the Health Board.
- The Corporate Risk Register reflects significant risks to the Health Board and there is a clear process of escalation & review of risks from operational risk registers.
- The Risk Management Group has clear terms of reference and working arrangements that support its role; and it operates in accordance with them.
- The development of a Board Assurance Framework has been incorporated into the Health Board's risk management processes.
- There is clear guidance for staff on the management of risk and awareness of it has been promoted.
- Assurance reporting is adequate and in line with the current Health Board committee structure.

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.

The Health Board is in the process of implementing improvements to its Risk Management arrangements with some elements still to be finalised at the close of fieldwork. The revised Health Board Risk Register has been presented to the Audit Committee in January 2019.

This review was not intended to give an opinion on the effectiveness of an established risk management & assurance framework, but commentary on the developments being made to strengthen those arrangements. The table below in summary form captures the reasonable progress that is being made and the recommendations made in the Action Plan attached address those areas that require further attention and strengthening.

Scope of audit	**Position 31st January 2019**
The Risk Management Strategy and Policy have been reviewed and include clear roles and	The review of the Risk Management Policy and Strategy is contained within the work programme of the recently formed Risk

responsibilities across the Health Board.	Management Group (RMG). Once revised processes are established the Risk Management Policy and Strategy will be updated to reflect these arrangements.
The Corporate Risk Register reflects significant risks to the Health Board and there is a clear process of escalation and review of risks from operational registers.	A significant refresh is evident in the presentation of the Health Board Risk Register. At the meeting on 24th January 2019 the Audit Committee Chair noted the significant improvements that were being made in the management of risk. The Health Board Risk Register is currently being populated in the main by the Risk and Assurance team opposed to Executive Directors or designated officers. The Risk Escalation process and Risk Escalation SOP require the presentation of risks to the RMG which meets bimonthly. The DATIX system has been agreed as the only system for the recording of risk.
The Risk Management Group has clear terms of reference and working arrangements that support its role; and it operates in accordance with them.	The Risk Management Group Terms of Reference were approved at the Senior Leadership Team meeting in October 2018. The RMG is in its infancy with just three meetings having taken place. Attendance by members has been limited at these meetings leading to the cancellation of the November meeting.
The development of a Board Assurance Framework has been incorporated into the Health Board's risk management processes.	The Board Assurance Framework features within the recently developed Risk Escalation Process.
There is clear guidance for staff on the management of risk and awareness of it has been promoted.	The guidance document 'A Simple Guide to Risk Assessment' has been shared with the Senior Leadership Team and a strategy for further circulation is being considered.
Assurance reporting is adequate and in line with the current Health Board committee structure.	There has been consistent reporting at Executive/Senior Leadership team, Audit Committee and Health Board levels.

Action has been agreed with the Director of Nursing & Patient Experience to be completed by the end of September 2019.

3.2 BOARD ASSURANCE FRAMEWORK (ABM-1819-006)

Board Lead: Director of Corporate Governance

3.2.1 Introduction, Scope and Objectives

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

It is common practice across the NHS to consider the Board Assurance Framework (BAF) a key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board. The Academi Wales Good Governance guide considers the development of BAF as a logical extension of an organisation's existing risk management arrangements. The Health Board is currently developing its Board Assurance Framework with an implementation date of 1st April 2019.

The overall objective of this audit was to review the proposed Board Assurance Framework to consider if it will provide robust assurance to the Board.

The audit considered the following:

- The proposed Board Assurance Framework provides reference to the Health Board's strategic objectives.
- The Board Assurance Framework has been incorporated into the Health Board's Risk Management policies and processes.
- The Board Assurance Framework contains sufficient fields and appropriate content, including sources of assurance and Committees charged with scrutiny, to provide robust assurance once implemented.
- The process of drafting the Board Assurance Framework has engaged Executive Directors.
- The progress of developing the Board Assurance Framework has been reported appropriately at Board level.

In considering development to date, we have also considered the progress and content within the Unit level assurance framework piloted in PCCS Unit.

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.

During 2018/19 the Director of Corporate Governance has overseen the progress of the Governance Work Programme, which has been regularly reported at Audit Committee, and supported the refreshing of the Health Board's Risk Management arrangements. Both have been delivered against the backdrop of the upcoming boundary change.

Our review notes the early progress in identifying principle risks to the Health Board's objectives, the development of a template document and the continued intention to implement the framework from the 1st April 2019.

It is apparent that through prioritising the refresh of the Health Board Risk Register (HBRR) there has been little headway in developing the framework following the sharing of the template in September 2018. As such there has been limited content for us to consider against our main audit objective.

Fieldwork for this audit was undertaken alongside our review of Risk Management & Assurance (ABM-1819-003). As such some of the issues identified there are referenced within this report. We anticipate on-going management action to address the recommendations raised in those areas.

The findings for further action are noted below:

- The Health Board's Corporate Objectives were updated in November 2018. There had been no matching update to the BAF template to reflect this at the time of fieldwork.
- The Risk Management Strategy and Policy are yet to be updated to include reference to the BAF.
- There is an intention to populate the BAF with information taken from the HBRR, but at the point of audit the information contained in the BAF was limited. As we have noted in our review of Risk Management & Assurance (ABM-1819-003) the Executive ownership of Health Board risk entries is not fully embedded. We recognise that there is on-going management action in this area.
- The current layout of the template includes a column for 'Form of Assurance' in its current format this would not clearly differentiate between assurance sources as outlined in the three lines of defence.
- The Risk Management Group will oversee the on-going development of the BAF. The group has seen slippage it its work programme and we note attendance could be improved.

Action has been agreed with the Director of Corporate Governance to be completed by December 2019.

3.3 ANNUAL PLAN: DELIVERY FRAMEWORK (ABM-1819-010)

Board Lead: Director of Strategy

3.3.1 Introduction, Scope and Objectives

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

In its Planning Framework 2018-2021 (issued under WHC/2017/047), Welsh Government expects each NHS Wales organisation to have internal mechanisms in place to provide visible assurance to the Board on delivery against their IMTP/Annual Plan commitments and any necessary corrective action taken. Robust arrangements are expected for monitoring and intervening at organisational, directorate, divisional, cluster, and corporate department levels, and there should be effective risk identification and mitigation arrangements. Quality and delivery against plan should be monitored on a monthly basis and as a minimum there should be an executive group to oversee delivery and Board sub-committee to challenge progress and performance regularly.

The overall objective of this audit is to review the framework in place to monitor delivery of the improvement priorities set out in the Health Board's Annual Plan.

This audit considered the following:

- The role & responsibility of the Recovery & Sustainability Programme board and Performance & Finance Committee;
- The operation of those groups in accordance with their defined terms of reference and the effectiveness of monitoring arrangements;
- Reporting & escalation arrangements at Executive and Board level.

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.

The Annual Plan presented a framework for assurance that sat below the Finance & Performance Committee, which included for the Health Board-wide assurance arrangements the work of the Recovery and Sustainability Programme Board (RSPB), and beneath that the work of the four Improvement Boards (all meetings were to be held monthly). Whilst this was the intention at the time the Health Board was developing its annual plan, at the outset of this audit the Chief Operating Officer

clarified that instead the operating arrangements involved the Improvement Boards reporting to the Executive Team and the Performance & Finance Committee.

To support our review of papers Internal Audit attended three Improvement Boards in an observational capacity. It was encouraging to note they included examples of shared practice, were chaired and administered effectively, agendas included service improvement and items requiring detailed discussion were handled appropriately.

The key findings identified during this audit were:

- The Terms of Reference in use across the four Improvement Boards had been recently refreshed, but when reviewed vary in outlining purpose/role and administrative detail.
- The Annual Plan stated that each Improvement Board would establish and maintain a risk register to monitor the risks to delivery. No risk registers were received.
- The Performance and Finance Committee Terms of Reference include reference to its role in monitoring the Annual Plan, but there is no mention of the Improvement Boards and their relationship to the Committee.
- The Performance and Finance Committee work programme does not include scheduled updates/reporting from the Improvement Boards. It is yet to receive a report from the Planned Care Improvement Board although we note there has been performance reporting on Planned Care from the COO and Associate Director of Performance.
- The reporting provided to the Performance and Finance Committee has predominantly concerned performance, with limited information on the work of the Improvement Boards themselves.
- Improvement Boards do not have work plans/programmes which reflect their purpose in monitoring the implementation of the Annual Plan. The turnaround time required by this year's IMTP/Annual Plan process means that the Stroke Improvement Board will not receive a draft plan and will provide scrutiny through comments provided to the Chair.
- The Improvement Boards do not receive or include their elements of the Annual Plan for regular review at each meeting and so there is no consistent, structured monitoring of implementation of the actions within it.
- The Unscheduled Care Improvement Board received Unit improvement plans for quarter one but has not reviewed the progress of implementation or Units plans for quarter two. We note quarter two plans were provided to the Senior Leadership team.

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

3.4 BUDGETARY CONTROL & FINANCIAL REPORTING (ABM-1819-013)

Board Lead: Director of Finance

3.4.1 Introduction, Scope and Objectives

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

A budgetary framework is important within the organisation's overall performance management process, to support the achievement of its objectives and planned priorities within the resource limits set by the Welsh Government.

The Health Board Month 9 Financial Report is now forecasting a year-end deficit of £10m for 2018/19; there is work ongoing in the Finance Directorate and Recovery and Sustainability Programme, to scrutinise and test the current financial position, and agree actions to be able to meet the planned deficit.

Budgetary control and financial reporting are key to being able to manage the enormous challenges facing the Health Board, including changing and increasing demand for services, substantial workforce difficulties and inflationary pressures.

The overall objective of this audit was to access compliance with the Health Board's Standing Financial Instructions (Schedule 6) and the Financial Control Procedures; including a review on the effectiveness of operation of the Performance & Finance Committee and the Recovery & Sustainability Board.

The audit has reviewed arrangements in place to ensure that:

- Budgetary control objectives are clearly identified.
- Budgetary responsibility is clearly delegated to budget holders and consistent with the scheme of delegation.
- Sufficient relevant, reliable information is available to budget holders, including non-financial information and forecasts of the year end position.
- Budgetary variations are analysed, investigated, explained and acted upon in accordance with monthly financial recovery meetings and agreed escalation arrangements.
- Monitoring of management action to correct variances is evident.
- The Performance & Finance Committee and Recovery & Sustainability Board operate effectively.
- Financial reports to the Board and/or committees are timely and include information outlined in the SFIs.

3.4.2 Overall Opinion

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.

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 Health Board financial objective as reported in the Annual Plan for 2018/19, was to contain its year end deficit to within £25m. A reduced control total of £20m was required by Welsh Government in period 6, which was further amended in December 2018 following the provision of additional funding of £10m to facilitate the development of savings plans; subsequently revising the control total down to £10m.

The assurance rating above reflects the measures in place to monitor, manage and report assurance to the Board in respect of delivery of the control total. The Health Board has demonstrated a high level of focus on financial control & improvement through the provision of information to management, and the operation of its Recovery & Sustainability Board and the Performance & Finance Committee.

There were no further actions required following the review.

3.5 NURSING QUALITY ASSURANCE (ABM-1819-027)

Board Lead: Director of Nursing & Patient Experience

3.5.1 Introduction, Scope and Objectives

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

In 2014, an independent review into aspects of care and practice at the Princess of Wales and Neath Port Talbot Hospitals were undertaken by the Dementia Services Development Centre (DSDC) and The People Organisation (TPO) at the request of the Minister for Health and Social Services in the Welsh Government. Amongst its findings the review reported examples of basic failings in the standard of nursing care.

In response, the Health Board embarked upon a significant programme of cultural change and quality & safety improvement, and commenced the development of ward to board assurance framework. The introduction of the 'Matron' role was one such change, one of the responsibilities of the role being undertaken regular audits / spot check audits for professional assurance relating to the expected standard and quality of care.

The Healthcare Inspectorate Wales continues to review care at ward level, and following its unannounced visits it has made further recommendations to improve aspects of care and the quality of record keeping.

The Health Board has a number of policies & procedures setting out record keeping requirements in support of high quality, safe care. In particular, *the Record Keeping Policy for Nurses* (Oct 2016) sets out the responsibilities of Matrons/Senior Nurses with respect to the conduct of regular checks of nursing documentation including risk assessments, care bundles and plans. Additional policies set out further responsibilities with respect to assuring management of quality & safety on wards eg *Policy for the Management of Controlled Drugs* (Dec 2016).

In April 2017, following a pilot within Morriston Hospital, the Quality & Safety Committee was presented with a report describing a proposed Quality Assurance Framework including an Ideal Ward/Team Toolkit. The tool kit and assurance framework had been developed in line with the health and care standards domains.

The intention was to deliver it via a multidisciplinary peer review approach. To support this peer review it was also recognized that an electronic ward to board dashboard was required to present a consistent data set of quality metrics.

An update paper in June 2018, reported that following the launch of the Quality Assurance Framework, a further pilot year had concluded with two further Service Delivery Units (Singleton and Neath Port Talbot) and work had been undertaken to adapt the toolkits for use in other specialist areas. It indicated that the Framework was in a position for full implementation, with a view to undertaking annual reviews on all wards, with additional ones where required. A plan had been developed for the implementation of an information dashboard across the Health Board (it was live on 5 wards at NPT) to support provision of intelligence to review teams, for identifying outliers and performance reporting. Some of the information areas within the dashboard remained in development and timescales for rollout were still to be agreed following an evaluation of the implementation at Neath Port Talbot Hospital.

The overall objective of this audit was to review the role and effectiveness of the Matron in undertaking Quality Assurance audits at ward level.

The audit focused firstly on the implementation of the *Quality Assurance Framework* (QAF) where implemented within acute units. In areas where this was not fully operational, we considered any equivalent, alternative arrangements in place (though we did not review all of these in detail). The audit also considered the checks required by the Health Board policies and their inclusion within the QAF. Our review of the QAF coverage of these checks has been supplemented by unannounced substantive testing of those checks in a small number of areas sampled at two hospital sites.

The audit scope consisted of the following control objectives:

- Units have a programme of checks designed to provide assurance in respect of the quality of nursing care, environment and equipment across all care environments;
- Checks comply with the requirements of key Health Board policies and address key issues raised by external reviews.
- Records are maintained of checks undertaken and of the person(s) undertaking them;
- The effectiveness of assurance is promoted by the independence of reviewers;
- Progress, outcomes and action agreed are monitored within Unit quality & safety governance arrangements.

3.5.2 Overall Opinion

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

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

The Quality Assurance Framework provides a structured basis from which to derive ward to board assurance. Our review of its content indicates that it is a comprehensive tool overall and has potential to demonstrate assurance with a good level of independence. However, the QAF alone may not be responsive enough to provide assurance on areas of current concern quickly. Additionally, discussions with Units suggest that it is a challenge to administer and this is supported by a number of inconsistencies in record-keeping. We have recommended that the approach be reviewed by unit and corporate senior management to ensure that it is sustainable and meets local and corporate needs. Key findings for consideration include:

- The QAF was originally introduced with the intention of covering all wards areas at least once during a year. This will prove challenging for some Units noting previous coverage and the likelihood of recurring pressures as winter approaches. There is no corporate mechanism operating yet to monitor whether all areas of need are covered sufficiently. Unit Directors are positive in respect of the intent of the QAF approach, but some expressed concern regarding the ability to administer it within their current resources. It is possible the continued development and rollout of the ward-to-board dashboard will assist ease some burden, but the difficulties of coordinating a multi-disciplinary teams to undertake the work may continue to be challenging.

- With the expectation of one QAF visit per ward per year, the full approach is not responsive to issues highlighted during the year eg HIW inspections. Whilst Units are free to use individual toolkits as they see fit in between the main, full QAF visits, this aspect of the approach is not coordinated centrally, so the opportunity to provide quick, consistent assurance on such issues – and to demonstrate lessons learnt across the whole of the Health Board – is not being grasped. Additionally, these supplementary checks are undertaken with a reduced level of independence and are not expected to be reported corporately for assurance purposes.
- Our supplementary testing at a sample of wards, reviewing controlled drugs and resuscitation trolley checks – both areas where HIW inspections have found repeated issues, have found areas of poor compliance with expected controls / record-keeping.
- Whilst toolkits were provided for most themes on wards we sampled, a small number were missing. Additionally, some toolkits provided did not include the names of staff who completed the toolkits; and some appeared to include the incorrect names, or content relating to different wards. As currently implemented the toolkit documents do not provide a reliable record.

Action has been agreed with Director of Nursing & Patient Experience to be completed by the end of July 2019.

3.6 IT / CYBER SECURITY (ABM-1819-029)

Board Lead: Director of Corporate Governance

3.6.1 Introduction, Scope and Objectives

Cyber-security is the protection of information assets by addressing threats to information processed, stored, and transported by internetworked information systems. It is the protection of computer systems from theft or damage to their hardware, software or information, as well as from disruption or misdirection of the services they provide.

Cyber-security includes controlling physical access to the hardware, as well as protecting against harm that may come from malware, viruses and unauthorised or inappropriate software.

A strong cyber awareness culture is one of the best defences against cyber-attacks. Regulations such as the Network and Information Security (NIS) Directive and the General Data Protection Regulation (GDPR) will increase the burden on organisations to ensure they have effective cyber-security strategies and culture in place, in addition to robust controls and policies, to prevent and remediate attacks.

In October 2017, Stratia Consulting was commissioned by Velindre NHS Trust, on behalf of NHS Wales, to carry out external cyber security assessments for its organisations.

For each organisation, a cyber-security assessment report and security improvement plan (SIP) was produced. Additionally, an overarching security assessment and SIP for NHS Wales as a whole was produced.

The overall objective of this internal audit review was to evaluate and determine the adequacy of the systems and controls in place for cyber-security, 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 establish if the mechanisms in place for cyber-security are appropriately designed, and procedures and controls have been implemented within the previously agreed timeframes as outlined in the SIP derived from the recent external review of cyber-security.

To do this we reviewed the assessment report and SIP and evaluated evidence to support the organisation's current positional statement and reviewed the progress in addressing the recorded actions.

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

- Governance: An appropriate governance and management structure is in place to ensure cyber-security.
- External review awareness: Information contained within the Health Board's cyber-security assessment report and SIP has been discussed and monitored by an appropriate group or committee.
- Implementing actions: any actions contained within the cyber-security SIP have been completed within the agreed timeframes, or where there is significant variance from plan, this is clear within assurance reported to the monitoring group / committee.

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.

3.6.2 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.

It is worth noting that this review of cyber-security arrangements within the Health Board focused on the governance and visibility of the Stratia assessment report and SIP. We evaluated evidence to support the organisation's current positional statement on its action plan developed from the SIP; as such, our follow-up testing was limited to the areas contained in the original Stratia report.

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.

- In discussions with Health Board IT staff it was noted that an additional £20k is needed to implement the nationally procured Nessus vulnerability assessment solution. This coupled with the reality that implementing and running the software would generate the need for additional resource in order to act upon findings, may prove to be prohibitive for the organisation.
- The Head of ICT Operations has oversight for cyber-security with the strategic lead being the IT security manager; however, the Health Board recognises the need to establish a cyber-security technical lead who will report to the Head of ICT Operations
- Because there is currently no dedicated resource within the organisation with the responsibility for technical/operational cyber-security, other teams are required to carry out technical tasks such as patching, email filtering etc. when possible. Consequently, these responsibilities have not been formally assigned.
- A lack of resource in cyber-security has been recognised nationally through the WAO report and the Stratia review. The ABMU SIRO review of 17/18 stated that an additional cyber security role will need to be recruited. This has not yet been undertaken.

Action has been agreed with Director of Corporate Governance to be completed by the end of December 2019.

3.7 MEDICAL APPRAISAL TO SUPPORT REVALIDATION (ABM-1819-039)

Board Lead: Executive Medical Director

3.7.1 Introduction, Scope and Objectives

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

In December 2015, a Limited Assurance report was issued following the review of arrangements in place for medical appraisal to support revalidation (report reference 040/2014). In May 2016, a follow up report was issued that again reported Limited Assurance (1516-042).

In the Audit Committee meeting, November 2017, the Medical Director presented a paper indicating progress against this area but noted that the implementation of some actions associated with ensuring the quality of medical staff appraisal was dependent upon the appointment of staff to Appraisal Lead roles within the units. The area was not ready for re-audit but the Committee asked for management update at a future meeting.

In December 2017, the Medical Director approached Internal Audit and requested deferral of this audit into the 2018/19 Audit Plan as completion of action and further information relating to quality assurance arrangements was dependent upon the Appraisal Lead roles which were going through job planning but not yet complete. In January 2018, the Audit Committee approved the request for further deferral.

The objective of this audit review was to confirm that adequate arrangements are in place to support revalidation of the Health Board's medical workforce. In particular, the review considered compliance with the ABMU Medical Appraisal Policy (adopted from the All Wales Policy) and the General Medical Council Good Medical Practice framework for appraisal and revalidation requirements.

The audit considered mechanisms in place to ensure the effectiveness of appraisal processes within both primary & secondary care, though those functions undertaken by Health Education & Improvement Wales were excluded from testing. The following actions were reviewed within the scope of this audit:

- There is reconciliation of ESR and GMC Connect data to ensure all doctors with a connection to the Health Board are captured;
- An Appraisal Lead has been identified and appointed in each unit;
- Completed appraisals have an agreed summary and Personal Development Plan;
- The Health Board has an Appraisal Operating Plan;
- Supporting information provided by doctors for appraisal includes:
    - Continuing professional development

- Quality improvement activity
- Significant events
- Feedback from patients or those to whom they provide medical services
- Feedback from colleagues
- Compliments and complaints

- Doctors identified as not engaging with the appraisal process are managed in line with the All Wales Escalation Policy;
- There is effective monitoring and reporting of appraisal completion rates for Primary and Secondary care;
- Reporting requirements of Board Committees is clear and documented, and information is reported as required.

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 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 Corporate Appraisal and Revalidation Team have provided comprehensive supporting arrangements and information within the Health Board to support medical personnel in both Primary and Secondary Care.

The key issues identified during this audit are:

- In February 2018 the Health Boards Appraisal and Revalidation process was the first in Wales to be subjected to an external Revalidation Quality Review. The review was largely considered positive and included an action plan. The report was presented to Medical Workforce Board but not reported to the Board or any of its Committees. The Appraisal Manager is monitoring progress against the agreed action plan, however the progress is not being reported internally.

Audit recognised that a key action towards good quality assurance within the appraisal/revalidation process has been achievement of appointing Appraisal Leads to the Secondary Care SDU's. The initial Leads were appointed to post in April 2018 with Morriston the final SDU to appoint to post in October 2018. At the time of audit it was noted that the Appraisal Leads were still in training and not fully active in all aspects of their roles.

Action was agreed with the Executive Medical Director to be completed by the beginning of March 2019.

3.8 STATUTORY & MANDATORY TRAINING (FOLLOW UP) (ABM-1819-044)

Board Lead: Director of Workforce & OD

3.8.1 Introduction, Scope and Objectives

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

The Health & Care Standards require that the workforce is provided with appropriate support to enable participation in induction and mandatory training programmes. The Statutory & Mandatory Training Framework was first subject to internal audit review in 2009. At that time there was no formal management framework or strategy with which to ensure clarity of roles and responsibilities, the organisation's requirements and how to go about ensuring they were achieved. Subsequent audits noted improvements – particularly with respect to the introduction of a formal, documented framework.

An audit review was undertaken in June 2017 (audit reference: ABM-1718-043) to review the Health Board's statutory and mandatory training, focusing on the actions being taken to improve the Health Board's compliance performance figures. Concluding that review, a limited level of assurance was given.

The overall objective of this audit was to establish the progress made by management to implement actions agreed to address key issues identified during the 2017/18 review of statutory and mandatory training.

The scope of this audit is 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 **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.

Progress has been made in a number of areas, including the monitoring of the numbers of Learning Administrators and work to link higher level learning to competencies in ESR. The Board is also aware of recorded

performance figures. At the close of the audit fieldwork Statutory & Mandatory Training compliance was reported to the Performance & Finance Committee at 72.8% for December 2018. This is an improvement on the 38% figure reported for April 2017.

Monitoring and reporting was evidenced across the Workforce & OD Committee, Performance & Finance Committee and the Board through the Integrated Performance report. However, this was, necessarily, summarised and more detail would be required periodically to provide assurance on the monitoring of action completion against target dates. This may be further supported when the Workforce & OD Forum is fully established.

A number of actions from the previous audit recommendations are either ongoing or alternative mechanisms are being developed. These are in process but require further management action – no further recommendation has been made currently.

There are no key findings to report but the following has been identified which requires management attention:

- The Health Board mandated Integrated Performance report is the mechanism for performance and progress reporting. The report provides information that is, necessarily, summarised. It does not report timescales for progressing actions for Statutory & Mandatory Training.

We are aware that the Director of Workforce & OD has implemented an action plan to monitor Statutory & Mandatory Training, as part of a wider issues tracker.

Action has been agreed with the Director of Workforce & OD to improve the monitoring & reporting of progress with improvement actions by June 2019, and to review training information with a view to improving the oversight of compliance with higher level mandatory training requirements, by the end of March 2020.

3.9 CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (ABM-1819-S12)

Board Lead: Director of Strategy

3.9.1 Introduction, Scope and Objectives

The review of the UHB's arrangements to manage the Control of Substances Hazardous (Estates Assurance assignment), was completed in accordance with the agreed internal audit plan. COSHH legislation requires employers to control substances that are hazardous to health and to prevent/ reduce their exposure to employees, contractors or other people.

The audit considered (from an Estates perspective), the adequacy of the UHB's management arrangements and associated processes to identify, risk assess and implement control measures in compliance with regulations (i.e. how control was assured throughout the Estate). The audit did not include audit of clinical practices e.g. control of biological material, nor prescribed medicines, but audited controls relating to more general substances (e.g. disinfecting materials) as operated by officers throughout UHB, and to consider how the Board were appropriately assured.

3.9.2 Overall Opinion

RIDDOR requires that significant injuries and incidents to staff, resulting in absent from work over 7 days are formally reported to HSE. There is also a requirement to report dangerous occurrences. For patients, the majority of accidents and clinical incidents are not normally reportable, unless there has been a significant failure in ABM arrangements. The annual report did not indicate any COSHH related incidents during this period. The review noted that for the 2017/18 period the relatively low number (55) RIDDOR incidents reported.

Good practice was evidenced in the establishment of a Health and Safety Committee (in accordance with The Safety at Work Act 1974 - duties under this Act including those relating to COSHH), and a Quality and Safety Committee. This therefore provides the basis of an effective structure to inform the Board.

Whilst recognising this context, the audit has identified a number of control weaknesses.

- There was an absence of over-arching UHB wide procedures relating to COSHH (as recognised at the August 2018 annual Health & Safety report), similarly monitoring and reporting arrangements (and associated assurance arrangements) were not adequately defined.

  However, audit testing undertaken at a departmental level identified good practice in the allocation of responsible officers and defined procedural arrangements for the handling of substances. At the departments examined, no associated non-compliance was evidenced against the local procedures. However, departmental procedures and their associated requirements varied.

- Similarly, inconsistencies were identified across the departments reviewed in the approach to the risk identification, assessment and management of Substances Hazardous to Health.

  Departmental risk registers did not specify COSHH specific substances, training, storage, movement, dispensing requirements etc.

Accordingly, departmental COSHH substance risks did not inform the Health and Safety risk register, which only contained COSHH as a generic risk.

- The August 2018 Health and Safety report outlined the need for "periodic audit" of each aspect of Health & Safety (including COSHH compliance). However, periodic audits were not evidenced or outcomes of the same reported to the Health & Safety Committee.

- UHB monitoring and reporting requirements should also determine appropriate areas of coverage e.g. equipment / calibration monitoring and the built environment.

- The escalation into the corporate risk management processes needed to be improved; and

- Noting the devolved nature of controls, and their variability, while much good practice was evidenced, there was a potential for systems to become more disparate.

The audit raised 12 recommendations to be addressed by management (5 high priority, 6 medium priority and 1 low priority recommendation). While recognising the context of the low number of RIDDOR reportable incidents, the level of assurance in relation to COSHH is presently **Limited Assurance**, noting the range of issues identified relating to the control environment.

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.