Meeting Date	**12th March 2020**	**Agenda Item**	**3.1**
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	Helen Higgs, 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	Four final reports have been agreed with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. Full reports can be made available on request. The assurance levels derived can be summarised: *1 Substantial* *3 Reasonable* The Report indicates the timescales for completion of actions agreed with management.		
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	
Workforce and OD Framework (SBU-1920-039)	
DBS Checking (SBU-1920-042)	
Nurse Rostering (SBU-1920-043)	
Specialist Services Unit	
Primary & Community Infrastructure Projects	

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 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.

[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.

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 WORKFORCE AND OD FRAMEWORK (SBU-1920-039)

Board Lead: Director of Workforce & OD

3.1.1 Introduction, Scope and Objectives

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

Staff are key to enabling delivery of the aims set out in the health board's organisational strategy. On 30th May 2019, the Health Board received a Workforce and OD Framework for consideration. It was noted that its development had been informed by the Health Board's current position and strategic ambitions, and with the recognition that it should support the delivery of financial plans and opportunities, and align to the emerging Transformation Programme.

The Board was informed that the Framework would be supported by a suite of detailed supporting plans which would include a recruitment and retention plan and a multi-disciplinary education training and development plan.

The Framework was ratified in the knowledge that the Health Board was yet to have the resources to fully deliver it and that until funding could be agreed, the work needed to be undertaken on a phased basis.

The overall objective of this audit was to review the management & reporting of the delivery of the Workforce & Organisational Development Framework.

The audit scope has considered the following:

- Action plans are in place to support delivery of the framework commitments and staff responsibilities assigned;
- There is adequate evidence to support progress reported so far.

3.1.2 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 Framework document did not set out milestones for completion of the activities listed within, but progress reporting to WODC has presented narrative commentary on activities undertaken and planned. The audit has reviewed a sample of activities against the narrative position as reported in the progress reports to WODC and the assurance rating represents the outcome of that review. It is not an assessment of progress made against the Framework overall.

As noted earlier, the Framework was ratified in the knowledge that the Health Board was yet to have the resources to fully deliver it and that until funding could be agreed, the work needed to be undertaken on a phased basis. Following the agreement of future resources available to management for the delivery of the framework, the effectiveness of assurance reporting to Committee would be enhanced in 2020/21 by the completion of the high level plans supporting its delivery and reporting against milestones as appropriate for priority areas.

There are no key issues arising from the review of actions taken to date. Discussion with senior managers within the Directorate supplemented by review of documentation and records has provided adequate evidence overall to support the narrative description of activities reported to the Workforce & OD Committee sampled by Audit and reported within this report.

We would note that whilst this is the case the management updates indicate that progress has not been made in all areas due to the lack of resource during the year. There is also work to do to complete the action plans intended to support the Framework delivery.

Action has been agreed with the Director of Workforce & OD to implement a recruitment plan for medical staff by the end of June 2020 with a wider action in respect of recruitment and training plans to be completed by the end of March 2021.

3.2 DISCLOSURE AND BARRING SERVICE (DBS) CHECKS (SBU-1920-042)

Board Lead: Director of Workforce & OD

3.2.1 Introduction, Scope and Objectives

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

One of the most important principles of safeguarding is that organisations must ensure that they do everything they can to protect adults and children from abuse and neglect. As a result NHS staff should be DBS checked if they come into contact with children and adults at risk.

A HIW review into the Health Board's handling of the employment and sexual abuse allegations made against a former employee identified that there were a number of employees within the mental health and learning disability directorate who did not have a DBS check because their employment had predated the requirement for those checks. It also noted that DBS checks were not updated on a regular basis.

The report made a number of recommendations, some for the Health Board and some for Welsh Government. The Health Board agreed an action plan to address the risks presented, which was received by the Workforce & OD

Committee in February 2019. A report on progress against actions was received by the Committee in July 2019.

The overall objective of this audit was to review progress made to improve arrangements in place for the checking of staff through the Disclosure & Barring Service.

The audit sought to verify progress against the agreed action plan as reported to the Workforce & OD Committee.

It was recognised that the Health Board is supported in the checking of staff during recruitment by NWSSP Employment Services. It was not within the scope of this audit to review the operation of checks undertaken on the Health Board's behalf by the NWSSP, or to provide assurance regarding the same.

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.

Whilst the above is noted we would highlight that there is one key risk that needs to be addressed in respect of the ongoing governance of checks being undertaken of staff already in employment that have not had checks previously – target dates & milestones need to be agreed for completion of this work and the progress should be reported in a quantitative way to the Workforce & OD Committee to support provision of assurance to the Board.

Overall the narrative updates against the agreed WODC HIW action plan were supported by evidence in place. The operational DBS roll out plan and action log supported the implementation of processes to ensure that all staff members who require DBS checks are identified.

However, review of the action plan that is reported to the WODC identified a number of issues, outlined below:

- There were some occasions when the narrative and traffic light status of action were not consistent, resulting in a lack of clarity regarding the status of some actions.
- More importantly, there was no target completion date or milestones (see above) for completion of DBS checks for staff currently employed who have not been checked previously (or supporting targets within the underlying rollout plan). There was a lack of quantitative detail in the WODC action plan updates: Progress reported to WODC through the action plan did not include key information such as the number of DBS checks that have been completed, are in progress or are yet to be started. Without this core

information it is difficult for members of the WODC to gain an insight into the progress of checks.

Action has been agreed with the Director of Workforce & OD to be completed by the end of February 2020.

3.3 NURSE ROSTERING (SBU-1920-043)

Board Lead: Director of Nursing and Patient Experience

3.3.1 Introduction & Background

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

Efficient Nurse Workforce is one of the High Value Opportunity projects currently being implemented within the Health Board. Whilst the project is still ongoing, key milestones set for achievement in Quarter 2 included:

- Implement the Efficiency Framework for efficient nurse rostering in the delivery units
- Embed and improve the main KPIs using the Insight Report in all delivery units (first report expected September 2019)
- Complete the "Big Bang" (implementation) at Morriston
- Scrutiny Panels for e-Roster in place and embedded in the Delivery Units

An August 2019 report to the Workforce & OD Committee indicated that the Big Bang within Morriston was complete and signed-off, and that further work had been undertaken to develop a consistent approach to e-Roster scrutiny panels. In addition to this a consultation process had been undertaken for the Nursing & Midwifery Rostering Policy ("the Policy"). Whilst there was further work to do to standardise scrutiny arrangements in units, discussion with the Assistant Director of Nursing indicated that e-Rostering and scrutiny arrangements had been established within Singleton for some time and staff were operating in accordance with the revised policy.

The overall objective of this audit was to review compliance with nurse rostering policy and the effectiveness of use of the e-rostering system.

The audit scope considered the following:

- Individual ward roster templates are set up in accordance with agreed ward staffing levels;
- Planned rosters are prepared and approved in advance by the appropriate staff and in accordance with timescales set out in the Policy;
- Approval controls ensure that planned rosters are designed in accordance with the requirements of the Policy;

- Supervisory review and audit of rosters is recorded by matrons as required by policy;
- Unit Scrutiny Panels are chaired by UNDs and minutes record the monitoring of compliance with policy and KPI performance and agreement of action to address/improve rostering where required;
- Unit Scrutiny Panel minutes & agreed actions are included on Unit Business Meeting Agendas;
- Unit Scrutiny Panels minutes & agreed actions are received at quarterly, corporate Nurse Staffing Group meetings.

Recognising that different Units were at different stages of maturity in the use of the new rostering system, the scope of the audit included Singleton and the early implementer wards at Morriston. The review of arrangements at Singleton included the effectiveness of the established Scrutiny Panels. The audit work at Morriston reviewed the operation of Scrutiny Panels but not the effectiveness.

3.3.2 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.

Our attendance at the new Sign-Off Panel meetings at Singleton observed thorough review of rosters, the Unit Nurse Director supported by corporate rostering expertise challenging matrons on the effectiveness of their review of rosters and identifying actions to improve rosters presented.

Scrutiny Panels had not commenced in Morriston at the time of audit fieldwork. Whilst this is the case we noted discussions of aspects of rostering within the minutes of Workforce & Finance Work Stream meetings (and also the Professional Nursing Forum). We did not undertake as part of this audit to review the effectiveness of scrutiny at Morriston but would note that the current arrangements at Singleton provide a platform for greater focus and the support of rostering expertise for the review of detail of rostering processes. The Rostering policy currently requires Scrutiny Panels in each Unit. We would recommend that an approach to implementing this be discussed and agreed between the Unit and corporate nursing.

The agreement of an approach to exception reporting to be adopted for corporate reporting (and for use within Units) was agreed during fieldwork but not yet implemented. Implementation has been reflected within the management action plan accompanying the audit report.

Action has been agreed with the Director of Nursing and Patient Experience to be completed by the beginning of April 2020.

3.4 PRIMARY & COMMUNITY CARE INFRASTRUCTURE PROJECTS (SBU-1819-S04)

Board Lead: Chief Operating Officer & Director of Strategy

3.4.1 Introduction, Scope and Objectives

This review was commissioned in order to evaluate the processes and procedures that support the delivery of the Primary and Community Care infrastructure projects.

The audit sought to assess the governance and proposed delivery arrangements for the Welsh Government provision to be utilised for the provision/ refurbishment of projects planned within the UHB.

The Murton and Penclawdd Health Centre projects were selected for this initial audit, being the furthest progressed within the group of Primary Care projects.

The projects aimed to deliver full internal refurbishments, for sites in poor condition due to lack of investment or maintenance over the last 30 years.

Welsh Government approval was granted in November 2018 in the sum of £1.869m (£1.176m Penclawdd and £0.693m Murton), with both projects at construction stage at the time of audit fieldwork.

At the time of reporting, the Murton project had been completed on 25th October 2019 and opened to patients. However, the Penclawdd works had been delayed past their contract completion date of 29th November 2019, and were now forecast for completion in late January 2020.

Accordingly, the scope and remit of the audit included the following:

- **Programme Strategy** – assurance that:
  - strategic and service planning requirements were appropriately determined;
  - proposed outcomes remain aligned to approved strategies and the objectives of the business cases;
  - the projects effectively contribute towards the fulfilment of the strategy; and
  - the developments are appropriately future proofed.
- **Programme Governance** - including allocation of defined roles and responsibilities for individuals and working groups, reporting and approval.
- **Project Management** – assurance that appropriate project management controls were in place, including risk management, cost control, leases, project planning and performance monitoring, at the sampled projects.
- **Appointments** – assurance that the developer and any advisers were appropriately appointed with approved contracts, at the sampled projects.

- **Other** – Any other issues identified at the project affecting project delivery.

3.4.2 Overall Opinion

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

The audit raised 1 high and 9 medium priority recommendations. The current review identified some control weaknesses in the delivery of the projects, which impact on the overall assurance provided. These included:

- A number of changes were made to the scope of the works at both projects, post-business case approval. These included requirements for additional consulting rooms and space for health visitors etc., thereby increasing project cost pressures. An assessment of the effectiveness of the engagement with key stakeholders during the design development and service planning stages and the adequacy of project brief sign-off and business case approval mechanisms has therefore been recommended as a part of a formal post project evaluation exercise;
- Contractor performance issues resulted in the delayed agreement of revised delivery programmes and compensation events (contract changes); and
- Adviser contracts were executed significantly after the commencement of adviser duties.

Improvements were also recommended to the governance arrangements applied.

It has been recommended that a formal post project evaluation be undertaken at both projects to ensure lessons are learnt and inform the delivery of future Primary Care projects.

Management have agreed actions to implement all recommendations arising from the audit.

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.