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

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Abertawe Bro Morgannwg University Health Board

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2018/19

FINAL

May 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS

Report status: FINAL
Draft report issued: 03/05/2019
Final report issued: 21/05/2019
Author: Head of Internal Audit
Executive Clearance: 07/05/2019
Audit Committee: 16/05/2019 (Draft); 29/05/2019 (Final)

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance in comparison to the plan and an assessment of conformance with the Public Sector Internal Audit Standards (these are the requirements of Standard 2450).

1.2 Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved internal audit plan is biased towards risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

The overall opinion has been formed by summarising audit outcomes across eight key assurance domains. The overall opinion is then based upon these grouped findings. In a change to previous years all domains now carry equal weighting.

In my 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 with **low to moderate impact on residual risk** exposure until resolved.

1.3 Delivery of the Audit Plan

The internal audit plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit Committee. Regular audit progress reports have been submitted to the Audit Committee during the year.

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2018/19. We are now able to state that our service 'conforms to the IIA's professional standards and to PSIAS'.

1.4 Summary of Audit Assignments

The report summarises the outcomes from the internal audit plan undertaken in the year and recognising audit provides a continuous flow of assurance includes the results of legacy audit work reported subsequent to the prior year opinion. The report also references assurances received through the internal audit of control systems operated by NWSSP for transaction processing on behalf of the Health Board.

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

In overall terms we can provide positive assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the following assurance domains:

- *Corporate Governance, Risk Management and Regulatory Compliance*
- *Financial Governance and Management;*
- *Information Governance and Security;*
- *Operational Services and Functional Management;*
- *Workforce Management;*
- *Capital and Estates Management.*

However, in the domains below the significance of the matters raised in some subject areas where there are improvements to be made in governance, risk management and control has impacted upon our overall audit assessment:

- *Clinical Governance Quality and Safety;*
- *Strategic Planning, Performance Management and Reporting;*
- *Capital and Estates Management.*

Please note that our assessment across each of the domains has also taken into account, where appropriate, the number and significance of any audits that have been deferred during the course of the year (See also Section 2.4.2 and 5.7).

1.5 Organisational Context

During 2018/19 ABMU Health Board has remained in targeted intervention status under the NHS Wales Escalation Framework arrangements with focus and support received from the Welsh Government in driving improvement in challenging and difficult times.

In addition, early 2018/19 with new Board membership the strengthening of the Health Board's governance arrangements was a priority. The Director of Corporate Governance has supported the Board in the development of a Board Assurance Framework and has also strengthened the risk management processes.

At the 28th March 2019 meeting the Health Board received a redesigned Health Board Risk Register along with an interim Risk Management Framework. Also, the Board approved the Interim Risk Management Framework for the new Swansea Bay University Health Board for a period of 6 months with the aim of a further review post the Bridgend Boundary changes. The Board Assurance Framework document was received by the Audit Committee in March 2019; this will become operational during 2019/20 for the new Swansea Bay University Health Board.

In addition to the redesigned governance arrangements referred to above, the Director of Corporate Governance has provided the Audit Committee during the year with a Governance Work Programme that enabled the Audit Committee to gain assurance that that the recommendations made by the Wales Audit Office Structured Assessment and the Financial Governance Review were being addressed. The Wales Audit Office have recognised that with strengthened leadership the health board is improving governance.

The additional demands placed upon the Health Board Executives during 2018/19 in managing the Bridgend Boundary changes was considerable. The challenges of maintaining business continuity whilst such large-scale organisational change was taking place was evident.

The audit plan has been delivered with the support of the Board in the context of the challenges that the Health Board has encountered with the continued targeted intervention of Welsh Government.

Finally, in addition to the support of the Board, Internal Audit has seen increased engagement from management in responding to audit findings. The Health Board's achievement of target times for the agreement of management action plans following the issue of draft reports has improved again this year, from 41% in 2016/17, and 58% in 2017/18, to 72% in 2018/19.

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.

- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Abertawe Bro Morgannwg University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Wales Audit Office in the context of their external audit.

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide formulation of the opinion for 2018/19.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix D**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the eight assurance domains that were used to frame the internal audit plan at its outset. The aggregation of audit results by these domains gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the assurance domain ratings and overall opinion are consistent with the underlying audit evidence and in accordance with the criteria for judgement at **Appendix E**.

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

 Reasonable	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.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any *limited assurance* reports issued during the year and the significance of the recommendations made.

2.4.2 Basis for Forming the Opinion

In reaching the opinion the Head of Internal Audit has applied both professional judgement and the Audit & Assurance "*Supporting criteria for the overall opinion*" guidance produced by the Director of Audit & Assurance and shared with key stakeholders, see **Appendix E**.

The Head of Internal Audit has concluded that *Limited* assurance can be reported for *Clinical Governance, Quality and Safety*; *Strategic Planning, Performance Management and Reporting and Capital and Estates. Reasonable* assurance can be reported for *Corporate Governance, Risk and Regulatory Compliance; Financial Governance and Management; Information Governance and Security; Operational Services and Functional Management; and Workforce Management* domains.

The audit work undertaken during 2018/19 and reported to the Audit Committee has been aggregated at **Appendix B**.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module; and
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

As stated above these detailed results have been aggregated to build a picture of assurance across the eight key assurance domains around which the risk-based Internal Audit plan is framed.

The Head of Internal Audit has considered residual risk exposure across those assignments where limited or no assurance was reported. Additionally, a number

of assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. Where changes were made to the audit plan then the reason was presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes (deferrals) made to the plan when forming the overall opinion.

A summary of the findings in each of the domains is set out below. Each domain heading has been colour coded to show the overall assurance for that domain.

Corporate Governance, Risk Management and Regulatory Compliance

- Substantial assurance was reported in respect of *Corporate Governance Code Compliance.*
- Reasonable assurance was reported in respect to *Corporate Legislative Compliance: WFG Act, Health & Safety Follow-Up, Risk Management & Assurance,* and *ARCH Programme Governance.*
- Limited assurance has been reported in respect of the review of *Fire Safety Follow-Up* and *Board Assurance Framework.*

Strategic Planning, Performance Management & Reporting

- Limited assurance was reported for *Third Sector Commissioning/Contracts Follow-Up, Vaccination & Immunisation* and *Annual Plan Delivery Framework.*

Financial Governance and Management

- Substantial assurance was reported in respect of *Financial Ledger, Budgetary Control & Financial Reporting* and *Welsh Risk Pool Claims*.
- Reasonable assurance was reported in respect of *Payroll (Local Controls) Radiology Overtime*
- Limited assurance was reported in respect of the *Funds Held on Trust: Golau Governance Follow-Up Review*, and *Charitable Funds (Parts 1 & 2: Wards & Central).*

Clinical Governance Quality & Safety

- Reasonable assurance has been reported regarding *Pressure Ulcers Follow-Up Review* and *Putting Things Right.*
- Limited assurance was reported in respect of *Mortality Reviews Follow-Up Review, Nurse Quality Assurance, Clinical Audit & Assurance* and *POVA (DoLS) Follow-Up Review.*
- A limited scope review was undertaken of the *Annual Quality Statement* with the aim of ensuring that it was consistent with information published and/or reported to the Board. Based on the outcome of our review and action taken by management to address issues raised, there were no

significant issues known to us that caused us to believe that, for the year ended 31st March 2018 the Annual Quality Statement was not consistent with the information presented at the Board during the year.

Information Governance & IT Security

- Substantial Assurance was reported for the *General Data Protection Regulations*.
- Reasonable assurance was derived in respect of *Business Continuity & Disaster Recovery, Health Records Management (Physical notes), IT/Cyber Security and IT Application: Planet (Estates).*
- Limited Assurance was derived in respect of *Outpatient Delayed Follow-Up Review.*

Operational Service and Functional Management

- *Morriston Hospital Service Delivery Unit, GP Managed Practice, Strategy & Planning Directorate,* and *Princess of Wales Service Delivery Unit Follow-Up Review* all reported Reasonable assurance.
- Limited Assurance was derived for *Princess of Wales Service Delivery Unit* (noting that a follow up in year reported an improved position).

Workforce Management

- Reasonable assurance was reported for *Medical Appraisal for Revalidation, Statutory & Mandatory Training Follow-Up Review, Contractual Band Changes,* and *Junior Doctors Follow-Up Review*.
- Limited Assurance was reported for *Staff Performance Management & Appraisal* and *Medical Locum Cover Follow-Up Review.*
- A limited scope review for *Sickness Absence Management Follow-Up* indicated some improvement but a revised rating was not applied. Additionally, an interim follow up was undertaken with respect to an ongoing project through which improvements were being made to *Nurse Rostering.* A revised rating was not applied, recognising the different scope agreed and the interim nature of the review.

Capital & Estates Management

- Reasonable assurance was reported in respect *of Equipment Replacement, Follow-Up Estates Assurance (2017/18 and 2018/19 reviews),* and *Follow-Up Capital (2017/18 and 18/19 reviews)*.
- *Estates Assurance: Control of Substances Hazardous to Health, Estates Assurance: Safe Water Management, Systems (Risk Management/Declarations of Interest)* and *Environmental/Infrastructure Modernisation Programme* received Limited assurance.

2.4.3 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards and with the agreement of senior management and the Board Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.4.4 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and subject to the key financials and other mandated items being completed in-year the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, all other work in progress will be rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2018/19 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews which remain relevant to the reporting of the Annual Report required to be published by 30 June 2019. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance

work completed as part of this current year's plan albeit relating to the 2017/18 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2018/19 Annual Report and Quality Statement.

2.5 Required Work

There are a number of pieces of work that Welsh Government has required previously that Internal Audit should review each year, where applicable. These pieces cover aspects of:

- Health & Care Standards, including the Governance, Leadership and Accountability standard;
- Annual Governance Statement;
- Annual Quality Statement;
- Environmental Sustainability Report;
- Carbon Reduction Commitment; and
- Welsh Risk Pool.

Where appropriate, our work is reported in Section 5 – Risk based Audit Assignments and at **Appendix B**.

Please note that there are discussions ongoing with Welsh Government as to whether this work will be required in future years.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms to all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS'.

The NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audit at Abertawe Bro Morgannwg University Health Board in conformance with the Public Sector Internal Audit Standards.

Our conformance statement for 2018/19 is based upon:

- The results of our internal Quality Assurance and Improvement Programme (QAIP) for 2018/19 which will be reported formally in the Summer of 2019;
- The results of the work completed by Wales Audit Office; and

- The results of the External Quality Assessment undertaken by the IIA.

We have set out in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP are included in the 2018/19 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- Direct assurances from management on the operation of internal controls through the upward chain of accountability;
- Internally assessed performance against the Health & Care Standards;
- Results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- Reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- Reviews completed by external regulation and inspection bodies including the Wales Audit Office and Healthcare Inspectorate Wales.

2.7.1 Health & Care Standards

Welsh Government guidance for preparation of the Annual Governance Statement 2018/19, indicates that the Health Board should provide a summary of the steps the organisation is taking to demonstrate that they operate in accordance with the Governance, Leadership & Accountability standard and wider Health & Care Standards (HCS) framework to which it belongs.

In the previous 2017/18 year, the Health Board's process of assessment and monitoring of improvement against the Health & Care Standards was monitored by a Health & Care Standards Scrutiny Panel (a sub-committee of the Health Board's Quality & Safety Committee). At the Panel's April 2018 meeting, the Executive Directors present and the Non-Officer Panel members agreed that the Panel would cease to operate for 2018/19 and that performance against the Health and Care Standards would form part of the routine performance management arrangements. During 2018/19, the Executive-led quarterly performance review meetings with Delivery Units have received integrated performance reports within which measures have been cross-referenced to elements of the Health & Care Standards, providing some opportunity to review performance outcomes linked to some, but not all, of the Standards.

Internal Audit attended the Board Development Meeting on 25th April 2019 to consider the Board's discussions in respect of its assessment for 2018/19. At the

meeting the Director of Nursing & Patient Experience indicated that in Quarter 4 Delivery Units had been requested to undertake a self-assessment against each of the Standards. The Director of Nursing & Patient Experience noted that the self-assessments had been received, signed off by the Unit management teams, and had been validated by the corporate nursing team.

He presented a slide showing the individual assessment ratings for each Unit and a combined rating for the Health Board against each HCS theme – firstly as reported in 2017/18, and then as assessed in 2018/19. (However, whilst the Princess of Wales Delivery Unit was part of the ABMU Health Board during 2018/19, it was not included in the assessment presented.)

The Board discussed the process and the ratings derived. Whilst the combined ratings presented indicated an improvement from 2017/18 to 2018/19 overall, there was some debate as to whether some individual Delivery Unit scores were too low against themes where improvements were known to Board members, and conversely whether some of the improved ratings were appropriate where it was known to Board members that work needed to be done.

Some indicated that the reintroduction of Executive Director sign-off/Board Panel scrutiny of assessments should be reintroduced for the coming year in order to improve the level of assurance previously gained in the process. Another added the importance of being able to demonstrate the use of the standards to drive improvement and the visibility of this during the year.

Due to the late availability of the self-assessment information, Internal Audit has not had sufficient time to undertake an assessment of the adequacy of evidence in support of ratings presented. However, we would support Board members' requests to improve the process for 2019/20 by strengthening the Director level scrutiny of assessments, and increasing the visibility of improvement monitoring during 2019/20.

In respect of those improvements, we recognise that a review and refresh of the process for assessing compliance and reporting against the Health and Care Standards has been identified as one of the Governance Priorities for 2019/20 in slides presented at the Board Development meeting.

2.7.2 Governance and Accountability Board self-assessment

At the same Board Development meeting on 25th April 2019, the Board received its self-assessment results for discussion.

Information made available to members to accompany the session included:

- A covering paper setting out expectations for the session and summarising sources of assurance (one of which was the Wales Audit Office *Structured Assessment*) received by the Board during the year. The paper also referred to the Health & Care Standards (see above).
- The results of some Board members' individual assessments of Board governance against a maturity matrix. An additional on-screen slide presented the average scores as the summary position for discussion.
- The results of an online Board Effectiveness survey.

- The Internal Audit report on *Corporate Governance Code: Board & Committee Arrangements.*

The session was introduced by the Director of Corporate Governance. In doing so, she described the context as one of an organisation that had experienced a period of significant change amongst its Board membership, starting the year with a number of areas for improvement recommended by external auditors. In terms of assurances available to the Board, she drew particular attention to:

- Wales Audit Office Structured Assessment 2018/19 findings, its presentation to the Board in January 2019, and the fewer recommendations it raised this year, compared to last.
- Internal Audit's review of *Corporate Governance Code: Board & Committee Arrangements,* the scope of that work and the *Substantial* assurance rating.
- The governance work programme introduced for 2018/19 following a stocktake in 2017/18, its incorporation of recommendations from external reviews, and the monitoring process at Audit Committee, reported to the Board.

It was indicated that the self-assessment matrix and online survey were used in replacement of the *Governance & Accountability* module previously adopted, to provide more granularity of information.

Disappointment was expressed by several present at the low levels of response to the maturity matrix (only seven individuals had submitted, which differed from the greater number of submissions received in relation to the online Board survey). However, the responses received and average levels calculated provided a basis upon which a balanced discussion reflecting the variety of views across Board membership took place.

Whilst it was indicated that an improved response rate was required for future exercises, the usefulness of the summarised position as a baseline upon which to measure progress going forward was established.

The Director of Corporate Governance presented a slide indicating the Governance Priorities for 2019/20:

- Quality Governance arrangements including role and accountabilities of supporting structures
- Implementation of a Board Assurance Framework
- Further development of Risk Management arrangements
- Governance Framework between Corporate and Delivery Units as part of the operating model including legislative compliance framework
- Further strengthening of the role of committees including reviewing the size, quality of board papers as well as financial consequences of all Board and Committee papers
- Review and refresh the assessment process in terms of compliance and reporting against the Health and Care Standards

The average results were agreed provisionally by the Board, subject to further review at Audit Committee before publication.

It is Internal Audit's view that the Board undertook that an adequate process to assess the effectiveness of its governance arrangements, taking into account the appropriate recognition given to aspects of the process that could have worked better, and the clear indication of improvements expected for the next year.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. The Head of Internal Audit has had regard to these audits, which are listed below.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

- Primary Care Services: Overall Substantial
    - General Medical Services (Substantial)
    - General Pharmacy & Prescribing Services (Substantial)
    - General Dental Services (Substantial)
    - General Ophthalmic Services (Substantial)
- Accounts Payable (Reasonable)*(Draft)*
- Employment Services – Payroll (Reasonable)
- Information Governance – GDPR (Substantial)

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme.

NHS Wales Informatics Service (NWIS)

We have also undertaken two audits relating to the processes and operations of NWIS:

- Business Continuity (Reasonable)
- Change Control (Limited)

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report along with the NWIS audits.

In addition, as part of the internal audit programme at Cwm Taf UHB a number of audits were undertaken in relation to both the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services

Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialised Services Committee

- Governance arrangements (Reasonable)
- Risk management (Reasonable)
- Review of network groups and advisory boards (Reasonable)
- High cost drugs review (Reasonable)

Emergency Ambulance Services Committee (EASC)

- Governance and performance (Reasonable)
- Non-emergency patient transport service – follow up of baseline review (No opinion given).

The WHSSC and EASC audits are detailed in the Cwm Taf UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. The assignment status summary is reported at section 5 and **Appendix B**.

In addition, throughout the year we have responded to requests for advice and/or assistance across a variety of business areas. This advisory work undertaken in addition to the assurance plan is permitted under the standards to assist management in improving governance, risk management and control. This activity has been reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. These have become part of the routine reporting to the Audit Committee during 2018/19. The key performance indicators are listed at **Appendix C**. All indicator targets have been met.

Post audit questionnaires are issued following the finalisation of all audit assignments. We revised our post audit questionnaires for 2018/19 to make them more engaging and easier to complete. The illustration below presents feedback from auditees describing their view of the service they received:

As at 3rd May 2019, the response rate has been 52% (27 out of 52 finalised audits). Where respondents have made specific comments these have been reviewed by the Head of Internal Audit for any necessary action.

The table below present a selection of additional comments returned by managers:

"It was helpful to have support to develop clear management responses to the recommendations."
Health & Safety (Follow up): Reasonable Assurance
Assistant Director of Strategy

"Excellent support from* [auditor] *to help navigate through a complex history with the IA report. Very sensible and helpful advice provided."
Sickness Absence Management (Follow Up): No standard rating applied
Director of Workforce and OD

"Positive engagement and I had a genuine feeling that the auditors I met were seeking to add value to the Unit through their audit and that is welcomed. Engagement through to final production of report also welcomed."
Princess Of Wales Delivery Unit Governance Review: Limited Assurance
POWH Unit Service Director

"Many thanks to the team for their ongoing support."
Annual Quality Statement: No standard rating applied
Director of Nursing & Patient Experience

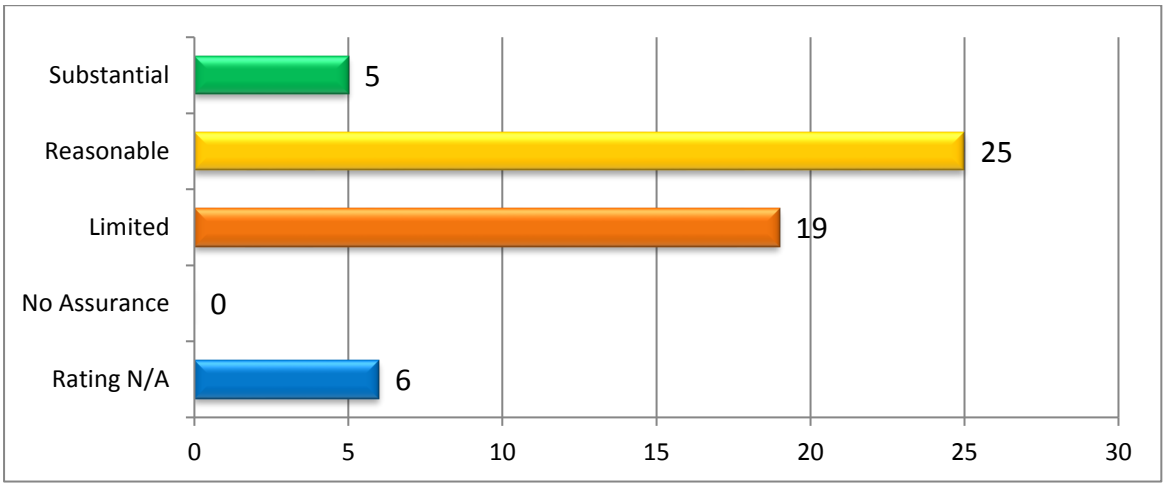
5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total **55** audit reviews were reported during the year (figure includes draft & final reports). Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



The assurance ratings and definitions used for reporting audit assignments are included in **Appendix D**.

In addition to the above, there were three audits which did not proceed following preliminary planning with the agreement of management, as it was recognised that there was action required to address issues / risks already known to management and an audit review at that time would not add additional value.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating. The conclusions of the last remaining assignments for which fieldwork has been agreed to complete by the end of May 2019 will be reported in 2019/20.

5.2 Substantial Assurance

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Corporate Governance: Code Compliance (ABM-1819-005)	The overall objective of this audit was to review the conformance of Board and Committee arrangements with relevant principles of HM Treasury Corporate Governance in Central Government Departments: Code of Good Practice 2016. In reviewing the information received by Board Committees we collated the subject titles of papers provided to the quality & safety committees of other organisations and presented this for management information. In light of the ongoing review of groups reporting into Board Committees, we did not review the effectiveness of groups such as the Quality & Safety Forum or Clinical Outcomes Group.
Budgetary Control & Financial Reporting (ABM-1819-013)	The overall objective of this audit was to assess compliance with the Health Board's Standing Financial Instructions (Schedule 6) and the Financial Control Procedures; including a review of the effectiveness of operation of the Performance & Finance Committee and the Recovery & Sustainability Board.
General Ledger (ABM-1819-014)	The overall objective of this audit was to give assurance that the Health Board maintains records of all financial transactions and ensures their completeness and integrity, with the aim of providing the basic data from which management accounts, final accounts and statutory returns can be prepared. The financial ledger relies upon data from a number of feeder systems. This audit reviewed the interface with those systems but did not

Review Title	Objective
	include controls within the individual feeder systems.
Welsh Risk Pool Claims (ABM-1819-015)	The overall objective of this audit was to confirm the accuracy of reimbursements sought from the Welsh Risk Pool as required within the WRP Claims Management Standard.
General Data Protection Regulation (GDPR) (ABM-1819-032)	The overall objective of this audit was to review progress made to comply with the requirements of the GPDR. As part of the work, we considered how Units/Directorates had been engaged and reflected in the progress reported.

5.3 Reasonable Assurance

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Risk Management & Assurance (ABM-1819-003)	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.
Corporate Legislative Compliance – Wellbeing of Future Generations (Wales) Act (ABM-1819-004)	The overall objective of this audit was to review progress made to implement the requirements of the Wellbeing of Future Generations (Wales) Act. Whilst it was recognised that the Health Board is a member of the statutory public service boards (PSBs), assurance in respect of PSB

Review Title	Objective
	achievements was not included within the scope of this review. The audit considered the Health Board responsibilities as a "public body" described in the Act.
ARCH Programme Governance (ABM-1819-007)	Recognising the *Quality Assurance and Programme Design Review* undertaken by Deloitte (September/October 2016), and the subsequent *Gateway Review*, assurance was sought that appropriate actions have been taken, or were effectively programmed, to implement the recommendations arising from the reviews. In recognition of the primacy given by the Programme Board to the Welsh Government OGC Gateway Review recommendations over those raised earlier by Deloitte, this audit scope focused on the follow up of action taken in response to the Gateway recommendations.
Health & Safety (Follow Up) (ABM-1819-008)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit review of Health and Safety. This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
Payroll (Local Controls): Radiology Overtime (ABM-1819-018)	The overall objective of the audit was to review key financial controls with respect payroll expenditure.
Putting Things Right (ABM-1819-020)	The overall objective of this audit was to review compliance with the relevant standard operating procedures by Service Units and the promptness of actions taken to address concerns highlighted by the Datix Team. This review considered the information and activities of key corporate groups, including the Datix/Snap User Group, in addition to an analysis of available information extracted from

Review Title	Objective
	the DatixWeb system before selecting Service Delivery Units to test.
Pressure Ulcers (Follow up) (ABM-1819-024)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit review of Pressure Ulcers (ABM-1718-023). This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
IT/Cyber Security (ABM-1819-029)	The overall objective of the audit 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 the system's objectives were managed appropriately. The specific purpose of the review was to establish if the mechanisms in place for cyber-security were appropriately designed, and procedures and controls had 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.
Business Continuity & Disaster Recovery (ABM-1819-030)	The overall objective of this audit was to confirm that action had been taken to address issues highlighted in the Wales Audit Office reviews of business continuity arrangements. The scope of this audit was limited to a review of management action to address the issues raised in the Wales Audit Office Communications Technology audit report issued in November 2016 and the entries in the corporate risk register.

Review Title	Objective
Health Records Management (Physical Notes) (ABM-1819-031)	The overall objective of this audit was to review the arrangements in place for the management of paper health records within the Health Board. This audit arose from the corporate risk register entry with respect to the management of paper health records on acute hospital sites, which indicated that current controls in place included temporary retention & destruction plans; alternative storage arrangements; and ward protocols and audits rolled out across all sites. The register also indicated the pursuit of funding for radio-frequency identification technology to allow the organisation to accurately track health records and reduce the number of physical records in circulation. Accordingly, the audit considered arrangements in place at Singleton, Morriston, Neath Port Talbot and Princess of Wales hospitals.
IT Application: Estates *Planet* System (ABM-1819-033)	The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the Estates MRI Planet system, in order to provide assurance to the organisation's Audit Committee that risks material to the achievement of system's objectives are managed appropriately. The specific purpose of the review was to provide assurance that data held within the Estates MRI Planet system is accurate, secure from unauthorised access and loss, and that the system is used fully.
GP Managed Practice (ABM-1819-035)	The overall objective of this audit was to review the arrangements in place for the direct management of the Cymmer GP Health Centre. The scope focused on arrangements in place to ensure improvements have been made following the June 2017 HIW inspection at Cymmer Health Centre. The audit reviewed monitoring arrangements in place within the Unit firstly. Following this, we reviewed evidence in support of progress

Review Title	Objective
	reported, undertaking desktop review of key documentation and a sample of changes made at the practice.
Morriston Hospital Service Delivery Unit (ABM-1819-037)	The objective of this review was to confirm the Unit governance structures follow the principles set out in the Health Board's current system of assurance, and support the management of key risks and the achievement of the Unit's objectives. The approach taken was a desktop review of the terms of reference, work plans/programmes, agendas, minutes & action logs relating to key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.
Strategy & Planning Directorate (ABM-1819-038)	The overall objective of this audit was to review the governance arrangements in place within the Directorate. Consideration was also given to the review of policies and procedures in place, but it was determined that noting the disparate functions within the Directorate, imminent changes to the Director of Strategy portfolio and organisational structure, that we would not review current procedures in place.
Medical Staff Revalidation (ABM-1819-039)	The objective of the 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.
Contractual Band Changes (ABM-1819-040)	The objective of this review was to ensure a robust framework was in place for contractual changes affecting pay banding.

Review Title	Objective
Junior Doctor Bandings (follow up) (ABM-1819-042)	The overall objective of this audit was to establish progress made by management to implement action agreed, and if those actions had been superseded to consider what controls were in place to address key issues identified during the 2015/16 review of the management of junior doctor rotas.
Statutory and Mandatory Training (Follow Up) (ABM-1819-044)	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 was limited to the follow-up of action taken in response to issues raised in the last report.
Princess of Wales Service Delivery Unit (follow up) (ABM-1819-048)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the previous audit. This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
Equipment Replacement (SSU-ABM-1718-06)	The objective of the audit was to evaluate the systems and controls in place within the University Health Board to manage the capital equipment replacement programme.
Follow Up Reviews (Estates Assurance) *c/fwd 17/18 & 18/19* (SSU-ABM-1718-10) (ABM-1819-S08)	These reviews encompassed an evaluation of the management action taken by the University Health Board to address previously agreed recommendations identified by Audit arising from previous estates assurance reports.

Review Title	Objective
Follow Up Reviews (Capital) *c/fwd 17/18 and 18/19* (SSU-ABM-1718-01) (ABM-1819-S01)	The overall objective of these audits was to establish progress made by management to implement actions agreed to address key issues identified at previous capital project and capital systems reviews.
Follow Up Digital Strategy (ABM-1819-S13)	The overall objective of these audits was to establish progress made by management to implement actions agreed to address key issues identified at previous IM&T project/programme reviews.

5.4 Limited Assurance

In the following review areas 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.

Review Title	Objective
Board Assurance Framework (ABM-1819-006)	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. In considering development to date, we also considered the progress and content within the Unit level assurance framework piloted in PCCS Unit.

Review Title	Objective
Fire Safety (Follow up) (ABM-1819-009)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit reviews of Regulatory Compliance: Fire Safety (ABM-1718-109). This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
Annual Plan: Delivery Framework (ABM-1819-010)	The overall objective of this audit was to review the framework in place to monitor delivery of the improvement priorities set out in the Health Board's Annual Plan.
Vaccination & Immunisation (ABM-1819-012)	The overall objective of this audit was to review the arrangements in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.
Charitable Funds: Part I *(Wards)* (ABM-1819-016a)	The overall objective of this part of the review was to ensure that charitable donations were being identified and properly safeguarded, recorded and accounted for, in accordance with the requirements of the donors, relevant legislation, and the Charity Commission.
Charitable Funds: Part II *(Central Systems & Expenditure)* (ABM-1819-016b)	The overall objective of the review was to ensure that charitable donations were being identified, recorded and accounted for, in accordance with the requirements of the donors, relevant legislation, and the Charity Commission. In addition, the review sought to ensure that access to funds has been made in compliance with the requirements of Health Board's SFIs and Financial Control Procedures.

Review Title	Objective
Charitable Funds: Golau Governance (Follow up) (ABM-1819-017)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the last audit. Audit work considered information presented to the Charitable Funds Committee to support review of progress against the original audit actions and schedule of actions within the Golau Business Plan 2017/18.
Clinical Audit & Assurance (ABM-1819-022)	The overall objective of this audit was to review the management of clinical audit, including how it is used by Committees of the Health Board to demonstrate improvement and support assurance. In undertaking this audit, we also considered the relevant requirements of the current policy and compliance with it corporately and at Unit level. However, we were aware that the corporate structures in place for the governance of clinical audit were currently undergoing change. We reviewed the revisions made to the design of clinical audit arrangements during the audit fieldwork and considered this within our final assurance opinion, but the effectiveness of those arrangements was excluded.
Mortality Reviews (Follow up) (ABM-1819-025)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the internal audit report issued in February 2017 (Reference ABM-1617-020) (noting that this was a follow up to an audit report issued in 2014). This was a follow up audit and as such the audit scope focused on progress against the high and medium priority actions contained in the previous internal audit report only.

Review Title	Objective
Protection of Vulnerable Adults: Deprivation of Liberty Safeguards (Follow up) (ABM-1819-026)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the previous audit. This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
Nursing Quality Assurance: Matron Checks (ABM-1819-027)	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 was supplemented by unannounced substantive testing of those checks in a small number of areas sampled at two hospital sites.
Data Quality: Delayed Follow ups (ABM-1819-028)	The overall objective of this audit was to review action taken to reduce outpatient follow up delays and to improve the quality of information reported to the Board and Welsh Government. The scope of the audit was restricted to a review of evidence demonstrating progress against WAO recommendations identified in the Follow-up Outpatient Appointments: Update on Progress ABMU Health Board report, with particular consideration to how this was managed and monitored via the Outpatient Improvement Group.

Review Title	Objective
Princess of Wales Service Delivery Unit (ABM-1819-036) *See also the subsequent follow up review of this subject.*	The objective of this review was to confirm the Unit governance structures follow the principles set out in the Health Board's current system of assurance, and support the management of key risks and the achievement of the Unit's objectives. The approach taken was a desktop review of the terms of reference, work plans/programmes, agendas, minutes & action logs documented of key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.
Staff Performance Management & Appraisals (Follow up) (ABM-1819-043)	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 the effectiveness of arrangements in place to ensure staff performance management and appraisals. The audit was limited to a review of evidence in place to address the issues raised in the last report and support the implementation of the actions agreed previously.
Medical Locum Cover (Follow up) (ABM-1819-046)	The overall objective of this audit was confirm progress made by management to implement actions agreed following the last review of this area. Noting that improvements to the authorisation of extended hours beyond original shifts booked were reliant upon electronic systems for effective implementation, we agreed to exclude previous audit recommendation R6 from the scope of this review. Follow up of that action was agreed to be considered as part of future audit planning. The scope of this audit was limited to a review of progress made in respect of previous recommendations R1-R5 (details provided within the follow up table within the full report).

Review Title	Objective
Third Sector Commissioning (Follow up) **(**ABM-1819-047)	The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified during the 2017/18 review of the effectiveness of the system of internal control in place to manage the risks associated with third sector commissioning. The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.
Estates Assurance: Control of Substances Hazardous to Health (COSHH) (ABM-1819-S12)	This audit considered (from an Estates perspective), the adequacy of the COSHH 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). This audit did not consider 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 was appropriately assured.
Estates Assurance: Safe Water Management (ABM-1819-S09)	The overall objective of this audit was to evaluate the associated processes and procedures that support safe water management across the estate. The audit assessed compliance with relevant legislation and guidance to manage and minimise the risks to health including clinical risks, microbial and chemical contamination and changes to the water system. There was also emphasis on related staff competencies and implementation of water hygiene awareness training.

Review Title	Objective
Systems (Risk Management / Declarations of Interest) (ABM-1819-S07)	The overall objective of this audit was to affirm that there were effective systems operating to manage delivery of the discretionary capital programme. The focus of this review (as requested by management), was targeted on: • Declarations of interest arrangements operating within key directorates; • Risk identification and management arrangements within the capital and estates function; and • The management of contractor final accounts.
Environmental/ Infrastructure Modernisation Programme (ABM-1819-S05) *DRAFT*	This programme/project audit sought to provide the University Health Board with assurance that systems and controls were adequate for the management of the estimated £60m/10-year programme and associated project. Particular emphasis was given to Programme/Project Delivery. Assurance was also sought that arrangements for post project evaluations were appropriately applied ensuring lessons were learnt for future planned infrastructure projects and that identified benefits from the delivered schemes had been achieved.

5.5 No Assurance

There are no audited areas in which the Board has **no assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively, or where action remains to be taken to address the whole control framework with high impact on residual risk exposure until resolved.

5.6 Assurance Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Review Title	Objective
Performance Management & Reporting (ABM-1819-011)	The overall objective of this audit was to confirm the continuing quarterly submission of Unit updates to support Executive monitoring of Unit actions to address performance. It also sought to identify and compare the effectiveness with which actions have been monitored within Unit Boards, or their nominated groups. Additionally, by review of publicly available papers of other NHS bodies within and outside Wales, we have benchmarked the performance management framework documents adopted elsewhere to identify possible good practice elements and examples for consideration by the Health Board when drafting its own.
Annual Quality Statement (ABM-1819-019)	The overall objective of this assignment was to assist the Health Board with accuracy checking and triangulation of data and evidence before publication of the AQS. The scope was limited to verifying that the 2017/18 AQS was consistent with information already published and/or reported to the Board and its committees over the period. It did not audit the internal controls over data quality within the underlying information systems generating the data reported. During the audit, consideration was given to compliance of AQS contents with extant Welsh Government requirements and the potential impact any gaps in information may have on the representativeness of the AQS with respect to the quality of Health Board services. These were highlighted during fieldwork for management consideration and action if appropriate.
Nurse Rostering (ABM-1819-41)	The overall objective of this audit was to review progress made by management (through the involvement of the Sustainability and Recovery

Review Title	Objective
	Board) to implement action to address key issues identified during the previous audit. The scope of the audit was limited to a follow-up of issues & action taken to address issues identified in the last report (ref ABM-1516-013). Noting that improvement to rostering arrangements were being taken forward via the ongoing rollout of *HealthRoster* and that this was ongoing within the Health Board, our work reviewed the activities of the Recovery & Sustainability Programme (RSPB) and its Workforce Delivery work stream to ensure effective rostering across the whole of the Health Board.
Sickness Absence Management (Follow up) (ABM 1819-045)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during previous audits. This was a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.
Environmental Sustainability Report (ABM-1819-S10)	The overall objective of the review was to assess the adequacy of management arrangements for the production of the sustainability report within the Annual Report; whether the form and content of the statement complied with the Welsh Government requirements, and whether the information published within the report provided an accurate and representative picture of the quality of services it provided and the improvements it has committed to undertake.
Carbon Reduction Commitment (ABM-1819-S11)	This review sought to provide the Health Board with assurance that operational procedures were compliant with the CRC Scheme guidelines, including mandatory and best practice elements.

5.7 Deferred Audits

Additionally, the following audits were deferred for reasons outlined below. The reason for deferment is outlined for each audit together with any impact on the Head of Internal Audit Opinion.

Review Title	Objective
Patient Reported Outcome Measures	A review of *Patient Reported Outcome Measures (PROMs)* was included in the 2018-19 Audit Plan, the scope of which was to review arrangements in place to implement PROMs across all service areas and their use to monitor the quality of services. Following discussion with the new Executive Medical Director, and his subsequent review of the Health Board's current PROMS arrangements, he requested deferral of the audit in recognition that: • Local Health Board PROMs clinical leads have been stood down as part of recent Welsh Government changes to the National PROMs programme. • The Health Board's erstwhile lead for the Value Programme has stood down from this role in order to take up her new post as Unit Medical Director at the Princess of Wales Hospital in Bridgend. Her replacement as the Value Programme lead has yet to be appointed. • Board prioritisation of the Bridgend Boundary Change and Clinical Services Plan has required the limited resource of staff working on Value/PROMs to be realigned to support these temporarily. He has indicated his intent to refresh and reinvigorate PROMS work in 2019/20 and requested deferral of the audit review to the following year. This request was approved by the Audit Committee in January 2019 and the audit deferred for reconsideration as part of 2020/21 planning.
Discharge Planning (Follow-Up Review)	This audit was originally scoped to follow up actions taken following an external audit review of this subject. It was agreed with the Audit Committee in March 2019 that the audit be deferred to 2019/20 and the scope broadened.

Review Title	Objective
HR & OD Directorate (Follow-Up Review)	In respect of the planned HR&OD Directorate follow up review, we suggested to the Director of Workforce & OD that a straight-forward follow up of the audit undertaken in 2015 might not be of great value now, but that a fresh audit of the function may be more appropriate. She indicated she would be undertaking a fundamental review of her Directorate structure and capacity following completion of the Bridgend transfer and she had has updated the Workforce & OD Committee in that respect. We 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. The Audit Committee approved deferral of this subject for inclusion in the audit plan for 2019/20 in March 2019.
ARCH (SSu element)	Fieldwork in respect of the ARCH Programme was placed on hold with the agreement of management and reported as such to the Audit Committee during the year. Fieldwork in respect of the financial section of the audit is scheduled to recommence during Quarter 1 2019/20.
Capital Projects: Primary and Community Care Infrastructure Projects	To enable the consideration of two Primary and Community Care Infrastructure Projects which were commencing on site in Spring 2019, within the scope of the programmed audit, management requested deferment of the progression of the review until June 2019. It was agreed with the Audit Committee in March 2019 that the audit be deferred to 2019/20.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2018/19 plan.

Paula A. O'Connor M.Sc

Head of Internal Audit - Abertawe Bro Morgannwg University Health Board

Audit and Assurance Services

NHS Wales Shared Services Partnership

May 2019

ATTRIBUTE STANDARDS:	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee.
1100 Independence and objectivity	Appropriate structures and reporting arrangements in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. WAO complete an annual assessment. An EQA was undertaken 2018.
PERFORMANCE STANDARDS:	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the shared services partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee.

	Policies and procedures which guide the Internal Audit activity are codified in an Audit Quality Manual. There is structured liaison with WAO, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
23000 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issued.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN

Assurance domain	Audits Deferred	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Clinical Governance, Quality and Safety	● PROMS ● Discharge Planning		● Annual Quality Statement		● Mortality Reviews – Follow up ● Nursing Quality Assurance ● POVA (DoLS) – Follow up ● Clinical Audit & Assurance	● Pressure Ulcers – Follow up ● Putting Things Right	
Corporate Governance, Risk and Regulatory Compliance					● Fire Safety – Follow up ● Board Assurance Framework	● Corporate Legislative Compliance: WFG Act ● Health & Safety – Follow up ● Risk Management & Assurance ● ARCH: Programme Governance	● Corporate Governance: Code Compliance

Assurance domain	Audits Deferred	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Financial Governance and Management					• Charitable Fund Golau Governance – Follow Up • Charitable Funds: Wards & Central (Parts I & II)	• Payroll (Local Controls): Radiology Overtime	• Budgetary Control & Financial Reporting • Financial Ledger • Welsh Risk Pool Claims
Strategic Planning, Performance Management and Reporting			• Performance Management		• Vaccination & Immunisation • Annual Plan: Delivery Framework • 3rd Sector Commissioning – Follow Up		

Assurance domain	Audits Deferred	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Information Governance and Security					● Outpatient Delayed Follow Ups	● Business Continuity & Disaster Recovery ● Health Records Management (Physical notes) ● IT/Cyber Security ● IT Application: Planet	● General Data Protection Regulations
Operational Service and Functional Management	● HR&OD Follow Up				● Princess of Wales Service Delivery Unit	● Morriston Hospital Service Delivery Unit ● GP Managed Practice ● Strategy & Planning Directorate ● Princess of Wales Service Delivery Unit – Follow up	

Assurance domain	Audits Deferred	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Workforce Management			● Sickness Absence Management – Follow up ● Nurse Rostering – Interim Follow Up		● Staff Performance Management & Appraisal – Follow up ● Medical Locum Cover – Follow Up	● Medical Appraisal for Revalidation ● Statutory & Mandatory Training – Follow up ● Contractual Band Changes ● Junior Doctors – Follow Up	

Assurance domain	Audits Deferred	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Capital and Estates	● ARCH ● Primary and Community Care Infrastructure Projects		● Environmental Sustainability Report ● Carbon Reduction Commitment		● Estates Assurance: Control of Substances Hazardous to Health ● Estates Assurance: Safe Water Management ● Systems (Risk Management/ Declarations of Interest) ● *Environmental / Infrastructure Modernisation Programme*	● Equipment Replacement ● Follow up (Estates Assurance) *c/fwd 17/18* ● Follow up (Capital) *c/fwd 17/18* ● Follow up (Estates Assurance) *18/19* ● Follow up (Capital) *18/19* ● Follow up (Digital Strategy)	

Key:
● = an audit undertaken within the annual Internal Audit plan, or deferred
Italics = Reports not yet finalised but have been issued in draft

Notes:
- The above table excludes the outputs from *Capital & Estates* final account work completed during the year.
- Commentary following audit work on *Governance, Leadership and Accountability* is reported within the Head of Internal Audit Annual Report. Commentary in respect of the draft *Annual Governance Statement* is provided directly to the Director of Corporate Governance. Neither are included in the above.
- The audit of *Charitable Funds: Wards & Central (Parts I & II)* was undertaken and reported in two parts, but with one combined assurance rating reflected above.

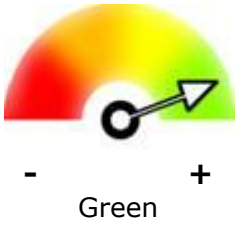
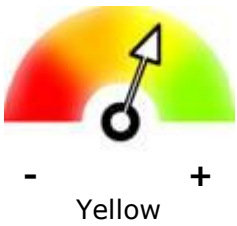
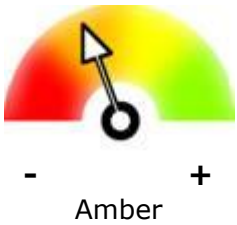
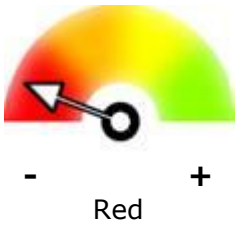
PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status[1]	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2018/19	G	March 2018	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2018/19	G	100%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	72%[2]	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	95%[3]	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

[1] Figures reflect the position recorded as at 3rd May 2019. It includes the 44 assignment reports expected within the first seven domains of the annual audit plan. The *Charitable Funds: Wards & Central (Parts I & II)* audit was conducted and reported in two parts but given one combined rating. The audit commentary on the *AGS* and *Governance, Leadership & Accountability* are not issued via reports, so excluded from the above. Figures also exclude the SSU performance that is reported separately to the NWSSP Audit Committee in aggregate form across organisations.
[2] This percentage is based on the 43 reports finalised at the point of preparing this annual report. Where a draft report has been issued firstly for comment and later for action plan response, it reflects timeliness in respect of response the latter. The performance represents a continued improvement on the 41% reported for 2016/17 and 58% for 2017/18. We are in discussion with management to agree action in response to the last remaining draft report.
[3] As per the KPI above, this percentage is based on the 43 reports finalised at the point of preparing this annual report.

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.

Overall opinion assessment matrix

Supporting criteria for the overall opinion

Criteria	Substantial Assurance	Reasonable Assurance	Limited assurance	No assurance
Audit results consideration				
Overall results				
Assurance domains rated green	≥5 green; and			
Assurance domains rated yellow	≤3 yellow; and	≥5 yellow; and		
Assurance domains rated amber	No amber; and	≤ 3 amber; and	≥5 amber; and	
Assurance domains rated red	No red	No red	≤3 red	≥4 red
Audit scope consideration				
Audit spread domain coverage	All domains must be rated	No more than 1 domain not rated	No more than 2 domains not rated	3 or more domains not rated

Note: The overall opinion (see section 2.4.2) is subject ultimately to professional judgement notwithstanding the criteria above.

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and

detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, Internal Audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Office details: Audit and Assurance Services
Matrix House
Northern Boulevard
Matrix Park
Swansea Enterprise Park
Swansea
SA6 8BX

Contact details: 01792 860590