Meeting Date	**22nd August 2019**	**Agenda Item**	**5.3**
Report Title	**Audit & Assurance Assignment Summary Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Freedom of Information	Open		
Purpose of the Report	To advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports.		
Key Issues	The Audit Committee looks to other Board Committees to monitor the effectiveness of action taken in response to risks and issues raised in internal audit reports. Key audit reports for Quality & Safety Committee consideration are: • Medicines Management • Nurse Staffing Levels • Infection Prevention & Control • WHO checklist • Annual Quality Statement		

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 information or action required in respect of the subjects reported.

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. INTRODUCTION

The purpose of this report is to advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports to support monitoring of action and the provision of assurance to the Board.

2. BACKGROUND: REPORTS ISSUED

Since the last meeting of the Quality & Safety Committee the following audit assignments have been reported:

Subject	Rating[1]
Internal Audit	
Medicines Management	
Nurse Staffing Levels	
Infection Prevention & Control	
WHO Checklist	
Annual Quality Statement	No rating applied

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. A full copy of the report can be made available to 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 Directors for monitoring. The Director of Finance's team 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 Directors.

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

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 Medicines Management (SBU-1920-024)

Board Lead: Executive Medical Director

3.1.1 Introduction, Scope and Objectives

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

The Executive Medical Director is the Board Director with lead responsibility for Medicines Management. The senior management lead is the Clinical Director (Integrated Pharmacy & Medicines Management) (IPMM) who reports administratively via the Neath Port Talbot Delivery Unit to the Chief Operating Officer. The Clinical Director also occupies the separate role of Accountable Officer for Controlled Drugs, as required by the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008.

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

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

- *Health & Care standard 2.6: Medicines management*

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

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

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

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

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

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

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

The audit has reviewed arrangements in place to ensure that the Medicines Management Strategic Board, its supporting Medicines Management Operational Board and sub-groups, were operating effectively in order to

provide assurance on medicines management strategy and objectives within the Health Board.

The audit scope considered the following:

- Roles and responsibilities for Medicine Management Strategic Board, Medicines Management Operational Board and supporting sub-groups are clearly documented
- The boards/groups meet regularly in accordance with their terms of reference
- The boards/groups are well-attended and quorate
- The meetings of the boards/groups are adequately documented and in accordance with the requirements of their terms of reference.
- The information the boards/groups require in order to deliver their objectives are established comprehensively within the meeting business cycles / work programmes and arrangements are in place to ensure that the information is provided as required
- Arrangements are in place to ensure that the additional information needs of the Boards and the sub-groups and actions agreed are addressed in a timely way (*Action logs)*
- The groups report to their parent group/board on key matters in a timely way.

3.1.2 Overall Opinion

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

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

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

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

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

3.2 Nurse Staffing Levels (SBU-1920-041)

Board Lead: Director of Nursing & Patient Experience

3.2.1 Introduction, Scope and Objectives

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

The Nurse Staffing Levels (Wales) Act 2016 (the 'Act') commenced in Wales in March 2017. Sections of the Act which came into force in April 2018 introduced a duty for Local Health Boards and NHS Trusts in Wales to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level.

The nurse staffing level is the number of nurses (registered nurses and others to whom the registered nurses delegate care tasks) appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The duty to calculate nurse staffing levels currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards (as defined within the statutory guidance) with all Health Boards and Trusts required to make arrangements to inform patients of the calculated nurse staffing level.

The overall objective of this audit was to review arrangements in place to ensure that the Health Board has appropriate processes in place to ensure that it is complying with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

The audit scope considered whether:

- The Health Board has agreed an appropriate operating framework and procedures and these are made accessible to all relevant staff;
- Nurse staffing levels are calculated, using the prescribed methodology, for all adult acute medical and surgical inpatient wards (as defined within the statutory guidance of the Act) and these levels are reviewed at least every six months, in accordance with the requirements of the Act;
- The Health Board has identified an appropriate Designated Person to calculate the nurse staffing levels, and this person formally presents the nurse staffing levels for every adult medical and surgical inpatient ward (as required by the Act) at least annually to the Board;
- Effective processes are in place to ensure that patients are informed of the nurse staffing levels, in accordance with the requirement of the Act;
- Arrangements are in place to monitor compliance and steps taken to enable wards to maintain nurse staffing at the calculated levels;
- Effective arrangements are in place for reporting to the Board on the extent to which levels have been maintained, the impact of any shortfall and action taken.

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.

Audit recognised that key decisions with respect to levels calculated for 2018/19 and options with respect to meeting them and funding implications were discussed and supported by the Board in June 2018.

The review identified two key findings for consideration as part of current and future calculation and reporting cycles:

- Whilst we were provided with an example of template documentation returned to Unit Nurse Directors in September 2018 setting out their calculated levels for 2018/19 following corporate scrutiny, and the Corporate Matron's covering email indicated that they were digitally signed by the former Director of Nursing & Patient Experience, the signature was just her name typed into a spreadsheet. There was no robust record of her approval of the ward levels calculated.
- The 2018/19 end-of-year report followed a format used across Wales, though the format allows flexibility in the narrative description and data individual bodies may choose to include. Within the content it did not present any data on the extent to which the calculated levels were achieved during the year. Discussion with the corporate nursing team indicates that reporting this information is a complex matter and subject to All Wales work. (A review of reports of four other organisations in Wales indicated only one that had provided any data in this respect.) This has been highlighted as a key area for improvement in future reporting cycles.

The majority of the actions have been agreed with the Director of Nursing & Patient Experience to address issues raised by the end of November 2019, with action relating to the next annual report due by the end of June 2020.

3.3 Infection Prevention & Control (SBU-1920-019)

Board Lead: Director of Nursing & Patient Experience

3.3.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

In the 2017/18 Annual Quality Statement, one of the quality priorities going forward for the Health Board was to reduce harm arising from all forms of Health Board attributable healthcare associated infections, specifically Clostridium Difficile infection (C.Diff) and Staphylococcus Aureus bacteraemia and Eschericia Coli (E.Coli) bacteraemia.

The overall objective of this audit was to review compliance with the Welsh Government guidance and Health Board policies & procedures.

The objective of the review is to assess across a sample of the 10 elements of the Standard Infection Control Precautions arrangements in place to ensure they are being followed: Patient Placement, Hand Hygiene, Respiratory Hygiene and cough etiquette, Personal Protective Equipment, Safe management of linen, Management of Blood and Bodily fluids, Safe Disposal of Waste and Occupational Exposure Management.

The audit scope considered the following:

- The Health Board has an infection prevention and control policy in place, which provides clear guidance for the staff to apply. The policy is also available to staff and is subject to regular review;
- The Health Board has a comprehensive strategy in place to ensure there is strategic focus and innovation going forward;
- The role of the Infection Prevention Control Committee is clearly defined and is fulfilling the requirements of its terms of reference;
- Management responsibilities and arrangements are appropriately defined and adequate governance and reporting arrangements demonstrated;
- Appropriate controls are in place to ensure that risk areas appropriate and effectively managed;
- All incidents of reportable Health Care Acquired Infections are carried out whereby incidents are examined and analysed to identify any recurring themes across the Health Board;
- The Board via the Quality & Safety Committee are kept informed of all issues arising.

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.

The following key findings were identified:

- There is a significant shortfall in data on the incidence of infections recorded in Datix when compared with ICNet.
- Also long delays were noted in the closure of investigations into infection incidents recorded on Datix.
- These impact upon the ability of the Health Board to apply effective scrutiny.

Action has been agreed with the Director of Nursing & Patient Experience to address issues raised by the end of November 2019.

3.4 WHO Checklist (SBU-1920-021)

Board Lead: Executive Medical Director

3.4.1 Introduction, Scope and Objectives

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

The World Health Organisation (WHO) Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery.

The overall objective of this audit was to review whether the Health Board has arrangements in place to demonstrate compliance with completion of the WHO checklist.

The audit scope considered the following:

- Documented procedures are available and have been communicated to staff indicating roles & responsibilities and processes for completing the WHO checklist;
- Completed checklists have been signed off by staff in accordance with roles specified in procedures;
- Management monitor & audit the completeness and effectiveness of WHO checklist completion and take action to improve use where necessary;
- Where theatres never events are identified, investigations record a review of WHO Checklist usage and where failings are identified management ensure that action is taken to address them and spread the learning widely.

The audit has considered controls operating corporately and within the Morriston, Singleton and NPT acute units of the new Swansea Bay University Health Board. Whilst this is the case, the data analysed related to the last financial Quarter of the former Abertawe Bro Morgannwg UHB and includes procedures recorded against the Princess of Wales Hospital.

3.4.2 Overall Opinion

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks is **Limited** Assurance.

Whilst we have reported limited assurance overall, we noted a high level of completion of the checklist within the theatres system (TOMS), though analysis of the data has highlighted some areas where further management review has been recommended.

Additionally, we noted that the need for improvement following the investigation of never events and feedback from HIW inspection, has been recognised by management and units have been engaged in the review of operating standards and discussion of improvements required at the Theatres Board. Copies of local standards developed were shared and we were informed that they were in the process of finalisation during the audit period.

The following key areas have been identified for attention:

- New standards are not consistent or clear on observational audit expectations and the reporting arrangements. One unit had not performed any observational audits; the other two provided examples but they had adopted different approaches to recording the audits which could make the provision of consistent assurance corporately more difficult.
- At the time of audit, unit and corporate governance groups were not reviewing WHO checklist data analyses or observational audit findings in relation to compliance with the expected approach to the use of the checklist and record-keeping requirements.

Action has been agreed with the Executive Medical Director to address issues raised by November 2019.

3.5 Annual Quality Statement (SBU-1920-017)

No Rating Assigned

Board Lead: Director of Nursing & Patient Experience

3.5.1 Introduction & Background

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

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

3.5.2 Scope & Objectives

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

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

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

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

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

3.5.3 Audit Approach

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

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

As part of this timeline, Internal Audit was to be provided with a copy of the Draft AQS on 7th May 2019. At the request of management in response to

software issues, we delayed the review by two days, but mitigated this by providing some early feedback following review of a preliminary draft of the AQS that had been shared in advance. In addition to this, auditors attended a meeting of the Editorial Board and were provided with papers for others.

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

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

Finally, whilst it was not a core objective of the audit to proof read the document text, comments have been shared with management to address some typographic, spelling and punctuation errors and to enhance clarity, where opportunities were evident in the draft provided.

3.5.4 Key Findings: AQS Content

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

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

- Improve consistency in the use of reporting periods for performance information. Recognising the challenge presented by the earlier publication deadline this year, the WHC gave direction on the presentation of performance data where a full financial year's data was not yet available. There were some inconsistencies in how this had been applied; and in some cases there was more up to date information available which would enable a more positive picture to be presented appropriately e.g. infection control, never events.
- Enhance staffing information, including greater balance on NHS staff survey outcomes.
- Improve clarity in respect of outcomes of two of the 2018/19 year's quality priorities presented in the *Looking Back* section of the draft AQS.

- Look to address differences between draft AQS data and figures previously reported within the public domain for some subject areas: friends & family, formal complaints, pressure ulcers, cancer performance targets.
- Add information to the *Timely Care* section to reflect targeted intervention performance: Stroke, Referral to Treatment, Accident & Emergency waiting times.
- The *Dignified Care* section was based almost entirely upon patient stories, without an evaluation of how the Health Board has performed overall. Look to enhance the section to reflect a wider assessment of performance.
- Review and develop the *Looking Forward* section to improve clarity and alignment with the Health Board's top priorities for the year ahead.

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

At the Audit Committee on 16/05/2019 members received the draft AQS and made some additional observations. The Director of Nursing & Patient Experience undertook to provide assurance that comments will have been addressed when the revised statement is presented to the Board for approval at the end of May.

3.5.5 Key Findings: AQS Process

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

<u>Good Practice</u>

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

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

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

Suggested Areas for Improvement

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

One of last year's agreed recommendations was to identify in advance, information already submitted to committees of the Board as possible sources of information for the AQS for 2018/19, rather than rely upon many individuals. The January Editorial Board meeting considered recommendations following the last internal audit review and agreed action for this year. Whilst this is the case, we have noted that data has continued to be provided by individuals for some of the reported measures and some figures in the draft AQS differed from those reported to Committees/Board. Opportunities exist to improve consistency of information and the efficiency of AQS production by using Board and Committee information already within the public domain.

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

3.5.6 Conclusions & Recommendations

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

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

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

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

a) We would recommend starting with a new template. Whilst retaining the high-level Health & Care Standard-led structure for the AQS as laid down

in the WHC directions, think afresh what core content the new Health Board wishes to include.

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

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

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

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

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

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

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

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

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

4. RECOMMENDATION

4.1 The Committee is asked to note:

- **The internal audit findings and conclusions**
- **The exposure to risk pending completion of agreed management actions**

4.2 The Committee is asked to consider:

- **Any further information or action required in respect of the subjects reported, to support monitoring and assurance.**

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.