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|---|---|---|---|
| **Meeting Date** | **6th December 2018** | **Agenda Item** | **5a** |
| **Report Title** | **Audit & Assurance Assignment Summary Report** | | |
| **Report Author** | Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A<br>Huw Richards, Deputy Director, NWSSP A&A (SSu) | | |
| **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.<br><br>This paper presents the *Audit Assignment Summary Report* received at the last Audit Committee meeting in November 2018 to support this monitoring role and the provision of assurance to the Board. Copies of full reports can be provided at the request of the Quality & Safety Committee.<br><br>Key reports for Quality & Safety Committee consideration are:<br>• Mortality Reviews (Follow Up)<br>• Delayed Follow Ups<br>• Morriston Unit Governance | | |
| **Specific Action Required** ***(please ✓one only)*** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | ✓ | |
| **Recommendations** | Members are asked to:<br>• Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management.<br>• Consider any further information or action required in respect of the subjects reported. | | |

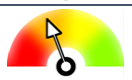
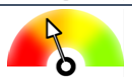
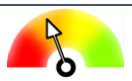
**AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT**

## 1. INTRODUCTION

The purpose of this report is to present the Committee with the last *Audit Assignment Summary Report* received by the Audit Committee to support monitoring of action and the provision of assurance to the Board.

## 2. BACKGROUND: REPORTS ISSUED

At the last meeting of the Audit Committee the following audit assignments were reported:

| Subject | Rating[1] |
|---|---|
| **Internal Audit** | |
| Golau Governance (Follow up) (ABM-1819-017) |  |
| Mortality Reviews (Follow up) (ABM-1819-025) |  |
| Delayed Follow Ups (ABM-1819-028) |  |
| Business Continuity and Disaster Recovery (ABM-1819-030) |  |
| Morriston Unit Governance (ABM-1819-037) |  |
| Strategy and Planning Directorate Governance (ABM-1819-038) |  |
| Sickness and Absence Management (Follow up) (ABM-1819-045) | **No rating assigned** |
| Third Sector Commissioning (Follow up) (ABM-1819-047) |  |

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

Audit report findings and conclusions are summarised below in Section 3. Full copies of the reports can be made available to 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 Associate Director of Finance /

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

Head of Accounting analyse and summarise 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.

## 3. INTERNAL AUDIT FINAL REPORT SUMMARY

### 3.1 GOLAU GOVERNANCE REVIEW (FOLLOW UP) (ABM-1819-017)

Board Lead: Director of Finance

#### 3.1.1 Introduction, Scope and Objectives

An audit review in 2017/18, requested by the Charitable Funds Committee, identified major concerns with the way that Golau Charitable funds were operating. In addition, the audit highlighted the absence of a Health Board wide strategy. As a result, *limited* assurance was reported.

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.

The outcome of this review may contribute to the organisation's assessment of its achievements in respect of the Governance, Leadership and Accountability standard of the Health and Care Standards (2015).

#### 3.1.2. Overall Opinion

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

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

The minutes of the Charitable Funds Committee for March and June 2018 evidence an increase in scrutiny with regard to progress made by the Service Unit to action Internal Audit recommendations from the 5th

February 2018 reported review. Although some progress has been made there are a number of key areas that are yet to be finalised.

Since the issue of the previous Internal Audit report, there is now a Golau Fundraising Manager in post. The Fundraising Manager has attended the Charitable Funds Committee to provide updates both at the March and June 2018 meetings.
It is clear from the minutes that the Charitable Funds Committee are concerned with progress made and the Chair and another Member of the Committee will be meeting with the Unit Service Director in September 2018 to discuss this further.

Whilst progress is ongoing the key documentation that will promote sound governance is yet to be finalised.

Internal Audit would note that a number of findings and recommendations in this report are interim assurance measures as the overarching Health Board wide charitable funds strategy is yet to be produced. A comprehensive strategy encompassing all endowment funds both large and small would negate the need for the development of a separate policy and strategy and standardise processes in the management of these funds.

Action has been agreed with the Director of Finance to be completed by the beginning of April 2019.

## 3.2 MORTALITY REVIEWS (FOLLOW UP) (ABM-1819-025)

Board Lead: Interim Executive Medical Director

### 3.2.1 Introduction, Scope and Objectives

This assignment has been undertaken as part of our 2018/19 audit plan agreed by the Audit Committee in March 2018.
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 of an audit report issued in 2014).

This is 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.

### 3.2.2. Overall Opinion

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

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

Whilst some action has been taken against recommendations previously raised, it has not been completed consistently or effectively across all areas.

The following key findings have been identified which require management attention:

- Reporting of performance in respect of Stage 2 reviews was not evident at all Unit quality & safety groups.
- Information on the outcomes of mortality reviews was limited across Unit quality & safety groups.
- Action had been taken to improve performance information in respect of stage 2 review completion presented to the Quality & Safety Committee; however, it is still not clear on the total number of reviews outstanding. Additionally, the new format of reporting has changed for October 2018 and does not include this information. Assurances on performance have been given verbally by Executives at meetings.
- The Annual Clinical Audit report has presented some assurance in respect of the outcomes of mortality reviews completed, but the detail in respect of action taken for those requiring it was limited.

We are aware that the Director of Corporate Governance and Deputy Medical Director have begun a process of review to improve the governance of Clinical Audit and that Mortality Reviews will feature as part of this. We recommend that this include consideration of Unit and corporate roles & responsibilities, expected processes, and the reporting requirements of Units and corporate team in order to ensure effective assurance is provided to the Quality & Safety Committee. We would recommend that agreed arrangements are documented in a policy / procedural documentation as a clear point of reference for all involved.

Action has been agreed with the Interim Executive Medical Director to be completed by the end of December 2018. Actions & timescales may be subject to review by the substantive Executive Medical Director following his start in post.

## 3.3 DELAYED FOLLOW UPS (ABM-1819-028)

Board Lead: Chief Operating Officer

### 3.3.1 Introduction, Scope and Objectives

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

The Outpatient Departments see more patients each year than any other hospital department. A follow-up appointment is an attendance to an outpatient department following an initial or first attendance and make up the largest part of all outpatient activity. The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date is identified as a key delivery measure within the NHS Outcomes Framework 2017-20.

The Wales Audit Office (WAO) undertook a review of follow-up outpatients across all seven Health Boards in Wales in 2015. A subsequent follow up report was published by the WAO in February 2018 noting the progress made in addressing the recommendations raised in the original report. Their work generated recommendations in respect of data quality and performance monitoring, both of which are informed are being processed via the Health Board's Outpatient Improvement Group. This audit has looked at the progress made in relation to the WAO recommendations.

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 is managed and monitored via the Outpatient Improvement Group.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Information Governance and Communication Technology (3.4)* standard of the Health and Care Standards 2015 and the *Delivering Excellent Patient Outcomes, Experiences and Access* corporate objective.

### 3.3.2 Overall Opinion

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

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

Concluding this review, three key findings were identified.

- Whilst we noted the development of Delivery Unit plans for 2018/19, there continues to be an absence of identified clinical risks recorded in these plans.
- There continues to be a lack of an overarching mechanism to

capture and share lessons learned from service changes implemented within specialties and delivery units. Whilst we noted a proposal within the project outline document to mitigate this risk, there continues to be no system in place to share lessons learned.

- The WAO follow-up report issued in February 2018 noted that the POW Hospital Unit outlined the clinical validation that is being undertaken, with no reference to how they planned to identify and prioritise high-risk patients. Following fieldwork, this issue continues to remain in place.

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

## 3.4 BUSINESS CONTINUITY AND DISASTER RECOVERY (ABM-1819-030)

Board Lead: Director of Strategy

### 3.4.1 Introduction, Scope and Objectives

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

Business continuity planning enables an organisation to help ensure that business processes can continue during a time of emergency or disaster, whilst a disaster recovery plan is a documented process or set of procedures to aid the recovery of returning an organisation to a state of normality after the occurrence of a disastrous event.

In November 2016, the Wales Audit Office (WAO) issued a *Communications Technology Audits* report that provided an update on progress against previous communication technology audits including IT Disaster Recovery and Business Continuity.

The overall objective of this audit was to confirm that action have been taken to address issues highlighted in the Wales Audit Office reviews for 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 report *Communications Technology Audits* report issued in November 2016 and also the entries in the corporate risk register.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Information Governance and Communication Technology (3.4)* standard of the Health and Care Standards 2015.

### 3.4.2 Overall Opinion

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

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

Concluding this review, no key findings were identified. However the following have been identified for further action.

- We confirm that a progress report on the development/review of the business continuity plans for cross-cutting services was reported to the EPRR Strategy Group in July 2018, with a further request that each Unit and cross cutting service provide an updated at the September 2018 meeting. However, no deadlines or timescales were evident in progress reports or updates provided to the group.
- Of the four Executive Directors listed as members of the EPRR Strategy Group, only once did an Executive Director attend a meeting in May and July 2018.
- The EPRR Strategy Group terms of reference also notes one of their key responsibilities as "Receiving and approving emergency response plans". However, given the poor attendance of Executive Directors and the lack of a defined quorum in the EPRR Strategy Group terms of reference, we would recommend that the responsibility for the approval of organisation-wide plans and procedures should be allocated to the Executive Team.

Action has been agreed with the Director of Strategy to be completed by the end of November 2018.

## 3.5 MORRISTON HOSPITAL DELIVERY UNIT GOVERNANCE REVIEW (ABM-1819-037)

Board Lead: Chief Operating Officer

### 3.5.1 Introduction, Scope and Objectives

This assignment originates from the agreed 2017/18 internal audit plan.

The Morriston Hospital Delivery Unit was established as a managed unit in October 2015. The Unit's senior leadership team is made up of a Unit Service Director, Unit Nurse Director and Unit Medical Director, with support in maintaining & developing governance arrangements from a Head of Quality & Safety. The framework of unit groups was subject to a high level audit review shortly after its formation, but this is the first audit to consider the operation of some of the key groups within the structure.

Since the original audit there has been a change of person occupying the Unit Medical Director role and revision to group structure (and this audit has been undertaken at a time of transition).

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.

### 3.5.2 Overall Opinion

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

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

The key issues identified during this audit were:

- The Morriston Management Board does not regularly receive the risk register. When a report was included in April 2018 papers it did not include an extract of the register due to the need for cleansing of duplicates and other administrative concerns.
- The Unit risk register at the time of testing held 190 risks which were overdue for review.

While the above are noted, we would highlight that work is currently underway with Service Groups, led by the Unit Medical Director and Unit Nurse Director, to remedy this situation.

In addition to the above, a number of additional observations and recommendations have been made to maintain the documentation of supporting group administration and operation.

Action has been agreed with Morriston Unit Service Director to be completed by the end of December 2018.

## 3.6 STRATEGY AND PLANNING DIRECTORATE GOVERNANCE (ABM-1819-038)

Board Lead: Director of Strategy

### 3.6.1 Introduction, Scope and Objectives

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

The Director of Strategy has a varied portfolio of responsibilities, incorporating:

- Strategic Service Planning & Commissioning
- Partnerships & Engagement
- Business Planning & Performance (including Health & Safety)
- Capital Planning
- Estates
- Facilities Management

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, we have not reviewed current procedures in place.

The outcomes of this review may contribute to the Board's assurances in respect of achievement of the *Governance, Leadership and Accountability* and *Workforce (7.1)* standards of the Health and Care Standards 2015.

### 3.6.2 Overall Opinion

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

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

Concluding this review, one key finding was identified.

- The financial limits for two staff on the Directorate authorised signatory register exceeded the Health Board's Standing Orders Scheme of Delegation limits. Some additional inconsistencies have been highlighted between this register and the limits set within Oracle.

In addition, the following have also been identified for further action.

- Sample testing, we noted one instance when an individual with a financial limit of £120k had approved an invoice for £174k. Six others had approved non purchase order invoices in excess of their limits on the authorised signatory register, but five of these were within the limits ascribed in the electronic Oracle purchasing hierarchy; the email

approving payment for the sixth copied in the approver's manager (who had an appropriate limit).

- The Strategy & Planning Directorate does not have a risk register. No local registers are maintained for the Partnership & Engagement and Business Planning & Performance functions either.
- The objectives received for Estates managers were old (dated 2015/16 and 2016/17).
- Job descriptions were not provided for two posts reviewed: the Head of Strategy & Values and the Strategic Planning Manager.

Action has been agreed with Director of Strategy to be completed by the end of December 2018.

## 3.7 SICKNESS AND ABSENCE MANAGEMENT (FOLLOW UP) (ABM-1819-045)

***No rating assigned***

Board Lead: Director of Workforce and OD

### 3.7.1 Introduction, Scope and Objectives

In accordance with the 2018/19 audit plan agreed with the Audit Committee in March 2018, a follow up review has been undertaken in respect of sickness absence management.

A previous follow up audit reported in October 2017 (ref ABM-1718-103) a *Limited* assurance rating, identifying two high priority issues remaining for management action in respect of project governance supporting Occupational Health service improvements.

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 is a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.

### 3.7.2 Overall Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. The last audit review of this area derived a *limited* assurance rating.

Since that audit there has been continued change amongst the Executive Team, including the appointment of a new Director of Workforce & OD. She commenced in post in April 2018.

We have noted that the previous action assigned to the Senior HR Manager within the Primary Care & Community Services Unit had been

completed. However, the actions relating to the Occupational Health Transformation Project, requiring Executive decision, had not been completed prior to the commencement of the new Director and had not yet been brought to her attention. Immediate action was agreed with the operational management lead and the Director and steps have since been taken to facilitate completion of remaining points.

In view of the above, we have not applied a revised audit rating within this report currently. However, subject to management completion of remaining actions now in hand, it is anticipated that further improvement may be demonstrable in a relatively short time and before the end of the year.

The last audit made three recommendations, of which two were high priority and one medium. Progress can be summarised as follows:

- One has been addressed (1 x medium priority);
- Two have not been addressed (2 x high priority).

Action remains to review the Occupational Health Transformation Project and obtain Executive Sponsor decision in respect of its continuation and content. There are also considerations in respect of the governance arrangements a revised project may require if approved.

Action was agreed with the Director of Workforce and OD to be completed by the end of October 2018.

## 3.8 THIRD SECTOR COMMISSIONING (FOLLOW UP) (ABM-1819-047)

Board Lead: Director of Strategy

### 3.8.1 Introduction, Scope and Objectives

An audit was undertaken previously in June 2017 (ref ABM-1718-013) to review the arrangements adopted for the management of services provided to the Health Board by the third sector. The audit was undertaken following the Board's receipt of a paper on the development of the Health Board's *Strategic Framework for Voluntary Sector* and derived a reasonable assurance rating. At the conclusion of that review, actions were agreed to address issues raised and monitor the Framework's implementation.

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.

### 3.8.2 Overall Opinion

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

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

The overarching key finding was the delay in the development and implementation of the Voluntary Sector Strategic Framework following the paper received by the Board in March 2017. The need to revise timescales was reported to the Board in January 2018, but no detail has been presented in respect of revised timescales. Nothing has been received at the Strategic Planning & Commissioning Group between October 2017 and July 2018. It is appreciated that there are developments within the Health Board that may impact further on progress and senior management capacity. For the moment, the lack of clarity within reporting to Board and Executive Team in respect of revised timescales, or when these will be agreed, reduces the assurance that can be reported at this follow up review. Addressing timescales and clarity in respect of monitoring arrangements would provide greater assurance.

The previous audit made seven recommendations. Concluding testing, we can confirm that one recommendation had been addressed, three were partially addressed and three were not yet addressed.

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

## 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** |  <br>- +<br>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** |  <br>- +<br>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** |  <br>- +<br>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** |  <br>- +<br>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. |