Meeting Date	16th May 2019	Agenda Item	
Report Title	**Audit & Assurance Assignment Summary Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	To advise the Audit Committee of the outcomes of finalised Internal Audits.		
Key Issues	Thirteen reports have been finalised with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised: • *7 Reasonable* • *4 Limited* • *2 No rating applied*		

Specific Action Required *(please ✓ one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	

Recommendations	Members are asked to: • Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management. • Consider any further action required in respect of the subjects reported.

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. PURPOSE

The purpose of this report is to advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.

2. REPORTS ISSUED

Since the last meeting the following audit reports have been finalised:

Subject	Rating[1]
Internal Audit	
Clinical Audit & Assurance (ABM-1819-022)	
Contractual Band Changes (ABM-1819-040)	
Nurse Rostering (Interim Follow Up)(ABM-1819-041)	No Rating Assigned
Junior Doctors Bandings (ABM-1819-042)	
Staff Performance Management & Appraisal (Follow Up)(ABM-1819-043)	
Locum Medical Cover (Interim Follow Up)(ABM-1819-046)	
Princess of Wales Delivery Unit (Follow Up) (ABM-1819-048)	
ARCH: Programme Governance (ABM-1819-007)	
Performance Management & Reporting (ABM-1819-011)	No Rating Assigned
Specialist Services Unit	
Capital Systems: Declarations of Interest & Risk Management (ABM-1819-S07)	
Follow up – Capital (ABM-1819-S01)	
Follow up - Estates Assurance (ABM-1819-S08)	
Follow Up – Digital Strategy (ABM-1819-S13)	

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.

[1] Definitions of assurance ratings are included within Appendix A to this report. Explanations for reports without ratings are set out in the main body of the report.

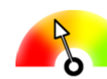
Audit report findings and conclusions are summarised below in Section 3. Full copies of the reports can be made available to Audit Committee members on request.

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

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

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 CLINICAL AUDIT & ASSURANCE (ABM-1819-022)



Board Lead: Executive Medical Director

3.1.1 Introduction, Scope and Objectives

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

The Healthcare Quality Improvement Partnership (HQIP) defines clinical audit as "*a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

An internal audit review of clinical audit arrangements was deferred by the Audit Committee in January 2018, pending revisions to arrangements then in place. A revised policy was approved in February 2018 setting out Health Board expectations regarding the organisation of clinical audit activity. More recently, discussions at the Audit Committee and Quality & Safety Committee have indicated a desire amongst Board members for improvement in the assurances on the quality of care via clinical audit. Additionally, the development of a formal Board Assurance Framework is likely to look to clinical audit as a key source of assurance in the future. Arrangements are currently subject to review by the Executive Medical Director, supported by the Director of Corporate Governance.

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.

The audit scope included a review of the following:

Roles, Responsibilities and Resources

- There is a nominated lead clinician with responsibility for clinical audit across the whole organisation;
- Clinical leads for clinical audit/quality improvement are in place at Unit level with dedicated time for this activity;
- There are resources in place for the management & administration of the audit programme.

Programme Planning

- There is a planned programme of clinical audit, which has been agreed at Board Committee and/or senior management level;
- Clinicians, managers and service users/patients have been consulted/engaged in the development of the programme;
- Arrangements are in place to engage clinicians, managers and service users/patients during the development of the programme, and to ensure health board priorities are considered alongside national requirements;
- Audit proposals are registered, reviewed and approved in accordance with policy to ensure that each has clear improvement aims & objectives and a named lead responsible for delivery.

Programme Delivery

- Progress against the planned programme is reported and monitored effectively by corporate and Unit management;
- Arrangements are in place to ensure that the outcomes of all planned audits are clearly reported, providing assurance or identifying action where improvement is required;
- Arrangements are in place to ensure action is agreed and implemented, and improved outcomes achieved (eg follow up audit).

Board Assurance

- The planned programme and subsequent progress of delivery is reported regularly to the Board and/or appropriate Committee(s);
- The Board and/or nominated Committee are provided with assurance on the outcomes of audits, and/or improvements made in response to them.

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 are 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; the effectiveness of those arrangements was excluded.

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. 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.

At the outset of this review the Interim Deputy Medical Director recognised that the quality of clinical audits was not up to expectation and that from clinical audit work completed the improvements made have been difficult to determine but general medical consensus is the improvement delivery is negligible. Also, the Interim Deputy Medical Director indicates that issues have arisen with some mandated National Audits not being completed properly.

The Interim Deputy Medical Director also raised concerns regarding the effectiveness of clinical audit in improving clinical practice being hampered by the data collection process, a proportion of the National Audits completed having had limited clinician input, and the reduction in the number of audit days in 2018.

The Chair of Audit Committee has also expressed concern with Clinical Audit and the reports and assurances presented at Audit Committee meetings.

Steps are being taken to address these issues. The Organisational Strategy and IMTP have been updated and the Clinical Audit Plan is in the process of being re-written. Additionally the Executive Medical Director is reviewing the end to end process.

There was evidence that the National Clinical Audit Programme was the main focus for Clinical Audit, administered and supported by the Clinical Audit and Effectiveness Team within the Medical Director's Directorate. Local Unit Clinical Audit Programmes were not the key focus of the work of the Clinical Audit and Effectiveness Team although Policy requires the recording of Local Clinical Audit in the Health Board's Clinical Audit Register.

However, there was a variation in approach and process adopted by Units in the production of a Unit Clinical Audit Programme, the approval of plans and the management of the overall Unit programmes. As a result, the assurances arising from this work reported to the Health Board through the Quality & Safety Committee and Audit Committee was limited.

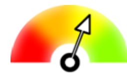
The following have been identified for further action:

- The Units should have a planned programme of clinical audit in place to coordinate audit activity;
- Units should have a Clinical Audit Group (or group whose role includes clinical audit) ensuring outcomes of all planned audits are clearly reported, provide assurance or identify action where improvement is required;

- Audit proposals should be registered, reviewed and approved in accordance with policy.

As noted earlier the Executive Medical Director has begun reviewing processes. He acknowledges that revised arrangements are required for corporate oversight of national audit plans and collation of Delivery Unit responses, with updates being provided to DUs and executives regularly. In addition, Delivery Unit annual audit plans and reporting need to be strengthened. He has agreed that a scoping exercise will be undertaken to establish the resource available to complete and monitor audit work; and this will be used to inform the future model. The target date for this action is September 2019.

3.2 CONTRACTUAL BAND CHANGES (ABM-1819-040)



Board Lead: Director of Workforce & OD

3.2.1 Introduction, Scope and Objectives

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

A review of this area was originally planned for 2015/16 with a scope agreed by the Chief Executive at the time. It has been deferred previously to allow for the implementation of actions from the Internal Audit review of the Human Resources Directorate which reported Limited Assurance (ABM-1516-027). This audit has not repeated the work undertaken by that review, instead it has focused on the processes in place for banding changes for a period of November 2018 – January 2019.

The objective of this review was to ensure a robust framework was in place for contractual changes affecting pay banding.

The audit reviewed arrangements in place to ensure that:

- Clear responsibilities and lines of accountability are established for all matters regarding changes to bands;
- Where changes to job bands have occurred, the changes are supported with up to date job descriptions;
- Job descriptions have been evaluated/matched in accordance with national directions and guidelines;
- Appropriate authorization is evident for all contractual changes;
- Information on band changes has been reported to support an appropriate level of oversight by the Committees of the Board in accordance with their terms of reference. In particular, matters relating to pay and terms of service relating to Very Senior Managers banding has been approved via the Health Board's Remuneration Committee.

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.

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.

There was one key finding identified which relates to the 'Clustering' process as currently used by the Human Resources department. The principle of identifying similar job descriptions to jobs which have previously been matched is sound. We also note that the NHS Job Evaluation Handbook allows for organisations to develop flexible approaches locally where agreed in partnership. However the current process requires the agreement of only one management and one staff-side matcher which does not meet the good practice outlined within the NHS Job Evaluation (JE) Handbook, nor does it present clustering decisions to Consistency Panels which is another NHS JE Handbook direction.

A number of procedure/protocol documents have been written in relation to aspects of the job evaluation processes, including the use of 'clustering'. We would recommend that these are considered by the Director and Staff Side representatives and adopted if agreed.

A small number of other minor weaknesses and possible improvements to the current process and documentation have also been outlined for management consideration.

Action has been agreed with the Director of Workforce & Organisational Development to be completed by the end of May 2019.

3.3 NURSE ROSTERING (INTERIM FOLLOW UP) (ABM-1819-041)

No Rating Assigned

Board Lead: Director of Workforce & OD
Cc Director of Nursing & Patient Experience

3.3.1 Introduction, Scope and Objectives

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

Effective management of nurse rosters is important to ensure the efficient use of organisation's nurse resource. Service Delivery Unit management and staff are expected to comply with Health Board's Nurse Rostering Policy. The importance of effective roster management has increased following the arrival of The Nurse Staffing (Wales) Act.

In 2015/16 an internal audit review of Health Board arrangements derived a *limited* level of assurance. Action was agreed to address the issue raised. Since then, a review of rostering arrangements by staff within the Workforce function identified continued issues in rostering practice. Improvement work was commenced, a decision taken to explore the standardisation of shift patterns and formal project arrangements established to drive improvements in E-rostering as part of the Workforce

Delivery work stream of the Recovery & Sustainability Programme. The purpose of this work is to:

- Implement a digital rostering solution to ensure efficient workforce utilisation to deliver good quality patient care;
- Improve measuring and reporting of rostering efficiency across ABMU (in line with recommendations in Carter Report)
- Support and enable all delivery units to implement standardised shifts to meet the requirements of service.

Completion of this work is not expected until 2019/2020. Implementation is ongoing in stages and the completion of rollout within the first of the service delivery units, Singleton Hospital, has been reported.

The overall objective of this audit was to review progress made by management (through the involvement of the Sustainability and Recovery 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.

3.3.2 Overall Opinion

The original audit provided an assurance opinion in respect of the effectiveness of rostering practice at that time. Noting the continued rollout of new systems, it was agreed that this audit would not seek to provide an equivalent opinion. Instead, audit sought to provide commentary on the arrangements in place to deliver the improvements necessary to support effective rostering when fully implemented, and to highlight issues for attention where appropriate.

Progress of the E-Rostering Project was being monitored effectively. Key issues, risks and their escalation via corporate or unit nursing routes, were recorded by the project manager. A new E-Rostering Steering Group was convened in January 2019 to consider particular issues in order that recommendations could be made to the Director of Nursing & Patient Experience for decision. The Recovery & Sustainability Project Board was kept informed of progress, key issues & risks, and action agreed at its meetings monitored via action logs.

Staff at the wards Audit visited had been trained in the use of the system and records supported training delivered and their understanding at that time. Whilst this was the case, discussion suggested that further training and/or ongoing support may be beneficial, though staff acknowledged that systems were becoming more familiar over time.

It was recognised that the project team capacity to provide this ongoing support whilst supporting further rollout and additional project work was limited. We were aware that steps were being taken to secure additional resource via the system provider to enable the rollout to continue at pace. Consideration should be given to the further training/support needs of staff where the system has been implemented when additional capacity becomes available.

There is more to do to embed the effective use of the system into operational rostering and management monitoring processes, but our review of its functionality indicates that it should support management to address issues highlighted at the last audit. Work to formalise the approach to demonstrating benefits realised by the project was ongoing, and again steps had been taken to engage the system provider to support this. The outcome of this work may go some way to supporting assurance that issues previously identified by internal audit are addressed operationally.

No formal recommendations were raised following this review. However, some observations were made within the report for consideration by management as rollout continues and during review of the policy.

A future internal audit review will assess the operational use of systems, supporting processes and revised policy requirements, in order to provide assurance that issues previously raised have been addressed.

3.4 JUNIOR DOCTOR BANDINGS (FOLLOW UP) (ABM-1819-042)

Board Lead: Director of Workforce & OD
Cc Medical Director

3.4.1 Introduction, Scope and Objectives

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

The New Deal introduced new national contractual arrangements for junior doctors in 1991 with the aim of improving the safety and quality of patient care, as well as the working conditions of junior hospital doctors. Additional Duty Hours were replaced by 'banding supplements', which were determined by the doctor in post completing a banding questionnaire.

The new system was designed to offer the highest rewards to those in the highest intensity posts, working the most unsocial hours, and provide incentives to employers to reduce hours and intensity in line with the New Deal and (European) Working Time Directive (WTD). The new contract requires the employers to monitor junior doctors' hours and breaks.

An audit was undertaken in December 2015 (audit reference 010/2015) to review the arrangements in place within the Service Delivery Unit (SDU)

to ensure junior doctors' rotas were managed to reduce the hours and intensity of work required of junior doctors, and minimise contractual payments due. The audit derived a limited assurance rating. At the conclusion of the review, actions were agreed to address issues raised.

During 2017/18 the Director of Workforce & OD / Medical Director have updated the Workforce & OD Committee regularly regarding the position with junior doctors.

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.

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.

The previous audit made eight recommendations. Out of the seven that were either high or medium priority, we can confirm that:

- 4 had been addressed
- 2 were partially addressed, and
- 1 was not tested at this audit[2].

The monitoring of junior doctor rotas was up to date. Whilst we were informed there was widespread non submission of exception forms required by the Health Board by the participants of monitoring exercises, the impact of this was effectively managed.

There were no key issues which had not been progressed to some extent; however, the development of formal procedural documentation and policies to support the management of junior doctors were drafted but not agreed. We recommended that further consideration be given to this by the Medical Director in conjunction with the Director of Workforce & OD.

Action has been agreed with the Director of Workforce & Organisational Development to be completed by the end of June 2019.

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[2] This referred to the accuracy/completeness of exception forms. This was not tested due to exceptionally low levels of submission.

3.5 STAFF APPRAISAL & PERFORMANCE MANAGEMENT (FOLLOW UP)(ABM-1819-043)

Board Lead: Director of Workforce & OD

3.5.1 Introduction, Scope and Objectives

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

Personal Appraisal Development Review (PADR) forms part of the mandatory management process established within the Health Board. PADR is a means by which managers are able to ensure employees understand their value to the organisation and their team, and give them the opportunity to discuss ways in which they can be more personally fulfilled in their role. It assesses an employee's skill and competence to undertake their role as described in their job description, but also takes into account the way in which their behaviour in their role reflects the values of the Health Board.

An audit was undertaken in June 2017 (audit reference: ABM-1718-041) to ensure that the systems and processes operating within the organisation contribute to the arrangements for staff performance management and appraisal within the Health Board. The audit derived a limited assurance rating. At the conclusion of the review, actions were agreed to address issues raised.

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.

3.5.2 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. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage risks was reported as **Limited** Assurance at the previous audit.

We have not revised this rating following our audit, as whilst progress was evident in some areas, there is more to do to address issues more fully and sustainably. The Director of Workforce & OD has implemented an action plan to monitor PADR compliance, amongst other issues, and is

exploring the possibility of ESR and the Self Service roll out being managed under the Workforce & OD department. This may support improvement in the completeness/timeliness of compliance data reported and the management of performance. Timescales have not been agreed yet for this whilst resource has focused on the Bridgend transitional arrangements.

The following key findings were identified which require management attention:

- The Director of Workforce & OD is exploring the possibility of ESR and the Self Service roll out being managed under the Workforce & OD department. Whilst this has been raised and is being discussed, no target dates or progress monitoring mechanisms have been agreed for the roll out.
- Hotel Services and Estates had varying degrees of discussion at their Board meetings regarding PADR compliance and actions. Neither area had a documented action plan to address issues.

To address issues in Hotel Services & Estates, the senior management leads for those services (Head of Support Services and Assistant Director of Operations (Estates) respectively) have undertaken to work with the Associate Head of Human Resources to produce a 12 month action plan by the end of May 2019. Progress against plan will be monitored at relevant management meetings from July 2019.

With respect to ESR, the Director of Workforce & OD has indicated:

- The responsibility for the system will transfer from the Director of Finance to the Director of Workforce and OD from April 2019.
- In preparation for the development of a full functionality deployment plan the national ESR team have already conducted a site visit (November 2018) to assess preparedness and support the development of a full functionality roll out plan.
- Whilst this is the case, a timetable and roll out plan for the deployment ESR self-service and other un-utilised ESR functionality cannot be developed without the identification and deployment of additional resource to undertake the significant digital transformation programme. SBU is a number of years behind other organisations in Wales in respect of the utilisation of ESR and the resourcing of the ESR team will need to be enhanced to take the required deployment forward. The pace of the deployment of ESR functionality across the Health Board will be dependent on the resource investment agreed to support this programme of work. Until this issue is resolved the timescales for full deployment cannot be agreed. However, capacity issues are subject to discussion at Executive Director level currently and it is intended to provide the Workforce & OD Committee with the vision and route map for use of the system by the end of June 2019.

3.6 MEDICAL LOCUM COVER (FOLLOW UP) (ABM-1819-046)

Board Lead: Executive Medical Director

3.6.1 Introduction, Scope and Objectives

An audit was undertaken in September 2017 (audit reference ABM-1718-106) to ensure that systems were in place to control expenditure arising from the engagement of locum medical cover. The audit derived a limited assurance rating. At the conclusion of the review, actions were agreed to address issues raised.

Internal Audit discussed progress against actions originally agreed with the Assistant Director of Workforce (Delivery Units & Medical Staffing) and Director of Workforce & OD. It was indicated when the original report was agreed that an electronic system might be required to address some of the issues raised effectively. Management confirmed this to be the case for one previous key recommendation (R6) aimed at improving the checks of hours worked against those authorised. Action has commenced to progress procurement of a system but implementation will not complete until 2019/20.

Whilst this is acknowledged we were informed that progress had been made to address the remaining recommendations including those that related to the pre-authorisation of shifts, the certification of timesheets and the use of off-contract cover.

Discussion with the Audit Committee in November 2018 indicated a desire for independent assurance on progress against this subject area. Therefore we agreed with management to undertake an interim, partial follow up review of actions indicated by management as complete, ahead of a future follow up of remaining actions at a later date (to be agreed).

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 are reliant upon electronic systems for effective implementation, we agreed to exclude previous audit recommendation R6 from the scope of this review. Follow up of this action will be considered as part of future audit planning.

The scope of this audit was limited to a review of progress made in respect of recommendations R1-R5.

3.6.2 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.

Whilst this interim, partial follow up review has confirmed action taken in some of the areas highlighted, including the introduction of a formal procedure and standard documentation designed to record the authorisation of agency bookings, the level of non-compliance with that process / weaknesses within record-keeping undermined the audit trail available for review, so we would not be able to report an increased assurance rating at this review.

Of the 5 recommendations made at the last audit:

- 2 were addressed
- 3 were partially addressed

The key issue to be addressed is the widespread non-compliance / poor record-keeping associated with current processes.

Action has been agreed with the Executive Medical Director to be completed by December 2019. In particular, meetings are being scheduled with the Medical Director, Chief Operating Officer and Director of Workforce & OD with Delivery units to explore all elements of locum utilisation which includes the processes associated with bookings. Management anticipate that this will be superseded quickly over coming months once the *Locum on Duty* implementation commences.

3.7 PRINCESS OF WALES SERVICE DELIVERY UNIT (FOLLOW UP)(ABM-1819-048)

Board Lead: Chief Operating Officer
cc Director of Corporate Governance

3.7.1 Introduction, Scope and Objectives

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

The Health Board's Service Delivery Units became operational from October 2015. Whilst this was the case, Princess of Wales Hospital had been managed already as a separate unit from February 2014 under the direction of a previous hospital director. An internal audit review of Princess of Wales Delivery Unit Governance arrangements was undertaken in early 2018/19 and derived a *Limited* level of assurance. Action was agreed to address the issues raised.

This follow up assignment was agreed by the Audit Committee for addition to the 2018/19 internal audit plan. The audit was undertaken with the support of the Unit Service Director and his team in order to complete and report before the end of the financial year, in view of the imminent organisational changes affecting the Unit.

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.

3.7.2 Overall Opinion

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

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

The previous audit made 16 recommendations, of which two were high priority, thirteen medium priority, and one low priority. Concluding testing, we can confirm there are no key findings to report and progress against recommendations was as follows:

- 11 had been addressed,
- 4 were partially addressed, and
- 1 was not addressed.

At the outset of the audit the Service Director informed us that whilst many areas had been addressed some had not been prioritised, in the knowledge that the forthcoming organisational transfer of services to a new Health Board would impact on how they should be addressed. The audit report highlights areas not yet addressed, but does not repeat recommendations. Instead, remaining issues have been highlighted for the consideration of management for action as appropriate under the new organisational arrangements.

There were no further actions required following the review.

3.8 ARCH PROGRAMME GOVERNANCE (ABM-1819-007)

Board Lead: Director of Strategy

3.8.1 Introduction, Scope and Objectives

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

It is anticipated that ARCH will deliver a holistic regional model for health built on the principles of collaboration across Hywel Dda UHB, ABM UHB and Swansea University.

It will include significant investment proposals and the reconfiguration of services between both Singleton and Morriston Hospital sites. Significant investment is anticipated on healthcare capital builds, and other health infrastructure across the entire ARCH region (funded from a number of sources i.e. innovative financing, NHS capital funding and European structural funding).

Initial funding was provided by Welsh Government for the ARCH Programme. The approval letter stated the following under schedule 1:

"The Minister for Health and Social Services has agreed to make available £1.200m of capital funding to Abertawe Bro Morgannwg University Health Board between 2015-16 and 2017-18 for the Establishment of a Regional Collaboration for Health (ARCH) programme.

"The funding will facilitate staff appointments and the provision of external advice including legal, financial and technical support for the development of the Programme Business Case (PBC). The funding is to cover the period up to and including the initial approval of the PBC by the Welsh Government and is provided on the basis that partner organisations ABM and Hywel Dda University Health Boards and Swansea University – will provide at least match funding and will manage the risk of any further funding (over the £1.200m) required for the development of the Programme Business Case. It should be noted that any underspend against the £1.2m funding will be retained by the Welsh Government

"The funding will include costs covering the appraisal period associated with the case."

The ARCH Programme Board submitted the Portfolio Delivery Plan to the University Health Board for approval in January 2017.

The objective of this audit was to review the adequacy of, and operational compliance with, the systems and procedures of the University Health Board, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

One objective of the audit was to evaluate the systems and controls in place within the Health Board and review information made available through partnership arrangements with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.

The scope and objectives of the current review acknowledge and consider the governance and gateway reviews previously undertaken. Accordingly, the scope and remit agreed for this audit review were limited to the following aspects originally:

Internal Audit Coverage	Programme/Project Governance - Recognising the Quality Assurance and Programme Design Review undertaken by Deloitte (September/October 2016), and the subsequent Gateway review, assurance would be obtained that appropriate actions had taken, or were effectively programmed, to implement the recommendations arising from the reviews. A review would be undertaken of the proposed assurance strategy for the programme.
Specialist Service Unit (SSU) Coverage	Funding approvals/ monitoring - Recognising the Welsh Government funding approvals to date, and the associated match funding requirements by partner organisations, obtain assurance that robust internal and external cost control and management arrangements were implemented. Adviser selection, appointment and contractual arrangements – obtain assurance that key adviser appointments e.g. master site planners, Health Care and QS Planners had been made, in accordance with the ABM University Health Board's procedural requirements and associated national guidance. Assurance would also be sought that appropriate contractual arrangements had been applied to protect the interests of the ABM University Health Board and that the defined contractual requirements were being appropriately and effectively managed. Fee monitoring/payments – obtain assurance that adequate processes and procedures were in place to ensure that advisers were correctly reimbursed in accordance with the contract. Obtain assurance that appropriate control mechanisms were applied.

This internal audit report provides assurance on the Programme governance arrangements. In recognition given by the Programme Board to the primacy of the Welsh Government OGC Gateway Review recommendations over those raised earlier by Deloitte, this audit scope has focused on the follow up of action taken in response to the Gateway recommendations. Audit work on funding, advisors, and fees/payments will be reported separately.

3.8.2. Overall Opinion

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

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

During 2018/19 work was undertaken to refresh the ARCH Programme, recalibrating its priorities and strengthening its governance arrangements. This followed a period of change amongst the Programme team and amongst the Executive Team of the ABMU Health Board. The steps taken to enhance the clarity of governance arrangements were evident to Internal Audit over the course of meeting papers reviewed as part of the audit. There was more to develop (eg further work is needed to refresh the scopes of some programmes/projects within the portfolio) and then to embed what has been put in place – but this was largely recognised amongst the Programme Board and Delivery Leadership Group.

The key finding for consideration by the Health Board with its ARCH partners was the development of an independent assurance mechanism for the programme: the agreement of some form of programme audit arrangement, whereby the assurance is provided for the Programme as a whole, rather than individual partners. This was highlighted as part of one of the original Gateway Review recommendations.

In addition to this there were some issues within the terms of reference for the Programme Board for which we recommended clarification was required.

We did not set out recommendations in the standard action plan format for agreement, but presented them for consideration by the Health Board and for agreement with its partners as appropriate.

The Director of Strategy has accepted the report and indicated that the recommendations will be reviewed through the ARCH Portfolio mechanisms and an action plan will be formulated during summer 2019.

3.9 PERFORMANCE MANAGEMENT & REPORTING (ABM-1819-011)

No Rating Assigned

Board Lead: Director of Performance
Cc Director of Strategy

3.9.1 Introduction, Scope and Objectives

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

The 2018/19 year was one in which management processes have continued to develop as the new leadership arrangements and Committees have become operational. Alongside the continued targeted intervention of Welsh Government, the Health Board has been contending with the additional challenge of organisational change to transfer the management of services delivered to the Bridgend population to Cwm Taf Health Board.

The last audit of this area focused on the executive-led quarterly performance review process and the completeness of performance information. The finalisation & agreement of a documented performance management framework (PMF), which had been in development during the year, and the expansion of assurance on performance measures to the Board, were recommended.

We understood that the conduct of executive-led quarterly performance meetings varied during 2018/19 in response to other priorities. However, we were informed that quarterly corporate monitoring of Unit performance management actions continued to be supported via the quarterly submission of action log progress updates. Discussion with the Health Board's Associate Director of Performance indicated that changes had been made to performance reporting arrangements, but the development of a formal PMF was ongoing, alongside the development of an operating framework for the new organisation. The latter had been progressed alongside other performance management improvements as an element of the Health Board's Governance Work Programme, with a view to having it in place for 2019/20.

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 aimed identify and compare the effectiveness with which actions had 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 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.

3.9.2. Overall Opinion

In recognition of ongoing work to develop a performance management framework alongside an operating framework for the new Health Board, we agreed a narrow focus of work for this audit. This concluded by confirming the ongoing operation of systems to monitor key actions arising from quarterly executive performance reviews. Minor recommendations were raised for consideration to improve the effectiveness of this process.

To supplement the above we provided some examples of performance management framework documents, including a template previously developed by the Welsh Government Delivery Unit for another organisation, for consideration by management.

In view of the ongoing work within the Health Board and limited scope of this audit a standard assurance rating and dial were not allocated.

3.10 CAPITAL SYSTEMS: DECLARATIONS OF INTEREST & RISK MANAGEMENT (ABM-1819-S07)

Board Lead: Director of Strategy / Director of Corporate Governance

3.10.1 Introduction, Scope and Objectives

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

Capital systems reviews seek to provide assurance on the systems operating to manage delivery of the University Health Board's discretionary capital programme in accordance with the Welsh Government Capital Resource Limit. The focus of this review (as requested by management), was targeted to two specific areas i.e. declarations of interest and risk management arrangements.

This audit was solely focused on the systems and processes operating within the Capital Planning and Estates functions. As a part of this review, we were also cognisant of the ongoing work being progressed corporately to enhance the current risk management arrangements within the UHB, and recognition of a planned review of the declarations of interest arrangements across the organisation.

The audit scope included a review of the following:

<u>Declarations of Interest</u>

To obtain assurance that:

- an appropriate declarations policy was implemented and consistently applied across all relevant departments, e.g. Estates, Procurement, Finance etc.,
- registers of interest were adequately maintained;
- staff were required to provide annual declarations;
- appropriate arrangements were in place to manage any identified conflicts of interest;
- all gifts and hospitality were declared and reported;
- appropriate arrangements were in place to enable concerns and breaches to be raised; and
- appropriate training was afforded to all staff.

<u>Risk Identification and Management Arrangements</u>

To obtain assurance that:

- estate risk registers were maintained, consolidated centrally, routinely updated and reflect all risk issues, which have been scored on a consistent basis;
- risks were reported to an appropriate forum to ensure bids for discretionary capital were made from a standard level; and

- regular interface and management between the Oakleaf system and risk registers was undertaken to ensure only programmes / schemes included in the risk register were presented for consideration.

3.10.2 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. 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. Noting the same, the following issues were identified:

Declarations of Interest

- Clear procedural guidance was available outlining the UHB's requirements in respect of declarations of interests and gifts and hospitality at the Standards of Business Conduct Policy. The Director of Corporate Governance has identified a number of potential improvements to be considered at the forthcoming review;
- General compliance with the Policy was observed within the Capital Planning and Estates departments, with a small number of recommendations raised re: completeness / retention of records; and
- Whilst this audit did not review arrangements applied across other departments within the UHB, the overall low rate of returns for both declarations of interest and reporting of gifts and hospitality was highlighted.

Risk Management

- We acknowledged the ongoing process of review and revision of the risk management strategies across the UHB and the process of implementing improvements to these arrangements, elements of which were still ongoing at the close of the audit fieldwork;
- Whilst the Datix system had been agreed as the only system for recording of risk within the UHB, Capital Planning and Estates functions were operating separate risk management systems i.e. Oakleaf for estates infrastructure and individual project risk registers for capital investment schemes. At the time of the current review, the Director of Corporate Governance was assessing how these risks were to be integrated into the Datix system, noting the potential volume of high rated areas;
- Issues have been raised at this and other reports in respect of the linkage to unit risk registers and risk reporting arrangements (COSHH, Water Safety and Backlog Maintenance amongst others); and
- Whilst we were advised that the annual ring-fenced discretionary capital allocation for estates / backlog maintenance was prioritised

using a risk based approach, there was insufficient transparency / documentation to support that funding was directed to the highest risk priority areas.

All of the recommendations raised at the report have been agreed by management.

3.11 CAPITAL (FOLLOW UP) (ABM-1819-S01)

Board Lead: Director of Strategy

3.11.1 Introduction, Scope and Objectives

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

The overall objective of this audit was to establish progress made by management to implement action agreed arising from previous capital audit recommendations contained within the following reports:

- Renal Ward Refurbishment (Reasonable Assurance: issued January 2018);
- Capital Equipment (Reasonable Assurance: issued July 2018); and
- Follow Up of Outstanding Capital Recommendations (Reasonable Assurance: issued July 2018) containing the following:
    - Capital Systems;
    - RMHSS Phase 8 Glanrhyd LSU;
    - Clinical Support Accommodation – HVS Phase 1B Scheme 2;
    - Existing Medical School –HVS Phase 1B; and
    - Cardiac Intensive Therapy Unit.

The audit was limited to a review of evidence in place to address the issues raised in the previous report(s) and support the implementation of the previously agreed actions.

3.11.2 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.

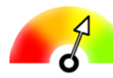
The review sought to obtain evidence to support the action taken by management to address sixteen recommendations arising from the previous audits. Out of the sixteen recommendations, we can confirm that:

- 15 had been closed or superseded, and
- 1 had been partially addressed.

The one remaining (medium priority) issue requiring management closure related to the finalisation of the review of Financial Control Procedures, namely 5 [Financial Planning] and 15 [Capital Investment, Private Financing, Fixed Asset Registers & Security of Assets] – arising from the July 2018 Capital Equipment audit.

The Finance Manager Capital/Assistant Director of Strategy (Capital) anticipate that the review of the UHBs Financial Control Procedures would be complete by the end of June 2019.

3.12 ESTATES ASSURANCE (FOLLOW UP) (ABM-1819-S08)



Board Lead: Chief Operating Officer

3.12.1 Introduction, Scope and Objectives

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

The overall objective of this audit was to establish progress made by management to implement actions agreed arising from the previous estates assurance follow up report [Reasonable Assurance: issued July 2018] containing the following:

- Backlog Maintenance (Limited Assurance: issued October 2017).
- Health & Safety – Primary Care Estates (Reasonable Assurance: issued March 2017).
- Property & Lease Management (Reasonable Assurance: issued January 2017).
- Neath Port Talbot Operational PFI (Reasonable Assurance: issued July 2017).
- Legionella Management (Limited Assurance: issued November 2014).
- Disability Discrimination Capital Follow Up (Reasonable Assurance: issued March 2015).

The audit was limited to a review of evidence in place to address the issues raised in the previous report(s) and support the implementation of the actions agreed previously.

3.12.2 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 review sought to obtain evidence to support the action taken by management to address eighteen recommendations arising from the previous audits. Out of the eighteen recommendations, we can confirm that:

- 4 had been closed or superseded, and
- 14 had been partially addressed.

A summary of the recommendations remaining to be fully addressed is outlined below by priority:

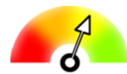
	H	M	L	Total
Backlog Maintenance	1	2	1	**4**
Health & Safety	-	2	-	**2**
Neath Port Talbot Operational PFI	-	7	-	**7**
Disability Discrimination Capital Follow Up	-	1	-	**1**
Total	**1**	**12**	**1**	**14**

The key issues for management are:

- Backlog Maintenance / Health & Safety – additional facet survey work should be performed for the remaining estate to better inform the Estates Strategy; which will also require update to reflect the new Swansea Bay University Health Board (high priority);
- Health & Safety – clarity is required on reporting lines on issues of Health & Safety within the Estate noting changes in designated officers;
- NPT Operational PFI – the Operational Contract Manual for users and management should be completed [incorporating life-cycle maintenance requirements / authorisation processes] and shared accordingly;
- NPT Operational PFI – the service variance request guidance should be further refined to address the involvement of finance in the management / monitoring of the PFI contract; and
- NPT Operational PFI – clarity should be obtained regarding the landlord/ tenant arrangement.

Progress was being made to fully address the previously agreed audit recommendations. Noting the same, updated timescales and responsibilities for their full implementation are agreed by management.

3.13 DIGITAL STRATEGY (FOLLOW UP) (ABM-1819-S13)



Board Lead: Chief Operating Officer

3.13.1 Introduction, Scope and Objectives

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

The overall objective of this audit was to establish progress made by management to implement action agreed arising from previous audit recommendations contained within the Digital Strategy report [Reasonable Assurance] issued in May 2018.

The audit was limited to a review of evidence in place to address the issues raised in the previous report and support the implementation of the actions agreed previously.

3.13.2 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 review sought to obtain evidence to support the action taken by management to address eight recommendations (5 medium priority and three low priority items) arising from the previous audit. Out of the eight recommendations, we can confirm that:

- 2 had been closed or superseded,
- 5 were partially addressed, and
- 1 was outstanding.

The key (medium priority) issues for management are:

- The Transformation Programme should be aligned to the delivery of the three-year IMTP, to be fully supported by a three-year digital delivery plan / road map.
- Digital Transformation should be governed within a Transformation Programme, aligned to the Organisation Strategy for the new Swansea Bay University Health Board.
- The new Swansea Bay University Health Board should collaborate with Workstream leads in 2019/20 to produce a granular assessment of its digital strategy.

The Associate Director of Informatics has agreed implementation dates for all of the remaining audit recommendations (the latest being December 2019).

4. RECOMMENDATION

4.1 The Audit Committee is asked to note the summarised findings and conclusions presented by Audit & Assurance, and the exposure to risk pending completion of action by management.

4.2 The Audit Committee is asked to consider any further action required in respect of subjects reported.

APPENDIX A

AUDIT ASSURANCE RATINGS

RATING	INDICATOR	DEFINITION
Substantial assurance	- + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	- + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	- + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	- + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.