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

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Agenda item: 4a

Abertawe Bro Morgannwg University Health Board

HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT 2017/18

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NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS

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1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

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

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

1.2 Head of Internal Audit Opinion

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

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

In my opinion the Board can take **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 with **moderate impact on residual risk** exposure until resolved.

1.3 Delivery of the Audit Plan

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

Our External Quality Assessment (EQA), conducted by the Chartered Institute of Internal Auditors, and our Quality Assurance and Improvement Programme have both confirmed that our internal audit work 'generally conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2017/18. We are now able to state that our service 'conforms to the IIA's professional standards and to PSIAS'.

1.4 Summary of Audit Assignments

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

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

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

- *Financial Governance and Management;*
- *Strategic planning, performance management and reporting;*
- *Information governance and security;*
- *Operational services and functional management;*
- *Capital and estates management;*

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

- *Corporate governance, risk management and regulatory compliance*
- *Clinical governance quality and safety*
- *Workforce management.*

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

1.5 Organisational Context

During the 2017/18 year ABMU Health Board has remained in targeted intervention status under the NHS Wales Escalation Framework arrangements with focus and support received from the Welsh Government in driving improvement in challenging and difficult times.

In addition, during the year there was significant changes to Board membership and there is almost an entirely new Board in place at the close of 2017/18. At Executive Director level a number of key Executive departures occurred that

were filled on an Interim basis. From September 2017 a number of Non-Officer Member changes occurred as a result of their "term of office" ending, these changes resulted in new Non-Officer Member appointments to Chair(s) positions for most of the key Committees.

Towards the end of 2017/18 the newly appointed Director of Corporate Governance completed a governance stocktake and is now in the process of developing a Board Assurance Framework and also strengthening the risk management processes. The Board has supported this work and are aiming to strengthen governance arrangements early 2018/19 with the ongoing development of an integrated governance work programme.

The audit plan has been delivered with the support of the Board in the context of the challenges that the Health Board has encountered with increased monitoring by Welsh Government and the significant changes at the Board re Executive Director/Interim Executive Director appointments, and new Non-Officer Membership at key Committee(s) of the Board. Finally, in addition to the support of the Board Internal Audit has seen increased support and engagement from management that is demonstrated with a report turnaround time taken for management response improving from 41% in 2016/17 to 58% in 2017/18.

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

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

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

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives.
- The purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

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

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and

limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

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

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

2.2 Purpose of the Head of Internal Audit Opinion

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

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

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

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The assurance rating framework for expressing the overall audit opinion was refined in 2013/14 in consultation with key stakeholders across NHS Wales. In 2016/17, following further discussion with stakeholders, it was amended to remove the weighting given to three of the eight domains when judging the overall opinion. The framework applied in 2016/17 has been used again to guide formulation of the opinion for 2017/18.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions as clarified in 2012/13 has proven effective in giving an

objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

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

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

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

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

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

 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. Some matters require management attention in control design or compliance with **moderate impact on residual risk** exposure until resolved.

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

2.4.2 Basis for Forming the Opinion

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

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

The audit work undertaken during 2017/18 and reported to the Audit Committee has been aggregated at **Appendix B**.

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

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.

- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module; and
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3 – Other Work for details).

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

The Head of Internal Audit has considered residual risk exposure across those assignments where limited or no assurance was reported. Additionally, a number of assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. Where changes were made to the audit plan then the reason was presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes (deferrals) made to the plan when forming the overall opinion.

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

Corporate Governance, Risk Management and Regulatory Compliance

- Reasonable assurance was reported in respect to *Risk Management & Assurance and Primary Care Clusters Governance arrangements.*
- Limited assurance has been reported in respect of the review of *Fire Safety and Health and Safety*.
- Limited assurance has also been reported in respect of *Corporate Legislative Compliance: Well Being of Future Generations Act (Proposed final report issued).*

Strategic Planning, Performance Management & Reporting

- Reasonable assurance was reported for *Third Sector Commissioning/Contracts, Performance Management & Reporting*, and *Annual Planning: Engagement and Integration (currently in draft)*

Financial Governance and Management

- Substantial assurance was reported in respect of *Financial Ledger, Budgetary Control & Financial Reporting and Welsh Risk Pool Claims*.
- Limited assurance was reported in respect of the *Funds Held On Trust: Golau Governance Review*, and *Non-Pay Expenditure: Goods Receipting (currently in draft).*

- *Medical Equipment: Home Maintenance Payments* was a limited scope review and did not require an assurance rating.

Clinical Governance Quality & Safety

- Reasonable assurance has been reported regarding *Primary Care: Core Quality & Delivery Measures* and *Safety Alerts (Follow Up)*
- Limited assurance was reported in respect of *Pressure Ulcers, Medical Equipment & Devices* and *POVA(DoLS)*
- A limited scope review was undertaken of the *Annual Quality Statement* with the aim of ensuring that it was consistent with information published and/or reported to the Board. Based on the outcome of our review and action taken by management to address issues raised, there were no significant issues known to us that caused us to believe that, for the year ended 31st March 2017 the Annual Quality Statement was not consistent with the information presented at the Board during the year.

Information Governance & IT Security

- Substantial Assurance was reported for the *Data Quality Review: Stroke*.
- The follow up reviews of *Information Governance & Information Assurance* and *Data Quality: Mental Health Measure* derived reasonable levels of assurance.
- Limited assurance was derived in respect of *IT Infrastructure Assets (draft report issued)*

Operational Service and Functional Management

- *Singleton Hospital Unit Governance*, *NPT & Clinical Support Services Delivery Unit Governance, Nursing Directorate, Community Dentistry (CDS) and Mental Health Unit Governance Framework* and *Finance Directorate Governance Review (draft report issued)* all reported reasonable assurance.
- *Medical Directorate* received limited assurance; however an in-year follow up review subsequently reported substantial assurance.

Workforce Management

- A limited scope review of the monitoring arrangements for *Workforce Delivery Plan Actions* derived a substantial assurance rating.
- *Staff Performance Management and Appraisal, Statutory & Mandatory Training, Sickness Absence Management (follow up), Medical Locum Cover and EWTD: Portering Services Morriston (draft report issued)* derived limited assurance opinions.

Capital & Estates Management

- Reasonable assurance was reported in respect of NTP – *Operational PFT, Follow up Capital, Follow up Estates, Capital Systems, Informatics Programme, Renal Ward Refurbishment*.

- *Backlog maintenance* review received limited assurance.

2.4.3 Limitations to the Audit Opinion

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

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

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

2.4.4 Period covered by the Opinion

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

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

The majority of audit reviews will relate to the systems and processes in operation during 2017/18 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment. Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide limited scope update on the current condition of control and a measure of direction of travel.

There are also some specific assurance reviews which remain relevant to the reporting of the Annual Report required to be published by 30 June 2018. These specific assurance requirements relate to the following two public disclosure statements:

- Annual Quality Statement; and
- Environmental Sustainability Report.

The specified assurance work on these statements has been aligned with the timeline for production of the Annual Report and accordingly will be completed

and reported to management and the Audit Committee subsequent to this Head of Internal Audit opinion. However, the Head of Internal Audit's assessment of arrangements in these areas is legitimately informed by drawing on the assurance work completed as part of this current year's plan albeit relating to the 2016/17 Annual Report and Quality Statement, together with the preliminary results of any audit work already undertaken in relation to the 2017/18 Annual Report and Quality Statement.

2.5 Required Work

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

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

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

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

2.6 Statement of Conformance

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

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of internal audit is also subject to an annual assessment by the Wales Audit Office. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Internal Auditors (IIA) in February and March 2018. The IIA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles (100% achievement) and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS'.

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

Our conformance statement for 2017/18 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2017/18 which will be reported formally in the Summer of 2018;
- the results of the work completed by Wales Audit Office; and
- the results of the External Quality Assessment undertaken by the IIA.

We have set out in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP are included in the 2017/18 QAIP report. There are no significant matters arising that need to be reported in this document.

2.7 Completion of the Annual Governance Statement

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

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

2.7.1 Health & Care Standards

The Head of Internal Audit and/or the Deputy Head of Internal Audit have observed each meeting of the Health & Care Standards Scrutiny Panel during the year. The Scrutiny Panel non-officer membership changed during the year but the Panel continued to have three Non-Officer Members throughout the year, and was chaired by the Chair of Quality & Safety Committee.

The Executive Team agreed the Health and Care Standards Scrutiny process at the beginning of the year. However, difficulties were encountered in following the process during the 2017/18 period and the Chair of the Scrutiny Panel liaised directly with the Director of Nursing to escalate the Panels concerns.

At the Scrutiny Panel meeting on 9th April 2018 the Chair commented positively on the high level of Executive presence and engagement; Internal Audit observed similarly a high level of discussion and explanations to support the maturity judgements being made. Generally, the Executive Team were considering a level three (Developing) maturity score for the Health Board for the 2017/18 period. The overall maturity level of 3 ("*Developing*") was supported by the Scrutiny Panel members.

At the same meeting the Executive Directors present and the non-office Members of the Scrutiny Panel agreed that the Scrutiny Panel would cease to operate for 2018/19 and performance against the Health and Care Standards would form part of the Performance Management framework.

The Developing maturity judgement was appropriately highlighted in the report for the Board for the governance and accountability self-assessment on 26th April 2018.

During 2017/18 it was evident that the Scrutiny Panel had a number of concerns with the information that was being presented and the limited engagement by the Executive Director Leads. However, it is the Head of Internal Audit's opinion that the Interim Director of Nursing & Patient Experience had ensured that appropriate actions were taken to:

- Ensure the engagement of each of the Service Delivery Units in the self-assessment process using a standard template to promote consistency of approach;
- Use the Standards as a means to identify areas for improvement and actions to address them;
- Support a corporate assessment of overall Health Board achievement against the Standards.

2.7.2 Governance and Accountability Board self-assessment

It is the Head of Internal Audit's opinion that an adequate process was conducted to self-assess the maturity level of ABMU Health Board with respect to governance and accountability.

The Head of Internal Audit attended the Board Development Session on 26th April 2018 to observe Board interactions with the self-assessment. The Director of Corporate Governance presented a paper to the Board that outlined the Board's requirement and positioned the paper with reflection on the key governance related reports that the Board had received during the year. The Director of Corporate Governance also reminded the Board of the findings from the Governance Stocktake that she had recently completed and the Actions that were in progress to develop a Board Assurance Framework and enhancements being made to the Health Board's risk management arrangements.

In addition, the Board were presented with the views and judgements from the Health & Care Standards Scrutiny Panel (Non-Officer Member led) on the Health Board's performance against the Health & Care Standards.

The views of all Board members were sought and considered at this meeting, and the outcome maturity at Level 3 was consistent with the Head of Internal Audit's own view of the organisation's governance and accountability arrangements.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

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

NHS Wales Shared Services Partnership (NWSSP)

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

- Primary Care Services: Overall Substantial
    - General Medical Services (Substantial)
    - General Pharmacy & Prescribing Services (Substantial)
    - General Dental Services (Reasonable)
    - General Ophthalmic Services (Substantial)
- Accounts Payable (Reasonable)
- Employment Services – Payroll (Reasonable)
- Information Governance – GDPR (Substantial)
- 2017-18 Procurement Services – Accounts Payable – Carbon Reduction Commitment Payment Review

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

In addition, as part of the internal audit programme at Cwm Taf UHB a number of audits were undertaken in relation to both the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). These audits are listed below and derived the following opinion ratings:

Welsh Health Specialised Services Committee

- Governance framework and action (Reasonable)
- Prioritisation process review (Reasonable)
- Mental Health Services (Reasonable)

- Core Financial Systems (Substantial)

Emergency Ambulance Services Committee

- Emergency Medical retrieval and transfer system (Reasonable)
- Follow up of Wales Audit Office review of EASC commissioning (Reasonable)

Finally a report was produced for NWIS, with support from Welsh Government and Velindre NHS Trust, which was received by and discussed with the Velindre Audit Committee. The report was entitled 'Independent Review' and our review covered three areas: compliance with the terms and conditions of the annual business plan; compliance with the funding agreement; and a high level consideration of value for money. Our review was not given an assurance rating. Our review was referenced in the Wales Audit Office report on NWIS "Informatics Systems in NHS Wales" –

"…The NHS Wales Internal Audit services carried out a review of aspects of NIWS's governance and delivery. Where appropriate, we draw on the findings of that work to inform our conclusions (para 10 in the Summary report); and

"The NHS Wales internal audit report reflects our own findings in key areas, including the need to strengthened oversight arrangements" (para 1.38 on governance arrangements).

While these audits do not form part of the annual plan for Abertawe Bro Morgannwg University Health Board, they are listed here for completeness as they do impact on the Health Board's activities, and the Head of Internal Audit does consider if any issues raised in the audits could impact on the content of our annual report.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report; the WHSSC and EASC audits are detailed in the Cwm Taf UHB Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year.

The assignment status summary is reported at section 5 and **Appendix B**.

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

4.2 Service Performance Indicators

In order to be able to demonstrate the quality of the service delivered by Internal Audit, a range of service performance indicators supported by monitoring systems have been developed. These have become part of the routine reporting to the Audit Committee during 2017/18. The key performance indicators are summarised in the **Appendix C**.

Whilst the figure for achievement of the 15 working day target for completion of management responses appears low, it does not reflect the higher level of management engagement evident to Internal Audit during the report clearance process. The figure measures the time taken from draft report issue to the receipt of the completed management response, but it does not include iterations of management action plans during discussion / correspondence with internal audit to ensure effective action and clear assignment of responsibilities & targets. In our opinion, management engagement in discussion of issues arising from audit reports and agreement of actions to address them has improved on previous years.

Post audit questionnaires are issued following the finalisation of all audit assignments. As at 24th April 2018, the response rate has been 32.5% (13 out of 40). Where respondents have made specific comments these have been reviewed by the Head of Internal Audit for any necessary action.

The specific comments provided by Post Audit Questionnaire respondents input into Wordle presents the following picture:

Irrespective of the audit assurance opinion reported, the comments received reflect positively on the audit service as illustrated below:

"As is usual, this was a well conducted, thoughtful and helpful audit."
Corporate Medical Directorate Review: Limited Assurance
Executive Medical Director

"All comments and dialogue were positive and constructive" and "The recommendations have helped us to improve the quality of data collection further."
Data Quality: Mental Health Measure (Follow Up): Reasonable Assurance
Swansea Locality Manager, MH&LD Unit

"The internal audit department input was extremely useful in shaping the final version of the [2016/17] AQS, there was a tight deadline for completion and many versions were produced before printing but the comments received strengthened the final document."
Annual Quality Statement (no standard rating applicable)
Nursing Directorate Business Manager

"We value audit and audit input ... and the team is a strong supportive team."
Performance Management & Reporting: Reasonable Assurance
Assistant Director of Strategy

The above is supplemented by similarly positive feedback gathered by the Institute of Internal Auditors Quality Assessor during the EQA process.

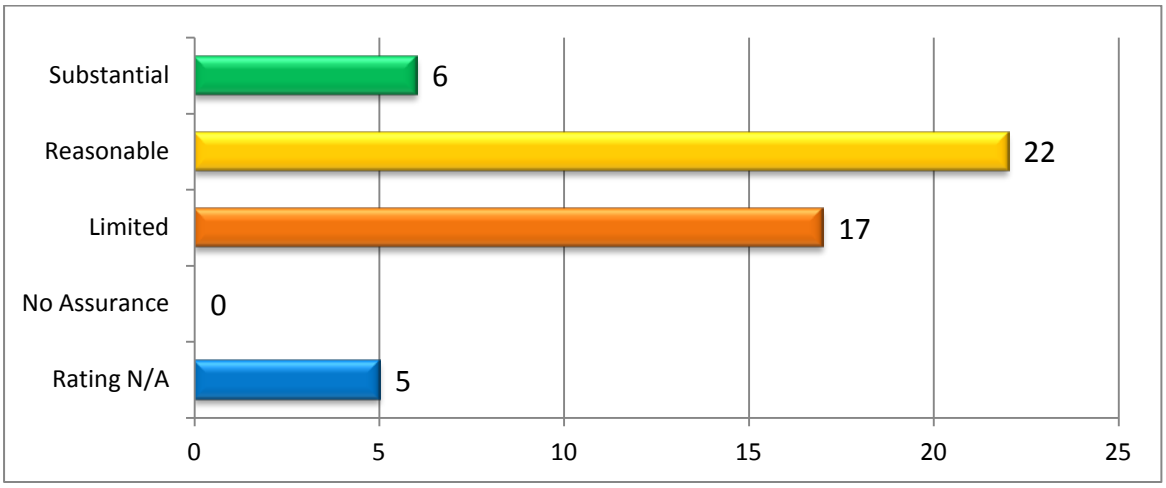
5. RISK BASED AUDIT ASSIGNMENTS

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

5.1 Overall summary of results

In total **40** audit reviews were reported during the year. Figure 1 below presents the assurance ratings and the number of audits derived for each.

Figure 1 Summary of audit ratings



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

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

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance

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

Review Title	Objective
Budgetary Control & Financial Reporting (ABM-1718-014)	The overall objective of this review was to ensure financial reports provide accurate and sufficient information to enable the organisation to meet its business objectives and satisfy external reporting requirements.
Financial Ledger (ABM-1718-015)	The overall objective of the audit was to give assurance that the health board maintains records of all financial transactions and ensures their completeness and integrity, with the aim of providing the basic data from which management accounts, final accounts and statutory returns can be prepared. The audit reviewed the interface with feeder systems but did not include controls within the individual systems.
Welsh Risk Pool Claims (ABM-1718-016)	The overall objective of this audit was to confirm the accuracy of reimbursements sought from the Welsh Risk Pool as required within the WRP Claims Management Standard.

Review Title	Objective
Worforce Planning – Limited scope review (ABM-1718-042)	The overall objective of this audit was to review arrangements in place to monitor delivery of the current *Workforce Delivery Plan 2017/18*. This audit approach has been limited to a desktop review of the papers presented to the Board and Workforce & OD Committee, supplemented by additional committee or Executive-led group papers, where required, to confirm evidence of information reported during the year on matters related to actions listed in the *Plan*.
Medical Directorate follow up review (ABM-1718-107)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the first 2017/18 audit review of the Executive Medical Directorate (ABM-1718-035). 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.
Date Quality: Stroke (ABM-1718-102)	The overall objective of this audit was to review systems in place to ensure provision of reliable stroke performance figures to the Board.

5.3 Reasonable Assurance

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

Review Title	Objective

Review Title	Objective
Risk Management & Assurance (ABMU-1718-003)	The overall objective of this audit was to review the process that has been adopted to establish a robust risk management and assurance framework across all activities of the Health Board.
Finance Directorate (ABMU-1718-037)	The overall objective of this audit is to review the governance arrangements in the Finance Directorate and interface with the Service Delivery Units.
Performance Management & Reporting (ABMU-1718-12)	The overall objective of this audit was to review the organisational structures and information flows to and from the Health Board in respect of performance.
Primary Care Clusters: Governance arrangements (ABMU-1718-007)	The overall objective of this audit was to review the Health Board organisational structure and information flows to support governance in respect of primary care clusters. The audit focused on the aspects outlined in the basic requirements of the *Organisational & Governance Models for Clusters* framework outlined in the Primary Care Annual Report 2015/16. Consideration of Health Board arrangements to support good governance, and whether the clusters themselves are meeting expectations are set out in this report.
Third Sector Commissioning contract (ABMU-17-18-013)	The overall objective was to review the arrangements adopted for the management of services provided to the Health Board by the third sector. The audit was undertaken shortly following the approval by the Board in March 2017 of its *Strategic Framework: Working Together with the Voluntary Sector 2017-2020*. The audit has considered the content of the Strategy itself; systems for monitoring its delivery; arrangements for in place for engaging with the third sector; and current performance management arrangements.

Review Title	Objective
Primary Care: Core quality & delivery measures (ABMU-17-18-027)	The overall objective of this audit was to confirm that Health Board reports primary care performance information in line with the requirements of the NHS Wales Delivery Framework 2017-2020 and current Primary Care Measures for Wales, and to review the development and use of additional information sources alongside these to gain assurance regarding the quality & safety of primary care, and to support improvement.
Safety Alerts Communication (follow up) (ABMU-17-18-111)	The overall objective of this audit was to review action taken to address key issues identified during the 2016/17 review of safety alerts. The scope of this audit was limited to the central receipt and dissemination of alerts as covered previously, and the follow up of actions previously agreed.
Data Quality: Mental Health measures (follow up) (ABMU-1718-028)	The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified during the 2016/17 review of the effectiveness of arrangements in place to ensure the provision of high quality data to support the reliability of Mental Health Measure figures reported to the Board. The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.
Annual Planning: Engagement & Integration *(in draft)*	The overall objective of this audit is to review the approach taken by management to ensure the engagement and integration of key functions of the Health Board during the development of the Health Board's annual plan.

Review Title	Objective
Information Governance & Information Assurance (follow up) (ABMU-1718-030)	The overall objective of this audit was to confirm progress in implementing appropriate structures, responsibilities & accountability arrangements to support the effective management and use of information. The audit provides an interim review of evidence supporting actions completed to date following the last review of this area. For those actions remaining, it has sought to confirm that progress towards revised target dates is being monitored by management.
Singleton Hospital Service Delivery Unit (ABMU-1718-032)	The overall objective of this review was to confirm that Unit governance structures follow the principles set out in the Health Board's system of assurance, and supports the management of key risks and achievement of the Unit's objectives. The approach taken was a desktop review of the terms of reference, work plans/ programmes and agendas documented of key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business. The audit has not considered the detail of discussions at meetings or the effectiveness with which the groups operate. The effectiveness of arrangements will be considered at future reviews.

Review Title	Objective
NPT & Clinical Support Service Delivery Unit (ABMU-1718-033)	The overall objective of this review was to confirm that Unit governance structures follow the principles set out in the Health Board's system of assurance, and supports the management of key risks and achievement of the Unit's objectives. The approach taken was a desktop review of the terms of reference, work plans/ programmes and agendas documented of key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business. The audit has not considered the detail of discussions at meetings or the effectiveness with which the groups operate. The effectiveness of arrangements will be considered at future reviews.
Nursing Directorate (ABMU-1718-036)	The overall objective of this audit was to review the governance arrangements in the Nursing directorate and interface with the Service Delivery Units.
Community Dentistry (ABMU-1718-038)	The overall objective of this audit was to review the processes adopted to manage the CDS.

Review Title	Objective
Mental Health Unit Governance Framework (ABMU-1718-039)	The overall objective of this audit was to confirm the Unit governance structure is designed and operates in accordance with the principles set out in the Health Board's system of assurance, and supports 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, agendas, minutes and action notes for 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. We have also reviewed the Unit's use of its risk register for the assessment and management of recorded risks, in accordance with the Risk Management Strategy. Findings of the previous Unit governance review have been considered but we have not reported against specific, previously agreed actions, noting the new Delivery Unit structure.
NPT – Operational PFI SSu ABMU 1617 012	The audit assessed the Health Board's arrangements for monitoring and managing the operational PFI contract. This is the third periodic review of the operational phase of the PFI contract. The audit also considered the status of management actions agreed at the prior reports.
Follow up (Capital) SSu ABMU 1617 001	The audit evaluated and assessed compliance with the established systems, processes and procedures that support the management of capital, particularly: • Governance • Capital Planning and Approval • Selection and Appointment (particular focus on compliance with established controls for Single Tender Action)

Review Title	Objective
Follow up (Estates Assurance) SSu ABMU 1617 008	An audit was undertaken to determine the status of previously agreed recommendations arising from the following audits: • Follow – Up of Outstanding Estates Recommendations (Issued 4th November 2015) containing the following: o Energy and Water Management (Issued August 2012); o Energy and Water Management (Issued July 2014); o Legionella Management (Issued November 2014); • Disability Discrimination Capital Follow-Up (Issued March 2015).
Capital Systems / crl SSu ABMU 1617 006	An audit was undertaken to determine the status of previously agreed recommendations arising from the following audits: • Follow – Up of Outstanding Capital Recommendations (Issued 13th July 2016) containing the following: o Combined Service Redevelopment (Issued September 2013); o Phase 1b Follow-Up Report (Issued November 2015); o RMHSS Phase 8 Glanrhyd LSU (Issued December 2015); • Emergency Medical Retrieval and Transfer Service (Issued 1st June 2016); • Clinical Support Accommodation - HVS Phase 1B Scheme 2 (Issued 23rd June 2016) • Existing Medical School - HVS Phase 1B (Issued 23rd June 2016); and • Cardiac Intensive Therapy Unit (Issued 1st November 2016).

Review Title	Objective
Informatics Programme SSu ABMU 1617 004	The scope and remit of the audit review was limited to the following aspects. We sought to assess these areas against the overall Informatics Programme, and a sample of supporting projects as appropriate
Renal Ward Refurbishment SSu ABMU 1718 003	The objective of the audit was to evaluate the associated processes and procedures supporting the delivery of the Renal Ward Refurbishment project.
Digital Strategy – *in draft* SSu ABMU 1718 005	The objective of the audit was to evaluate and determine the appropriateness of ABMU's Digital Strategy in its alignment to the organisations business needs and the National Health and Social Care Strategy, in order to provide assurance to the Health Board's Audit Committee that the ambitions of the Digital Strategy are relevant and achievable.

5.4 Limited Assurance

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

Review Title	Objective
Health & Safety (ABMU-1718-009)	The overall objective of this audit was to assess the adequacy of framework in place within the Health Board for the management of health and safety, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.
Fire Safety (ABMU-1718-010)	The overall objective of this audit was to assess the adequacy of arrangements operating within

Review Title	Objective
	the Health Board for the management of fire safety, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate. The audit has reviewed corporate arrangements for ensuring fire risks are identified, assessed and managed, focusing on selected elements of the Fire Policy. Delivery Unit processes and structures for managing fire safety were not within the scope of the review. Fire safety training was also outside the scope of this audit as it is reviewed separately as part of our internal audit of mandatory training arrangements.
Funds Held on Trust: Golau Governance review (ABMU-1718-112)	The overall objective of the system under review is to ensure that the governance and financial management of the Foundation complies with the Health Board's Standing Financial Instructions and Financial Control procedures.
Pressure Ulcers (ABMU-1718-023)	The overall objective of this audit was to review the arrangements in place to ensure the quality and safety of healthcare in relation to the prevention, assessment and management of pressure ulcers in the Health Board.
Medical Devices & Equipment Maintenance (ABMU-1718-024)	The overall objective of this audit is to review the management of risks associated with acquisition and use of medical devices. The audit has considered policies & procedures, the operation of the Medical Devices Committee in respect of the management, monitoring of risk and provision of assurance to the Health Board. Noting the presence of risks within the risk register with respect to the lifespan and maintenance of equipment the audit has focused on the management of the medical equipment register and the monitoring of maintenance arrangements.

Review Title	Objective
POVA (DoLS) (ABMU-1718-025)	The overall objective of this audit was to review the process for DoLS applications to ensure that these are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice and Health Board procedures.
Medical Directorate (ABMU-1718-035)	The overall objective of this audit was to review the governance arrangements in the Executive Medical Directorate and interface with the Service Delivery Units.
Staff performance management and appraisal (ABMU-1718-041)	The overall objective of this audit was to review staff performance management and appraisals. In view of the issues and actions recently reported to the Board with respect to this area, the audit has focused on action being taken to improve performance of PADRs and recording of the same within ESR.
Statutory & Mandatory Training (ABMU-1718-043)	The overall objective of this audit was to review arrangements in place to ensure all staff comply with statutory and mandatory training requirements determined by the Health Board, including the management and monitoring of actions and risks identified at the last review.
Sickness Absence Management (follow up) (ABMU-1718-103)	The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2016/17 audit review of Sickness Absence Management. This is a follow up audit and as such the audit scope has focused on progress made in those areas highlighted previously as requiring management action only.
Medical Locum Cover (ABMU-1718-106)	The overall objective of this audit was to review systems in place to control expenditure arising from the engagement of locum medical cover. The audit considered controls over expenditure arising from both external agency locums, and internal locum cover paid via Additional Duty Hour payroll submissions.

Review Title	Objective
IT Infrastructure – Assets – *in draft* (ABM 1718-029)	The overall objective of this audit was to review compliance with the Health Board's agreed procedures and systems for the management of IT infrastructure assets, taking into account relevant government directions. The audit scope focused on hardware assets and considered the following: • Policy and procedures • IT equipment asset register maintenance • IT hardware physical security • Losses and disposals
Fire Safety follow up review – *in draft* (ABMU-1717-109)	The overall objective of this audit is to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit review of Regulatory Compliance: Fire Safety (1718-010).
Corporate Legislative Compliance: Wellbeing of Future Generations Act (ABMU-1718-004)	The overall objective of this audit is to review progress made to implement the requirements of the Wellbeing of Future Generations Act (Wales) 2015.
Non pay expenditure: Goods receipting - *in draft* (ABMU-1718-018)	The overall objective of this audit is to review the systems in place to effectively account for goods received and engage actively with suppliers to resolve issues and facilitate the timely payment of invoices received.
EWTD: Portering Services Morriston Hospital – *in draft* (ABMU-1718-046)	The overall objective of this audit is to review the processes adopted to ensure compliance with Working Time Regulations. Following an analytical review of overtime worked by staff over a 6 month period, we have selected the Portering Service for review. The focus will be on arrangements in place within Morriston.

Review Title	Objective
Backlog Maintenance SSu ABMU 1617 009	In accordance with the agreed internal audit plan, a review of the processes and procedures put in place by the University Health Board (UHB) to support the management and control of the backlog maintenance programme including statutory compliances has been undertaken.

5.5 No Assurance

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

5.6 Assurance Not Applicable

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

Review Title	Objective
Annual Quality Statement (ABM-1718-019)	This audit report was the result of a limited scope audit of the Health Board's Annual Quality Statement for the year 2016/17. The breadth of content and timescale for the production of the AQS inherently limit the extent and depth of independent verification possible. The overall objective of this audit was to assist the Health Board with accuracy checking and triangulation of data and evidence before publication of the AQS. The scope was limited to ensuring that the AQS was consistent with information published and/or reported to the Board and its committees over the period, though supplementary sources have been used where

Review Title	Objective
	required and appropriate.
Medical Devices Home Maintenance Payments – *in draft* (ABM 1718-017)	The overall objective of this limited scope audit is to review the risks and controls with respect to the probity of payments to external companies for the maintenance of equipment in patients' homes. The scope did not include contact with any patient or with the equipment within their home. Internal Audit assessed the extent to which the maintenance of equipment is contracted to external companies and the value of payments made. We have liaised with the Head of Counter Fraud throughout the audit, sharing the detail in the scope and audit testing.
Medical Devices & Equipment follow-up – *in draft* (ABM 1718-113)	The overall objective of this audit is to review progress made against actions agreed to address issues raised at the last audit. The previous audit focused on the management of the medical equipment register, the timely servicing of equipment and associated monitoring arrangements. This scope of this audit will be restricted to a review of actions taken to address issued previously highlighted only.
Carbon Reduction Commitment (SSU-ABM-Briefing paper)	This review sought to provide the Health Board with assurance that operational procedures were compliant with the CRC Scheme guidelines, including mandatory and best practice elements.
Sustainability Reporting (SSU-ABM-Briefing paper)	The overall objective of the review was to assess the adequacy of management arrangements for the production of the sustainability report within the Annual Report; whether the form and content of the statement complied with the Welsh Government requirements, and whether the information published within the report provided an accurate and representative picture of the quality of services it provided and the improvements it has committed to undertake.

5.7 DEFERRED AUDITS

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

Review Title	Objective
Corporate Governance: Code of Compliance **Health Board System of Assurance**	Internal Audit re-scheduled these assignments to late Q3/Q4 to allow for changes in Board membership and Committee structures to take place and settle. Since then positions have been filled (some on an interim basis amongst the Executive team) and there have been changes at Committee level – though in respect of the latter reconsideration during the year has meant that final changes remain to be agreed and embedded in some cases (eg the Performance & Finance Committee and relationship with Workforce & OD matters). The Head of Internal Audit met with the Health Board's new Director of Corporate Governance in the first week of January. She is undertaking a review of Health Board governance and assurance arrangements as one of her first priorities, the outcome of which may result in further changes to arrangements in place. It has been agreed in principle with her that internal audit reviews of these areas would be more appropriately deferred to follow her review and implementation of revised arrangements. **The Audit Committee approved the <u>removal</u> of these reviews from the 2017/18 audit plan and their inclusion within the audit plan for 2018/19.**
Partnership Governance: ARCH **ARCH Programme** (SSU-ABM-1617-003)	The ARCH Partnership Board commissioned a governance review for the ARCH project from Deloitte. The emerging findings and recommendations were made available to the Head of Internal Audit. Recognising the Deloitte report and subsequent Gateway review, Management requested the deferment of the commencement of the audit. Audit fieldwork is to be initiated during Q1 17/18. This audit was scheduled to be delivered jointly between Internal Audit and the Specialist Services unit (SSu), ensuring co-ordination of delivery and minimal disruption to both programme and UHB

	staff. The draft audit brief was originally issued for management agreement in July 2017, with the aim of evaluating the systems and controls in place within the Health Board and reviewing information made available through partnership arrangements. The commencement of the review has previously been deferred to enable management to address recommendations arising from the Deloittes report on Programme Governance arrangements. More recently, we have been informed that the partnership programme has been affected by the Swansea City Deal. The former Director of Corporate Governance has requested an update to the Executive Team from the lead Executive. This is awaited. It is therefore proposed to defer the commencement of the audit until the Executive team has considered the current governance arrangements in light of the recommendations arising from the Deloittes review and impact of the City Deal. **The Audit Committee approved the deferral of this work until 18/19 (Q1/2).**
Putting Things Right	This subject area has been a routine component of our audit plan for a number of years. Last year, a *reasonable* assurance rating was derived, but it was recognised that the Welsh Risk Pool had previously identified the need for improvement in respect of lessons learned. While audit review of the papers of Health Board groups has identified that improvements have been made in this respect, we are aware that further work is planned in partnership with the Welsh Risk Pool to improve systems for managing & monitoring actions to address issues. Additionally, the Welsh Government Delivery Unit will shortly be reviewing the Health Board arrangements for complying with Putting Things Right and learning lessons. In view of this, an internal audit review of this area would not be an effective use of our resource at this time. T**he Audit Committee approved deferral of this audit for reconsideration in**

	2018/19.
Patient reported Outcome Measures	Whilst we understand that progress has been made in implementing Patient Reported Outcome Measures (PROMS) within Orthopaedics, the intended rollout across other major services has been slowed by a desire nationally to implement a Once-For-Wales approach. At a recent meeting, the Executive Medical Director informed us that he has now appointed to the role of clinical lead for PROMS within the Health Board and intends using this to coordinate a more comprehensive update to the QSC in February. Noting the current position, he has agreed in principle to the deferral of this audit. **The Audit Committee approved the removal of this subject from this year's audit plan for consideration within a future audit year, the timing of which will be kept under review as part of ongoing audit planning and in light of future updates to QSC.**
Clinical Audit & Assurance	Correspondence with the Executive Medical Director and Clinical Effectiveness & Governance Manager indicates the Health Board Policy on Clinical Audit is under review and due for discussion at Clinical Outcomes Group and then approval by Quality & Safety Committee in February 2018. Revisions are anticipated to clarify expectations as the extant version does not reflect current arrangements (reported earlier this year by Audit and now being addressed by management). **Internal Audit agreed in principle to the deferral of this audit with the Executive Medical Director, to allow for approval and implementation of the new policy providing direction to Units. The Audit Committee subsequently approved deferral of this audit, for consideration within the 2018/19 audit plan.**
Discharge Processes (follow up)	We last reviewed this area in 2015/16 (audit ABM-1516-040 refers) and identified areas for action. The 2017/18 audit plan includes a follow up audit in respect of our original review. However, the Wales Audit Office report on *Discharge Planning* is currently being cleared with the Health Board and

	is making additional improvement recommendations. Noting this, and the passage of time since the original internal audit review, it may be appropriate to remove this audit from the 2017/18 internal audit plan and consider a fresh audit within future year audit planning after time has been allowed for implementation of action following the WAO review. **The Audit Committee approved the removal of this review from the 2017/18 audit plan.**
IT / Cyber Security	The Medical Director informs us that a national, external review of cyber security is being commissioned by the NHS Wales Informatics Service at the request of the National Informatics Management Board in order to provide assurance regarding cyber security arrangements within Health Boards in Wales. In view of this, we have agreed with him that an additional internal audit review would not be beneficial at this time. **The Audit Committee approved removal of this audit from the 2017/18 audit plan.**
Data Quality: OP delayed follow ups	Wales Audit Office (WAO) have recently completed work that included a follow up of actions agreed to improve data validation & the reliability of figures relating to delayed outpatient follow up appointments. This is due to report imminently and it is possible that further action may be required to address issues. **Noting the coverage by WAO it is proposed to defer this audit into the 2018/19 audit plan, and include a consideration of any further action required of management in respect to the WAO report findings at that time.**
HR & OD Directorate (follow up review)	There was a delay in finalising the audit report on *Corporate HR*. Work undertaken as part of that audit and to address the former Chief Executive's request for further assurance highlighted issues in respect of the application of organisational change policy, for which action in response in the *Corporate HR* report was aimed at addressing. The follow up review of the *Corporate HR* audit and a dedicated review of *Organisational Change / Pay Bandings* were scheduled to be undertaken following implementation of the *Corporate HR* action plan. Noting that the target date for

	completion actions agreed are within Quarter 1 of 2018/19, it would not be appropriate to proceed with this work in 2017/18. **The Audit Committee approve <u>deferral</u> of these audits for reconsideration in 2018/19, following the appointment of the substantive DOHR**.
GP Managed Practices	The Head of Internal Audit [HOIA] has liaised with the Health Inspectorate Wales [HIW] in respect of progress with their ongoing work on primary care, their scope and the anticipated timing of their reports. She has also met with the Service Director and senior management team of the Primary Care & Community Services [PCCS] Unit to discuss planned Internal Audit work in primary care areas. HIW are currently undertaking work in the Health Board's *GP Managed Practices* and anticipate reporting in September. Noting this we have agreed with the Service Director of the PCCS Unit that we would recommend removal of the GP Managed Practice audit from this year's audit plan for reconsideration in 2018/19 strategic audit planning. **The Audit Committee approved <u>removal</u> of this audit from the 2017/17 audit plan.**
Organisational Change Policy / Contractual Changes	The aim of the review was to assess controls in place over changes in staff contractual arrangements and confirm compliance with organisational change policy. It was included in the 2016/17 plan following Internal Audit concerns raised in 2015/16. However, management were still finding resolutions to the issues raised in the 2015/16 Audit Report and the Chief Executive requested that the 2016/17 audit be re-scheduled to 2017/18. **The Audit Committee approve <u>deferral</u> of this audit and the HR & OD Directorate follow up for reconsideration in 2018/19, following the appointment of the substantive DOHR**.
Medical Staff Revalidation	The Audit Committee was updated by the Executive Medical Director in November on progress against recommendations made following the last audit of this subject, highlighting that the completion of action and further improvement to quality assurance arrangements

	is dependent upon the identification of Appraisal Lead roles within Units – this was being progressed through job planning, so ongoing but not yet complete. The Executive Medical Director has recommended deferring this follow up audit to 2018/19. **The Audit Committee to approved deferral of this audit, for inclusion within the 2018/19 audit plan.**
Nurse Rostering (follow up review)	Our previous report in this subject recommended the full utilization of electronic rostering systems to support effective rostering. At the end of March 2017, management did not consider it feasible to implement electronic systems in all areas within a short timescale, so implemented the requirement for the monitoring of rostering effectiveness by senior management within Units. We indicatively scheduled time within Quarter 3 to verify that action was in place. Since then the Director of Human Resources has made us aware of work undertaken to review rostering practices by her team as part of the Recovery & Sustainability Programme Board. That work has highlighted a variety of shift patterns in place within wards/departments, and the inconsistency of rostering practices & shifts across the Health Board, making the rostering process complex and adding to the risks in respect of efficiency, quality and compliance with workforce regulations. A paper to the Recovery & Sustainability Board in November makes recommendations for further action to address this, the implementation date for which is April 2018. **Recognizing that management have identified continued issues in respect of rostering practices and additional action is being planned to address this, the Audit Committee approved deferral of internal audit work in this area for further consideration within 2018/19.**
Junior Doctor Bandings (follow up review)	We have discussed the status of action following the last audit with the DOHR. Key improvements have not been completed as some staff affected have appealed formally and the BMA is supporting their appeal. The DOHR is seeking external legal advice. **This subject area will not be ready for**

	re-audit within 2017/18, the Audit Committee approved deferral for reconsideration in 2018/19.
Transitional Care Unit / Neonatal and Paediatrics Capacity	In accordance with the agreed internal audit plan, this proposed review was to evaluate the processes and procedures that support the development of increased Neo-natal and Post-natal capacity at the Singleton Hospital site. A Business Justification Case in the sum of £9.629m has been submitted to Welsh Government for approval. However, initial feedback provided by the Welsh Government has indicated that due to capital resource pressures this scheme is unlikely to be funded until 2019/20. **The Audit Committee approved deferral of the audit of this scheme until BJC approval is received and consider inclusion at future annual planning updates.**

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2017/18 plan.

Paula A. O'Connor M.Sc

Head of Internal Audit - Abertawe Bro Morgannwg University Health Board

Audit and Assurance Services

NHS Wales Shared Services Partnership

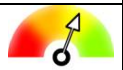
May 2018

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

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

AUDIT RESULTS GROUPED BY ASSURANCE DOMAIN

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Clinical Governance, Quality and Safety	**Original nbr = 9** **Final nbr = 7** 4 Deferred: ● Putting Things Right ● PROMS ● Clinical audit & assurance ● Discharge process 2 Added: ● Medical Devices & Equipment follow up ● Safety Alerts Communication		● Annual Quality Statement ● *Medical Devices & Equipment – follow up*		● Pressure Ulcers ● Medical Devices & Equipment Maintenance ● POVA (DoLS)	● Primary Care: Core Quality & Delivery Measures ● Safety Alerts Communication	
Corporate Governance, Risk and Regulatory Compliance	**Original nbr = 8** **Final nbr = 6** 3 Deferred: ● Corporate governance: code compliance ● System of Assurance – HB ● Partnership Governance - ARCH 1 Added: ● Fire Safety (Fup)				● Health and Safety ● Fire Safety ● *Fire Safety – follow up review* ● Corporate Legislative Compliance: Wellbeing of Future Generations Act	● Risk management & Assurance ● Primary Care Clusters: Governance	

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Financial Governance and Management	**Original nbr = 5** **Final nbr = 6** 1 Added: ● Golau governance review		● *Medical Devices Home Maintenance Payments*		● Golau Governance Review ● *Non Pay Expenditure: Goods Receipting*		● Financial Ledger ● Budgetary Control & Financial Reporting ● Welsh Risk Pool Claims
Strategic Planning, Performance Management and Reporting	**Original nbr = 3** **Final nbr = 3** (No changes)					● Third Sector ● Performance Management & Reporting ● *Annual Planning: Engagement & Integration*	
Information Governance and Security	**Original nbr = 4** **Final nbr = 4** 2 Deferred: ● IT / Cyber security ● Date Quality; Op delayed follow ups 2 Added: ● Data Quality: mental health measures follow up ● Data Quality: stroke follow up				● *IT Infrastructure Assets*	● Data Quality: Mental Health – follow up ● Information Governance & Information Assurance	● Data Quality: Stroke follow up

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Operational Service and Functional Management	**Original nbr = 9** **Final nbr = 8** 2 Deferred: ● HR&OD Directorate follow up ● GP Managed Practices 1 Added: ● Medical Directorate follow up				● Medical Directorate *(now superseded)*	● Singleton Hospital Service Delivery Unit ● NPT & clinical Support Services Delivery Unit ● Nursing Directorate ● Community Dentistry ● Mental Health Unit Governance framework ● Finance Directorate	● Medical Directorate – Follow up review

Assurance domain	Audit Count	Overall rating	Not rated	No Assurance	Limited assurance	Reasonable assurance	Substantial assurance
Workforce Management	**Original nbr = 8** **Final nbr = 6** 4 Deferred: ● Medical staff revalidation ● Organisational change / contractual changes ● Nurse rostering follow up ● Junior Doctor Bandings follow up 2 Added: ● Sickness Absence Mgt follow up ● Medical Locum cover				● Sickness Absence Management – follow up ● Staff Performance Management & Appraisals ● Statutory & Mandatory Training ● Medical Locum Cover ● *EWTD: Portering Services*		● Workforce planning: WF Delivery Plan Actions
Capital and Estates Management	**Original nbr = 16** **Final nbr = 14** 2 Deferred: ● ARCH Programme ● Transitional Care Unit / Neonatal and Paediatric capacity 4 audits in progress will be reported in 2018/19		● Sustainability reporting ● Carbon Reduction		● Backlog maintenance	● NPT Operational PFI ● Follow up capital ● Follow up estates assurance ● Capital Systems ● Informatics programme ● *Digital Strategy* ● Renal ward refurbishment	

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

Notes:
The *Audit Count* indicates the number of audits in each domain at the start of the year and at the end of the year following changes agreed with the Audit Committee. Beneath these figures, the audit subjects added or removed are listed. “Added” audits also appear under the assurance columns if they have been reported by the end of April 2018.
The above table excludes the outputs from *Capital & Estates* final account work completed during the year.
Commentary following audit work on *Governance, Leadership and Accountability* is reported within the Head of Internal Audit Annual Report. Commentary in respect of the draft *Annual Governance Statement* is provided directly to the Director of Corporate Governance. Neither are included in the above.

PERFORMANCE INDICATORS

Indicator Reported to NWSSP Audit Committee	Status[1]	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2017/18	G	March 2017	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2017/18	G	100%	100%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	95%	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	58%[2]	80%	v>20 %	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%[3]	80%	v>20 %	10%<v<20%	v<10%

Key: v = percentage variance from target performance

[1] Figures reflect the position reported as at 30th April 2018. It includes the 40 assignment reports expected within the first seven domains of the annual audit plan. The audit commentary on the AGS and Governance, Leadership & Accountability are not issued via reports, so excluded from the above. Figures also exclude the SSU performance that is reported separately to the NWSSP Audit Committee in aggregate form across organisations.
[2] This figure represents a percentage of the 31 reports finalised at the point of preparing this annual report – it represents an improvement on the 41% achievement reported for 2016/17.
[3] As per the KPI above, this figure represents the percentage of the 31 reports finalised at the point of preparing this draft report.

Audit Assurance Ratings

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

Overall opinion assessment matrix

Supporting criteria for the overall opinion

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

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

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

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

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

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

Responsibilities

Responsibilities of management and Internal Auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a

substitute for management's responsibilities for the design and operation of these systems.

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

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