Meeting Date	**15th May 2020**	**Agenda Item**	**3.1**
Report Title	**Audit & Assurance Assignment Summary Report *(DRAFT AUDIT REPORTS)***		
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Report Sponsor	Helen Higgs, 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 Internal Audit assignments reported in **draft** form.		
Key Issues	Ten draft reports have been issued to Executive leads since the last meeting. Recognising the impact COVID-19 is having on management priorities, we have agreed to suspend the normal target timescales for response to draft reports. We will monitor the position with the Director of Corporate Governance and seek responses at an appropriate time and bring finalised reports back to the Committee in due course. In the meantime, the outcomes and key findings are summarised for Audit Committee information and noting. The conclusions derived from these assignments will inform the Head of Internal Audit Opinion. The assurance levels derived can be summarised: *7 Reasonable* *2 Limited* *1 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. • Note the extended timescales within which responses will be agreed, due to the pressures arising from COVID-19, and that this position will be monitored by Internal Audit with the Director of Corporate Governance.		

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. PURPOSE

The purpose of this report is to advise the Audit Committee of the outcomes of Draft Internal Audit reports.

2. DRAFT REPORTS ISSUED

This report summarises the outcomes of the following assignments currently reported in Draft form:

Subject	Indicative Rating[1]
Internal Audit	
Regional Partnership Board (IPC Recommendations) (SBU-1920-008)	
Performance Management & Reporting (Cancer) (SBU-1920-011)	
Discharge Planning (SBU-1920-025)	
Discharge Summary Communication: Improving Performance (SBU-1920-028)	No rating applied
IT Infrastructure Assets (Follow Up) (SBU-1920-030)	
Workforce & OD Directorate (SBU-1920-032)	
Singleton Hospital Replacement Cladding (SBU-1920-S03)	
Follow Up – Capital Assurance (SBU-1920-S01)	
Follow Up – Estates Assurance (SBU-1920-S08)	
Follow Up – Informatics (Digital Strategy & Wireless Infrastructure) (SBU-1920-S01.1)	

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

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

[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.

Actions have not yet been agreed with Executive Directors in respect of audit recommendations. Recognising the impact COVID-19 is having on management priorities, we have agreed to suspend the normal target timescales for response to draft reports. We will monitor the position with the Director of Corporate Governance and seek responses at an appropriate time and bring finalised reports back to the Committee in due course. In the meantime, the outcomes and key findings are summarised for Audit Committee information and noting.

3. INTERNAL AUDIT REPORT SUMMARY: DRAFT REPORTS

3.1 PARTNERSHIP: REGIONAL PARTNERSHIP BOARD (IPC RECOMMENDATIONS) (SBU-1920-008)

Board Lead: Director of Strategy

3.1.1 Introduction, Scope and Objectives

SBU Health Board's Standing Orders require the health board to '…work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens…' and the health board has entered into a number of partnerships arrangements within organisations within and outside of the NHS to discharge this responsibility.

The governance arrangements relating to the Western Bay Regional Partnership Board [RPB] were reviewed by the Institute of Public Care [IPC] and a final report published in September 2018. The report presented a number of recommendations to strengthen arrangements in place. In response to the Bridgend boundary changes, the RPB partnership arrangements have changed also, the new partnership being titled the West Glamorgan Regional Partnership Board.

The overall objective of this audit was to review the consideration and implementation of recommendations made within the IPC September 2018 report.

The audit scope has considered information available to health board members of the partnership providing assurance regarding consideration of the IPC recommendations and how they have been implemented.

The audit scope has considered the following IPC recommendations:

Vision & priorities

- RPB and leadership group agree a draft vision and priorities statement and new Western Bay brand.
- Partners undertake a consultation exercise with the public and staff about the vision and priorities.

Programme delivery

- Review the programme to refocus projects and resources on key joint strategic priorities for the new Western Bay collaboration and ensure that each project is working to a specific model agreed by partners within an agreed timescale which delivers on the new vision of the collaborative and is designed effectively to deliver on the 'regional design, local delivery' principal.
- Complete this through an intensive event for the leadership group to review current projects and priorities and prepare a new plan to which all partners are committed for the RPB to consider.
- Follow this with a series of engagement events run by the RPB with stakeholders to test and develop the plan for final sign-off.
- Complete the review through publication and dissemination of the new Plan and share with staff and public across the region.

Governance arrangements

Following the completion of an agreed vision and shared principles and programme review:

- RPB consider and agree the recommendations relevant to them in [the IPC] report including the proposed additional membership and arrangements for the RPB, citizen's engagement and project management arrangements.
- RPB agrees a revised job description for the Chair of the RPB.
- Leadership group consider and agree the recommendations relevant to them in this report.
- PSBs [Public Service Boards] consider merger and revised governance arrangements linked to the RPB.

The scope was reduced to limit enquiries of key staff during the increasing pressures of COVID-19 management. In particular, we have excluded coverage of recommendations made by the IPC in relation to Programme Office arrangements and individual project-level governance.

The IPC review included interviews with a range or RPB members and stakeholders. The approach taken with this internal audit review has been to discuss action taken with the health board's management lead, the Assistant Director of Strategy (Partnerships), followed by desktop review of health board and partnership board papers. The audit has not reviewed the effectiveness of new arrangements implemented. Enquiries have been made of health board officers only. The audit has not sought access to partners' staff and systems, though information has been provided through health board colleagues.

3.1.2 Overall Opinion

The Board can take **reasonable** assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters

require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

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

There are no key issues. We have identified action taken to make improvements in the areas that the IPC report recommends – though we would note that decisions made in respect of the IPC report's particular recommendations have not been documented against those recommendations and progress against them has not been reported in a consolidated way through the programme structure to the RPB. In some cases recommendations do not appear to have been taken forward as presented, but alternative actions have been taken that may address issues in different ways. We have recognised these where apparent, but we have not sought to review the effectiveness of alternative actions. Improvement continues to be made in some areas. In particular, improving arrangements to engage with citizens is being taken forward by a dedicated co-production work stream of the programme.

While there is evidence of progress in improving governance arrangements, a consolidated management report indicating progress against the actions the partnership has decided to take in response to the IPC report recommendations, would provide the health board and the RPB partners with comprehensive, formal management assurance in respect of improvements made across all areas. This has not been raised as a formal recommendation, but noted for consideration and action as appropriate by the Director of Strategy.

We would note that the scope & depth of independent assurance in respect of partnership arrangements that can be delivered through the internal audit plan of an individual partner organisation will be subject to limitations. The health board and its partners may wish to explore adopting an internal audit arrangement for the partnership as a whole.

3.2 PERFORMANCE MANAGEMENT & REPORTING (CANCER) (SBU-1920-011)

Board Lead: Interim Director of Finance

3.2.1 Introduction, Scope and Objectives

The health board's Governance Work Programme 2019/20 indicated the development of a new performance management framework as an action to take forward in 2019. An operating model for the organisation would be developed alongside, recognising it as an opportunity to make accountabilities clearer, help incentivise performance and reflect earned autonomy of delivery units relative to their performance. At the point of planning for this audit, the framework was not yet agreed but a paper to

the Performance & Finance Committee (PFC) indicated the intent to develop it in Q4 for implementation for 2020/21.

While the above was in development, this audit considered the effectiveness of assurances in respect of current performance improvement actions as reported to the PFC via the integrated performance reports, with a focus on cancer.

The overall objective of this audit was to review the arrangements in place to drive performance improvement whilst the performance management framework was in development.

The audit reviewed arrangements in place to ensure that the actions outlined in the integrated performance report to improve performance in key areas, were being progressed as described. Consideration was given to evidence presented regarding the impact in driving improvement. We agreed that the scope of our work would focus on cancer performance and actions to make improvements.

Consideration was also given to the contribution of corporate mechanisms, including weekly cancer tracking meetings and the Cancer Improvement Board that aimed to drive and/or monitor delivery of actions highlighted. Additionally, we reviewed the activities of the groups nominated at each unit to monitor cancer performance (Singleton & Morriston Units selected), to confirm the local monitoring of actions as reported to PFC, actions agreed at corporate meetings, and performance information.

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. This rating is reflective largely of the outcome of our sample testing of actions reported to the Performance & Finance Committee.

At the request of management we also considered meetings & processes to deliver improvements. This work focused on the operational meetings within and between units with a view to highlighting areas for improvement – it was not a review of the overall cancer performance management framework and our findings have been considered accordingly when assessing the above rating. Whilst this work identified active operational management of patient lists and consideration of service issues, there were clear areas where improvement could be made. Recommendations were raised and management should give attention to addressing these.

Integrated Performance Report Actions
The main focus of our work was on the verification of actions reported within the Integrated Performance Report (IPR). Following review of a sample of actions, we found there was generally good evidence of action taken. We highlighted potential to improve the clarity of communication within the organisation of those actions agreed at management meetings and included in reports. There were some areas in our sample where work had commenced in accordance with actions reported in the IPR earlier in the year, but had subsequently stalled. Adopting the improvements we have recommended may assist in ensuring that changes to actions and/or timescales are clearly communicated in subsequent reports.

Operational Level Issues
At an operational level it was evident that management within Units is receiving information on performance and on actions to address issues within services. Those responsible for service areas were reviewing patients who had breached target waiting times for treatment and those at risk of breaching. This was discussed at meetings within units and cross-unit meetings. However, from observations of a number of meetings, we identified areas for improvement. It should be noted that our observations were made during a period of long-term absence of the health board Cancer Lead Manager (an independent Service Director whose substantive unit is not responsible for delivering cancer services) and during the departure of the Morriston Cancer Lead.

Whilst the weekly cross-unit meetings were reviewing patient lists as described in the IPR, discussion with staff and observation of the meetings has provided us with feedback which suggests a lack of shared clarity relating to the meeting purpose, the roles of those attending and routes for escalation. Management should consider the current arrangements to support Cancer performance and cross Unit working, including the role and occupant of the chair of this weekly meeting.

Both Units were actively reviewing patient lists at their local weekly meetings, and had arrangements in place to consider wider service issues. There is scope to demonstrate better, the oversight of Service Directors in the consideration and agreement of actions entered in the common Service Issue Log which is becoming the source of assurances for inclusion in integrated performance reports to the Board.

3.3 DISCHARGE PLANNING (SBU-1920-025)

Board Lead: Director of Nursing & Patient Experience

3.3.1 Introduction & Background

SAFER is an improvement tool used widely across the NHS. In 2018, the Welsh Government published its *SAFER: Patient Flow Guidance*, but it was recognised by management within SBU Health Board that it was not adopted consistently across all units and areas. In October 2019, following a process

of review and revision, the health board re-launched its *Patient Flow Policy and SAFER Framework* highlighting the imperative that the SAFER process is established and entrenched within daily culture.

The overall objective of this audit was to review compliance with key aspects of the SAFER patient flow process.

The audit scope has considered the following:

- All patients have a Clinical Management Plan (CMP) documented within the first 24 hours of admission.
- All patients have an Expected Discharge Date (EDD) set within the first 24 hours of admission.
- All patients have a Consultant review before midday and this is recorded in the patient notes.
- The EDD is up to date, and where changes have been made the reasons are recorded and appropriate (i.e. clinical).
- Delays in discharge beyond the EDD date arising from non-clinical reasons do not result in a change to the EDD date, but the delay and reasons for it are recorded appropriately in accordance with policy.
- Patient notes record discussion of EDD and changes with the patient and/or carers.
- Action taken to manage timely discharge and avoid delays is recorded.

The audit visited 12 wards across four sites: Singleton, Morriston, Neath Port Talbot and Gorseinon hospitals. It reviewed data within local information systems (ABMU Clinical Portal, Welsh Clinical Portal, Signal, white boards and patient notes) and we spoke with staff. We are very grateful to the Senior Corporate Matron, who joined us on each of our visits and provided valuable insight and clinical perspective to the review, and to the Director of Nursing & Patient Experience who provided this valuable resource.

3.3.2 Overall Opinion

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

Detailed testing of the SAFER Patient Flow Policy in line with the objectives identified above has identified the following key findings:

- Clinical Management Plans varied in detail – most did not contain all the elements set expected within policy. In particular, the participation of senior medical staff in the setting of EDD was not evident in patient records.
- The reasons for changes to EDD were not consistently recorded.
- EDDs have been updated for non-clinical reasons.

- Patients have been identified as being medically fit for discharge within patient notes, but EDDs have been updated beyond this point within electronic systems.
- Records of actions in relation to discharge planning were inconsistently completed and in some places limited – few wards demonstrated effective adoption of the red/green day approach set out in policy (a red day for a patient means a day where there is little or no value adding care; a green day means a day of value for the patient's progress towards discharge).

The health board is in a period of transition between clinical portal systems currently and alongside this it is continuing to develop and implement its in-house Signal system to assist manage flow. The systems are not fully integrated, but it is acknowledged that the new system is well-received by staff as a tool to assist in managing patient flow. There is no current reference to Signal within the Policy and the functionality it provides is different to that of the clinical portals. The availability of the variety of systems, without guidance for staff, increases the risk that record keeping expected will not be captured effectively.

In addition to the above issues in relation to patient flow, we noted inconsistencies in relation to approaches to information governance and patient information displayed within view of patients and visitors.

3.4 DISCHARGE SUMMARY COMMUNICATION: IMPROVING PERFORMANCE (SBU-1920-028)

No rating assigned

Board Lead: Executive Medical Director

3.4.1 Introduction, Scope & Objectives

The Robert Powell Investigation (February 2012) recommended that General Practitioners needed to be adequately informed, in writing, of the material facts and intended course of further investigation when a patient is discharged from hospital. The timely provision to general practice of an appropriately completed discharge summary has been identified as an important factor in maintaining the continuity of care and reducing the incidence of readmission.

In September, the health board Integrated Performance Report indicated that only 36% of discharge summaries were sent to GPs within 24 hours, and 55% within 5 days. It was proposed that a formal recovery plan be developed.

Following commencement of the audit, an early discussion with the Medical Director's team in respect of the timing of recovery plan implementation, and the emerging pandemic during the fieldwork period, have caused us to alter our audit approach and limit coverage on corporate and unit arrangements. Consequently, we are reporting our findings without the

usual assurance barometer, recognising this limited scope. Nonetheless we have highlighted some issues for consideration by management and recommendations to address them in due course.

The overall objective of this audit was to review the arrangements in place to improve compliance with targets for discharge summary completion.

The audit scope has considered the following:

- The effectiveness of corporate arrangements to monitor implementation of the recovery plan, its impact on performance and additional action required.
- The consideration of discharge summary performance information at Unit performance and/or quality & safety meetings and actions to drive improvement.

3.4.2 Overall Opinion

Recognising that the development of the recovery plan has paused pending the implementation of national system improvements, we have limited the scope of our corporate work to a consideration of high level oversight at the executive quarterly performance review meetings and a discussion of electronic systems with the programme manager. Additionally, fieldwork in respect of unit actions has been restricted to a limited review of desktop papers. We have not sought further discussions with clinicians at units during March/April in view of the emerging pandemic.

Consequently, we have closed this audit and are reporting our findings narratively without the usual assurance barometer, recognising the limited scope of work undertaken. Nonetheless we have highlighted some issues for consideration by management and recommendations have been raised to address them in due course. These have been presented for consideration at the appropriate time when the new electronic system is in place and the pandemic risk has abated.

A further review of arrangements to management improvements in discharge summary communication will be included in our considerations for the next year's audit planning round.

3.5 IT INFRASTRUCTURE ASSETS (FOLLOW UP) (SBU-1920-030)

Board Lead: Associate Director of Digital Services

3.5.1 Introduction, Scope and Objectives

Information technology hardware is a key asset used by the health board to support the effective delivery of clinical services and management processes. The information technology infrastructure underpins all health

board business critical systems and must be procured, supported, maintained and disposed of accordingly.

Effective management, administration and controls over the asset life cycle, from procurement through to disposals, are important to the success of the health board.

In 2017/18 an internal audit review reported *limited* assurance in respect of IT infrastructure assets (ABM-1718-029). The review was undertaken to assess compliance with the health board's agreed procedures and systems for the management of IT infrastructure assets, taking into account relevant government directions.

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 review.

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

3.5.2 Overall Opinion

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

The previous audit made four recommendations, of which two were high priority and two were medium priority. Concluding current testing, we can confirm that one recommendation had been addressed prior to the audit, one was addressed during our fieldwork, and another is partially addressed. The remaining recommendation related to gaps / inconsistencies in the recording of asset 'ownership'. However, following the original audit, management indicated that they were satisfied that record-keeping arrangements were adequate to identify asset users, pending the rollout of ESR (Electronic Staff Record) functionality across the health board. As this is subject to wider organisational considerations, no further recommendations have been raised.

The following key findings from the follow up review were noted:

- During the time of fieldwork no inactive/dormant asset audits were recorded. We were informed that audits on quarantined assets (assets not used in 60 days) have recently been undertaken, however the results were not available on conclusion of the audit to confirm this.
- Progress against the Trustmarque IT Asset action plan had not been reported to senior management prior to our review. This was addressed by the close of fieldwork, however we would note that continued, periodic monitoring should be maintained.

3.6 WORKFORCE & OD DIRECTORATE (SBU-1920-032)

Board Lead: Director of Workforce & OD

3.6.1 Introduction, Scope and Objectives

Following appointment in April 2018, the Director of Workforce & OD highlighted the risks and challenges faced by the health board due to significant reductions in capacity as part of historic savings programmes. Further issues and challenges were outlined through a 'Stocktake' paper to the Workforce & OD Committee in August 2018.

The health board's Annual Plan 2019/20 states that *'Resolving the workforce challenges of the Health Board requires an exceptional workforce team who have the capacity and capability to work with managers and staff to deliver the extensive range of workforce interventions outlined in this plan. Without this intensive focus on strategic workforce issues the Health Board will be unable to secure the organisational transformation outlined in this plan.'*

The Plan highlighted the need for investment and re-structuring. Health board structures were subject to review and consultation at the point of planning for this audit.

The overall objective of this audit was to review the management of risks associated with capacity of the Workforce & OD function.

The audit scope considered the following:

- Progress is being made to achieve Annual Plan priorities in relation to Workforce Resource Capacity & Structure.
- All WOD directorate staff have up to date, documented objectives & priorities, and their performance has been appraised, in accordance with PADR policy.
- Action is taken in accordance with policy to manage WOD staff sickness absence.
- WOD directorate expenditure is controlled and approved in line with policies, procedures and financial delegations.

Following an analysis of performance information, we sampled two areas for local review of records in support of compliance with key policies and procedures:

- 6F22 Occupational Health
- 6C31 Education Centre

3.6.2 Overall Opinion

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

One of the key risks facing the Directorate is its capacity to support health board strategy and objectives. Positive progress was evident in addressing capacity issues via the Executive Board approval of funding for a number of critical posts.

Our review of individual staff performance appraisals (PADR) and the management of staff attendance and sickness absence in the two areas visited found evidence of controls in operation but inconsistent application, with some areas of non-compliance in which improvement could be made:

- Whilst the Directorate's overall PADR performance percentage for October 2019 was low and below the health board average, review of underlying data indicated a significant number had only missed the target by a few months. Nonetheless, there was a smaller number of staff whose records suggested they were overdue by over a year. These should be prioritised for action.
- Documentation indicated the key points of discussions during appraisal for a number of staff. However, the completion of documentation was inconsistent: whilst narratively performance was recorded the final outcome in respect of whether performance was satisfactory was not always marked; additionally explicit records of agreement were not provided for some. The completion of some was limited.
- Overall, record-keeping in respect of sickness absence management demonstrated an active process was operating in the sampled areas; however, there were some instances in gaps in Return-To-Work documentation and one of the departments was not aware of the need for self-certification forms for short term sickness absence, so several gaps existed in their records.

Our analysis of non-pay expenditure and limited walk-through testing did not identify any concerns.

3.7 SINGLETON HOSPITAL REPLACEMENT CLADDING (SBU-1920-S03)

Board Lead: Chief Operating Officer

3.7.1 Introduction, Scope and Objectives

Initial consultancy and investigatory works were undertaken by external advisors on the cladding systems installed at Singleton Hospital in late 2017/ early 2018. Investigations concluded that the systems were not compliant with the required Health Technical Memoranda (HTM 05-02).

An options appraisal, identifying feasible options and supporting cost estimates for removing and replacing the cladding systems and associated work, was subsequently issued to the UHB in March 2019.

The work was to be undertaken in a phased approach, as follows:

- Phase 1: The removal of the cladding and support systems on the eastern and western flank walls only. Approval was granted by the

Welsh Government in March 2019 in the sum of £0.315m. Works were completed in December 2019, with a reported outturn cost of £0.338m (i.e. a £23k overspend).

- Phase 2: Cladding removal on the main façade. A performance specification and scope of works has been developed, with work commencing in January 2020 to develop the business case. The current cost forecast is in the region of £10m. Works may commence in October 2020, subject to progress with the business case and WG approval.

Alongside the development of the cladding removal and replacement project, the UHB has investigated its legal position with regards to the original design and installation of the cladding.

This audit considered the delivery of the Phase 1 works, and the wider arrangements in place to progress Phase 2 i.e.

Phase 1

- **Project Delivery** and **Lessons Learned**
  - assurance that the project was delivered in accordance with defined time, cost and quality parameters, including achievement of expected benefits; and
  - an assessment of any relevant issues that may have limited the successful delivery of the project. Assurance that lessons learned from delivery of Phase 1 have been appropriately considered to inform Phase 2.

Phase 2

- **Governance arrangements -** assurance that adequate governance arrangements have been implemented in respect of the wider project, including defined roles & responsibilities, clearly defined accountability & delegation arrangements. That appropriate reporting and approval arrangements are in place;
- **Risk management** – assurance that key risks associated with the current cladding installation were being appropriately managed;
- **Advisors –** assurance that advisors have been appropriately managed, including contractual arrangements, management of fees etc; and
- **Quality Issues –** Assurance that appropriate arrangements have been made to determine the extent of quality issues identified at the existing cladding systems installed at Singleton Hospital, that appropriate advice has been sought, and actions proposed, in addressing the same.

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 following was noted:

- Robust delivery of the Phase 1 Flank Walls scheme was observed. Whilst some overspend to budget occurred, this was largely due to the SCP's inability to deliver the scheme within the pre-tender estimate upon which funding was based (recognising the project did not go through the full business case development process to secure funding approval). We have recommended that a formal assessment of the reasons for the variance between the pre-tender estimate and initial tender submission be undertaken to inform the Phase 2 development;
- Sound arrangements have operated in the monitoring and reporting of ongoing risk within the UHB. In an update report to the Welsh Government in January 2019, the UHB reported that all recommended short and medium term mitigation measures had been actioned.

The long-term measures will only be addressed via removal and replacement of the current cladding installation, which is currently being progressed. Until that time, key safety, financial, service and reputational risks etc. will remain.

In the interim, the cladding risk was seen to receive appropriate focus and scrutiny via inclusion on the Health & Safety Committee and Corporate Risk Registers. The periodic reporting of the ongoing risk management measures to relevant forums was also evidenced.

Whilst recognising the risk reporting / management arrangements in place, and mitigating measures implemented to date, until the full cladding replacement is achieved, the key risks will remain to be addressed.

- Governance arrangements for Phase 2 were in the early stages of development, with focus to date on the appointment of the SCP and technical team via the Designed for Life Framework. We have evidenced regular reporting to key UHB forums, with approvals appropriately sought, prior to the formal project governance structure being implemented. We have made recommendations to ensure the proposed governance structure is implemented effectively, and to improve the clarity of reporting to key forums, in terms of slippage and risks;
- There was a lack of formal contractual documentation for the external advisors appointed at the scheme to date (with only purchase orders in place to instruct significant values of advisory work), which may leave the UHB at risk in the event of any dispute/claim.

Accordingly, we have made 1 high, 6 medium and 2 low priority recommendations. It is recognised that, due to the present situation regarding Covid-19, we have been unable to formally conclude the audit fieldwork with a debrief meeting.

3.8 CAPITAL FOLLOW UP (SBU-1920-S01)

Board Lead: Director of Strategy & Chief Operating Officer

3.8.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 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:

- Capital Systems: Declarations of Interest & Risk Management (*issued April 2019 – Limited Assurance*);
- Environmental Infrastructure Modernisation Programme (*issued June 2019 – Reasonable Assurance*); and
- Follow Up of Outstanding Capital Recommendations *(issued April 2019 – Reasonable Assurance*), principally in respect of the Capital Equipment audit (*issued July 2018 – Reasonable Assurance*).

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.

3.8.2 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.

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

- 9 had been closed;
- 7 had been partially addressed; and
- 10 remained outstanding (of which 2 were future assurance matters).

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

	H	M	L	Total
Capital Systems: Declarations of Interest & Risk Management	1	6	2	**9**
Environmental Infrastructure Modernisation Programme	0	6	1	**7**
Capital Equipment	0	1	0	**1**
Total	**1**	**13**	**3**	**17**

The key issues for management are:

Capital Systems: Declarations of Interest & Risk Management

- Substantial progress has been made by Corporate Governance in the review and updating of the Standards of Business Conduct Policy. The finalisation, approval and implementation of the revised Standards, and the associated implementation of the planned electronic Declarations of Interest (DOI) system, will enable the closure of the majority of '*partially implemented'* issues in relation to Declarations of Interest (including the one high priority matter);
- DOI proformas were still not in use at relevant Estates procurement exercises as reviewed and reported in the 2019/20 Capital Systems review; and
- Further evidence was also required to support the processes in place for the allocation of Estates discretionary capital.

Environmental Infrastructure Modernisation Programme

As above, three of the outstanding recommendations in this area have not yet been addressed as the BJC2 (Phase 1) project has not reached the appropriate stage of the project life cycle. Management should ensure these areas of best practice are reviewed and incorporated into the relevant forthcoming project review points for the project, including the post-project evaluation exercise and the benefits realisation exercise.

A further recommendation is classed as '*future assurance,'* as a relevant project has not yet occurred against which to assess this action.

Other areas remaining outstanding at this review include:

- The utilisation of an appropriate range of KPIs to monitor SCP/adviser performance;
- The appropriate review and closure of schemes via the final account process; and
- The updating of the Programme Business Case and implementation of appropriate monitoring and reporting arrangements for the Programme.

Capital Equipment

- The updated Financial Control Procedures required publication.

3.9 ESTATES ASSURANCE (FOLLOW UP) (SBU-1920-S08)

Board Lead: Chief Operating Officer

3.9.1 Introduction, Scope and Objectives

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

The audit sought to determine the current status of previous Estates Assurance recommendations contained within the following reports:

- Water Safety (*issued May 2019 – Limited Assurance*);
- Control of Substances Hazardous to Health (*issued February 2019 – Limited Assurance*); and
- Estates Follow-Up (*issued May 2019 – Reasonable Assurance*) which included:
    - Backlog Maintenance (*issued October 2017 – Limited Assurance*)
    - Health & safety – Primary Care Estates (*issued March 2017 – Reasonable Assurance*);
    - Neath Port Talbot Operational PFI (*issued July 2017 – Reasonable Assurance*)
    - Disability Discrimination Capital Follow-Up (*issued March 2015 – Reasonable Assurance*).

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.

3.9.2 Overall Opinion

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

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

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

- 6 had been closed or superseded;
- 17 had been partially addressed; and
- 17 remained outstanding.

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

	H	M	L	Total
Water Safety	7	4	1	**12**
Control of Substances Hazardous to Health (COSHH)	4	5	1	**10**
Backlog Maintenance	1	1	0	**2**
Health & safety – Primary Care Estates	0	2	0	**2**
Neath Port Talbot Operational PFI	0	7	0	**7**
Disability Discrimination Capital Follow-Up	0	1	0	**1**
Total	**12**	**20**	**2**	**34**

The following issues were noted in respect of the above:

Water Safety

The updated position regarding the Water Safety audit was largely determined from the management update report and action plan submitted to the January 2020 Audit Committee. No additional evidence / updated position has been received as part of this follow up review**,** therefore we are unable to close the majority of recommendations.

Control of Substances Hazardous to Health (COSHH)

It is recognised that whilst the majority of these recommendations remain open at this review, management advised that six have been actioned, with a further three ongoing. However, we have not been provided any evidence to support the same.

Backlog Maintenance, Primary Care Estate & Disability Discrimination Act

The outstanding issues at these reviews relate to the need to complete the development of the Estates Strategy, and to undertake the planned six-facet survey of the estate (which will also include a DDA review). Progress has been demonstrated in the last year, but actions remain to be completed.

Neath Port Talbot PFI

The status of recommendations remains unchanged in the last year, with no further action taken by management to address the outstanding issues. Whilst recognising that the external review commissioned by the UHB found the contract to contain the required information, with no need for

an additional user manual, it remains the position of the Audit that the contract documentation was not held in a user-friendly/accessible format.

Further work was recommended to ensure relevant users have easy access to the information, e.g. via a checklist and supporting procedural notes provided as appropriate.

3.10 INFORMATICS (DIGITAL STRATEGY & WIRELESS INFRASTRUCTURE FOLLOW UP) (SBU-1920-S01.1)

Board Lead: Chief Operating Officer

3.10.1 Introduction, Scope and Objectives

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

The audit sought to determine the current status of previous Informatics recommendations contained within the following reports:

- Digital Strategy Follow Up (*issued April 2019 – Reasonable Assurance*); and
- Wireless Network Infrastructure Project (*issued July 2019 – Reasonable Assurance*).

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

3.10.2 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 nine recommendations arising from the previous audits. Out of the nine recommendations, we can confirm that:

- 4 had been closed;
- 4 were partially addressed; and
- 1 was outstanding.

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

	H	M	L	Total
Informatics Modernisation Programme – Wireless Infrastructure Project	0	3	0	**3**
Digital Strategy	0	1	1	**2**
Total	**0**	**4**	**1**	**5**

The key issues for management to fully address are:

- The utilisation of acceptance certificates at Informatics projects;
- The use of mapping exercises to identify resource and skills gaps;
- Evidence that governance arrangements have been appropriately applied at project subgroups; and
- The finalisation of the new governance arrangements for the Digital Strategy, specifically for the Transformation Board to commence meeting as planned.

4. RECOMMENDATIONS

4.1 The Audit Committee is asked to <u>note</u> the summarised findings and conclusions of draft reports presented by Audit & Assurance, pending the receipt of management responses.

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.