Meeting Date	**24th January 2019**	**Agenda Item**	
Report Title	**Audit & Assurance Assignment Summary Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	To advise the Audit Committee of the outcomes of finalised Internal Audits.		
Key Issues	Seven reports have been finalised with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised: • *4 Substantial* • 3 *Reasonable* • 1 *Limited*		

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

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

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. PURPOSE

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

2. REPORTS ISSUED

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

Subject	Rating[1]
Internal Audit	
Corporate Legislative Compliance: Wellbeing of Future Generations (ABM-1819-004)	
Corporate Governance: Code Compliance (ABM-1819-005)	
Health & Safety (Follow up) (ABM-1819-008)	
Fire Safety (Follow up) (ABM-1819-009)	
Financial Ledger (ABM-1819-014)	
Welsh Risk Pool Claims (ABM-1819-015)	
Pressure Ulcers (Follow up) (ABM-1819-024)	
General Data Protection Regulation (ABM-1819-032)	

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.

Actions have been agreed with Executive Directors in respect of audit recommendations made for Final reports issued. Progress against agreed actions is input into an online database by lead officers and visible to Executive Officers for monitoring. The Head of Accounting & Governance

[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.

analyses and summarises the status for Audit Committee meetings as a matter of routine.

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

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 CORPORATE LEGISLATIVE COMPLIANCE: WELLBEING OF FUTURE GENERATIONS (ABM-1819-004)

Board Lead: Director of Strategy
cc Director of Corporate Governance

3.1.1 Introduction, Scope and Objectives

The Well-being of Future Generations (Wales) Act was introduced to improve the social, economic, environmental and cultural well-being of Wales. It is intended to make public bodies listed in the Act think more about the long-term, work better with people, communities, and each other, look to prevent problems and take a more joined-up approach. This review seeks to provide the Board with assurance that it is meeting the requirements of the Well-being of Future Generations (Wales) Act 2015 ["the Act"].

The overall objective of this audit was to review progress made to implement the requirements of the Wellbeing of Future Generations (Wales) Act.

The audit scope included a review of the following:

- The Board's well-being objectives have been approved by the Board;
- Steps to meet those objectives have been documented and reported;
- A statement about its well-being objectives has been published;
- Arrangements to achieve its well-being objectives are reflected within the Health Board long-term strategy and Annual Plan;
- The Health Board is appropriately represented and participates at the Public Service Board(s) of which it is a member;
- The Health Board has contributed to the Public Services Board well-being plans;
- Assurance is reported to the Board in respect of progress to implement the requirements of the Act, and participation in Public Service Boards.

Whilst it is recognised that the Health Board is a member of the statutory public service boards (PSBs), assurance in respect of PSB achievements was not included within the scope of this review. The audit considered the Health Board responsibilities as a "public body" described in the Act.

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.

No key findings were identified during this review and Internal Audit have acknowledged the Health Board's intention to progress the amendments to the Health Board's wellbeing objectives to align them more closely with those of the Public Service Board (reported to September 2018 Board).

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

3.2 CORPORATE GOVERNANCE CODE: CODE COMPLIANCE (ABM-1819-005)

Board Lead: Director of Corporate Governance

3.2.1 Introduction, Scope and Objectives

Each year the Board is required to publish an Accountability Report, incorporating a Corporate Governance Report and Annual Governance Statement (AGS) alongside its Annual Accounts. An essential feature of the Governance Statement is to provide an account of corporate governance, including the board's assessment of its compliance with the Corporate Governance Code, with any explanations of departures. At the end of 2017/18, the Board declared in its AGS, *"The Board is clear that it is complying with the main principles of the Code, is following the spirit of the Code to good effect and is conducting its business openly and in line with the Code."*

The 2017/18 year was a period of continued, significant change at Board level. The Health Board started 2018/19 with a number of new members at non-officer and executive director positions, including its Chief Executive. Board Committee structures, membership and operating arrangements have been refreshed and have entered their first full year of operation.

The UK Corporate Governance Code says there should be a formal and rigorous annual evaluation of the performance of the board, its committees, the chair and individual directors. The Health Board Director

of Corporate Governance is currently arranging for the Board and its Committees to undertake self-assessments of their effectiveness.

This audit has been undertaken to supplement the qualitative self-assessment process with a desktop review of Board and Committee operational arrangements to support conformance with the principles of the Code.

The overall objective of this audit is to review the conformance of Board and Committee arrangements with relevant principles of *HM Treasury Corporate Governance in Central Government Departments: Code of Good Practice 2016*.

In reviewing the information received by Board Committees we have collated the subject titles of papers provided to the quality & safety committees of other organisations and presented this for management information. In light of the ongoing review of groups reporting into Board Committees, we have not reviewed the effectiveness of groups such as the Quality & Safety Forum or Clinical Outcomes Group.

3.2.2. Overall Opinion

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.

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 Board and its Committees are administered effectively and operating in accordance with Standing Orders and terms of reference, with only minor points of note raised for management information. The Board receives information from its Committees, in accordance with its cycle of business, and additional needs are tracked and met through action logs. Improvements to arrangements are being taken forward via a governance work programme and action plans in response to other audit reports agreed with management. One recommendation has been raised in respect of the need to for the Board's Local Partnership Committee to report on its activities to the Board.

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

3.3 HEALTH & SAFETY (FOLLOW UP) (ABM-1819-008)

Board Lead: Director of Strategy

3.3.1 Introduction, Scope and Objectives

In 2017/18 an internal audit review reported limited assurance in respect of the Health & Safety management framework. It identified a lack of monitoring of the Health & Safety improvement plan and weaknesses in the reporting line to the Board/Quality & Safety Committee. Actions were agreed to address the issues raised.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit review of Health and Safety.

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

3.3.2 Overall Opinion

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

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

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

Action has been agreed with the Director of Strategy to be completed by the beginning of March 2019.

3.4 FIRE SAFETY (ABM-1819-009)

Board Lead: Director of Strategy

3.4.1 Introduction, Scope and Objectives

In 2017/18 an internal audit review reported limited assurance in respect of the Fire Safety management framework. It recognized the focus given to the Health Board's performance of fire risk assessments. However, the assessments undertaken identified high priority issues for action which sample testing indicated had not been completed; mechanisms were not operating to report the risks and actions required and to monitor action to completion. A follow up review later in the year reported limited assurance also but noted the priority given to addressing risks in Singleton hospital that year.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit reviews of Regulatory Compliance: Fire Safety (1718-109).

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

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

- Two have been addressed (1 x medium priority, 1 x low priority);
- Two have been partially addressed (2 x high priority);
- Four are not addressed (1 x high, 1 x low, 2 x medium).

The fire risk assessment monitoring spreadsheet developed and managed by Health & Safety was presented to the Operational Health & Safety Group in October 2018 as the monitoring tool for progress against actions identified through risk assessments. The intention was that information recorded in this spreadsheet would then drive reporting to Units / Departments to enable management to monitor and review progress against actions, address issues and report back on completion. At the time of the audit fieldwork, the spreadsheet had not been fully

populated and, therefore, impacted on the completion of other management actions from the previous audit (ABM-1718-109).

The Head of Health & Safety and the Assistant Director of Strategy explained the impact on staff resource, in particular the priority given to addressing risks in Singleton Hospital, and their plans going forward to update the information in the spreadsheet as a priority.

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

3.5 FINANCIAL LEDGER (ABM-1819-014)

Board Lead: Director of Finance

3.5.1 Introduction, Scope and Objectives

The financial ledger records all financial transactions of the organisation and provides the basic information for the preparation of management accounts, final accounts and financial returns. In order to maintain proper financial control it is essential that adequate accounting routines operate to protect the integrity of the ledger and that those routines are implemented in practice.

The overall objective of this 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 financial ledger relies upon data from a number of feeder systems. This review has reviewed the interface with those systems but has not included controls within the individual feeder systems.

The following control objectives were reviewed:

- All transactions of the Health Board are recorded;
- All input to the financial ledger is complete, accurate, timely and valid;
- All journals within the financial ledger are authorised and adequately documented;
- Output from the ledger is controlled, secure, timely and appropriate to the need of the Health Board;
- Data within the financial ledger is secure and free from risks of loss or corruption.

3.5.2 Overall Opinion

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.

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 were no key findings identified during the audit. Access to the ledger was controlled, and well-established monthly processes were operating effectively.

We have advised on an improvement to the evolving month-end interface checks for the new pharmacy JAC system within the main body of the report.

There were no further actions required following the review.

3.6 WELSH RISK POOL CLAIMS (ABM-1819-015)

Board Lead: Director of Nursing & Patient Experience

3.6.1 Introduction, Scope and Objectives

The Welsh Risk Pool (WRP) is a risk-pooling scheme which reimburses member organisations (i.e. Local Health Boards and Trusts) for losses incurred as described in WHC 2000(12). Claims for reimbursement must be made in accordance with the WRPS Reimbursement Procedure and will be considered by the WRP Services Advisory Board. All successful claims are subject to an excess of £25,000.

The WRP requires that a proportion of claimed costs submitted to it for reimbursement are subject to internal audit review. This audit has been undertaken to meet that requirement.

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.

3.6.2 Overall Opinion

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.

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 were no key findings were identified during the audit and no actions required of management.

3.7 PRESSURE ULCERS (FOLLOW UP) (ABM-1819-045)

Board Lead: Director of Nursing & Patient Experience

3.7.1 Introduction, Scope and Objectives

This assignment was proposed for the 2018/19 internal audit plan following the 2017/18 limited assurance Pressure Ulcers audit (ABM-1718-023). Following discussions between the Audit Committee Chair and the former Interim Chief Operating Officer this follow up audit was requested by year end.

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the 2017/18 audit review of Pressure Ulcers (ABM-1718-023).

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

3.7.2 Overall Opinion

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 Health Board Policy for the Prevention and Management of Pressure Ulcers was updated in August 2018. The date of issue was taken into account when undertaking audit fieldwork.

The previous audit made eight recommendations, one of which required actions for both the Pressure Ulcer Prevention Strategy Group (PUPSG) and the Units. We have reviewed progress against this recommendation as two separate actions.

Concluding testing, we can confirm that four recommendations had been addressed, four were partially addressed and one had not been addressed.

No key findings were identified during this review. However, the following have been identified for further action:

- Pressure Ulcer Scrutiny Panels should ensure that all grade 2 and higher pressure ulcers are reviewed (grade 3 and higher in Community);
- The POWH Unit Quality & Safety Group is not receiving reporting on pressure ulcers, in part due to meetings being cancelled;
- Over the year an audit template has been developed specifically for Primary Care. PCCS Audits had not been completed, although Internal Audit were informed there were plans for the first audits to commence in the coming weeks.

Action was agreed with the Director of Nursing & Patient Experience to be completed by the beginning of February 2019.

3.8 GENERAL DATA PROTECTION REGULATION (ABM-1819-005)

Board Lead: Director of Corporate Governance (SIRO)

3.8.1 Introduction, Scope and Objectives

The General Data Protection Regulation (GDPR) was passed on 27th April 2016, came into effect from 25th May 2018 and is immediately enforceable as law in all member states of the European Union (EU). The primary objectives of the new legal framework are to institute citizens' rights in controlling their personal data and to simplify the regulatory environment through a unified regulation within the EU. Many principles of the GDPR are similar to the Data Protection Act (DPA) that preceded it. One of the most significant changes is the increased penalties. Under the new regulations penalties for an organisation have an upper limit of €20m or 4% of annual turnover (whichever is higher).

The overall objective of this audit was to review progress made to comply with the requirements of the GPDR.

The audit reviewed arrangements in place to ensure that:

- The strategic work plan to address GDPR compliance reflects the Information Commissioner's 12 steps;
- The reported progress is supported by appropriate evidence; and
- There is adequate reporting of assurance to the Board, or nominated Committee.

As part of the work, we considered how Units/Directorates have been engaged and reflected in the progress reported.

3.8.2 Overall Opinion

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.

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 audit is not an assessment of compliance with GDPR. It acknowledges management's recognition that there is an ongoing programme of work in order to improve compliance across the Health Board, but reflects substantial assurance in the governance arrangements in place to support delivery of those improvements.

There were no key findings identified during the audit and only one recommendation. The Director of Corporate Governance has agreed to complete action by the end of February 2019.

4. RECOMMENDATION

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

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

APPENDIX A

AUDIT ASSURANCE RATINGS

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

Meeting Date	**24th January 2019**	**Agenda Item**	
Report Title	**Internal Audit Progress Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	The main purpose of this report is to report progress in delivering agreed audit work.		
Key Issues	The report presents: • Progress in respect of the planning & delivery of assignments agreed within the annual operational audit plan 2018/19. • The audit assurance ratings of finalised reports.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Recommendations	**Members are asked to:** • **Note the progress of the internal audit programme of work.** • **Approve proposed changes to plan**			

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

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Private & Confidential

INTERNAL AUDIT PROGRESS REPORT

ABM University Health Board
Audit Committee
24th January 2019

NHS Wales Shared Services Partnership

Audit and Assurance Services

1 INTRODUCTION

1.1 The main purpose of this report is to report on the progress of work within the agreed 2018/19 audit plan and present changes to plan for approval where required.

Additionally, it reflects on support provided to management and Board members and updates the Committee on developments within the internal audit service.

1.2 The report records progress of general (section 2) and specialist (section 3) internal audit work at the start of January 2019.

2 GENERAL INTERNAL AUDIT SERVICES

2.1 PROGRESS OF THE 2018/19 (GENERAL) INTERNAL AUDIT PLAN

2.1.1 We continue to report to the Executive Team on matters arising from audit work and progress against the plan. The most recent report has been submitted for consideration at the 16th January 2019 Executive Board meeting.

2.1.2 Since the last meeting of the Audit Committee, we have finalised the following reports:

Ref	Subject	Rating[1]	Executive Officer Recipient(s)	Receiving C'ttee(s)
1819 -004	Corporate Legislative Compliance: Wellbeing of Future Generations		DOS Cc DOCG	AC
1819 -005	Corporate Governance: Code Compliance		DOCG	AC
1819 -008	Health & Safety (Follow Up)		DOS Cc DON&PE	AC HSC
1819 -009	Fire Safety (Follow Up)		DOS Cc DON&PE	AC HSC
1819 -014	Financial Ledger		DOF	AC
1819 -015	Welsh Risk Pool Claims		DON&PE Cc DOF	AC
1819 -024	Pressure Ulcers (Follow Up)		DON&PE	AC QSC

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

Ref	Subject	Rating[1]	Executive Officer Recipient(s)	Receiving C'ttee(s)
1819 -032	GDPR		DOCG	AC

2.1.3 In addition to the above, we have issued a Draft report on the following:

- 010 Annual Plan: Delivery Framework

We have met with management to discuss the findings of our review of *Nurse Quality Assurance*. Information has been forwarded to us for further consideration prior to the report's finalisation.

2.1.4 Work is in progress in respect of:

- 003 Risk Management & Assurance
- 006 Board Assurance Framework
- 013 Budgetary Control & Financial Reporting
- 018 Payroll (Local Controls)
- 029 Cyber Security
- 039 Medical Appraisal for Revalidation
- 043 Staff Appraisal (Follow Up)
- 044 Statutory & Mandatory Training (Follow Up)

The Health Board received an external audit report on Discharge Planning in February 2018 from the Wales Audit Office. We have held preliminary discussions with senior management and reviewed the online action tracker which indicates that actions identified in response to that report are ongoing and remain to be completed. We intend discussing the appropriateness of timing of internal audit work on *Discharge Planning* with the Director of Nursing & Patient Experience shortly.

Following reorganisation of audits amongst the team, fieldwork on *Partnership Governance: ARCH* was paused following an initial set up meeting and it has been agreed with the Director of Corporate Governance and Health Board Chairman to resume it at the end of February 2019.

Our review of *Payroll (Local Control)* arrangements started in November and includes substantive testing of overtime controls. We are working to close this and report in January.

2.1.5 Audit briefs have been issued in respect of:

- 022 Clinical Audit & Assurance *(agreed)*
- 041 Nurse Rostering (Follow Up) *(agreed)*
- 046 Medical Locum Cover (Interim Follow Up) *(agreed)*

At the last meeting of the Committee we reported that we had received feedback that some actions intended to address issues in the previous *Medical Agency Locums* report were to be progressed via the implementation of an electronic system which has been procured but is yet to be fully rolled out. Following the November 2018 Committee meeting, Internal Audit discussed progress with the Director of Workforce & Organisational Development (DOWOD) and her senior management lead. Whilst some issues remain to be addressed, it was considered that an interim follow up focussing on those key controls where action has been taken may be appropriate to provide assurance in respect of progress. A brief has been agreed with the DOWOD and new Executive Medical Director. We are arranging to commence this work in January and report in February.

2.1.6 A review of *Patient Reported Outcome Measures (PROMs)* is included in the 2018-19 Audit Plan, the scope of which is to review arrangements in place to implement PROMs across all service areas and their use to monitor the quality of services. Following discussion with the new Executive Medical Director, and his subsequent review of the Health Board's current PROMS arrangements, he has requested deferral of the audit in recognition that:

- Local Health Board PROMs clinical leads have been stood down as part of recent Welsh Government changes to the National PROMs programme.
- The Health Board's erstwhile lead for the Value Programme has stood down from this role in order to take up her new post as Unit Medical Director at the Princess of Wales Hospital in Bridgend. Her replacement as the Value Programme lead has yet to be appointed.
- Board prioritisation of the Bridgend Boundary Change and Clinical Services Plan has required the limited resource of staff working on Value/PROMs to be realigned to support these temporarily.

He has indicated his intent to refresh and reinvigorate PROMS work in 2019/20 and requested deferral of the audit review to the following year.

In accordance with this request, the Audit Committee is asked to approve the removal of PROMS from the 2018/19 audit plan for reconsideration as part of audit planning for 2020/21.

2.1.7 The 2018/19 Internal Audit Plan was agreed by the Audit Committee in March 2018. It remains flexible and we are continuing to work with Executive Directors to ensure that audit work is appropriately focused and timed. Work is underway to prepare and agree briefs for the remaining audits in our plan.

Progress against plan is detailed at Appendix A.

2.2 HANDOVER OF CARE AT EMERGENCY DEPARTMENTS FOLLOW UP

In 2017/18, the Welsh Ambulance Services NHS Trust (WAST) commissioned a review of Handover of Care at Emergency Departments. The audit was

undertaken by the NWSSP Audit & Assurance team serving that Trust and involved some fieldwork on Health Board (including ABMU) premises. The recommendations following the audit required responses from both the Trust and the Health Boards that it supports.

WAST has commissioned a follow up review of the original audit as part of its 2018/19 audit plan. The brief has been discussed at the All Wales Board Secretaries Group and approved within ABMU Health Board by the Chief Operating Officer and Director of Corporate Governance. Fieldwork will be undertaken by the same NWSSP Audit & Assurance audit team and is due to commence in March 2019.

2.3 ADDITIONAL WORK: FOLLOW UP, ADVICE, PROJECTS & ADDED VALUE

There are contingency days set aside within our Plan to provide for advice to individuals and groups, follow up work in response to audits reported in-year and other ad hoc tasks.

2.3.1 Advice

The Head of Internal Audit provides advice as a critical friend on the forthcoming Bridgend boundary change Governance work-stream and continues to attend meetings of the management-led review of governance arrangements within the Bridgend Private Clinic.

In addition to the above, we have offered advice and responded to requests for support in respect of the following:

- Datix data quality audit approach
- Clinical Council terms of reference

2.3.2 Added Value

In addition to planned assignments and responses to direct requests, we “scan the horizon” for good practice publications, national thematic audit reviews and emerging developments, to share with Executives and senior managers to promote improvement and the management of risk. Most recently this has included the sharing of UK guidance on managing risks associated with *Brexit*.

We have also agreed to support the Committee Services team in the collation and presentation of feedback from Board Committee self-assessment exercises. This will begin this month.

2.3.3 Board Engagement

The Head of Internal Audit continues to meet and/or maintain ongoing correspondence/discussion with Board members. Since the last meeting:

- Chairman
- Director of Corporate Governance

3 SPECIALIST SERVICES UNIT

3.1 PROGRESS OF THE 2018/19 CAPITAL AND ESTATES DOMAIN

3.1.1 Since the last meeting, we have issued draft reports on the following:

- Capital Projects: Infrastructure Modernisation Programme;
- Capital Systems;
- Estates Assurance: Control of Substances Hazardous to Health; and
- Estates Assurance: Water Safety.

3.1.2 Fieldwork in respect of the ARCH Programme has been placed on hold as highlighted in section 2.1.4.

3.1.3 The audit brief in respect of the Informatics Modernisation Programme (Installation of Wireless Network Infrastructure) has been finalised following agreement by management. Fieldwork is scheduled to commence imminently.

3.1.4 The following audit briefs have been issued and are awaiting management agreement:

- Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity; and
- Capital Projects: Primary and Community Care Infrastructure Projects.

3.1.6 Further details including changes to timings are available at Appendix A as applicable.

4 DEVELOPMENTS

4.1 Health Board Boundary Change

As noted earlier, the Head of Internal Audit attends the Bridgend boundary change Governance work-stream. As part of that work the internal audit provision for the two new organisations created by the change is being considered. Your Head of Internal Audit and her counterpart for Cwm Taf have written a joint status paper recognising that the final position on audit needs would be made available following receipt of the legacy statement. The draft status paper has been circulated to Executive Directors and discussed with the Chair of the Audit Committee.

4.2 Internal Audit Plan for 2019/20

The Head of Internal Audit has commenced planning for 2019/20. Consideration is being given to the following:

- The Board's vision, values and forward priorities as outlined in the Annual Plan in the absence of the three year Integrated Medium Term Plan (IMTP);
- An assessment of the Health Board's governance, risk management and assurance arrangements;
- Risks identified in papers to the Board and its Committees (in particular the Audit Committee and Quality & Safety Committee);
- Key strategic risks identified within the corporate risk register and themes apparent across in Unit risk registers;
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- New developments and service changes;
- Legislative requirements to which the organisation is required to comply;
- Other assurance processes including planned audit coverage of systems and processes now provided through NHS Wales Shared Services Partnership (NWSSP) and, where appropriate, WHSSC, EASC and NWIS;
- Work undertaken by other assurance bodies including the Health Board's Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV)
- Work undertaken by other review bodies including Wales Audit Office (WAO), Delivery Unit and Health Inspection Wales (HIW); and
- Coverage necessary to provide reasonable assurance to the Accountable Officer in support of the Annual Governance Statement.
- Potential risks associated with the Bridgend boundary changes.

All Executive Directors have been offered the opportunity to identify any key risks or concerns for consideration as part of this process and meetings have been arranged with several to discuss further. To date we have met with the Director of Corporate Governance, Chief Operating Officer and Audit Committee Chair.

We aim to produce a draft audit plan for the consideration, comment and endorsement of the Executive Team at its formal meeting in February, prior to submission to the Audit Committee in March for approval.

5 ACTION

5.1 The Audit Committee is asked to note progress against the audit plan.

5.2 The Audit Committee is asked to approve the removal of the audit of PROMS from the 2018/19 audit plan for reconsideration as part of planning for 2020/21.

INTERNAL AUDIT PROGRESS AGAINST PLAN — APPENDIX A

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Corporate governance, risk and regulatory compliance domain			
Governance, leadership and accountability (incorporating Health & Care Standards)	Mar 19	May 19	DOCG
Annual Governance Statement	Apr 19	May 19	DOCG
Risk Management & Assurance	Work in progress	Jan 18	DON&PE
Corporate Legislative Compliance – Wellbeing of Future Generations (Wales) Act	Final report issued Nov 2018		DOS[2]
Corporate Governance – Code Compliance *(deferred 17/18)*	Final report issued Dec 2018		DOCG
Board Assurance Framework *(deferred 17/18)*	Work in progress	Feb 19	DOCG
Partnership Governance: ARCH *(deferred 16/17 & 17/18)*	End Feb 19	Apr 19	DOCG
Health & Safety (follow up)	Final report issued Nov 2018		DOS
Fire Safety (follow up)	Final report issued Nov 2018		DOS
Strategic planning, performance management and reporting domain			
Annual Plan (in absence of IMTP)	Draft report issued Nov 2018		DOS
Performance management and reporting	~~Dec 18~~ Jan 2019	~~Jan 19~~ Feb 2019	DOS
Vaccination and Immunisation	Final report issued Aug 2018		DOPH
Third Sector Commissioning (follow up)	Final report issued Oct 2018		DOS
Financial governance and management domain			
Budgetary control & financial reporting	Work in progress	Jan 19	DOF
General Ledger	Final report issued Jan 2019		DOF
Welsh Risk Pool Claims	Final report issued Dec 2018		DON&PE
Charitable Funds – Part 1 Charitable Funds – Part 2	Final report (I+II) Sep 2018		DOF
Charitable Fund: Golau Governance (follow up)	Final report issued Oct 18		DOF
Payroll – local controls	Work in progress	~~Nov 18~~ Jan 19	DOF
Clinical governance, quality & safety domain			
Annual Quality Statement	Final report issued Aug 2018		DON&PE[3]
Putting Things Right *(deferred 17/18))*	Final report issued Aug 2018		DON&PE
Patient Reported Outcome Measures *(deferred 17/18)*	**AC approval to remove requested**		EMD
Clinical Audit & Assurance *(deferred 17/18)*	Brief agreed	~~Jan 19~~ Feb 19	EMD
Discharge Planning *(deferred 17/18)*	Prelim work	Dec 18	DON&PE

[2] With support of DOCG
[3] With support of EMD and DOTH&HS

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Pressure Ulcers (follow up)	Final report issued Nov 2018		DON&PE
Mortality Reviews (follow up)	Final report issued Oct 2018		EMD
POVA (DoLS) (follow up)	Final report issued Sep 2018		DON&PE
Nursing Quality Assurance / Matron Checks	Draft report issued October 2018		DON&PE
Information governance & security			
Outpatient Delayed Follow Ups	Final report issued Oct 18		COO
IT / Cyber Security	Work in progress	Jan 19	CIO/DOCG
Business Continuity & Disaster Recovery	Final report issued Oct 2018		DOS
Health Records Management (Physical notes)	Final report issued Jul 2018		EMD
GDPR	Final report issued Dec 2018		DOCG
IT Application	Jan 19	Feb 19	CIO/DOCG
Operational service and functional management domain			
HR&OD Directorate (follow up) *(deferred 17/18)*	Jan 19	Feb 19	DOWOD
GP Managed Practice: *Cymmer Health Centre* *(deferred 17/18)*	Final report issued Sep 2018		COO
Princess of Wales Service Delivery Unit	Final report issued Aug 2018		COO
Morriston Hospital Service Delivery Unit	Final report issued Oct 2018		COO
Strategy and Planning Directorate	Final report issued Oct 2018		DOS
Workforce management domain			
Medical Staff Revalidation *(deferred 17/18)*	Work in progress	~~Nov 18~~ Jan 19	EMD
Organisational Change Policy/Contractual Changes *(deferred 17/18)*	Jan 19	Mar 19	DOWOD
Nurse Rostering (follow up) *(deferred 17/18)*	Brief agreed	Feb 19	DON&PE
Junior Doctor Bandings (follow up) *(deferred 17/18)*	Jan 19	Mar 19	DOWOD
Staff Performance Management & appraisal (follow up)	Work in progress	Jan 19	DOWOD
Statutory and Mandatory Training (follow up)	Work in progress	Feb 19	DOWOD
Sickness absence Management (follow up)	Final report issued October 2018		DOWOD
Medical Locum Cover (follow up)	Brief agreed	~~Jan~~ Feb 19	EMD
Capital and Estates domain			
Equipment Replacement *c/fwd 17/18*	Final report issued July 2018		DOS
Follow up (Estates Assurance) *c/fwd 17/18*	Final report issued July 2018		DOS
Follow up (Capital) *c/fwd 17/18*	Final report issued July 2018		DOS
Environmental Sustainability Report	Final briefing paper issued 4th September 2018		DOS
Carbon Reduction Commitment	Final briefing paper issued 4th September 2018		DOS

Planned Output	Indicative audit start date	Indicative draft report date	Executive Lead
Capital Systems	Draft report issued Jan 2019		DOS/COO /DOCG
Major Strategic Investment Programmes: ARCH Programme	End Sep 18	~~Dec 18~~ TBC[4]	DOS
Capital Projects: Transitional Care Unit/Neonatal and Paediatrics Capacity	~~Dec 18~~ Mar 19	~~Mar~~ May 19	DOS
Capital Projects: Primary and Community Care Infrastructure Projects	~~Dec 18~~ Mar 19	~~Mar~~ May 19	DOS
Capital Projects: Environmental / Infrastructure Modernisation Programme	Draft report issued Jan 2019		DOS
Informatics Modernisation Programme	Dec 18	Mar 19	EMD
Estates Assurance: Control of Substances Hazardous to Health *c/fwd 17/18*	Draft report issued Jan 2019		COO
Estates Assurance: Water Management	Draft report issued Jan 2019		COO
Follow up (Estates Assurance)	~~Feb~~ Jan 19	Mar 19	COO
Follow Up (Capital)	~~Feb~~ Jan 19	Mar 19	DOS

Y:\IAudit\Internal Audit\2018\Reports\Audit Committee\Jan 2019\ABM AC Jan 2019 Progress v1.0.doc

[4] Fieldwork has paused but will resume in Quarter 4

ASSURANCE RATINGS

APPENDIX B

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.