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Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board



<b>Meeting Date</b>	<b>15<sup>th</sup> March 2018</b>	<b>Agenda Item</b>		
<b>Report Title</b>	<b>Audit &amp; Assurance Assignment Summary Report</b>			
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<b>Report Sponsor</b>	Paula O'Connor, Head of Internal Audit, NWSSP A&A			
<b>Presented by</b>	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)			
<b>Freedom of Information</b>	Open			
<b>Purpose of the Report</b>	To advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.			
<b>Key Issues</b>	<p>Eight reports have been finalised since the last meeting and their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised:</p> <ul style="list-style-type: none"> <li>• 2 Substantial</li> <li>• 4 Reasonable</li> <li>• 2 Limited</li> </ul> <p>The Report indicates the timescales for completion of actions agreed with management for each.</p> <p>Additionally, the attached paper presents for members' information a summary of a proposed final report on the <i>Well Being of Future Generations Act</i> whilst discussions are ongoing with respect to its finalisation.</p>			
<b>Specific Action Required</b> <i>(please ✓ one only)</i>	<b>Information</b>	<b>Discussion</b>	<b>Assurance</b>	<b>Approval</b>
			✓	
<b>Recommendations</b>	<p>Members are asked to:</p> <ul style="list-style-type: none"> <li>• <b>Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management.</b></li> <li>• <b>Consider any further action required in respect of the subjects reported.</b></li> <li>• <b>Note the summarised outcome in respect of the proposed final report on the <i>Well Being of Future Generations Act</i>, and ongoing action to finalise this audit.</b></li> </ul>			











## 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 <sup>1</sup>
<b>Internal Audit</b>	
Health & Safety review (ABM-1718-009)	
Performance Management & Reporting (ABM-1718-012)	
Budgetary Control & Financial Reporting (ABM-1718-014)	
Primary Care: Core Quality & Delivery Measures (ABM-1718-027)	
Data Quality: Mental Health Measure (Follow Up) (ABM-1718-028)	
Workforce Delivery Plan Actions – Limited Scope Review (ABM-1718-042)	
Safety Alerts (Follow Up) (ABM-1718-111)	
Fund Held On Trust: Golau Governance Review (ABM-1718-112)	

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.

In addition to the above, we are also presenting the outcome of our review of *Corporate Legislative Compliance: The Wellbeing of Future Generations Act* which was reported in Draft at the end of November 2017, but for which we are still in correspondence with management in order to finalise it – a proposed final report has been issued on 9<sup>th</sup> February 2018 to the Director of Strategy for approval. The Head of Internal Audit has offered to meet to discuss. The Executive Summary findings are included within this paper so as not to delay the communication of key findings any longer whilst a response is awaited.

<sup>1</sup> Definitions of assurance ratings are included within Appendix A to this report

Subject	Rating <sup>2</sup>
<b>Internal Audit Proposed Final Report</b>	
Corporate Legislative Compliance: The Wellbeing of Future Generations Act (ABM-1718-004)	

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 Associate Director of Finance / Head of Accounting analyse and summarise the status for Audit Committee meetings as a matter of routine.

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

### **3. INTERNAL AUDIT FINAL REPORT SUMMARY**

#### **3.1 HEALTH & SAFETY REVIEW (ABM-1718-009)**



Board Lead: Director of Strategy

##### **3.1.1 Introduction, Scope and Objectives**

Internal Audit first reviewed this subject in 2012/13. A limited level of assurance was derived. Follow up audit reviews in subsequent years continued to report limited assurance, until in 2016/17 when a reasonable level of assurance was derived (audit reference 031/2016). At the conclusion of that last review, further actions were agreed to address remaining issues.

Recognising the passage of time following the original review, this audit reviewed arrangements afresh, to provide assurance that the framework for health & safety management remains embedded following the organisational changes of subsequent years.

The overall objective of this audit was to assess the adequacy of framework in place within the Health Board for the management of health and safety, taking account of relevant NHS and other supporting regulatory and procedural requirements, as appropriate.

<sup>2</sup> Definitions of assurance ratings are included within Appendix A to this report

The audit reviewed arrangements in place to ensure that:

- The Health Board has up to date, approved health and safety policies that set a clear direction and clarify responsibilities at all levels of the organisation.
- There is a Health & Safety Committee with approved terms of reference, which operates in accordance with those terms and instigates, develops and ensures action is taken to improve H&S arrangements.
- Plans are developed to ensure the implementation of policy and improved management of health & safety risk.
- The Health Board measures and monitors the effectiveness of its implementation of policy & plans.
- The Board, or Quality & Safety Committee, receives information to provide assurance on health & safety matters.

The audit reviewed corporate arrangements for ensuring health and safety risks are identified, assessed and managed, focusing on selected elements of the Health and Safety Policy. Delivery Unit processes and structures for managing health and safety were not within the scope of the review, though the mechanisms in place to receive assurances corporately were considered.

### **3.1.2. Overall Opinion**

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

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

Whilst a limited assurance rating has been derived the audit has recognized significant improvements made in recent years to enhance the governance arrangements for health & safety. In particular, the improved content of the agendas for Health & Safety Committee meetings and the steps made to improve the presentation of risk and performance information. However, the monitoring arrangements for the improvement plan were not clearly demonstrable at Health & Safety Committee meetings and there were weaknesses in the reporting line to the Board/Quality & Safety Committee that require addressing.

This audit identified two key findings:

- An improvement plan has been developed and received by the HSC, but monitoring of progress against it is not evident within Health & Safety Committee (HSC) meetings.

- There were concerns raised within the Health & Safety reports to the Assurance & Learning Group which did not feature in the exception reports to Quality & Safety Forum (and so did not reach the Quality & Safety Committee (QSC)). The Health & Safety reports did not make specific recommendations in respect of further escalation – this could assist in determining what information to report further, noting that the direct reporting from HSC to the QSC is only required annually by the HSC terms of reference.

Action has been agreed by the Director of Strategy to address issues raised, with target completion date of the end of May 2018.

## **3.2 PERFORMANCE MANAGEMENT & REPORTING (ABM-1718-012)**



Board Lead: Director of Strategy

### **3.2.1 Introduction, Scope and Objectives**

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

The Health Board remains subject to the Targeted Intervention of Welsh Government. Over the last year, there has been significant change amongst the Non Officer and Executive Director membership of the Board and ongoing changes to the approach taken to performance management and reporting.

On 25th May 2017, the Health Board received its first, new Integrated Performance Report prepared by the Performance and Contracting Manager and Assistant Director of Strategy, and presented in a revised format that built on the former report card system. The changes were driven by the Welsh Government publication of the NHS Outcomes and Performance Framework directive in March 2016 and subsequent amendments to measures in the NHS Wales Delivery Framework. It was recognised that it was transitional in nature and needed further development.

At the same meeting as part of the Chairman and Chief Executive's report the terms of reference for a reconstituted Performance & Finance Committee were approved.

Discussion at the outset of this review indicated that quarterly performance reviews with the Executive Team were the main vehicle for managing Unit performance. At the Executive Team early in the financial year it was recognised that improved assurances were required from Units in respect of the completion of actions agreed at meetings with Executives. This audit has considered improvements made in this area and the reporting of performance information & assurance to the Board.

The overall objective of this audit was to review the organisational structures and information flows to and from the Health Board in respect of performance.

The audit scope considered the following:

- Health Board performance information & reports are aligned to the NHS Delivery Framework 2017/18.
- There is a clear, corporate performance management meeting structure to provide scrutiny, challenge & support in respect of Unit performance in priority areas, and seek assurance that remedial action is taken.
- The Health Board receives information & assurance on key performance matters, via its Committees where appropriate.

This audit focused on corporate arrangements in place for the monitoring of Unit (and wider Health Board) performance. The audit did not follow up remedial action taken to address the specific Unit-level issue highlighted at last year's Performance Management review. However, it did consider improvements made to corporate mechanisms for seeking assurance regarding action taken following Executive performance meetings.

The audit concentrated on the performance elements of the NHS Wales Delivery Framework. Coverage of the monitoring of financial performance was limited – this area is considered in our audit of Budgetary Control & Financial Reporting.

### **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 audit was undertaken in the context of exceptional levels of change at Board level, which has been ongoing throughout the year. The changes to membership have generated discussions about the Board Committee structure and how the Health Board's business is managed and assurance reported. A new Performance & Finance Committee has been implemented. Terms of reference were approved in May 2018, but appropriately the membership and role of this and other Committees have been subject to further consideration during the year. These are now subject to review by the new Director of Corporate Governance.

Unit performance has been monitored via Executive-led quarterly reviews and the actions agreed reported to the Performance & Finance Committee.

Whilst this is the case, the Health Board does not have a formal performance management framework. Draft arrangements for escalation of performance issues have been received and discussed by the Executive team during the year but final agreement has not been reached.

This audit has derived a reasonable level of assurance, recognizing whilst there have been significant changes at Board level and there is more to do to document and agree a formal performance management framework, arrangements to subject Unit performance to Executive scrutiny and direction have operated during the year, and information has been provided to the Board and Performance & Finance Committee from which to take assurance or challenge performance accordingly.

The one key issue identified was the absence of a performance management framework. Whilst papers have been received and discussed in relation to meetings for corporate scrutiny and management of performance, and escalation arrangements, a final, documented performance management framework had not been agreed.

Action has been agreed by the Director of Strategy to address issues raised with target completion date of the end of September 2018.

### **3.3 BUDGETARY CONTROL & FINANCIAL REPORTING (ABM-1718-014)**



Board Lead: Director of Finance

#### **3.3.1 Introduction, Scope and Objectives**

This audit was undertaken in accordance with the 2017/18 Internal Audit Plan, agreed by the Audit Committee in March 2017.

A budgetary framework is important within the organisation's overall performance management process, to support the achievement of its objectives and planned priorities within the resource limits set by the Welsh Government.

The Health Board is forecasting a year-end deficit of £36m for 2017/18; there is work ongoing in the Finance Directorate and Recovery and Sustainability Programme to scrutinise and challenge the position, and agree actions to meet the planned deficit.

The overall objective of this audit was to ensure financial reports provide accurate and sufficient information to enable the organisation to meet its business objectives and satisfy external reporting requirements.

The audit reviewed arrangements in place to ensure that:

- Budgetary control objectives are clearly identified in the business plan;

- Budgetary responsibility is clearly delegated to budget holders and consistent with the scheme of delegation;
- Risks in relation to the business plan and budget are established and reported to Board;
- The budget is set in a controlled manner and is soundly based on justifiable assumptions;
- Budgeted income and costs are consistent with planned activity and hence with budgeted outturn;
- Sufficient relevant, reliable information is available to budget holders, including non-financial information and forecasts of the year end position;
- Budgetary variations are analysed, investigated, explained and acted upon;
- Information reported to the Board, or sub-committees, is complete, appropriate, accurate, timely and clear;
- Information reported to the Welsh Government is consistent with reports to the Board.

### 3.3.2 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 Health Board objective for 2017/18 has been to contain its financial spend within a £36m deficit figure. The assurance rating reflects the measures in place to monitor, manage and report assurance to the Board in respect of the delivery of that target.

No key issues were identified. Action has been agreed with the Director of Finance to address the one recommendation raised by the end of May 2018.

## 3.4 PRIMARY CARE: CORE QUALITY & DELIVERY MEASURES (ABM-1718-027)



Board Lead: Chief Operating Officer

### 3.4.1 Introduction, Scope and Objectives

This audit was undertaken in accordance with the 2017/18 Internal Audit Plan, agreed by the Audit Committee in March 2017.

In Our Plan for a Primary Care Service for Wales up to March 2018 the Welsh Government (WG) undertook to develop a national set of core quality and delivery standards and measures for primary care for all health boards to report on to their boards and WG. The current WG reporting requirements in respect of primary care are set out in the NHS Delivery Framework 2017-2020. In a paper to the ABMU Health Board in September 2016 entitled Primary Care Measures for Wales, the Director of Primary Care & Community Services Unit reported the development of a portal accessible by GPs, presenting additional data, based on the Health Board's developmental work and that of Public Health Wales for use by practices and clusters. More recently (August 2017), the Unit Medical Director presented to the Quality & Safety Committee a developmental dashboard of key indicators for its consideration.

The overall objective of this audit was to confirm that the Health Board reports primary care performance information in line with the requirements of the NHS Wales Delivery Framework 2017-2020 and current Primary Care Measures for Wales, and to review the development and use of additional information sources alongside these to gain assurance regarding the quality & safety of primary care, and to support improvement.

The audit scope considered the following:

- Measures used and reported, in relation to those set out in the NHS Wales Delivery Framework and Primary Care Measures for Wales;
- The provision of practice-level information to primary care clusters to support monitoring and improvement;
- The use and development of supplementary measures and other sources of information, such as QOF, CGSAT, clinical audit, relevant aspects of the Post Payment Verification Visits, and Health Inspectorate Wales reports, to monitor the quality & safety of services as a whole and at practice level;
- The use of practice visits to provide independent assessment of quality;
- Monitoring arrangements in place within the Unit and assurance to the PC&C Unit Board;
- Assurance provided to the Health Board and/or its Committees.

We focused on information relating to general practice. Whilst the audit has considered measures and how they are used/reported it did not include a review of performance management systems or the particular actions taken (other than reporting) to address issues that the information may highlight.

### **3.4.2 Overall Opinion**

The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas

under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

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

Alongside the use of measures required by the Welsh Government Delivery Framework, this audit has considered action taken to develop additional measures to support quality assurance and improvement in primary care, and as such this audit recognizes work in progress within the assurance rating. Some arrangements remain to be finalised and embedded operationally, including the revised visiting programme approach. It is recommended that arrangements are finalised & implemented this year. Consideration will be given within audit planning for the coming financial years in order to review the implementation of measures in more depth when embedded in operation.

The Primary Care & Community Services Unit demonstrated action being taken to improve the suite of data used to provide an overall picture of quality within individual practices and the development of a process based on this to prioritise visits to practices based on the risks indicated by the picture produced.

Additionally, the Quality & Safety Committee receive regular updates on development of a Committee-level suite of indicators designed to provide assurance on quality within general practice.

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

- We noted that four HIW reports published in May and June 2017 were reported to the Unit QSC in October 2017, whilst another HIW report published in August 2017 was due to be reported to the January 2018 meeting (following a cancellation of the meeting in December 2017). There is potential to improve the promptness of reporting.
- There was no subsequent performance reporting to the Health Board on performance against the Phase 1 Primary Care Measures for Wales, following the original report received in September 2016.

Action has been agreed with the Unit Service Director and Interim Chief Operating Officer to address issues raised with target completion date of the end of October 2018.

### 3.5 DATA QUALITY: MENTAL HEALTH MEASURE (FOLLOW UP) (ABM-1718-028)



Board Lead: Interim Chief Operating Officer

#### 3.5.1 Introduction, Scope and Objectives

This assignment originates from the 2017/18 internal audit plan approved by the Audit Committee in March 2017.

In December 2010, the Welsh Government passed the Mental Health (Wales) Measure 2010. The intention of this new law was to ensure where mental health services are delivered, it is focused on people's individual needs by placing legal duties on Local Health Boards and Local Authorities for the assessment and treatment of mental health problems.

An audit was undertaken in June 2016 (audit reference ABM-1617-046) to ensure that the systems and processes operating within the organisation capture and record high quality data in respect of the Mental Health Measure targets, ensuring the reliable and accurate monthly performance figures are being submitted to the Board and Welsh Government. The audit derived a limited assurance rating. At the conclusion of the review, actions were agreed to address issues raised.

The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified during the 2016/17 review of the effectiveness of arrangements in place to ensure the provision of high quality data to support the reliability of Mental Health Measure figures reported to the Board.

The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.

#### 3.5.2 Overall Opinion

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

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

The original audit report noted the disparate systems operating across the Community Mental Health Teams (CMHTs) within the Health Board locality. The lack of an effective information system resulted in our inability to provide assurance of the accuracy of local figures used to generate total figures reported to the Board and Welsh Government.

The implementation of the national community information system is expected to improve record-keeping arrangements in due course. However, in the interim we can report that the Mental Health & Learning Disabilities Unit have implemented controls to validate the accuracy and completeness of reported Mental Health Measure figures whilst the national information system is being developed. The changes made represent significant improvements on arrangements previously in place. However this reports recognises that a little more time may be required for the cycle of management audit and action to become fully effective.

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

- Audits have been undertaken within the Swansea, Bridgend and NPT Local Primary Mental Health Support Services (LPMHSS) during the period of September 2017 to ensure the accuracy of referral receipt and assessment dates on original copies and the ABM Clinical portal. However, the testing of referral receipt date accuracy was not evident on the audit testing and findings sheet for Bridgend LPMHSS.
- Whilst progress has been made to ensure the reliability of CTP dates used in performance reporting, management audits have identified continued discrepancies which have not yet been addressed by actions agreed following the audits. This may be due to the process being new. However, we recommend that actions agreed with local managers to address identified issues be included on the periodic audit reports for follow up at subsequent audits. Consideration should be given to escalation if they remain unaddressed.

Action has been agreed by the Director of Strategy to address issues raised with target completion date of March 2018.

### **3.6 WORKFORCE DELIVERY PLAN ACTIONS – LIMITED SCOPE REVIEW (ABM-1718-042)**



Board Lead: Acting Director of Human Resources

#### **3.6.1 Introduction, Scope and Objectives**

An audit of Workforce Planning was agreed within the 2017/18 internal audit plan. The Health Board does not currently have an approved Integrated Medium Term Plan (IMTP) and it is reviewing its long term clinical strategy. It has an annual plan for the 2017/18 financial year. The Acting Director of Human Resources has indicated that whilst the information and processes for workforce planning are improving, workforce plans are not aligned to long-term clinical strategy currently.

The Annual Plan 2017/18 highlights the workforce challenges and risks facing the organisation along with the service change plans. Each Unit has submitted information in accordance with a workforce template issued to

them as part of the development of the annual plan. The annual plan includes a Workforce Delivery Plan which is aimed at making better use of the talent and experience of the workforce to provide services across traditional professional and care boundaries to create future workforce sustainability.

This year, steps have been taken to prepare a further annual plan for 2018/19, following which the development of the next three-year IMTP will commence. The Health Board was informed in September 2017 of plans being put in place to review its long-term clinical strategy by March 2018. In view of the current position: the anticipated changes to clinical strategy and Health Board approach that would support more effective medium- and long-term planning; and the fact that the Board is apprised of this position; we have agreed with the Director of Human Resources that this audit review the arrangements in place to monitor delivery of the current *Workforce Delivery Plan*.

The audit approach was limited to a desktop review of the papers presented to the Board and Workforce & OD Committee, supplemented by additional committee or Executive-led group papers, where required, to confirm evidence of information reported during the year on matters related to actions listed in the Plan.

### 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. The audit approach has been limited to a substantive desktop review of meeting papers and the assurance is provided in that context.

No key findings were identified during this review. The Annual Plan identified 27 workforce actions summarised from workforce plans and identified seven key actions in support of the corporate objectives. We noted information on each of the seven within papers to Board or the Workforce & Organisational Development Committee and progress summarised within the IMTP tracker document which is presented to the Board. Information is also presented on other action areas, though this is less routine for some.

There were no recommendations made for management action.

### 3.7 SAFETY ALERTS (FOLLOW UP) (ABM-1718-111)



Board Lead: Director of Strategy

#### 3.7.1 Introduction, Scope and Objectives

This assignment originates from the 2017/18 internal audit plan approved by the Audit Committee in March 2017.

Alerts are received from a number of sources, including Welsh Government, the Medicines & Healthcare products Regulatory Agency, NHS Wales Shared Services Partnership (NWSSP) Specialist Estates Services, and NWSSP Procurement Services. Alerts and Notices emanating from the NHS Wales National Reporting & Learning System (NRLS) database arise from patient safety incidents reported by NHS organisations. Welsh Government use information on significant risks identified by the NRLS to develop national Patient Safety Solutions ("Solutions") for dissemination across NHS Wales and expect confirmation back that organisations have complied within set timescales.

In 2016/17, a limited scope review of the systems in place for the receipt and distribution of alerts to accountable managers/ service leads was undertaken. The purpose was to provide assurance that important safety information is disseminated to the right people in a timely way.

The overall objective of this 2017/18 audit was to review action taken to address key issues identified during the 2016/17 review of safety alerts.

The scope of this audit was limited to the central receipt and dissemination of alerts as covered previously, and the follow up of actions previously agreed.

#### 3.7.2 Overall Opinion

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

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

The previous audit made five recommendations, of which one was a high priority and four were medium priorities. Concluding testing, we can confirm that four recommendations had been addressed, whilst one was partially addressed.

The partially addressed action identified a risk relating to the distribution list for safety alerts within DatixWeb not reflecting the nominated leads names submitted by the Units. With regard to the Unit submitted list

omissions, the Head of Health & Safety stated that until the nominated leads had completed the required training the names would not be added to DatixWeb. However, a nominated lead at Murrumbidgee Hospital confirmed that they had not been informed that any training was required. Similarly, DatixWeb included names that had received training prior to the restructure of the organisation in 2016.

Outside of the follow up audit fieldwork, one key finding emerged during the review that related to 'Field Safety Alerts' that were being distributed by a supplier directly to key individuals at hospital site locations and bypassing the Chief Executives central office of distribution.

Action has been agreed by the Director of Strategy to address issues raised with target completion date of the end of April 2018.

### **3.8 FUND HELD ON TRUST: GOLAU GOVERNANCE REVIEW (ABM-1718-112)**



Board Lead: Director of Finance

#### **3.8.1 Introduction, Scope and Objectives**

This assignment was requested by the Charitable Funds Committee. Terms of reference for the audit were agreed with the Director of Finance.

Health Boards are empowered by legislation to accept, hold and administer property in trust for purposes relating to health services. The financial and management control systems relating to funds held in trust are in many respects similar to those for Exchequer transactions, but there are special features including: the role and responsibilities of trustees, the need to follow trust and charity law and practice, the investment of fund balances, the separate and special accounting requirements, and the need to follow the wishes of the donors of the funds.

This audit reviewed the governance framework within which the South West Wales Cancer Services Foundation (Golau) charitable fund has operated. The overall objective of the system under review is to ensure that the governance and financial management of the Foundation complies with the Health Board's Standing Financial Instructions and Financial Control procedures.

The audit reviewed the Proposal agreed by the Charitable Funds Committee (CFC) at the 8 March 2012 meeting (minute reference 12.C.15) and approved by the Board of Trustees in May 2012 and sought to determine the following:

- The Fund was established as described in the Proposal;
- The Foundation Committee has fulfilled the requirements of its terms of reference;
- The Foundation Committee has agreed fundraising methods, monitored funds and ensured the proper, ethical and legal use of those funds;
- There is an Administration Policy in place that is in line with the Institute of Fundraising codes of practice and the fundraising standards board, and the Health Board's Financial Control Procedure;
- Expenditure plans have been agreed by the Foundation Committee and submitted for approval to the Health Board's Charitable Fund Committee;
- A fundraising plan has been produced and agreed by the Foundation Committee and the Charitable Funds Committee;
- The Foundation has provided bi-annual reports to the Charitable Funds Committee on all activities, both financial and non-financial, including activity, risks and performance.

In addition, the review considered progress being made against the 2017/18 Business Plan that was received at the June 2017 meeting of the Charitable Funds Committee.

This is a report on the governance framework relating to the Foundation. The audit did not include transactional testing of compliance with the system of internal control.

### 3.8.2 Overall Opinion

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

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

Golau Cancer Foundation was launched on 17<sup>th</sup> May 2012. The Health Board's organisational structures changed in 2015. When the current Unit Service Director took up post the Golau Cancer Foundation was already established and operational. The Unit Service Director confirmed that the original Fundraising Manager had left the Health Board in 2014 and since that time there had been a gap that has resulted in the slippage against the aims of the fund. She also highlighted that there had been long term sickness amongst those senior managers and administrative staff within Cancer Services associated with the Foundation, hence the Golau Cancer Foundation Committee had not met regularly since August 2017.

The financial balance of funds held and activity over the seven months from April to November 2017 can be summarised:

Prior Year Closing Bal. (£)	Donations (£)	Legacies (£)	Expenditure (£)	Period Closing Balance (£)
(504,705)	(119,638)	(30,975)	162,049	(493,268)

As expected of other Health Board charitable funds, Golau is required to operate within the over-arching directions of Standing Financial Instructions and Financial Control Procedures. However, additional governance requirements were agreed at the establishment of the Foundation within proposals approved by the Trustees. Our work has found a number of those governance requirements have not been put in place since its launch in May 2012.

The following key findings were identified:

- Meetings of the Foundation Committee occurred monthly in accordance with its terms of reference until August 2017. However, no further meetings have been held within the calendar year and no future dates were agreed at the point of audit closure.
- The approved operating arrangements for the Golau Cancer Foundation Committee required two Non Officer Members of the Board amongst its membership, at least one of which must be present at for quorum at

meetings. No Non Officer Members have been appointed to the Foundation Committee, so meetings have never been quorate.

- A fundraising strategy has not yet been agreed.
- An administration policy has not been agreed.
- A final expenditure plan has not been agreed.

Whilst the above is highlighted, some of these requirements were known to management and featured within an action plan and timetable within the Golau Business Plan which has been reported previously to the Charitable Funds Committee. Progress against this plan should be reported to future Committee meetings.

Additionally, whilst the audit scope focused on the Golau Cancer Foundation, it was apparent that there is no over-arching, formal strategy in place covering the wider range of Health Board charitable funds.

Action has been agreed by the Unit Service Director and Director of Finance to address issues raised with target completion date of June 2018.

## **4. PROPOSED FINAL AUDIT REPORT (FOR INFORMATION)**

### **4.1 CORPORATE LEGISLATIVE COMPLIANCE: THE WELLBEING OF FUTURE GENERATIONS ACT (ABM-1718-004)**



Board Lead(s): Director of Strategy

#### **4.1.1 Introduction, Scope and Objectives**

The scope of Health Board operations is wide, requiring compliance with many, varied legislative requirements. 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 Well-being of Future Generations (Wales) Act has been 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 and communities and each other, look to prevent problems and take a more joined-up approach.

The Act places a duty on all public bodies to carry out sustainable development. To make sure organisations are all working towards the same vision, the Act puts in place seven well-being goals. It requires that the action a public body takes in carrying out sustainable development must include:

- Setting and publishing objectives (“well-being objectives”) that are designed to maximise its contribution to achieving each of the well-being goals, and

- Taking all reasonable steps (in exercising its functions) to meet those objectives.

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 considered whether:

- Well-being objectives had been set and published;
- Steps to take to meet those objectives had been identified;
- A statement about well-being objectives had been published, which explains:
  - Why the Health Board considers that its well-being objectives will contribute to the achievement of the well-being goals;
  - Why it considers that its well-being objectives have been set in accordance with the sustainable development principle and when doing so it explains how it will involve people with an interest in achieving the well-being goals, reflecting the diversity of the population;
  - The steps to be taken to meet the well-being objectives in accordance with the sustainable development principle;
  - How the Health Board will govern itself to meet its well-being objectives;
  - How it will keep the steps it takes to meet its well-being objectives under review;
  - How the Health Board will ensure that resources, including financial, are allocated annually for the purpose of taking steps to meet its objectives;
  - When it expects to meet its well-being objectives.
- Arrangements to achieve well-being objectives were reflected within the Health Board long-term strategy and IMTP (or annual plan).
- The Health Board was appropriately represented and participated at the Public Services Board(s) of which it is a member, and was informed of developments.

The outcomes of this review can contribute to the Board's assurances in respect of achievement of *Governance & Accountability* standard of the Health and Care Standards (2015), and *Embedding Effective Governance and Partnerships* corporate objective 2017-18.

#### 4.1.2 Overall Opinion

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

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

Draft Wellbeing Objectives were presented to the Board in March 2017 and approved then but subject to requested amendments. At the time of audit fieldwork those Wellbeing Objectives, inclusive of Board amendments, had not been finalised. Additionally, whilst a paper had presented a draft Wellbeing Statement to accompany the publication of the Objectives to the Board in March 2017, this had not been finalised and published since. The draft statement mapped the objectives to the national Wellbeing Goals, but did not expand to explain how they might contribute. Comments at the Board had indicated there was more to do to reflect what could be achieved.

In addition, there was more to do to fulfil the requirements of the Act including the determination of steps to deliver the final objectives and governance arrangements to ensure their delivery.

The Assistant Director of Strategy has reported that work is ongoing with partners to advance development of wellbeing objectives within Public Services Boards also. It has been recommended that timelines<sup>3</sup> are agreed for finalisation and publication of the Health Board's own arrangements as an individual public service body, so that the Board can be assured of the timescales within which all the requirements of the Act will be met.

The Committee will be updated in respect of the status of this report at the next meeting.

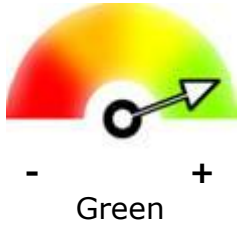

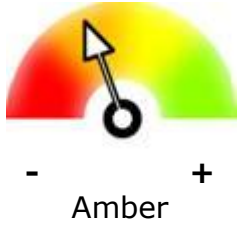
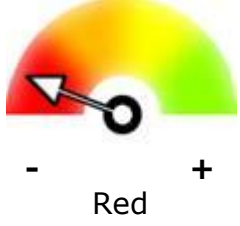
## **5. RECOMMENDATION**

- 5.1 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.**
- 5.2 The Audit Committee is asked to consider any further action required in respect of subjects reported.**
- 5.3 The Audit Committee is asked to note the summarised findings and conclusion in respect of the proposed final report on the *Corporate Legislative Compliance: Well Being of Future Generations Act*, and ongoing action to finalise this audit.**

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<sup>3</sup> It may be appropriate to agree Health Board timelines in common with those of the Public Services Boards.

AUDIT ASSURANCE RATINGS

RATING	INDICATOR	DEFINITION
Substantial assurance		<p>The Board can take <b>substantial assurance</b> 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 <b>low impact on residual risk</b> exposure.</p>
Reasonable assurance		<p>The Board can take <b>reasonable assurance</b> 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 <b>low to moderate impact on residual risk</b> exposure until resolved.</p>
Limited assurance		<p>The Board can take <b>limited assurance</b> 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 <b>moderate impact on residual risk</b> exposure until resolved.</p>
No assurance		<p>The Board has <b>no assurance</b> 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 <b>high impact on residual risk</b> exposure until resolved.</p>