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Bwrdd Iechyd Prifysgol  
Abertawe Bro Morgannwg  
University Health Board



<b>Meeting Date</b>	<b>20<sup>th</sup> September 2018</b>	<b>Agenda Item</b>	<b>4a.</b>
<b>Report Title</b>	<b>Audit &amp; Assurance Assignment Summary Report</b>		
<b>Report Author</b>	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
<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>Ten reports have been finalised with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate.</p> <p>The assurance levels derived can be summarised:</p> <ul style="list-style-type: none"> <li>• 3 <i>Reasonable</i></li> <li>• 4 <i>Limited</i></li> <li>• 3 No ratings applied</li> </ul>		
<b>Specific Action Required</b> <i>(please ✓ one only)</i>	<b>Information</b>	<b>Discussion</b>	<b>Assurance</b>
			✓
<b>Recommendations</b>	<p>Members are asked to:</p> <ul style="list-style-type: none"> <li>• Note the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management.</li> <li>• Consider any further action required in respect of the subjects reported.</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>	
Vaccination & Immunisation (ABM-1819-012)	
Charitable Funds: Part II (ABM-1819-016b) <i>This also presents the key findings of Part I again, and a combined assurance rating.</i>	
Annual Quality Statement (ABM-1819-019)	<b>No rating assigned</b>
Putting Things Right: Integrity of DatixWeb (ABM-1819-020)	
Protection of Vulnerable Adults: Deprivation of Liberty Safeguards (Follow Up) (ABM-1819-026)	
Health Records Management (ABM-1819-031)	
GP Managed Practice: Cymmer Health Centre (ABM-1819-035)	
Princess of Wales Delivery Unit Governance Review (ABM-1819-036)	
<b>Specialist Services Unit (SSU)</b>	
Sustainability Reporting (ABM-1819-S10)	<b>No rating assigned</b>
Carbon Reduction Commitment (ABM-1819-S11)	<b>No rating assigned</b>

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.

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

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

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

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

#### **3.1 VACCINATION & IMMUNISATION (ABM-1819-012)**



Board Lead: Director of Public Health

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

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

Immunisation is one of the most effective public health interventions. Outside of school flu immunisations all other Health Board childhood immunisation targets are currently not being met. This is documented in the Health Board's corporate risk register.

From October 2016 Health Boards were to implement the Healthy Child Wales programme which sets out what contacts children and their families can expect from their Health Boards over three areas of intervention screening, surveillance and immunisation. All Health Boards in Wales have a required target for childhood immunisations of 95% set by the Welsh Government.

The overall objective of this audit was to review the arrangements in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.

This audit considered the following:

- The Health Board's Strategic Immunisation Group (SIG) has terms of reference, operates in accordance with them and is attended by representatives from relevant Health Board directorates;
- There is effective communication between the Strategic Immunisation Group and its subgroups;
- Clear plans are in place to achieve targets and objectives, and these are subject to regular monitoring and review;

- Arrangements are in place to manage compliance with national data quality requirements.

### 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. As detailed within the scope, the review has focused on the over-arching governance arrangements for promoting the uptake of vaccinations and immunisations amongst the public.

This review has considered the Strategic Immunisation Group (SIG) and its sub-groups. Following a review of performance information, particular consideration was given to governance with respect to childhood immunisations performance.

At the outset of the audit planning, discussions and review of papers noted that the Chair position had been rotated between Health Board and Public Health representatives on a number of occasions. From November 2017 the Consultant in Public Health has been confirmed as the chair and the group refreshed its terms of reference and a further iteration was provided during the audit which had not yet been subject to approval.

There had only been one meeting (February 2018) since the original terms of reference were introduced and there was evidence within minutes of the SIG and subgroups of the need to enhance arrangements and some of the steps being taken to address them. However, within the timeframe of this audit action to improve arrangements was ongoing and we made a number of recommendations to improve arrangements further. These included:

- Clear approval of group / sub group terms of reference by sponsor / parent groups (and some improvements to content)
- Development and formal approval of plans, including those of sub groups, by the Strategic Immunisation Group, in accordance with terms of reference
- Monitoring of progress against plans via written reports
- Inclusion within plans of actions to audit data quality during the year, and clear responsibilities and timeframes for making improvements to known issues.

Action has been agreed with the Director of Public Health to be completed in early September 2018.

## 3.2 CHARITABLE FUNDS: PART II (ABM-1819-016b)



Board Lead: Director of Finance

### 3.2.1 Introduction, Scope and Objectives

An audit of Charitable Funds has been undertaken in accordance with the approved 2018/19 Internal Audit Plan. With the agreement of the Director of Finance, the audit was split into two parts. The second report focuses on expenditure and corporate systems in Finance. However, the report reiterates the key findings identified in *Part I* and presents the level of assurance derived across both *Part I* and *Part II* of the audit.

The overall objective of the review was to ensure that charitable donations were being identified, recorded and accounted for, in accordance with the requirements of the donors, relevant legislation, and the Charity Commission. In addition, the review has sought to ensure that access to funds has been made in compliance with the requirements of Health Board's SFIs and Financial Control Procedures.

The scope included:

- Accounting for and monitoring donation income;
- Management control of Just Giving activity;
- Gift Aid claims;
- Expenditure authorisation from funds.

### 3.2.2. 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.

#### Part I (Reported in June 2018: ABM-1819-016a refers)

We visited 23 wards across Morriston, Singleton, Neath Port Talbot and Princess of Wales sites and spoke with staff regarding donation records. At eight, staff informed us that they did not have or were unable to provide ward donation receipt books for review.

At the Neath Port Talbot Unit these arrangements were well established – staff receiving donations there are required to take them directly to General Office for receipting. At one ward (Ward C) the Ward Sister expressed a desire to have a donations receipt book. At another (Ward D), the Ward sister said she was not confident that donations received were used for the purpose intended.

Three wards out of five visited at the POW Unit could not provide donations receipt books for review (Wards 4, 19 & 20). At two of these we were informed that cash donations were not banked at General Office but retained on the ward as staff were not confident that funds would be spent as intended or considered this the most efficient way of accessing funds.

At Morriston Unit there were no books available on four wards (one of which was Ward M, managed by Singleton) and at one ward at Morriston (Ward J) we were informed that cash was retained locally without receipting as the process for accessing funds was too slow. Fewer issues were apparent at the Singleton Unit, though there was no book at Ward 1 Pre Assessment (this service is managed by Morriston).

At the wards highlighted above we cannot provide assurance that all donations received have been banked promptly or completely, and it would be difficult to give any independent assurance regarding how donations have been spent, as there is no documentary trail.

Additionally, we noted instances whereby the Treasurer of an external charity supporting Ty Olwen (managed by Singleton) had collected cash recorded in the Unit, without it having been receipted within the Morriston Hospital Cash Office firstly. The Health Board has an agreed arrangement with this charity in respect of the collection of donations intended for use within Ty Olwen – however, the release of cash for collection as above did not comply with financial control procedure requirements. This was brought to the attention of the Finance & Business Partner and Director of Finance and steps have been taken to address this.

## Part II

Finance have reported to the Charitable Funds Committee (CFC) on staff funded from charitable funds relating to cancer services. There are other more recent appointments (made in early 2017/18) that have not been included in reporting to the CFC yet. Further information has been requested by the CFC on staff costs. Whilst this was carried forward via the action log, it has since been omitted from the log and work plan but without an update to the Committee.

Out of a sample of 20 purchase order-based expenditure transactions, the approval records were not adequate for four: One example of expenditure prior to authorisation and below delegated level; the authorisation for two was typed on forms but there was no signature or email from the fund manager; and another was signed by the Finance & Business Partner but not the fund manager.

Out of a sample of 22 expenditure transaction lines without purchase order reference recorded, six did not have an adequately completed request form: five related to staff costs and did not have authorised request forms and the remaining transaction was a payment processed in excess of the value authorised on the request form.

Additionally, the Head of Accounting & Governance informed the auditor that following a series of complex mergers and ward moves at Morriston Hospital in 2014, he discovered that two wards had been paying donations into one fund. Rectifying action was taken to provide separate funds and re-allocate donations. We have recommended additional controls be considered to assist detect this earlier in future and to enhance FCP in respect of the reporting requirements to the Charitable Funds Committee.

Action has been agreed with the Director of Finance to be completed by the beginning of December 2018.

### **3.3 ANNUAL QUALITY STATEMENT (ABM-1819-019)**

*No rating  
assigned<sup>2</sup>*

Board Lead: Director of Nursing & Patient Experience

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

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

The overall objective of this assignment was to assist the Health Board with accuracy checking and triangulation of data and evidence before publication of the Annual Quality Statement [AQS].

The scope was limited to verifying that the AQS is consistent with information already published and/or reported to the Board and its committees over the period. It did not review the internal controls over data quality within the underlying information systems generating the data reported.

During the audit, consideration was given to the compliance of AQS contents with extant Welsh Government requirements and the potential impact any gaps in information may have on the representativeness of the AQS with respect to the quality of Health Board services. These have been highlighted during field work for management consideration and action if appropriate.

#### **3.3.2 Approach & Findings**

Internal Audit received its first version of the draft Annual Quality Statement (AQS) for audit review on 13<sup>th</sup> June 2018.

The draft AQS had been produced by members of the Nursing Directorate with input and oversight from the Deputy Director of Nursing. Audit noted that the process for producing the AQS for 2017/18 did not follow the formal process previously agreed by the Quality & Safety Committee

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<sup>2</sup> The outcome of this assignment is expressed narratively in the main body text of this report.

in 2015 or the *1000 Lives* document '*Creating your Annual Quality Statement*'.

The Quality & Safety Committee received a draft AQS on 7<sup>th</sup> June 2018. It was presented to the Committee by the Director of Nursing who confirmed that the AQS required further work. Members of the Committee highlighted a number of issues for the Director of Nursing to consider. Internal Audit reviewed the draft AQS produced on 13<sup>th</sup> June 2018 to ensure they had been addressed.

Internal Audit checked the content of the AQS against the requirements of Welsh Health Circular [WHC/2018/011] to identify any areas of the circular that had been omitted. Additionally, we reviewed a sample of statements and performance indicators presented within the draft AQS to ensure that they were both accurate and representative of what the Board had received during the year. Internal Audit highlighted a considerable number of queries and issues in the draft AQS that were discussed at a meeting with the Deputy Director of Nursing and her team on 20<sup>th</sup> June 2018 for agreement and confirmation that the adjustments would be made.

Following that meeting on 20<sup>th</sup> June 2018 Internal Audit provided the Deputy Director of Nursing with schedules of the matters discussed at the meeting; at the closure of audit fieldwork the Nursing Directorate continued to action those adjustments highlighted by Internal Audit. (Detail of the adjustments being progressed at the close of fieldwork were attached to the Draft version of the audit report).

In addition, Audit noted there was no evidence of engagement with Stakeholders during audit fieldwork.

At the closure of audit fieldwork the Deputy Director of Nursing advised that the draft AQS would not be submitted to Quality & Safety Committee or Audit Committee for sign-off before Health Board approval. However, she confirmed that she would engage with the Executive Team to seek their views and approval for sign-off of the final draft before it was submitted to the Health Board on 31<sup>st</sup> July 2018.

### **3.3.3 Opinion**

This report is the result of a limited scope audit of the Health Board's Annual Quality Statement for the year 2017/18. The breadth of the subject matter and timescales for the production of the AQS inherently limit the extent and depth of independent verification possible. Additionally, non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of subject matter and the methods used for determining such information. The scope of our assurance work has not included governance over quality or the detail testing of systems generating performance indicators information.

Based on the outcome of our limited scope audit review we would confirm that:

- The sample of statements and performance indicators reviewed by Internal Audit were largely consistent with information presented to Board or its Committees (13 out of 20). For those not substantiated to Board papers, Internal Audit were provided with correspondence received by the Nursing Directorate to support input.
- The AQS addressed many of the requirements of the Welsh Government circular. However, several areas for improvement were highlighted to the Deputy Director of Nursing for consideration. Some of these were key and required improvement before publication to ensure the AQS is representative.
- It should be noted that due to time restraints the AQS was submitted to the Board on 31<sup>st</sup> July 2018 without having final draft sign-off by any of the Board's committees or stakeholder engagement. We were informed that key changes would be reviewed by the three Executive Directors prior to its submission to the Board.

The Deputy Director of Nursing agreed to provide confirmation that all adjustments were complete. Following issue of the draft audit report, feedback was returned on action taken. Internal Audit did not review the changes made, but the management assurances of action taken and/or intended as part of the 2018/19 AQS development process were attached to the final report issued to the Director of Nursing & Patient Experience.

For 2018/19 the Welsh Government has set tighter timescales of June 2019 for the submission of the AQS. Internal Audit recommended that the Health Board review its processes to ensure that the *1000 Lives* guidance for 'Creating your Annual Quality Statement' is considered and the information required for 2018/19 is built up as the year progresses, instead of an end of year task. Action has been agreed with the Director of Nursing & Patient Experience to develop a robust framework for production of the next Annual Quality Statement, by December 2018.

### **3.4 PUTTING THINGS RIGHT: INTEGRITY OF DATIXWEB (ABM-1819-020)**



Board Lead: Director of Nursing & Patient Experience

#### **3.4.1 Introduction, Scope and Objectives**

This assignment originates from the 2018/19 internal audit plan agreed by the Audit Committee in March 2018.

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, issued under Welsh Statutory Instrument 2011 No. 704 (W.108), came into force on 1 April 2011 and apply to all Health Boards, NHS Trusts in Wales, independent providers in Wales providing

NHS funded care and primary care practitioners in Wales. The Regulations introduced a single and consistent method for grading and investigating concerns, as well as encouraging more openness and involvement of the person raising the concern.

DatixWeb online reporting system went live on the 1<sup>st</sup> December 2014 and is the system that enables the Health Board to monitor patient safety activities. The system consists of seven modules:

1. Incidents
2. Complaints
3. Claims
4. Risk
5. Patient Experience
6. Safety Alerts
7. Dashboards

The overall objective of this audit was to review compliance with the relevant standard operating procedures by Service Units and the promptness of actions taken to address concerns highlighted by the Datix Team.

The audit has reviewed compliance with the requirements of the standard operating procedures in place to ensure that:

- Management audits are undertaken by the Unit Governance Teams to ensure data within DatixWeb is accurate and complete;
- Concerns identified following local audit reviews undertaken by the Datix Team are communicated to Unit Governance Leads; and
- Unit Governance Teams act upon audit findings and provide assurance to the Datix Team on their progress and/or completion.





This review considered the information and activities of key corporate groups, including the Datix/Snap User Group, in addition to an analysis of available information extracted from the DatixWeb system before selecting Service Delivery Units to test.

### **3.4.2 Overall Opinion**

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

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

The summary of assurance given against the corporate Datix Team and Service Delivery Unit roles and responsibilities is described in the table below.

<b>Assurance Summary</b>				
Corporate Datix Team				✓
Service Delivery Units		✓		

### Corporate Datix Team

We can confirm that the Datix Team are fully compliant with the standard operating procedures, in addition to having an established risk-based audit work programme in place for 2018/19 with the findings of each individual audit made available to the various governance teams within the Health Board through the use of a shared folder. The sharing of the findings allows the governance teams to investigate and amend individual records to ensure that the integrity of the information within DatixWeb is accurate and complete.

We were informed that audit findings identified for some specialties, such as Obstetrics, would be managed by the Women & Child Health (W&CH) Governance Team rather than POW Governance Team. Consideration should be given to ensuring that the W&CH Directorate governance team also provide assurance to the Datix Team for addressed audit findings.

### Service Delivery Units

We noted that the Service Delivery Units were not fully compliant with the standard operating procedure for addressing issues raised in the audit reports provided by the corporate Datix Team. Failure to complete the necessary actions poses a risk to the quality of data within the DatixWeb system.

One key finding was noted during this review:

- The June 2018 findings of Audit 4 – Investigations & Actions Combined identified 2697 issues relating to the incompleteness of the actions tab on the incident form. We noted that 2585 of these issues were incidents with 'No Harm' and 'Minor Harm' outcomes. Whilst we noted the positive changes to the DatixWeb incident form with the introduction of the 'Action Type' box in order to mitigate the risk above, many of the 2697 are historical issues that are still not amended and remain on the system.

In addition, the following have also been identified for further action:

- We noted that many of the Units and Directorates did not provide assurance to the Datix Team that identified issues had been

addressed on the DatixWeb system – only POW and NPT Hospital Units regularly reported assurance.

- We noted eight instances out of 50 where assurance had been provided by the Governance Lead; however, the audit findings had not been addressed in DatixWeb.

Action has been agreed with the Director of Nursing & Patient Experience to address key actions by the end of September 2018. One low priority recommendation will remain to be addressed by the end of March 2019 (in line with boundary change work).

### 3.5 POVA: DOLS (FOLLOW UP) (ABM-1819-026)



Board Lead: Director of Nursing & Patient Experience

#### 3.5.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan agreed by the Audit Committee in March 2018.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provide protection for vulnerable people in care homes or hospitals who lack capacity to consent to the care of treatment they need. Within ABMU DoLS apply to those who are considered to be deprived of their liberty within an inpatient hospital setting.

An internal audit review of Health Board arrangements undertaken in 2017/18 derived a *limited* level of assurance. Action was agreed to address 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 previous audit.

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.

#### 3.5.2. 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 previous audit made ten recommendations, of which three were high priority, six were medium priority, and one low priority. Concluding testing, we can confirm that five recommendations had been addressed, whilst five were partially addressed. It should be noted that the Unit Nurse Director in Primary Care & Community Services and Corporate Safeguarding Team confirmed that they had been monitoring progress against implementation of agreed action and shared the information with Internal Audit at the outset, recognising that at that point not all actions were complete.

The following key findings were noted:

- Although the master DoLS database had been enhanced to include the dates of key actions taken in the process and reason for breaches, Audit noted that the field 'date paperwork sent to ward' is not being consistently completed on all DoLS cases, this has resulted in a delay in communication to the ward.
- Staff within the Units are not reporting breaches via Datixweb. There are large inconsistencies between the number of DoLS breaches reported on DatixWeb and the number of breaches reported on the master DoLS database. A report run from Datixweb identified 15 breaches between April and June 2018 whilst in the same period the master DoLS database recorded 172 breaches.
- During 2017/18, 984 DoLS applications were processed – 70% of these applications used external Best Interest Assessors (BIAs) at a cost of £82,800. The use of BIAs in 2018/19 continues to be high. Further enquiries confirmed that the control and management of the services provided by external BIAs is not via a service agreement/contract therefore the quality of service provided cannot be guaranteed. Of the 70% of assessments that were undertaken by external BIAs, 91% breached the time target.
- In May 2018 the Mental Health Legislation Committee were informed that "The Health Board has now introduced a BIA rota" – Audit were advised that the BIA rota was prepared but was not introduced until 1<sup>st</sup> August 2018 as per the improvement plan. The Health Board now has 21 BIAs ready to be deployed with a further 11 BIAs trained and awaiting shadowing before being eligible for deployment; however of these, four had not had an enhanced CRB/DBS check which deems them ineligible to undertake any Deprivation of Liberty Safeguarding assessments.
- The information held within the central databases at Morriston, Singleton and Neath Port Talbot were compared for a period against the information held on the master DoLS database. It was identified that the information held on the unit databases do not reconcile. It was also evident that with the DoLS cases held on the units' databases were not always fully completed.

Action has been agreed with the Deputy Director of Nursing & Patient Experience to be completed by the end of October 2018.

## 3.6 HEALTH RECORDS MANAGEMENT (ABM-1819-031)



Board Lead: Medical Director  
cc Assistant Director of Informatics (CIO)

### 3.6.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan and agreed by the Audit Committee in March 2018.

Every patient admitted into ABM is assigned a physical health record that contains various sources of information such as clinical notes, correspondence, procedure results. The Health Records Department is responsible for organising, updating and storing these records. The tracking of patient health records is undertaken via the Welsh Patient Administration System (WPAS) with the data held electronically reconciling to the information held on the patient's physical health record.

The overall objective of this audit was to review the arrangements in place for the management of paper health records within the Health Board.

The audit scope reviewed arrangements in place to ensure that:

- Policies and procedures are clear in respect of the record-keeping requirements.
- Adequate storage facilities are in place for the secure retention of health records at ward and department levels.
- Mechanisms are in place to review and monitor compliance with record-keeping requirements and to ensure action is taken where issues are evident.

This audit arose from the corporate risk register entry with respect to the management of paper health records on acute hospital sites, which indicated that current controls in place included temporary retention & destruction plans; alternative storage arrangements; and ward protocols and audits rolled out across all sites. The register also indicated the pursuit of funding for radio-frequency identification (RFID) technology to allow the organisation to accurately track health records and reduce the number of physical records in circulation.

Accordingly, the audit has considered arrangements in place at Singleton, Morriston, Neath Port Talbot and Princess of Wales hospitals.

### 3.6.2 Overall Opinion

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

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

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 issues to highlight.

The Health Board has an extant *Health Records Policy* in place and the Health Records Department has introduced a number of initiatives to provide assurance regarding health records management through the implementation of a ward protocol, temporary retention and destruction plans and undertaking regular ward audits. In addition, we confirmed the Health Board had pursued funding for the introduction of RFID technology as indicated in the risk register. This had been approved recently at the time of audit.

Whilst there were no key findings identified during this review, the following were identified for further action:

- An Information Commissioner's Office (ICO) audit into data protection was undertaken in November 2016 with a total of 48 recommendations raised – 15 were directly related to records management. A subsequent follow-up was undertaken in November 2017.

We can confirm the incorporation of some ICO actions into a combined Health Board information governance action plan that is monitored regularly at the Information Governance Board, whilst other evidence was made available to the auditor to support the completion of recommendations. However, two outstanding recommendations were not monitored in minutes and papers.

- There was no evidence to demonstrate the receipt of Health Records Progress Update Reports (which include the findings of health records ward/department audits) at NPT and Singleton Unit Quality & Safety Groups.

An action plan was agreed with the Medical Director to address some actions within Units by the end of August 2018, but it is anticipated that the introduction of RFID will improve arrangements further, so some actions have been agreed for completion by September 2019, in line with RFID implementation timescales.

### 3.7 GP MANAGED PRACTICE: CYMMER HEALTH CENTRE (ABM-1819-035)



Board Lead: Chief Operating Officer

#### 3.7.1 Introduction, Scope and Objectives

This assignment originates from the 2018/19 internal audit plan. The Health Board directly manages Cymmer Health Centre. In June 2017, the Health Centre was subject to an announced inspection by the Health Inspectorate Wales (HIW). Their report, incorporating the Health Board's management action plan, was published in September 2017. The report noted that the inspection found evidence that the Health Centre provided safe and effective care. However, it found some evidence that the practice was not fully compliant with all Health and Care Standards in all areas.

The overall objective of this audit was to review the arrangements in place for the direct management of the Cymmer GP Health Centre. The scope focused on arrangements in place to ensure improvements have been made following the June 2017 HIW inspection at Cymmer Health Centre.

The audit reviewed monitoring arrangements in place within the Unit firstly. Following this, we reviewed evidence in support of progress reported, undertaking desktop review of key documentation and a sample of changes made at the practice.

#### 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.

Progress was evident in respect of most recommendations made by HIW. However, further action needs to be taken in order to address the some of the issues raised by HIW effectively.

There was one key finding identified during the audit:

- The risk register is the monitoring tool being used to monitor progress against actions from the HIW Inspection. However, while six of the actions have been marked as completed in the register, further action is required to address the associated issues in the

HIW report effectively. Further action had not been added at the time of the audit.

Amongst those areas requiring management attention to complete we would highlight the following:

- The development of an action plan with assigned responsible officers and completion dates was not evident for the Fire Risk Assessment and security risks remain to be formally assessed and addressed;
- There is no plan to address completion of mandatory training.

Action has been agreed with the Chief Operating Officer to be completed by the end of October 2018.

### **3.8 PRINCESS OF WALES DELIVERY UNIT GOVERNANCE REVIEW (ABM-1819-036)**



Board Lead: Chief Operating Officer

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

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

The Health Board's Service Delivery Units became operational from October 2015. Whilst this was the case, Princess of Wales Hospital had been managed already as a separate unit from February 2014 under the direction of a previous hospital director. An internal audit review undertaken in June 2015, assessed the governance arrangements in place up to that point and reported a *limited* assurance rating. The new Unit Service Director (the current post holder) who had recently taken up post at that time agreed action to address key findings raised.

The objective of this review was to confirm the Unit governance structures follow the principles set out in the Health Board's current system of assurance, and support the management of key risks and the achievement of the Unit's objectives.

The approach taken was a desktop review of the terms of reference, work plans/programmes, agendas, minutes & action logs documented of key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.

#### **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.

Prior to the commencement of fieldwork the Unit Head of Patient Experience, Governance & Planning submitted his resignation following extended sick leave which commenced in February 2018. Within the governance structure of the Unit this is a key role. We acknowledge the valuable contribution made by the Unit Nurse Director in taking on responsibilities within this area in the intervening period.

This audit has been undertaken in the context of these challenges and a number of the findings in the report reflect these circumstances. In considering our findings we have reflected on how they have will have affected the maturing of governance arrangements within the Unit.

Following the closure of fieldwork we note that the revised post of Head of Quality & Safety has been advertised, and the position will now report directly to the Unit Nurse Director.

The Patient Experience & Governance team have provided comprehensive supporting arrangements and information within the Princess of Wales Hospital Unit to Service Group Managers and Unit Directors aiding in the focus on patient Quality and Safety.

The key issues identified during this audit:

- The Unit Quality & Patient Safety (QPS) committee meetings held experienced poor clinical attendance (medical representatives and senior nurses). Additionally, four meetings were cancelled in the period April 2017 – March 2018.
- The QPS committee terms of reference were reviewed but were not subsequently revised. They require redrafting to ensure they reflect current Q&S priorities and reporting arrangements.
- The QPS has no workplan. A workplan would contribute to improved monitoring of Unit Q&S business in the event of the disruption of meeting cancellations. We noted gaps in the reporting of Unit quality and improvement plan management, health & care standards progress, formal progress against the HIW improvement plans, and work of the Unit Health & Safety Committee. A workplan would also contribute to strengthened reporting from groups such as Spot the Sick patient and Nutrition and Hydration which have not reported to QPS within the last year.
- Good communication between the Patient Experience Team and Service Group Managers was evident in respect of risk register management, though a number of risks were identified as overdue for review. However the reporting of risks to Hospital Management Committee (HMC) and the Unit QPS committee require improving. The HMC has not received the full risk register and the QPS had not done so for a period of September 2017 – June 2018.

Action has been agreed with the Chief Operating Officer to be completed by the end of October 2018.

### **3.9 SUSTAINABILITY REPORTING (ABM-1819-S10)**

**No rating**

Board lead: Director of Strategy

#### **3.9.1 Introduction, Scope and objectives**

The review of sustainability data for the Health Board's 2017/18 Annual Report was completed in accordance with the agreed internal audit plan. The review sought to assess the adequacy of management arrangements for the production of the sustainability report within the Annual Report.

The review focused on the following key areas:

- Compliance with relevant guidance;
- Accuracy of reported data;
- Underpinning systems for the collection and reporting of data; and
- Follow up of previously agreed recommendations.

This is a proactive review rather than assurance audit, and accordingly a summary briefing paper was issued for management information and action. An assurance opinion was therefore not determined.

#### **3.9.2 Key Findings**

A robust process for data recording was found to be in operation, with minimal issues identified in data accuracy during the review.

Sound working papers were in place to enable reconciliation of the reported totals to EFPMS and source data, for energy, water and waste.

Some issues were identified in content and accuracy at the compilation of the first draft of the report; however these were identified and corrected by management prior to its finalisation.

Five of the previous six outstanding recommendations have now been closed. The outstanding issue related to the timetable for completion of the sustainability report. There is a need for greater clarity within Estates of the deadline for submission of the Sustainability Report, and an understanding by Corporate Services of the implications in terms of accuracy of the report should it be required too soon after year end. Discussions needed to take place to reach an agreement to a realistic deadline to which the Estates team can work in the forthcoming year.

Four new recommendations were made aimed at strengthening or enhancing the processes currently being applied. These included:

- the inclusion of the systems and methods used to collect data within the Report narrative, i.e. in accordance with the NHS Wales Manual for Account;
- ensuring that the draft sustainability report is subject to a secondary check of narrative and data (including key calculations) prior to submission (for approval) to the Assistant Director of Strategy – Estates;
- notes and formulae should be added at the waste spread sheet where multiple invoices are used to calculate the total entered, to provide a clear audit trail of data sources; and
- details of any radioactive waste should be captured at the waste spread sheet and included within the sustainability report.

### **3.10 CARBON REDUCTION COMMITMENT (ABM-1819-S11) No rating**

Executive Lead: Director of Strategy

#### **3.10.1 Introduction, Scope and objectives**

The review of the Health Board’s participation in the Carbon Reduction Commitment (CRC) Scheme has been completed in accordance with the agreed internal audit plan. The review sought to assess the adequacy of management arrangements for participation in the Scheme, including mandatory and best practice elements.

The scope of the review was limited to the following aspects:

- Follow up of previous recommendations;
- A review of the 2017/18 annual report;
- Assessment of the management of the purchase of allowances; and
- Sufficiency of the evidence pack.

This was a review rather than assurance audit, and as such a briefing paper was issued in place of an audit report. An assurance opinion was therefore not determined.

#### **3.10.2 Key Findings**

The UHB has operated a robust data collection and management process throughout the year, with audit checking finding no errors in data recording. The Health Board was not required to report any data as estimated in 2017/18 (and thereby avoiding the 10% uplift applied to estimated data), due to the extensive collection of self-read meter data meant that.

Clear and accurate CRC working papers were prepared, with only one minor error identified during the review. This was corrected prior to reporting.

An administrative error during the 2016/17 buy to comply sale window resulted in the payment deadline being missed. Despite the potential for significant financial penalties as a result of this breach of the CRC Order, the risk was mitigated through liaison with the UK Government Environment Agency, but ultimately the Health Board incurred an additional £76k in costs as a result of the error. This issue has been separately reported within the UHB.

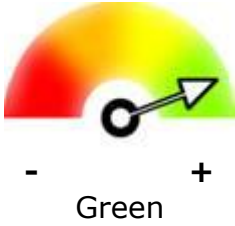
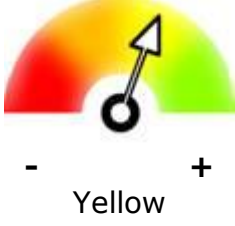
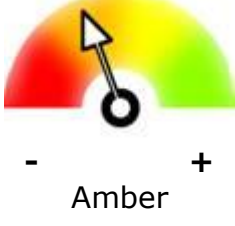
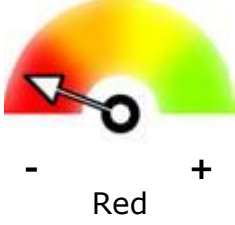
Of the three recommendations raised last year, two have been closed at this follow up and another was in progress.

No new recommendations have been made.

#### **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.**

## 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>