Meeting Date	**19th September 2019**	**Agenda Item**	**3.1**
Report Title	**Audit & Assurance Assignment Summary Report**		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Paula O'Connor, Head of Internal Audit, NWSSP A&A Huw Richards, Deputy Director, NWSSP A&A (SSu)		
Freedom of Information	Open		
Purpose of the Report	To advise the Audit Committee of the outcomes of finalised Internal Audit and Specialist Service Unit reports.		
Key Issues	Seven final reports have been agreed with Executive leads since the last meeting. Their outcomes are summarised for information and discussion as appropriate. The assurance levels derived can be summarised: *6 Reasonable* *1 Limited* The Report indicates the timescales for completion of actions agreed with management for each.		

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

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

AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. PURPOSE

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

2. REPORTS ISSUED

This report summarises the outcomes of the following finalised assignments:

Subject	Rating[1]
Internal Audit	
Infection Prevention & Control (SBU-1920-019)	
Prevention and Management of Inpatient Falls (SBU-1920-020)	
WHO Checklist (SBU-1920-021)	
Unit Governance: Mental Health & Learning Disabilities Unit (SBU-1920-034)	
Morriston Hospital Cardiac Services (SBU-1920-035)	
Hospital Sterilization & Disinfection Unit (SBU-1920-037)	
Nurse Staffing Levels Act (SBU-1920-041)	

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

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

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

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

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 INFECTION PREVENTION & CONTROL (SBU-1920-019)

Board Lead: Director of Nursing & Patient Experience

3.1.1 Introduction, Scope and Objectives

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

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

In the 2017/18 Annual Quality Statement, one of the quality priorities going forward for the Health Board was to reduce harm arising from all forms of Health Board attributable healthcare associated infections, specifically Clostridium Difficile infection (C.Diff) and Staphylococcus Aureus bacteraemia and Escherichia Coli (E.Coli) bacteraemia.

The overall objective of this audit was to review compliance with the Welsh Government guidance and Health Board policies & procedures.

The objective of the review was to assess across a sample of the 10 elements of the Standard Infection Control Precautions arrangements in place to ensure they are being followed: Patient Placement, Hand Hygiene, Respiratory Hygiene and cough etiquette, Personal Protective Equipment, Safe Management of Linen, Management of Blood and Bodily fluids, Safe Disposal of Waste and Occupational Exposure Management.

The audit scope considered the following:

- The Health Board has an infection prevention and control policy in place, which provides clear guidance for the staff to apply. The policy is also available to staff and is subject to regular review;
- The Health Board has a comprehensive strategy in place to ensure there is strategic focus and innovation going forward;
- The role of the Infection Prevention Control Committee is clearly defined and is fulfilling the requirements of its terms of reference;
- Management responsibilities and arrangements are appropriately defined and adequate governance and reporting arrangements demonstrated;

- Appropriate controls are in place to ensure that risk areas appropriate and effectively managed;
- All incidents of reportable Health Care Acquired Infections are carried out whereby incidents are examined and analysed to identify any recurring themes across the Health Board;
- The Board via the Quality & Safety Committee are kept informed of all issues arising.

3.1.2 Overall Opinion

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

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

The following key findings were identified:

- There was a significant shortfall in data on the incidence of infections recorded in Datix when compared with ICNet.
- Also long delays were noted in the closure of investigations into infection incidents recorded on Datix.
- These impact upon the ability of the Health Board to apply effective scrutiny.

Action has been agreed with the Director of Nursing & Patient Experience to be completed by the end of November 2019.

3.2 PREVENTION AND MANAGEMENT OF INPATIENT FALLS (SBU-1920-020)

Board Lead: Director of Nursing & Patient Experience

3.2.1 Introduction & Background

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

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospitals are the most commonly reported patient safety incidents, with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day). Swansea Bay University Health Board's May 2019 Performance report indicated there were a total of 3,761 falls recorded during the 2018/19 year (over 10 per day).

The Health Board's extant Policy for the Prevention & Management of Inpatient Falls was endorsed by the Nursing & Midwifery Board in September 2016, with the expectation that it be used in conjunction with an inpatient falls pack ratified in October 2016. The policy has been reviewed since and a revised version received and approved by the Quality & Safety Committee in August 2018. The new policy is intended to reflect recommended guidance from NICE and the recommendations from the 2017 National Inpatients Falls Audit. Whilst this policy has been revised, the Integrated Performance Report to the Board in May 2019 indicated that the policy has not yet been implemented but it was intended that once training had been completed within the Service Delivery Units it would be launched across the Health Board. The Deputy Director of Nursing & Patient Experience informed us during the planning of this audit that training levels have been monitored corporately and September 2019 is now envisaged as the implementation date.

During 2017/18 a Falls Prevention and Management Group was in place, chaired by the Princess of Wales Unit Nursing Director. The Group was stood down late 2018 and the inaugural meeting of the Hospitals Falls Injury Prevention Strategy Group took place on 25th June 2019, chaired by the Neath Port Talbot Unit Nurse Director.

The overall objective of this audit was to review compliance with key aspects of Health Board Policies and Procedures.

As the Hospitals Injury Prevention Strategy Group is newly established we agreed that the scope of this audit would exclude the work of this group. Additionally, as the revised policy was not yet implemented formally, the audit did not review compliance with newly introduced requirements. However, there were some expectations which were common to both the current and revised policies, and others set out within wider Health Board policies (e.g. incident reporting), which were considered within the scope of the audit.

The audit scope considered the following:

- Unit(s) performance of audits of compliance with falls policy, procedures and record-keeping, in particular the completion of falls risk assessments and care plans, in hotspot wards and departments.
- Compliance with policies for the investigation of falls classed as serious incidents (including fractured neck of femur).
- The effectiveness of the Unit Management Board(s) and/or Unit Quality & Safety Group(s) in monitoring and scrutinizing operational compliance with key elements of Health Board policy & procedures, in particular the completion of falls risk assessments and care plans reviewed within local falls audits and serious incident investigations.
- Evidence of actions outlined in Unit Risk Registers to address falls.
- Reporting of Unit(s) audits via Unit Nurse Director exception reports to the Health Board's Quality & Safety Forum.
- The steps being taken to strengthen the levels of falls management/prevention training in readiness for the launch of the

new policy (recognizing that the extant policy does not stipulate specific training).

- The potential impact of work undertaken under the Gold Command implemented by the Executive Medical Director as a result of the Health Board appearing as an outlier for mortality in the National Hip Fracture Database audit 2018.

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.

There were no key findings arising from the audit. However, action agreed has been agreed to improve the reporting of the coverage and outcomes of nursing quality assurance visits within units, an element of which assesses compliance with falls risk assessment and care planning documentation.

The majority of actions have been agreed with the Director of Nursing & Patient Experience to be completed by the end of December 2019 with action relating to the "gold command" due by the end of March 2020.

3.3 WHO CHECKLIST (SBU-1920-021)

Board Lead: Executive Medical Director

3.3.1 Introduction, Scope & Objectives

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

The World Health Organisation (WHO) Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery.

The overall objective of this audit was to review whether the Health Board has arrangements in place to demonstrate compliance with completion of the WHO checklist.

The audit scope has considered the following:

- Documented procedures are available and have been communicated to staff indicating roles & responsibilities and processes for completing the WHO checklist;

- Completed checklists have been signed off by staff in accordance with roles specified in procedures;
- Management monitor & audit the completeness and effectiveness of WHO checklist completion and take action to improve use where necessary;
- Where theatres never events are identified, investigations record a review of WHO Checklist usage and where failings are identified management ensure that action is taken to address them and spread the learning widely.

The audit has considered controls operating corporately and within the Morriston, Singleton and NPT acute units of the new Swansea Bay University Health Board. Whilst this is the case, the data analysed related to the last financial Quarter of the former Abertawe Bro Morgannwg UHB and includes procedures recorded against the Princess of Wales Hospital.

3.3.2 Overall Opinion

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

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 we have reported limited assurance overall, we noted a high level of completion of the checklist within the theatres system (TOMS), though analysis of the data has highlighted some areas where further management review has been recommended.

Additionally, we noted that the need for improvement following the investigation of never events and feedback from HIW inspection, has been recognised by management and units have been engaged in the review of operating standards and discussion of improvements required at the Theatres Board. Copies of local standards developed were shared and we were informed that they were in the process of finalisation during the audit period.

The following key areas have been identified for attention:

- New standards are not consistent or clear on observational audit expectations and the reporting arrangements. One unit had not performed any observational audits; the other two provided examples but they had adopted different approaches to recording the audits which could make the provision of consistent assurance corporately more difficult.
- At the time of audit, unit and corporate governance groups were not reviewing WHO checklist data analyses or observational audit

findings in relation to compliance with the expected approach to the use of the checklist and record-keeping requirements.

Action has been agreed with the Executive Medical Director to be completed by the beginning of November 2019.

3.4 UNIT GOVERNANCE: MENTAL HEALTH & LEARNING DISABILITIES UNIT (SBU-1920-034)

Board Lead: Chief Operating Officer

3.4.1 Introduction, Scope and Objectives

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

New Service Delivery Units became operational from October 2015, with work planned to implement a strengthened governance framework to address quality, performance, risk and assurance.

In the period since, the care provided to persons with mental illness, learning disabilities and dementia has continued to attract intense media interest and public concern.

- Following closure of the Tawel Fan ward at Betsi Cadwalladr UHB's Ysbyty Glan Clwyd in December 2013, an external review published by Donna Ockenden in June 2018 reported on failings in governance arrangements at that Health Board.

- Following a review within ABMU Health Board, in January 2019 the Healthcare Inspectorate Wales published a report on the handling of the employment and allegations made against a former employee, since convicted of murder, against whom allegations of sexual abuse had been made by patients in his care whilst an employee of the Health Board.

The overall objective of this audit was to review governance arrangements for both Mental Health and Learning Disabilities and the management of risk within the Service Delivery Unit.

The audit scope considered the following:

- The Unit has a clear organisational group structure with approved terms of reference;
- The terms of reference and work plans of Unit groups are constructed in such a way as to provide assurance on key areas of Unit business;
- The groups operate in accordance with their terms of reference and work plans;
- Arrangements are in place to ensure that the additional information needs of groups and actions agreed are addressed in a timely way (Action Logs);

- The Unit uses its risk register dynamically and in accordance with Health Board strategy, to record, assess, manage, monitor and report on risks.

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 Unit had a well-documented governance group structure. All groups with the exception of the Weekly Business Meeting had documented terms of reference that were on the whole well composed. Some were overdue for review but this is underway currently.

The Unit had arrangements in place to promote regular management review of its risk register. We also recognised the central support provided to Locality teams in management of risks which are Unit wide.

We noted the recent action by the Unit Head of Operations to gain assurance on the completion of actions from historic HIW action plans in the period 2016 – 2019. This was alongside reporting of action plans to the Unit Q&S Committee (Q&S) of recent external reviews.

Unit Management receive comprehensive Performance Scorecards which provide detail to ward/site level allowing for the identification of developing or emerging issues.

We also noted the commissioning by Unit Management of an external Clinical Services review with the purpose of providing strategic options to modernise the Community Learning Disabilities Service. A final report was shared by Unit Management and we noted consideration of future service provision was underway.

The key issues identified during this audit were:

- The Unit Q&S Committee received a 'Business Log' in January which outlined subject areas to receive additional reporting on a rotation basis. Meeting minutes noted that it was to be reviewed and re-presented but the following meeting was cancelled and the Business Log has not returned to the Committee. A review of papers identified that of the six expected reports for the January – April period only three were presented.

A workplan would contribute to improved monitoring of Unit Q&S business. This could also strengthen reporting from groups where predominantly verbal updates have previously been provided.

- The Unit Q&S Committee meetings have experienced poor attendance from members of Locality Senior Management Teams.
- The Specialist Services Locality Service Managers are assigned to undertake unannounced 15 step challenge assessments to sites within the Locality. For 2018/19 nine out of 21 assessments were either not completed (six) or reports not available (three). There was no mechanism for monitoring progress and outcomes at a Unit wide level.

In addition to the above, a number of observations and recommendations were made to improve the organisation of ongoing Unit business.

The majority of actions have been agreed with the Chief Operating Officer to address issues raised by the beginning of October 2019 with action relating to the Unit "15 steps programme" due by the end of March 2020.

3.5 MORRISTON HOSPITAL CARDIAC SERVICES (SBU-1920-035)

Board Lead: Chief Operating Officer

3.5.1 Introduction, Scope and Objectives

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

The Morriston Hospital Unit Risk Register contains a large number of high level risks associated with Cardiac Services. In response to an Internal Audit review of Unit Governance arrangements, management agreed actions including the development of a Risk Register Standard Operating Procedure and the enhancement of Service Group reporting on their management of risk.

The overall objective of this audit was to review the risk management arrangements within Cardiac Services.

The audit scope considered the following:

- Review of the Risk Register Standard Operating Procedure
- Effectiveness of the Cardiology Service Board (CSB), Cardiothoracic Surgery Service Board (CSSB) and other unit and service level management processes, where documented, for scrutinising and monitoring risks
- Completeness and currency of the Service Risk Register considered by the Service Boards
- Management of high level risks
- Reporting to Morriston Quality & Safety Group and Management Board

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.

Despite the gap in Cardiology Board meetings in the period December 2018 – May 2019 we noted that through the Unit Directors Risk and Assurance meetings and the support from the Q&S Lead Surgical Services that there has been effective management of the service risk register.

This reflects the progress in addressing some of the weaknesses in risk register management identified during previous audits of Unit governance. There remains a need to develop a standard format of reporting to ensure information provided within the Surgical Service Group is consistent and timely.

Action has been agreed with the Chief Operating Officer to be completed by the end of September 2019.

3.6 HOSPITAL STERILIZATION & DISINFECTION UNIT (SBU-1920-037)

Board Lead: Chief Operating Officer

3.6.1 Introduction, Scope and Objectives

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

The Health & Care Standards require that suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment. Within Swansea Bay UHB, the central function performing these services is the Hospital Sterilisation and Disinfection Unit (HSDU). The function has departments within Singleton and Morriston Hospitals, and is managed within the Morriston Hospital management structure. In addition to the service it provides for those sites, it also performs this service for other hospital sites and some community services.

The head of service indicates that the HSDU operates in accordance with ISO13485 and is inspected and accredited by an external organisation SGS. Monthly, documented Business Governance meetings address governance and risk management requirements.

The overall objective of this audit was to review the governance arrangements in place that provide senior management and the Board with assurance in respect of compliance with external directions and health board policies & procedures.

Recognising that the ISO requires a programme of management audit and monitoring arrangements, and that technical inspection and accreditation are performed via an external organisation, the internal audit review of compliance focused on the operation of these arrangements.

The audit scope has considered the following:

- Business Governance meetings are documented and operate effectively, receiving information with which to monitor and manage the quality of services provided.
- A planned programme of audit is implemented to determine whether the quality management system conforms to documented requirements, and the findings and remedial actions are monitored by senior management.
- Action is agreed to address issues of non-conformance identified during external inspections, and monitored to completion by senior management.
- The Unit uses its risk register dynamically and in accordance with Health Board strategy, to record, assess, manage, monitor and report on risks.
- Key issues & assurances are reported within the Morriston Hospital Unit management structure, and to the Quality & Safety Committee / Board via a clear reporting line.

In reviewing the above, consideration was given to the compliance of audits and information provided against the requirements of agreed management policies & procedures, including:

- Time to re-processing
- Cleaning validation & continuous monitoring
- Tracking & traceability
- Training & competency of HSDU staff
- Incident / defect reporting

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 audit, 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.

HSDU has established operating procedures, audit and performance monitoring and a reporting line to its service group (Clinical Support Services). Its most recent external inspection resulted in continued accreditation with only two minor issues raised. There have been changes in leadership and quality functions. The new management had identified areas for improvement and we noted evidence of progress (NB management of the HSDU has changed again following the completion of the audit review).

Whilst we identified no fundamental system weaknesses, the following have been raised for further attention:

- There was no mechanism to monitor time from close of procedure in theatres to re-processing in HSDU;
- There was scope to improve the monitoring of closure of actions identified following internal quality audits;
- External inspections were not included in the corporate risk team's "External Inspections" report to the Quality and Safety Committee.
- Additionally, we noted work undertaken to cleanse and refresh the HSDU risk register. We have highlighted the need to continue periodic review to incoming management.

Action has been agreed with the Chief Operating Officer to be completed by the end of October 2019.

3.7 Nurse Staffing Levels (SBU-1920-041)

Board Lead: Director of Nursing & Patient Experience

3.7.1 Introduction, Scope and Objectives

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

The Nurse Staffing Levels (Wales) Act 2016 (the 'Act') commenced in Wales in March 2017. Sections of the Act which came into force in April 2018 introduced a duty for Local Health Boards and NHS Trusts in Wales to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level.

The nurse staffing level is the number of nurses (registered nurses and others to whom the registered nurses delegate care tasks) appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The duty to calculate nurse staffing levels currently applies to adult acute medical inpatient wards and adult acute surgical inpatient wards (as defined within the statutory guidance) with all Health Boards and Trusts required to make arrangements to inform patients of the calculated nurse staffing level.

The overall objective of this audit was to review arrangements in place to ensure that the Health Board has appropriate processes in place to ensure

that it is complying with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

The audit scope considered whether:

- The Health Board has agreed an appropriate operating framework and procedures and these are made accessible to all relevant staff;
- Nurse staffing levels are calculated, using the prescribed methodology, for all adult acute medical and surgical inpatient wards (as defined within the statutory guidance of the Act) and these levels are reviewed at least every six months, in accordance with the requirements of the Act;
- The Health Board has identified an appropriate Designated Person to calculate the nurse staffing levels, and this person formally presents the nurse staffing levels for every adult medical and surgical inpatient ward (as required by the Act) at least annually to the Board;
- Effective processes are in place to ensure that patients are informed of the nurse staffing levels, in accordance with the requirement of the Act;
- Arrangements are in place to monitor compliance and steps taken to enable wards to maintain nurse staffing at the calculated levels;
- Effective arrangements are in place for reporting to the Board on the extent to which levels have been maintained, the impact of any shortfall and action taken.

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.

Audit recognised that key decisions with respect to levels calculated for 2018/19 and options with respect to meeting them and funding implications were discussed and supported by the Board in June 2018.

The review identified two key findings for consideration as part of current and future calculation and reporting cycles:

- Whilst we were provided with an example of template documentation returned to Unit Nurse Directors in September 2018 setting out their calculated levels for 2018/19 following corporate scrutiny, and the Corporate Matron's covering email indicated that they were digitally signed by the former Director of Nursing & Patient Experience, the signature was just her name typed into a spreadsheet. There was no robust record of her approval of the ward levels calculated.
- The 2018/19 end-of-year report followed a format used across Wales, though the format allows flexibility in the narrative description and data

individual bodies may choose to include. Within the content it did not present any data on the extent to which the calculated levels were achieved during the year. Discussion with the corporate nursing team indicates that reporting this information is a complex matter and subject to All Wales work. (A review of reports of four other organisations in Wales indicated only one that had provided any data in this respect.) This has been highlighted as a key area for improvement in future reporting cycles.

The majority of the actions to address issues raised have been agreed with the Director of Nursing & Patient Experience by the end of November 2019, with action relating to the next annual report due by the end of June 2020.

4. RECOMMENDATIONS

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

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

APPENDIX A

AUDIT ASSURANCE RATINGS

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