All-Wales Summary Report

Estates Assurance – Control of Contractors

October 2021

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

1. Introduction

In 2019/20 and 2020/21, we completed reviews of the arrangements in place for the management and control of contractors at the following NHS Wales organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board.

* One of the above reviews was advisory in nature, focussing on arrangements in place at the major programme/project being delivered by the UHB, and is therefore not included within the conclusions of this review.

NHS bodies and their appointed contractors have responsibilities under health and safety legislation, to ensure appropriate precautions are taken to reduce the risks of danger to patients, employees, visitors and the contractors themselves. Applicable legislation includes the Health and Safety at Work etc. Act 1974, Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002 and the Control of Asbestos Regulations 2012, amongst others.

The Health & Safety Executive (HSE) has produced a range of guidance on the safe management of contractors, including "Managing Contractors" (HSG 159), and the "Using Contractors – a Brief Guide." The audits assessed compliance with the requirements of this guidance.

Note that the assessment of compliance with the Construction (Design and Management) Regulations 2015 was outside the scope of the current reviews.

The areas considered within the reviews were:

Governance

That appropriate policy and procedural documents were in place to manage contractors, in line with Health & Safety Executive (HSE) requirements.

Appointment of Contractors

That potential contractors were appropriately checked to establish compliance with HSE requirements and the organisations' required standards for health and safety, including confirmation that contractors had sufficient skills/competencies/insurances to undertake the work safely.

Management of work on site

That appropriate arrangements were in place to manage contractors working on the organisations' premises, including risk assessments, site access controls, induction arrangements, operation of Permits to Work, and monitoring of contractors on site to ensure compliance.

Monitoring & Reporting

That there was ongoing monitoring and review of contractors / contractor-related incidents, in order to maintain the required standards of health and safety and to improve existing processes.

2. Summary of Consistent Messages

2.1 Overall position

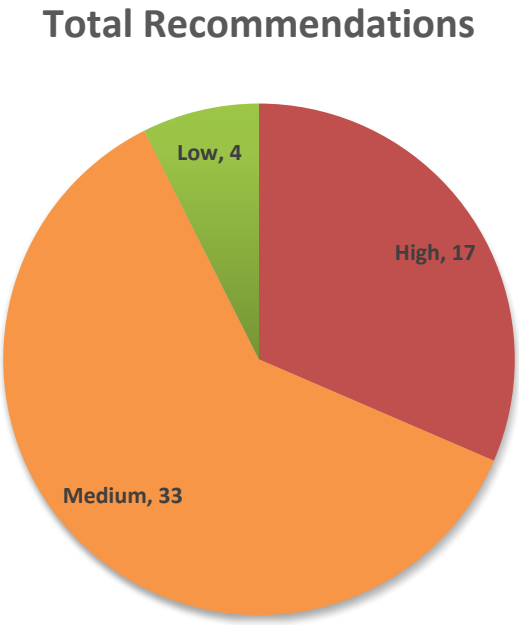
In line with our agreed audit approach, each objective area was assessed in relation to the adequacy and effectiveness of the system of internal control under review. An overall assurance rating, along with individual assurance ratings for each objective area, were determined (see **Appendix A** for a description of the assurance ratings applied).

These anonymised ratings are provided below to illustrate the strengths and potential for improvement in the organisations' control of contractors arrangements; with an overall limited assurance determined in five of the six audits undertaken.

	Number of organisations receiving each assurance rating			
				
2.1 Overall assurance rating	-	5	1	-
2.2 Governance	-	2	3	1
2.3 Appointment of Contractors	-	4	2	-
2.4 Management of work on site	-	5	1	-
2.5 Monitoring & Reporting	-	4	2	-

Note: The advisory review did not provide assurance ratings.

A total of 54 audit recommendations were raised, these are summarised by priority below:



Note: No recommendations were raised at the advisory review.

Governance arrangements across the organisations were generally well defined with procedural guidance (reflecting HSE requirements) in place for the control of contractors. Formal policies did, however, require development in a number of organisations.

Whilst recognising the procedural guidance, compliance issues were generally noted in the application of the defined/mandated control procedures, particularly in respect of the management of work on site, in the application of contractor's site inductions and site signing in processes. Improvements were also required at several the organisations examined in the contractor appointment checks and in the monitoring and reporting of compliance.

At the request of management within one of the organisations examined, where a limited assurance report was issued, a follow up review was undertaken within three months of the initial review. This work confirmed that the majority of agreed recommendations had either been implemented or were in progress.

2.2 Governance

Most organisations had developed appropriate procedural guidance for the control of contractors, in line with HSE expectations – although there was no procedural guidance in place at one organisation.

Only three organisations had implemented an overarching policy, and only one was appropriately communicated via its online publication

2.3 Appointment of Contractors

To ensure appropriate safe working practices are applied whilst contractors are working on site, organisations should operate robust controls when selecting and appointing contractors. Checks should include competencies, industry accreditations, prior experience, and validation of appropriate insurance cover to ensure sufficient indemnity is provided in the event of an incident occurring.

A number of organisations demonstrated robust controls in this area through the operation of local frameworks / measured term contracts, particularly for capital works. The contractors 'called-off' from such frameworks for individual jobs had generally been subject to appropriate checks upon their initial appointment.

However, where contractors were appointed on an individual job basis, typically for service/ maintenance work, there was insufficient evidence in most organisation to demonstrate that the key checks had been undertaken.

In some cases, prior experience with a contractor was relied upon. It was noted that in the majority of these instances, there was no appropriate audit trail to support previous checks having been made, or to ensure that insurances / accreditations remained up to date.

Some organisations had established electronic systems to facilitate the monitoring of contractors, including the central retention of supporting documentation. However, it was observed that these systems held out of date information thus reducing the potential benefits.

We consistently identified the following areas for improvement:

- Improved pre-selection checks for contractors, particularly those not appointed from frameworks / measured term contracts; and
- Improved updating of the electronic systems where relied upon for the appointment of contractors.

2.4 Management of work on site

Where in place (*refer to section 2.2*), the organisations' procedural guidance) clearly established the controls required before permitting contractors to commence work on site. These typically included the completion of the contractors' Risk Assessments/Method Statements, completion of an induction process and, in some cases, completion (with the works supervisor) of a pre commencement checklist.

Inductions were typically delivered in one of two ways:

1. Centralised, periodic 'classroom' based sessions, or
2. 'On the job' discussions with the works supervisor at the start of the job.

Both methods were capable of delivering the required information, however in most cases, organisations did not maintain adequate records, or make adequate checks, to ensure the inductions had been attended prior to allowing works to commence.

Risk Assessments/Method Statements were in place for the majority of jobs reviewed during the audits. However, in one organisation, there was no evidence these had been reviewed for adequacy by the appropriate works supervisors.

Most organisations operated a signing in/out system, however, in most cases compliance with the same was limited.

Where checklists were required to capture compliance with the above controls, these were not consistently applied across all contractor groups or by all works supervisors. In more than one organisation, other means of record keeping also required improvement (e.g. retention of Risk Assessments), to provide a retrospective audit trail in the event a job requires investigation post completion.

In most organisations, application of the required controls at community sites (i.e. without the presence of an Estates office), was further reduced.

We consistently identified the following areas for improvement:

- Improved controls in ensuring inductions have been attended prior to works commencing;
- Application of mandatory checklists in a consistent manner;
- Ensuring contractors comply with the established signing in/out systems;
- Retention of key paperwork such as Risk Assessments/Method Statements; and
- Improved application of required controls at community sites.

2.5 Monitoring & Reporting

It was noted that the number of contractor-related incidents in most of the organisations reviewed had been minimal in the years preceding the reviews;, with only one significant incident having occurred.). Most organisations had robust processes for ensuring contractor-related incidents were appropriately investigated, with lessons learnt clearly identified.

Whilst most organisations had also defined processes to monitor compliance with the agreed procedures, in some cases these were not being undertaken with sufficient regularity or with sufficient scope.

We consistently identified the following area for improvement:

- Improved application of in-house compliance audit processes to enable robust reporting of compliance to management, and to enable actions to be taken where compliance was deemed insufficient.

3. Good Practice Examples

This section provides some examples of good practice based upon our work across the organisations. Please note that this is not an exhaustive list of good practice across the five organisations.

- The use of local frameworks / measured term contracts, ensuring the robust application of selection and appointment checks at the outset, reducing the need for checks when calling off individual jobs.
- The use of such longer-term contractual arrangements improved collaborative working relationships between the organisations and the contractors, and provided an incentive for improved compliance with the organisation's procedures.
- The use of electronic systems, both for central document retention (for ease of reference when undertaking contractor checks) and for 'live' processes (such as signing in/out).
- Establishment of a dedicated Contracts Management team within the Estates department providing central contract management functions.

Appendix A: Audit Assurance Ratings

Substantial assurance

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

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

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

The Board can take **no assurance** that arrangements in place 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.

Assurance not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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Estates Assurance – Fire Safety

October 2021

NWSSP Audit and Assurance Services

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

1. Introduction

During the last five financial years (2016/17 – 2020/21), audits were completed assessing the arrangements in place for the management and control of fire safety at the following NHS Wales organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board
- Velindre University NHS Trust.
- Welsh Ambulance Service NHS Trust

The key objective of the reviews was to assess compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 05-01: *'Firecode – Managing healthcare fire safety'*, which provides practical guidance in the application of statutory regulation in healthcare premises.

The areas considered within the reviews were:

Control Framework – To obtain assurance that management had implemented robust local Fire safety procedures/protocols – meeting both internal and external requirements;

Governance - Assurance that each organisation had established robust governance arrangements to manage Fire Safety requirements and that they operated effectively;

Monitoring & reporting – To obtain assurance that effective central monitoring and reporting arrangements had been applied including drawings, risk assessments, training, incidents, actions and inspections; and

Local Implementation - to obtain assurance that effective assurance mechanisms operated in respect of local compliance and implementation of defined requirements, including:

- local management, appointment and operation of fire safety officers and wardens;
- signage;
- equipment; and
- records

Each organisation received an assurance report which contains considerations for the future that are specific to its circumstances. This summary report seeks to identify common themes and development areas.

2. Summary of Consistent Messages

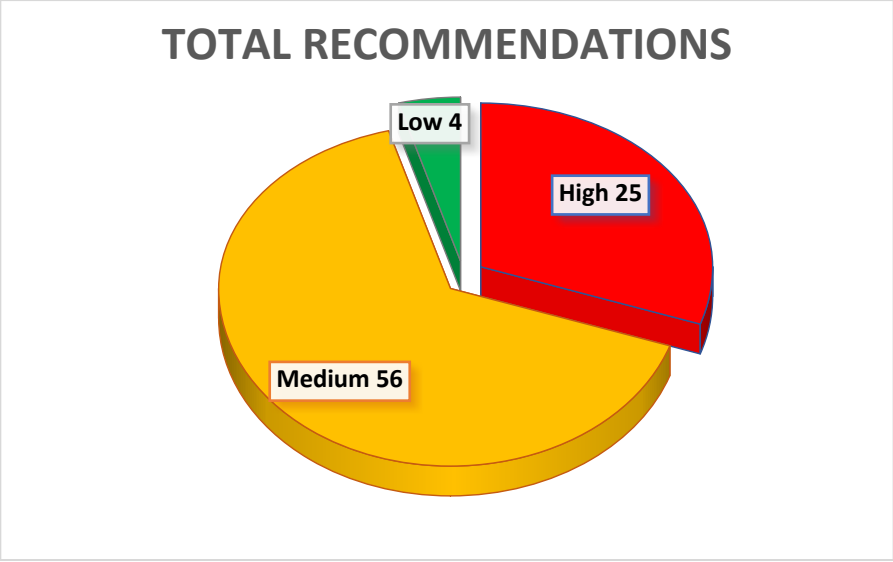
2.1 Overall position

In line with our agreed audit approach, each objective area was assessed in relation to the adequacy and effectiveness of the system of internal control under review. An overall assurance rating, along with individual assurance ratings for each objective area, were determined (see **Appendix A** for a description of the assurance ratings applied).

These anonymised ratings are provided below to illustrate the strengths and potential for improvement in the organisations' fire safety management arrangements.

	Number of organisations receiving each assurance rating*			
				
Overall assurance rating	-	7	1	-
Control Framework	-	5	3	-
Governance	-	5	3	-
Monitoring and Reporting	-	4	4	-
Local Implementation	1	7	-	-

A total of 85 audit recommendations were raised, these are summarised by priority below:



Two of the eight organisations had live fire enforcement notices at the time of the audits.

We note that in general, fire safety management arrangements required substantial improvement in most organisations – with seven of the eight audits determining limited assurance.

Follow up reviews were subsequently progressed at two organisations: one determining significant improvement and the other concluding that insufficient progress had been made to address the original recommendations.

2.2 Control Framework

The Regulatory Reform (Fire Safety) Order 2005 imposes a general duty to take such fire precautions as may be reasonably required to ensure that premises are safe for the occupants and those in the immediate vicinity.

Further clarity is provided for NHS Wales within the following Welsh Health Technical Memoranda:

- WHTM 05 01: Firecode – Managing Healthcare Fire Safety.
- WHTM 05 02: Firecode - Fire safety in the design of healthcare premises.
- WHTM 05 03: Firecode - Fire Safety in the NHS.

The above requires NHS organisations to have a clearly defined fire safety policy covering all buildings they occupy. At most organisations, the policies and other supporting procedural guidance were significantly out of date and required updating to reflect current Welsh Health Technical Memoranda guidance (together with issues raised at the respective audits). Additionally, certain mandated elements were omitted from policies e.g., Dangerous Substance and Explosive Atmosphere regulations (DSEAR).

Accordingly, we consistently identified the following area for improvement:

- The renewal/updating of Fire Safety policies (and associated supporting procedures) to reflect current guidance.

2.3 Governance

Most organisations had defined an appropriate governance structure, including committee-level responsibility for fire safety and the requirement for dedicated Fire Safety Groups.

At the majority of organisations examined the Fire Safety Groups were either inactive for significant periods or had not been established. Consequently, significant gaps in the effective scrutiny, accountability and control assurances were observed during the period of review.

Improvements were also recommended to enable appropriate monitoring and reporting arrangements to operate at the Fire Safety Groups.

In all organisations key fire safety roles, including a Fire Safety Manager and supporting Fire Safety Advisers, had been formally assigned.

However, for one, improved clarity in the roles and responsibilities of local (site/locality) management, estates personnel and fire safety advisers operating within the fire safety structure was required.

In a small number of instances, the Fire Warden role was not allocated, and Fire Warden and Incident Coordinator listings were out of date, meaning assurance could not be provided that the organisation would have sufficient, trained support in the event of a fire incident.

We consistently identified the following areas for improvement:

- Appropriate operation of the Fire Safety Groups; and
- The need to define/assign other local roles key to supporting/ implementing fire safety management.

2.4 Monitoring & Reporting

WHTN-05-01 Firecode notes that an essential element of any fire safety management system is a robust reporting and audit process.

The required annual fire safety audits submitted to NWSSP: SES had been reported in a timely manner in all organisations.

It is a statutory duty to complete Fire Risk Assessments on all NHS properties. Fire risk assessments are utilised to inform mitigating actions (e.g. required fire suppression, evacuation, and maintenance requirements etc.), and as such are a fundamental part of fire safety control. Management arrangements should therefore provide assurance on their completion and any associated mitigating actions.

Fire Risk Assessments had been completed as required in most organisations, however the quality, validity and currency of the completed risk assessments varied significantly i.e.

- The absence of completed risk assessments for key premises;
- Inconsistent completion of risk assessments for premises across the estate; and
- Risk assessments not updated for significant periods of time.

The majority of organisations highlighted significant backlog maintenance issues which included the need for fire safety improvements across the estate. The varying quality of the fire risk assessments would impact on the accuracy/extent of an organisations reported backlog maintenance requirements.

A particular (current) concern was the need to refresh risk assessments in relation to ward reconfigurations associated with the Covid response e.g. changes to the identified responsible staff; the risk profile of the changed service; and associated exit plans etc.

Also, as a result of the variable quality of the completed fire risk assessments, issues were noted in the corresponding monitoring and implementation of the resulting actions arising from the same.

The quality of monitoring and reporting of fire risk issues was also variable. As a consequence, effective scrutiny, accountability and control assurances were lacking, with common issues identified including:

- The absence of annual Fire Safety Reports;
- The absence of regular fire safety reporting at Committee or Group levels; and
- Lack of consistency in reporting.

A number of organisations highlighted insufficient resource available to address the significant number of actions identified at the risk assessments, however the resourcing issue and associated risks/impact had not always been reported.

We consistently identified the following areas for improvement:

- Improved quality and regular update of Fire Risk Assessments;
- Improved monitoring and implementation of actions arising from the Fire Risk Assessments.
- Reporting formats, coverage and summaries were insufficient to enable effective scrutiny and management;
- Consistent fire safety reporting at an appropriate forum (Fire Safety Group/Sub Groups) and escalation of issues to Committee levels e.g. Health and Safety Committees (or equivalents); and
- The sufficiency or resources afforded to fire safety issues.

2.4 Local Implementation

We sought to obtain assurance that effective assurance mechanisms operated in respect of local compliance and implementation of defined fire safety requirements. Performance in this area was poor, with seven of the eight organisations receiving 'Limited Assurance' ratings and the remaining organisation receiving "no Assurance".

The organisation receiving a 'no assurance' rating in this area was due to number of outstanding "fire safety actions", some of which related to fundamental fire safety requirements, and the insufficient resource available to monitor and action identified risks.

Most organisations operated maintenance and inspection regimes in key areas such as fire alarm systems, fire doors, fire extinguishers etc., but due to the quantum were unable to fully address the issues raised.

Site visits undertaken during the audits generally identified isolated instances of statutory non-compliance across a wide range of issues, however, when considered collectively, exposed the organisations to increased risks e.g. the need for up to date PAT testing, safe storage of materials, impediments to exit routes and potential arson risks. Key issues to note are:

- Within the localities sampled at one Health Board, all fire extinguishers were out of date – additionally the servicing/maintenance of fire alarms had not been completed; and
- Some issues were noted in the display of current site plans by the main fire alarm panels.

It is a legal statutory requirement, under Article 21 of the Regulatory Reform (Fire Safety Order) 2005, that all staff must receive appropriate fire safety training.

Delivery of fire safety training, including to key staff such as fire wardens, varied between the organisations - ranging from 58% to 92% at the time of the reviews.

Good practice included the development of a robust training needs analysis to ensure an appropriately directed training programme. However, in some organisations, compliance with training delivery was insufficient - potentially exposing individuals, patients and the organisation to undue fire risk. In some cases, improvements were also required in the monitoring and reporting of training compliance to the relevant forums e.g. Fire Safety Groups.

NHS Firecode states that the frequency of fire drills / evacuation procedures is a matter for local management, though recommending a minimum frequency of once a year. In most organisations, fire drills were not being undertaken in line with the recommended frequency. Whilst recognising physical evacuations were not always considered feasible, desktop alternatives were also not operating.

In some organisations, local fire management folders had been provided (in accordance with Firecode guidance and British Standards), incorporating site-specific fire safety guidance, and providing proformas for the local monitoring of fire risks. Whilst these provided a useful means of communicating fire safety requirements to local staff, in the cases observed, they were inconsistently applied, not appropriately updated or utilised to derive the intended benefits.

We consistently identified the following areas for improvement:

- Improved compliance with training requirements;
- Improved compliance with fire drill requirements;
- Improved updating and monitoring of usage of local fire management folders.
- The absence of periodic fire drills;

- Ensuring current site plans are located in the appropriate areas by main entrances / main fire panels; and
- Ensuring locality/premises comply with local fire safety requirements (e.g. kept clear from potential obstructions or arson risks).

3. Good Practice Examples

This section provides some examples of good practice based upon our work across the organisations. Noting the generally poor assurance assessments determined at the reviews undertaken, such evidence was understandably limited. Please note that this is not an exhaustive list of good practice across the eight organisations.

- The allocation of an Executive lead responsible for Fire Safety;
- The escalation of high priority risks escalated to an Executive Board or Committee;
- The operation of an electronic "tracker system" managing Fire Risk Assessments and associated actions/timetables;
- Where fire drills were not possible, desk top models or walk-through tests were undertaken;
- Assurance obtained from Landlords on fire safety controls and actions, where staff were located off-site;
- Positive interaction with Fire Authorities and NWSSP:SES;
- Delivery of Fire Training via Teams (noting the current COVID restrictions);
- As a consequence of the audit, at one organisation, the case for additional resource approved by the Executive Team; and
- Capital bid submissions and associated investment programmes developed to seek to address historic backlog and fire risks.

Appendix A: Audit Assurance Ratings

Substantial assurance

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

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

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

The Board can take **no assurance** that arrangements in place 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.

Assurance not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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All-Wales Summary Report Estates Assurance – Water Management

October 2021

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

1. Introduction

During the last four financial years (2017/18 – 2020/21), audits were completed assessing the arrangements in place for the management and control of water safety at the following NHS Wales organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board
- Velindre University NHS Trust.

The key objective of the reviews was to assess compliance with the requirements of Welsh Health Technical Memorandum (WHTM) 04-01: *'Safe water in Healthcare Premises'*, which was produced to promote good practice in the design, installation, commissioning, operation and maintenance of water services in healthcare premises.

The scope and remit of the reviews was directed to the following areas:

- **Governance -** That adequate arrangements were in place to support the implementation of the approved code of practice. Also, that an appropriate policy was in place to address water safety issues, there were defined allocation of responsibilities, clear lines of communication and reporting and approval processes.
- **Procedures -** To ensure that management were implementing applicable procedures – both internal and external requirements.
- **Monitoring and Reporting -** To ensure that the estate was appropriately monitored and that effective monitoring procedures were operating e.g. the establishment of appropriate Water Safety Groups (WSGs). Assurance that there was appropriate record retention and dissemination of information through to the Executive team and Board.
- **Management -** Assurance that relevant staff received appropriate training, and appropriate resources were allocated. Assurance that appropriate inspection / detection regimes were operated.
- **Risk Management -** Assurance that suitable and sufficient assessments of risks were performed and that identified risks were appropriately managed.

Each organisation received an assurance report which contained considerations for the future specific to its circumstances. This summary report seeks to identify common themes and development areas.

Following an initial Limited Assurance report, management at one of the organisations requested that further audits be undertaken at all of their remaining acute sites. Accordingly, the data/issues arising from these two additional reviews are included within this summary paper for completeness (i.e. ten reports issued at eight organisations).

2. Summary of Consistent Messages

2.1 Overall Position

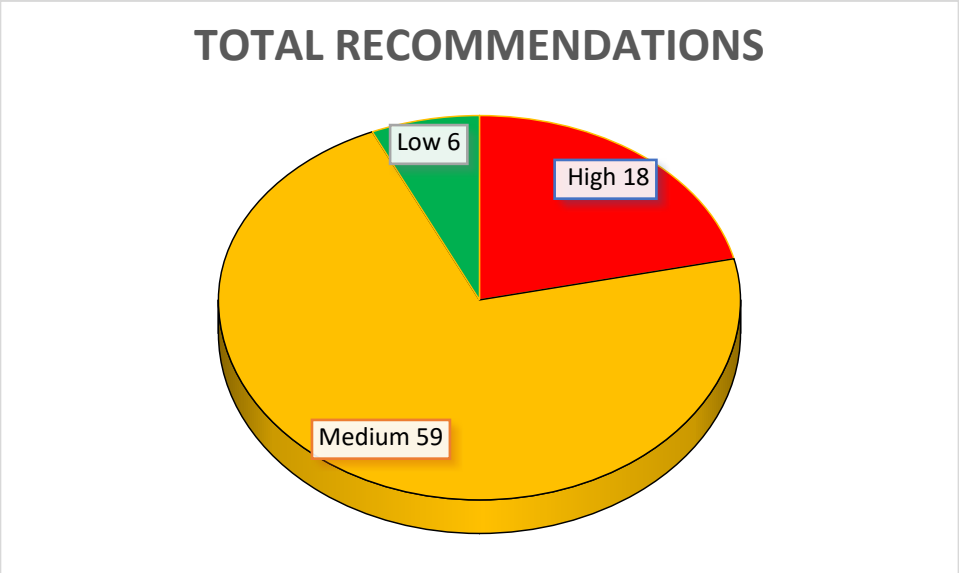
In line with our agreed audit approach, each objective area was assessed in relation to the adequacy and effectiveness of the system of internal control under review. An overall assurance rating, along with individual assurance ratings for each objective area, were determined (see **Appendix A** for a description of the assurance ratings applied).

These anonymised ratings are provided below to illustrate the strengths and potential for improvement in the organisations' management of water safety, with an overall limited assurance determined at five of the ten audits undertaken.

	Number of organisations receiving each assurance rating[1]			
				
Overall assurance rating	-	5	5	-
Governance	-	4	4	2
Policy & Procedures	-	3	4	3
Monitoring & Reporting	-	3	7	-
Management	-	6	4	-
Risk Management[1]	-	5	4	-

[1] *one report did not determine an assurance rating in respect of risk management.*

A total of 83 audit recommendations were raised, these are summarised by priority below:



Follow up reviews have since been undertaken in some organisations, with positive action noted in respect of actions taken to address the agreed recommendations.

2.2 Governance

All organisations had defined an appropriate governance structure, including the establishment of a Water Safety Group and associated sub-groups (in accordance with WHTM 04-01); with clear reporting lines to the relevant Board-level Committee. Responsibilities, including at Executive level, had also been clearly assigned.

Responsible and Deputy Responsible Persons, with specific responsibilities for water safety, had been formally assigned at most organisations in line with WHTM 04-01 requirements. However, not all organisations had sufficient coverage of officers across the estate. Improved arrangements were observed where follow up exercises were subsequently undertaken.

All organisations had appointed an external Authorising Engineer, as required by WHTM 04-01, in most cases via NWSSP: SES. The Authorising Engineer makes recommendations for improvement in the issue of annual reports and more detailed tri-annual site-specific reports. However, not all organisations had sufficient mechanisms in place for monitoring the actions taken to address the recommendations or adequate reporting of progress to appropriate forums ensuring identified issues were rectified in a timely manner.

We consistently identified the following areas for improvement:

- Ensuring sufficient coverage of Responsible and Deputy Responsible Persons; and

- Formal monitoring of progress towards implementation of recommendations from external assurance providers (e.g. NWSSP:SES).

2.3 Policy & Procedures

WHTM 04-01 outlines the importance of organisations having an appropriate Water Management Policy and Water Safety Plan. The Water Safety Plan should assist with understanding and mitigating risks associated with waterborne hazards in distribution and supply systems and associated equipment, and should provide a risk-management approach to the safety of water.

Four of the organisations reviewed had up to date policies and procedures in line with the requirements of WHTM 04-01. However, at the other four, both of the key documents required updating.

We consistently identified the following areas for improvement:

- The need for up to date policies reflecting current guidance; and
- More frequently updated Water Safety Plans providing 'live' guidance for staff.

Where follow up exercises have been undertaken, the required policies and procedures had been updated in line with agreed recommendations.

2.4 Monitoring & Reporting

All organisations had established a Water Safety Group, with appropriate remit and memberships determined in line with the requirements of WHTM 04-01.

However, attendance levels were insufficient in nearly all cases particularly in respect of designated clinical representatives and a microbiologist; with meeting held insufficiently frequent.

Areas of good practice were noted in some organisations, with designated Compliance Managers appointed to enable robust monitoring and reporting of performance against agreed Key Performance Indicators and the requirements of the Water Safety Plan.

Where monitoring and reporting was identified as poor, concerns were identified in respect of the adequacy, accuracy and reliability of testing/monitoring records maintained for the sites examined.

We consistently identified the following areas for improvement:

- Improvements in the attendance of agreed members at the Water Safety Group; and
- The need for enhanced monitoring and reporting of compliance with the Water Safety Plan including for example, exception reporting, escalation

of identified issues, planned works against targets, results of routine spot checks etc. The same would facilitate effective control by the (responsible) Water Safety Groups

2.5 Management

Most organisations maintained at least some paper-based records, such as log books to record water management activities.

One organisation had procured specialist water management software to facilitate the planning, delivery and recording of Estates water activities (testing and inspection).

Issues were noted in the completeness and retention of these records to provide a robust audit trail of activities undertaken.

Pre-Planned Maintenance System (PPMs):

In most organisations, audit testing of a sample of PPMs found some activities (including associated remedial works) not completed as required. It was noted, however, that where omissions were significant, the organisations had attributed the same to insufficient staff resource and formally reported the same to an Executive level.

WHTM 04-01 requires 'accurate as-fitted drawings' to be available to facilitate the identification of poor water circulation and "dead-legs". The absence of up-to-date record drawings resulted in reduced assurance opinions at a number of organisations.

A number of the organisations had reported insufficient staff resource within their Estates departments to deliver the agreed plan for water-related estates activities.

Where electronic systems were introduced this also presented difficulties in the level of resource required to ensure the system was accurately populated and operated effectively to maximise the possible benefits.

In a number of organisations there was the potential for a case to be for additional staffing to deliver improvements, but this had generally not been pursued.

Regular flushing (of the systems), is a key control in managing underutilised water outlets and pipework (as required by WHTM 04-01). Procedures/protocols, including record keeping requirements, had generally been appropriately defined within the Water Safety Plans and associated procedural documentation. In most organisations, the responsibility for flushing of infrequently used outlets in clinical areas was assigned to ward staff.

However, issues were identified in most organisations in the consistent application of agreed procedures, coupled with insufficient monitoring of testing compliance to provide assurance to the Water Safety Groups.

Training for key staff with assigned water safety responsibilities was up to date in all bar two of the organisations. Enhanced training records, to facilitate proactive monitoring of training requirements, were required in a number of the instances.

Where follow up exercises have been undertaken, it was noted that training had been updated for key staff.

We consistently identified the following areas for improvement:

- The completeness and adequacy of water management activities (incl. Pre-planned and unplanned maintenance, flushing records etc.).
- The adequacy of record drawings retained;
- Insufficient resource in some organisations to deliver the required level of water safety activities set out in the Water Safety Plans;
- The need for enhanced training records, to facilitate proactive management of training requirements; and
- The need for improved compliance and monitoring of flushing activities.

2.6 Risk Management

Corporate and operational risk management processes were found to be robust in most of the organisations reviewed, facilitating the identification, monitoring and escalation of water-related risks.

Additionally, in line with best practice, water infrastructure risk assessments were up to date in the majority of organisations; having been refreshed within the prior three years.

However, issues with the quality of assessments undertaken by the appointed external consultants had been experienced in two organisations, reducing the ability to place reliance on the reported findings.

In some organisations, there was also insufficient evidence of progress towards implementing the issues identified at the infrastructure risk assessments (in some instances priority one/high risk issues remained unaddressed for a number of years).

We consistently identified the following areas for improvement:

- The quality of infrastructure risk assessments undertaken by external parties;
- The time taken to address identified water related risks (arising from infrastructure risk assessments); and
- The associated reporting of progress to address identified risks.

3. Good Practice Examples

This section provides some examples of good practice based upon our work across the organisations. Please note that this is not an exhaustive list of good practice across the eight organisations.

- Well defined governance arrangements had been developed within most organisations in accordance with WHTM 04-01.
- Comprehensive Water Safety Plans operating at sites, including e.g.
    - defined roles and responsibilities;
    - temperature testing expectations;
    - definition of elevated levels of bacteria;
    - definition of infrequently used outlets;
    - response times for infrastructure works;
    - clarification of durations of flushing; and
    - approach to pipework labelling.
- The allocation of the "Responsible Persons" role (at each key site within organisations) - a key role having the responsibility for routinely monitoring and testing compliance for water safety.
- Clear reporting lines from Water Groups (and sub-groups), through to the Health and Safety Committee and Executive Board (where required). Reports including clearly established performance data, test results, exception reporting and appropriate management/mitigating actions with defined timescales.
- The appointment of external consultants to facilitate key management tasks such as updating of the Water Safety Plan, delivery of training and undertaking of risk assessments.
- Where resourcing was seen to impact specifically on water management at key audits, mitigating measures to address the issues identified.
- Dedicated compliance monitoring teams enabling robust monitoring and reporting of performance including against agreed KPIs.
- Procurement of specialist water management software; but recognising this comes with resource / training implications to ensure the system is operated correctly to provide the best value.
- The replacement and recycling of shower heads, removing the need for cleaning/maintenance.

- Assignment of flushing responsibilities to Hotel Services to facilitate daily attention.
- Implementation of an electronic flushing management system to coordinate ward activities and facilitate central monitoring.

Appendix A: Audit Assurance Ratings

Substantial assurance

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

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

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

The Board can take **no assurance** that arrangements in place 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.

Assurance not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

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Quality Assurance and Improvement Programme

Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Simon Cookson, Director of Audit & Assurance
Distribution:	Neil Frow, Managing Director Andrew Butler, Director of Finance & Corporate Services Velindre Audit Committee for Shared Services (12 October 2021) Board Secretaries Chairs of Audit Committees

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Please note
This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Audit Charter and Terms of Reference, approved by the Audit Committee. Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the NHS Wales Shared Services Partnership and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

This paper sets out the Quality Assurance and Improvement Programme (QAIP) for 2020/21 and the approach and work for 2021/22.

The QAIP is a requirement of the Public Sector Internal Audit Standards (PSIAS).

2. Approach

Audit & Assurance's Quality Manual states:

"The Director of Audit & Assurance must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity (Standard 1300). This should include internal and external assessments (standards 1311 and 1312)."

In 2018 we had the mandatory External Quality Assessment (EQA) which was undertaken by The Chartered Institute of Internal Auditors (the organisation that sets the International Standards for Internal Audit). As EQAs are required at least once every five years, we will need to have another one by March 2023 at the latest.

The internal assessments cover:

1. Quality Reviews - organisation focussed reviews to ensure each NHS organisation and Head of Internal Audit and the Specialist Services Team (SSu) are covered (Section 2.1)
2. Internal Audit Quality Assurance Framework (IAQAF) (2.2)
3. EQA Action Plan (2.3)

In addition, there will be other information that supports the QAIP:

4. Results of Audit Satisfaction Surveys (a survey is sent after each audit) (2.4)
5. Key performance Indicator Outcomes (2.5)
6. Audit Committee assessments of their own effectiveness that include Internal Audit (2.6)
7. Audit Wales review (AW) (2.7)
8. Head of Internal Audit/Head of SSu 'Conformance Statements' (2.8)
9. Formal meetings with Chairs of Audit Committees and Board Secretaries (2.9)
10. Other relevant Information (2.10 & Sections 3.1 to 3.2).

2.1 Quality Reviews

A total of 29 audit files were reviewed. These were chosen from the list of outputs at 31 December 2020 (note: 29 out of 299 delivered audits for 2020/21 equates to 9.7%).

Due to the impact of COVID-19 all of the 11 governance reviews relating to COVID-19 were reviewed as these were significant reviews supporting our overall opinions, plus 1 other per organisation. Two audits are included for NWSSP. Three audits undertaken by our Capital & Estates team and two audits undertaken by our IM&T team were also reviewed. One of the IM&T reviews covered an NWIS audit.

There were three audits undertaken for WHSSC and EASC – none of these have been reviewed in 2020/21. Details of the audit files reviewed are shown in the following table.

No.	Health Body	Audit (code)	Team	Rating
1	Aneurin Bevan	Governance Arrangements during COVID-19 (AB20201-01)	South East	N/A
2	Aneurin Bevan	Safeguarding (ABU-2021-18)	South East	Reasonable
3	Aneurin Bevan	Grange University Hospital – Site Management Assurance (SSU_ABU_2021_05.6)	C&E	Substantial
4	Swansea Bay	Governance Arrangements during COVID-19 (SBU-2021-044)	Swansea	N/A
5	Swansea Bay	Primary Care Cluster Plans & Delivery (SBU-2021-13)	Swansea	Reasonable
6	Swansea Bay	Capital Systems (SSU_SBUHB_2021_06)	C&E	Reasonable
7	Betsi Cadwaladr	Governance Arrangements during COVID-19 (BCU-2021-39)	North	N/A
8	Betsi Cadwaladr	Roster Management (BCU-2021-36)	North	Limited

9	Cardiff & Vale	Governance Arrangements during COVID-19 (CUHB2021.47)	South Central	N/A
10	Cardiff & Vale	Regional Partnership Board (CVU-2021-07)	South Central	Reasonable
11	Cardiff & Vale	Asbestos Management (SSU_CVU_2021_02)	C&E	Reasonable
12	Cwm Taf Morgannwg	Governance Arrangements during COVID-19 (file ref: CTM-2021-39)	South Central	N/A
13	Cwm Taf Morgannwg	Pathology Directorate Review (Management Arrangements) – Follow Up (CTM 20/21 – 26)	South Central	Reasonable
14	Hywel Dda	Governance Arrangements during COVID-19 (HDUHB2021-11)	Carmarthen	N/A
15	Hywel Dda	Research & Development Department Governance Review – Follow Up (HDUHB-2021-07)	Carmarthen	Reasonable
16	Hywel Dda	WCCIS Project (Ceredigion Locality) (HDUHB-2021-22)	IM&T	Reasonable
17	Powys	Governance Arrangements during COVID-19 (PTHB2021-33)	South East	N/A
18	Powys	GP Access Standards (PTHB-2021-21)	South East	Substantial
19	PHW	Governance Arrangements during COVID-19 (PHW2021-17)	South Central	N/A
20	PHW	Management of Alerts – Follow Up (PHW 20.21/09)	South Central	Reasonable
21	Velindre	Governance Arrangements during COVID-19 (VT2021-17)	South Central	N/A

22	Velindre	Nurse Staffing Levels Act (Wales) 2016 (VEL-2021-13)	South Central	Substantial
23	WAST	Governance Arrangements during COVID-19 (WAST-2021-31)	South East	N/A
24	WAST	Short Term Sickness Absence Management (WAST-2021-23)	South East	Reasonable
25	HEIW	Governance Arrangements during COVID-19 (HE2021.12)	South Central	N/A
26	HEIW	Service Review – Medical Commissioning Monitoring (HEIW-1920-10)	South Central	Reasonable
27	NWSSP	Declarations of Interest (NWSSP-2021-01)	South East	N/A
28	NWSSP	Credit Card Expenditure (NWSSP-2021-13)	South East	Substantial
29	NWIS	Organisational Resilience (NWIS-2021-02)	IM&T	Reasonable

The reviews comprise:
1). Checking that the audit file has completed correctly and fully
2). Reviewing evidence to support the completion of the checklist
3). Product reading of the final report/output
4). Follow-up questions with HIAs/Leads
5). Production of a summary note.

Overall, the results were positive and demonstrated a high level of quality consistent with recent years. However, in a small number of instances, discussions were needed with the Head of Internal Audit to confirm findings and a number of exceptions were noted. The exceptions will continue to be built into the TeamMate audit software approach and our ongoing training around audit quality.

The exceptions, communicated to the Heads of Internal Audit/Head of Specialist Services in March 2021, are covered at Appendix C.

On the basis of the reviews undertaken there were no specific matters that needed to be reported in the Annual Head of Internal Audit opinion in terms of compliance with the PSIAS.

2.2 Internal Audit Quality Assurance Framework (IAQAF)

One section of four has been reviewed, "Audit Execution". See Appendix A for an explanation of this approach and Appendix B for the detailed assessment underpinning this review.

For this section, the review was undertaken by the Director of Audit & Assurance with support from the Heads of Internal Audit.

The section covers four areas, each with a number of good practice statements. For each area, Audit & Assurance needs to decide whether, in terms of the statements, it conforms fully, generally, partially or not at all. Conforming fully or generally is considered appropriate to be able to state that the PSIAS are being complied with. The summary results are:

- Management of the IA service (6 statements) – 'fully conforms'
- Engagement planning (6 statements) – 'fully conforms'
- Performance if audit work/audit delivery (7 statements) 'fully conforms'
- Reporting (10 statements) – 'fully conforms'.

Despite being able to self-assess as fully conforming, we have identified four key actions to support continuous improvement:

- continue to review our methodologies to ensure they remain in line with current practice
- review our audit scopes to see if more detail needs to be included
- look at options to use more automated tools
- work with Board Secretaries and Audit Committees to improve the follow-up/recommendation tracking process.

The specific actions to address these points will be both discussed and agreed with key stakeholders – Board Secretaries and Chairs of Audit Committees.

2.3 External Quality Assessment Follow-Up

In February and March 2018 Audit & Assurance Services were subject to a formal External Quality Assessment. This assessment is required by the PSIAS and was undertaken by The Chartered Institute of Internal Auditors (IIA). Their report was presented to the Velindre Audit Committee for Shared Services on 24 April 2018.

The assessment concluded that:

"It is our view that NWSSP Audit and Assurance Services conforms to all … 64 fundamental principles … and it is therefore appropriate for NWSSP Audit and Assurance Services to say in reports and other literature that it '**conforms to the IIA's professional standards and to PSIAS**.'

There were two specific areas of focus/recommendations from the 2018 EQA:

1). Audit coverage – links to strategic objectives and risks and other assurance providers

All Heads of Internal Audit focused on this during audit planning for 2020/21 as far as the impact of COVID-19 allowed, and we worked effectively with Audit Wales to undertake joint interviews and share documentation as we undertook our COVID-19 governance reviews and they undertook their structured assessments. We have also changed our planning approach for 2021/22 as we are no longer required to undertake any Welsh Government mandated work. There is still further work for some organisations to undertake to ensure that their Board Assurance Frameworks (BAF) clearly identify the work of other assurance providers and the strength of the first and second lines of defence. We have included time within each audit plan to consider the ongoing effectiveness of the BAF. We are also implementing a suite of Quality and Outcome focused KPIs for 2021/22 and beyond that will include measures such as the % of time spent on corporate risks.

2). Achieving efficiency in the audit methodology

We are, at present, going through a review to determine if we need to change our audit software going forward. Until we make that decision, we have decided not to change our audit methodology unless there are changes to the PSIAS that we need to respond to.

We will provide an update on our response to the EQA and our work on Quality KPIs in next year's QAIP.

2.4 Audit Satisfaction Surveys

Audit satisfaction surveys are sent out at the conclusion of each audit. Response rates are relatively low although they are improving, and they do differ by organisation. Copies of the survey are retained on the individual

audit files. A summary of the response rates and findings are included in each Head of Internal Audit Opinion.

In addition, we receive feedback through regular meetings with both HB/Trust Executives and Audit Committees.

We continue to work with health bodies to improve the response rates to the surveys as this can be a key driver in helping to improve the focus and outcomes of audits.

2.5 Key Performance Indicators

At the end of May 2021 (when all Final opinions were issued), revised KPIs for 2020/21 showed:

KPI	SLA	Target	Overall
Audit plans agreed [2019/20]	√	100%	100%
Audit opinions/annual reports compiled [2019/20]	√	100%	100%
Audits reported over total planned audits *	√	Target	100%
		Actual	100%
Work in progress *	No	N/A	0%
Report turnaround fieldwork to draft reporting [10 days]	√	80%	97%
Report turnaround management response to draft report [15 days]	√	80%	79%
Report turnaround draft response to final reporting [10 days]	√	80%	100%

*Due to the impact of COVID-19 we delivered 299 outputs (Final and Draft reports). There were 32 reviews that were cancelled or postponed. In a few cases, work was in progress, but this was on the basis that the work would not form part of the 2020/21 annual opinions.

In 2020/21 we delivered 299 outputs (364 in 2019/20) to support the Head of Internal Audit Opinions and other reporting for the 13 NHS Bodies we audit (7 Health Boards, 3 Trusts, HEIW, NWSSP and NWIS).

There were changes agreed to the plans of all NHS bodies during the course of the year with audits and reviews being added and removed. In all cases, these changes were approved by the relevant Audit Committee.

In terms of the delivery of the audit programme we are often asked to delay reviews until late in the financial year. We are happy to accommodate this, but it does mean that we sometimes need to use contractor staff to ensure delivery which does increase costs. The KPIs for each HB/Trust are reported in each progress report and in their individual Head of Internal Audit Opinion.

2.6 Audit Committee self-assessments

Each year, Audit Committees will produce an annual report of their own activities and undertake a self-assessment against key criteria set out in the HFMA Audit Committee Handbook. Results of this work, which includes an assessment of Internal Audit, are used to help inform Audit & Assurance's forward strategy at both a Directorate and individual HB/Trust/SHA level.

2.7 Audit Wales review

Each year, Audit Wales undertakes an overview of Internal Audit as part of their work programme. In their Management Letter to NWSSP for 2020/21, Audit Wales have confirmed that they "did not identify any issues regarding (Internal Audit's) compliance with the PSIAS standards that would prevent us taking assurance from their work."

In addition, the Director of Audit & Assurance meets regularly with both Audit Wales NHS leads and the Velindre audit team to ensure that internal audit's work is co-ordinated, where appropriate, with the work of Audit Wales. Heads of Internal Audit also meet regularly with the relevant Audit Wales leads for each health Board, Trust and Special Health Authority to ensure work if co-ordinated effectively.

2.8 Conformance self-assessments

Each year, all Heads of Internal Audit/SSu complete a self-assessment against the PSIAS which is submitted to the Director of Audit & Assurance for review. After review, the self-assessments are discussed with the relevant Head of Internal Audit/SSu if there are any matters requiring attention.

Overall, there are very few highlighted areas of 'partial compliance' (and none of 'does not comply') from the self-assessments either from ticking a specific box or from the narrative. This is an in line with previous years and

reflects, in part, the successful outcome of the External Quality Assessment in March 2018.

The only areas of identified partial conformance related to:

1). The HIA not interacting directly with the Board (function delegated to Audit Committee)

2). Still more to do on training & development, linked to better use of IT and data analytics

3). Considering whether specialist teams need more of an understanding of the overall governance arrangements at each NHS Wales organisation

4). Assessing the costs of assurance in relation to the potential benefits.

In terms of actions against each of these areas we propose/are already doing:

1). The only action we take formally on this is to note it as the PSIAS assumes 'delegation' of some key roles

2). We continue to use all available non-pay funds for additional training and development. We are also recruiting an additional IM&T auditor to increase our data and IM&T capacity and capability

3). Beginning with the COVID-19 governance reviews in 2020 which were delivered through combined audit and specialist teams, we have built in more time for specialist staff to understand fully the wider governance and assurance arrangements at each NHS Wales organisation

4). In 2021/22 as part of a move to more quality and outcome focused based KPIs we will be undertaking specific work in a couple of areas to measure the cost and impact/benefits of assurance work. In addition, internal monitoring of the IMTP for 2021/22 within NWSSP will include a focus on costs versus benefits for all services/Directorates.

2.9 Formal meetings with Chairs of Audit Committees and Board Secretaries

During 2020/21 the Director of Audit & Assurance met with the Board Secretaries and Chairs of Audit Committee groups on the following occasions:

- Board Secretaries: 27 March, 29 May, 26 June, 28 August, 25 September, 30 October 11 December 2020, 29 January, 26 February and 26 March 2021

- Chairs of Audit Committee: 3 November 2020 and 10 February 2021.

Areas discussed included:

- Progress on the 2020/21 audit programmes
- The format of the annual opinion for 2020/21
- Findings from the COVID-19 Governance reviews
- Changes to the approach for audit planning for 2021/22 (see Section 2.10 below)
- Recommendation monitoring and tracking
- Quality based KPIs
- Themes emerging from audit work across NHS Wales
- NWIS and other 3rd Party assurances from within NHS Wales
- Audit resources and the Service Level Agreement
- Internal Audit's IMTP.

The Director of Audit & Assurance also met with the Directors of Finance on 19 June, 18 September, 16 October, 20 November, and 18 December 2020. These meetings were focussed, in the main, on the COVID-19 Governance reviews and the links to other related work undertaken by the Finance Academy, the Finance Delivery Unit and Welsh Government. Audit & Assurance produced a number of papers that summarised the key messages from all of these COVID-19 related reviews.

To further strengthen the links between Audit & Assurance and the finance function across NHS Wales, the Director of Audit & Assurance has joined the Finance Academy Governance Steering group.

Finally, a small governance steering group has been set up that brings together the Chair of the Board Secretaries, the Chair of the Directors of Finance and the Director of Audit & Assurance to ensure any cross-cutting themes/areas can be considered collectively.

Further meetings with these key peer groups are planned in 2021/22. In addition, the Director of Audit & Assurance has also met with a number of Chairs, Finance Directors, Executive Directors and full Boards during the course of the year.

2.10 Audit Approach

During 2020/21 we made a small number of changes to our audit approach. These covered:

- The process for forming the annual opinion for 2020/21
- The process for putting together an annual plan for all NHS Wales organisations for 2021/22.

Due to the uncertainty around COVID-19 we prepared a number of papers for the Board Secretaries on what our approach would be if we were unable to complete sufficient audit work to give a full annual opinion. Ultimately, we were able to complete sufficient audit work at each NHS Wales organisation to give a full annual opinion, so these contingency measures did not have to be implemented. We did make one change to our approach in relation to Health Boards – we removed the 'domain' element in the forming of the annual opinions for Health Boards so that all NHS Wales organisations now have their opinions determined on the same basis. This change was agreed by the Board Secretaries and reported to other key peer and stakeholder groups.

In terms of planning for 2021/22 audit programmes we agreed with Welsh Government, after preparing a paper for them on the work we currently do, to remove all of the work that they had previously mandated that Internal Audit cover. The work previously covered the Annual Governance Statement, the Annual Quality Statement, Welsh Risk Pool, Sustainability Reporting and Health & Care Standards. Work may well continue to be included in audit plans in relation to these areas, but it will not be mandated by Welsh Government.

In addition, we have also agreed changes to our planning approach to focus on 6 key components – some annual work that will support the effective delivery of an internal audit service, risk-based work, follow-up, national audits, work supporting key peer/stakeholder groups and Integrated Audit & Assurance plans for key capital/transformational schemes.

To support these changes to both the opinion and planning aspects of our work, the Board Secretaries agreed to the creation of a small sub-group of 3 Board Secretaries and the Director of Audit & Assurance. This group has proved effective in helping to bring forward the changes to the audit approach.

Where appropriate, amendments will be made to our audit approach manual (Quality Manual). There were no other changes to our audit approach in 2020/21.

3. Other Quality Assurance and Improvement Areas

3.1 Wider role of Director of Audit & Assurance/Heads of Internal Audit

The Director of Audit & Assurance is an observer on the Public Sector Internal Audit Standards Advisory Board and a member of the Wales Public Sector Heads of Internal Audit Forum. He is also an Independent Member

of the Audit Committee of Bristol City Council. One of the Heads of Internal Audit is a Trustee at Abbeyfield Wales Society Housing Association and another is a member of Caerwent Community Council.

3.2 QAIP Approach for 2021/22

The QAIP approach for 2021/22 will include (in addition to the standard areas):

1. A further part of the IAQAF approach
2. Follow up of the EQA and previous QAIPs
3. Implementing a new set of quality based KPIs.
4. Preparation work for the next External Quality Assessment due by March 2023

APPENDIX A

IAQAF

HM Treasury has put together an Internal Audit Quality Assessment Framework (IAQAF) – published May 2013 – to "help evidence effective internal auditing in line with the Public Sector Internal Audit Standards. If the Standards are followed appropriately, this should enable internal auditors to state that their work is 'conducted in conformance with the International Standards for the Professional Practice of Internal Auditing."

The IAQAF is intended to apply to all government internal audit services where compliance with the Public Sector Internal Audit Standards (PSIAS) is required. The definition of an internal audit service will vary depending on the arrangements in place for the particular government body. For NWSSP, the appropriate definition is a group internal audit service with an overall assessment being made on the quality of the internal audit provided to the bodies that the group audits.

Where an internal audit service is provided by an integrated group the assessment should be performed on the group service as a whole, with specific reference to a representative sample of bodies to which the group service is provided. The results of the assessment should then be shared with each of the individual bodies that receive a service from the group.

The Framework has four sections reflecting four questions that the evaluation seeks to address:

- Purpose and positioning – Does the internal audit service have the appropriate status, clarity of role and independence to fulfil its professional remit?
- Structure and resources – Does the internal audit service have the appropriate structure and resources to deliver the expected service?
- Audit execution – Does the internal audit service have the processes to deliver an effective and efficient internal audit service?
- Impact – Has the internal audit service had a positive impact on the governance, risk and control environment within the organisation?

Each section is divided into several sub-sections covering key elements of an effective internal audit service as follows:

Purpose and positioning	Structure and resources	Audit execution	Impact
• Remit • Reporting lines • Independence • Risk based plan • Assurance strategy • Other assurance providers	• Competencies • Technical training & development • Resourcing • Performance management • Knowledge management	• Management of the IA function • Engagement planning • Engagement delivery • Reporting	• Standing and reputation of internal audit • Impact on organisational delivery • Impact on governance, risk, and control

For each sub-section a series of statements of good practice are provided as a guide in determining the performance of the service. Against this an assessment should be made as to the degree of conformance using the following scale, aligned with the PSIAS:

- **Fully Conforms** the reviewer concludes that the internal audit service fully complies with each of the statements of good practice.
- **Generally Conforms** means the reviewer has concluded that the relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the section in all material respects. For the sections and sub-sections, this means that there is general conformance to a majority of the individual statements of good practice, and at least partial conformance to the others, within the sub-section. As indicated above, general conformance does not require complete/perfect conformance
- **Partially Conforms** means the reviewer has concluded that the internal audit service falls short of achieving some elements of good practice but is aware of the areas for development. These will usually represent significant opportunities for improvement in delivering effective internal audit. Some deficiencies may be beyond the control of the service and may result in recommendations to senior management or the board of the organisation.
- **Does Not Conform** means the reviewer has concluded that the internal audit service is not aware of, is not making efforts to

comply with, or is failing to achieve many/all of the objectives and good practice statements within the section or sub-section. These deficiencies will usually have a significant negative impact on the internal audit service's effectiveness and its potential to add value to the organisation. These will represent significant opportunities for improvement, potentially including actions by senior management or the board.

- An overall assessment of the performance of the internal audit service in conforming to good practice should be made using the same scale.

APPENDIX B

Does the internal audit service have the processes to deliver an effective and efficient internal audit service?

Management of the internal audit service		
Statements of good practice	***Assessment***	***Evidence***
• The CAE has established policies and procedures (typically in the form of a manual) to guide the internal audit activity	√ **Fully conforms** **Generally conforms** **Partially conforms** **Does not conform**	There is an audit manual – called the Quality Manual – and a consulting protocol that guides internal audit activity and is mapped to the Public Sector Internal Audit Standards. The relevant parts are included within our audit software file for each audit/review we undertake. The Quality Manual was last updated to reflect the changes to the Public Sector Internal Audit Standards from 1 April 2017.

• Audit methodologies have been developed and are regularly reviewed and updated to ensure they are in line with current practice
• Policies in respect of document confidentiality, retention requirements and the release to internal and external parties have been developed and are consistent with the organisation's guidelines and any pertinent regulatory or other requirements
• Quality assurance procedures are defined and cover all aspects of the internal audit activity including:
  • Supervision and review
  • QA procedures and checklists including periodic internal quality reviews
  • Compliance with applicable laws, regulations and government or industry standards
  • Auditee/customer satisfaction surveys.
	Associated references **PSIAS:**
	1310 Requirements of the Quality Assurance and Improvement Programme
	1311 Internal Assessments
	2040 Policies and Procedures
	2330 Documenting Information
		Audit methodologies are reviewed but there is more work to do to ensure we can evidence that they remain in line with current practice.
		
		All reports are produced solely for the organisation being audited and our disclaimers make this clear. We comply with NHS Wales' confidentiality and retention requirements.
		
		Quality Assurance procedures are undertaken by the relevant reviewer, Deputy Head of Internal Audit and Head of Internal Audit. A QA checklist is completed for all audits and a percentage of files are re-reviewed by the Director of Audit & Assurance. Compliance is measured against the PSIAS unless WG issues any specific requirements. Satisfaction

• Periodic self-assessments against the IAQAF are performed and actions taken to address weaknesses • Performance of the internal audit service is monitored and reported in accordance with the defined Central Government performance measures, performance is benchmarked and any remedial actions are monitored and followed-up		surveys are issued after every audit is complete. Annual self-assessments are undertaken annually and reported in the QAIP. Key performance Indicators and a Service Level Agreement have been established for Internal Audit.

Remedial actions	***Target date***	***Responsibility***
1. Review audit methodologies to ensure they remain in line with current practice.	Ongoing	Audit & Assurance Management Team

Engagement planning		
Statements of good practice	***Assessment***	***Evidence***
• Detailed plans are developed and documented setting out the scope, limitations, objectives, resources, timing and reporting lines for each engagement	√ **Fully conforms** **Generally conforms** **Partially conforms** **Does not conform**	Yes
• Engagement plans are discussed and agreed with relevant management prior to the start of the fieldwork		Yes
• Engagement plans include consideration of the relevant systems, records, personnel, and physical properties including those under the control of third parties	***Associated references*** **PSIAS:** **2200 Engagement Planning**	Yes, but this could be better articulated in our template.
• Plans include consideration of the risks to the area under review and the organisations' risk management and controls processes	**2210 Engagement Objectives** **2220 Engagement Scope**	Yes
• Budgets are developed for each engagement plan and are appropriate to the review scope and degree of associated risk	**2230 Engagement Resource Allocation**	Yes
• Where areas require, particular specialist knowledge subject matter experts are identified and included as part of the audit team		Yes, although we could be more systematic in doing this.

Remedial actions	***Target date***	***Responsibility***
2. Review audit scope document to consider if more detail needs to be added.	31 March 2021	Audit & Assurance Management Team

Performance of Audit work / audit delivery		
Statements of good practice	***Assessment***	***Evidence***
• Work programmes that will achieve the engagement objectives are developed and approved prior to use and include procedures for identifying, analysing, evaluating and documenting information during the engagement	√ **Fully conforms** **Generally conforms** **Partially conforms** **Does not conform**	Yes
• Internal auditors use standard documentation to ensure that evidence and findings are adequately documented	***Associated references*** **PSIAS:** **2240 Engagement Work Programme**	Yes, Teammate audit software used everywhere.
• Work papers are clear, concise, and appropriately cross-referenced to work programmes so as to enable independent review and comprehension.	**2310 Identifying Information**	Yes, based on Quality review results.
• There is evidence that internal auditors are identifying, analysing, evaluating and documenting sufficient information to support the audit conclusions and opinions	**2320 Analysis and Evaluation** **2330 Documenting Information**	Yes
• There is evidence to confirm that all engagements are led or supervised by suitably competent individuals	**2340 Engagement Supervision**	Yes
• Audit findings are discussed and confirmed with auditees prior to report drafting		Yes
• Automated tools (e.g. data interrogation) are used appropriately to undertake testing as efficiently as possible		Yes, but we need to expand our use of these tools.

Remedial actions	***Target date***	***Responsibility***

3. Look at options to use more automated tools across all audits/reviews.	30 September 2021	IM&T Team/NWSSP Head of Internal Audit

Reporting		
Statements of good practice	***Assessment***	***Evidence***
• Communications are accurate, objective, clear, concise, constructive and timely	√ **Fully conforms** **Generally conforms** **Partially conforms** **Does not conform**	Yes, but we recognise that reports could be more concise.
• Audit reports convey appropriate audit scopes, limitations of scope, results, recommendations and an opinion on the adequacy of controls		Yes
• Audit evidence is reviewed by a senior member of the audit function to ensure that the audit has been carried out in sufficient depth and to the function's quality standards prior to the audit findings being distributed to the auditee	***Associated references*** **PSIAS:** **2410 Criteria for Communicating** **2420 Quality of Communications** **2440 Disseminating Results** **2500 Monitoring Progress** **2600 Communicating the Acceptance of Risk**	Yes
• Findings and recommendations are appropriately classified according to relative levels of gross and net risk to the organisation		Yes
• internal audit recommendations help the organisation address the risk in a way that does not create unnecessary control and the recommendations are practical		Yes
• Draft audit reports are issued for consideration by the auditee within a reasonable, pre-agreed, timescale before they are released to management Audit issues are reported to appropriate levels of management and to the Audit Committee		Yes, this is set out in our KPIs.
• The CAE informs the Audit Committee and Accounting Officer if he/she believes that senior management has		Yes

accepted a level of residual risk that may be unacceptable to the organisation		
• There is a procedure for follow-up that ensures agreed recommendations are implemented effectively or that senior management has accepted the risk of not taking action		Yes, but there are opportunities to improve the efficiency and impact of these procedures.
• Unresolved or outstanding audit issues are reported to senior management in accordance with pre-agreed timescales and escalation procedures		Yes
• The CAE presents to the Board and or Audit and Risk Assurance Committee, at least annually, a report of internal audit activity containing an opinion of the overall adequacy and effectiveness of the organisation's governance, risk management, and control processes.		Yes

Remedial actions	***Target date***	***Responsibility***
4. Work with Board Secretaries to improve the follow-up/recommendation tracking procedures.	30 September 2021	Director of Audit & assurance

APPENDIX C

Quality Reviews 2020/21 – Exceptions and differences noted:

Independence, objectivity and competency (Q1 – 3)

No specific comments other than to note that external support was not used on any of the audits reviewed – due to the impact of COVID-19. We currently have 3 auditors working with us on contract, all of whom have worked with us for some time and have relevant backgrounds.

Engagement Planning (Q4 – 9)

Q5 – in a couple of instances, the scope had been changed either between draft and final or between final and the conclusion of the audit. In most cases the explanation was clear on the file and reasonable, however, in a couple of cases I needed to speak to the relevant HIA to understand the rationale. Also, in a small number of instances the brief on file was the 'draft' rather than the 'final' but there was evidence that the HB/Trust had agreed the scope.

Performing the engagement (Q10 – 11)

Q10 – it was clear generally how the findings recorded on the file linked to the findings in the report (draft and final), for example where the number of issues recorded did not match the number of recommendations made in the report it was clear how they had been merged or where additional information had cleared the original finding. Evidence recorded on files was generally to a high standard. This was consistent with previous years.

Supervision and review (Q12 – 13)

Q13 – Head of Internal Audit final review was clear in all cases, this is consistent with 2019/20.

Q13 – There are small differences in the way each team uses the structure and steps to record evidence of work done and the findings e.g. the use of 'Current Issues' and 'Formulate Findings'. In addition, Teams have added additional schedules and matrixes where appropriate.
Note: in a small number of cases the DAA signed-off the HIA step where the HIA was closely involved in the work. In addition, the DAA reviewed all draft COVID-19 Governance reviews before they were issued as part of the QR process we put in place around those large and complex pieces of audit work.

Reporting (Q14)

No specific comments other than to say I thought the quality of the reports was good and a number contained examples of good and comparative practice.

Completion (Q15 – 16)

Q15 – All teams now use the checklist to demonstrate that process and quality checks have been performed before the issue of the draft/final reports. In a few instances I think that files could have been signed-off as complete quicker than they were (after final report and the issue of a management feedback request).

Q16 – We have sought feedback for most reviews but only a couple had any evidence on file of the feedback. However, all reports do go through to Audit Committee which acts as a measure of the quality and relevance of our work and satisfaction surveys are included in each Head of Internal Audit and Annual Report.