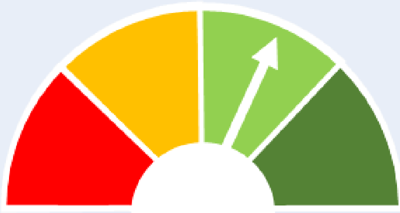
Follow Up Review

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference	HDU-2425-36
Fieldwork	April – May 2025
Executive Sign Off	3 June 2025
Audit Committee	June 2025
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Executive Summary

Purpose

To provide assurance on the status of implemented recommendations on the audit tracker and review the systems and arrangements the Health Board has in place to monitor progress with the implementation of actions.

The scope of this follow-up review does not provide assurance against the full scope and objectives of the original audits or that the matters arising to which they relate have been fully closed. The follow-up review opinion provides assurance against the level of implementation of the recommendations reviewed only.

Overview

The Health Board have established arrangements to track progress in relation to audit findings that is monitored by the Assurance and Risk Team through the Audit Management and Tracking (AMaT) system. The Assurance and Risk Team regularly engage with key stakeholders through meetings, including responsible officer, directorates, boards, committees and Internal Audit.

The tracking of audit and review recommendations through an internal escalation process is used to strengthen operational audit tracking arrangements was noted as robust in the Wales Audit Structured Assessment 2024. During 2024/25, follow up reviews were undertaken by Internal Audit for Consultant Job Planning and Discharge Management, with positive steps in the implementation of management actions noted.

We undertook a follow up review of five limited assurance internal audit reports (three issued in 2024/25 and two issued in 2023/24) to provide assurance that the Health Board has implemented a sample of the related recommendations appropriately and in a timely manner. We have also considered a sample of high priority recommendations from reasonable assurance reports and reviewed the systems and arrangements the Health Board has in place to monitor progress with the implementation of actions.

The following table sets out the sample of recommendations selected from the tracker (as at 19 March 2025):

Report Title	Report Assurance Rating	Matters Arising	Priority Rating	Internal Audit Status Opinion
Speaking Up Safely	Reasonable	4.1a	High	Implemented
		4.1b	High	Implemented
Falls Management	Limited	3.1	High	Partially Implemented (*Work Actively in Progress*)
Nursing Management	Limited	2.1	High	Implemented
		3.1	High	Not Implemented
Management of Bed Capacity	Limited	1	High	Implemented
		2	High	Partially Implemented (*Work Actively in Progress*)
		3	High	Partially Implemented (*Work Actively in Progress*)
		4	High	Partially Implemented (*Work Actively in Progress*)
		5	Medium	Partially Implemented (*Work Actively in Progress*)
Emergency & Business Continuity Planning	Reasonable	1.1a	High	Implemented
		1.1b	High	Implemented

Estates Condition	Limited	3	High	Implemented
		4.1	High	Not Implemented
		6	High	Partially Implemented (*Work Actively in Progress*)
GGH Fire Precautions Phase 1	Limited	1.1	High	Implemented

Testing identified eight recommendations where supporting documentation to confirm the implementation of management action was evident. Of the recommendations assessed as partially complete, progress was well established on these actions, whilst two recommendations require further work before they can be closed.

A number of recommendations identified as completed during this review and also throughout the year was not supported by evidence to corroborate the completion of the agreed management action. This was communicated to the identified responsible officer via AMaT, whilst the Assurance and Risk Team would also support in communicating this to the service or directorate at their regular meetings.

Overall, the Health Board has an established corporate system in place with sound internal controls and governance arrangements for the recording and monitoring of report/inspection recommendations. Whilst testing confirmed the implementation for several sampled recommendations, work was actively ongoing for the remaining recommendations. We have therefore concluded **reasonable** assurance on this area.

Full details of the progress of partially and not implemented actions are detailed within the Progress with Action Implementations section below.

Corporate Approach to Tracking Recommendations

The Health Board has effective arrangements to monitor progress in relation to the implementation of recommendations. Since 2024, Hywel Dda capture all inspection and report recommendations on the AMaT system, allowing designated responsible officers to record the progress in the implementation of agreed management actions. Concluding the implementation of the agreed action, supporting evidence is required to be uploaded before being approved as implemented by an authorised individual.

The Assurance and Risk Team are responsible for the monitoring of all recorded recommendations on the AMaT system through continuous monitoring arrangements of progress against the actions including providing update reports and working with departments and directorates.

The Audit and Risk Assurance Committee (ARAC) receive regular 'Audit Tracker' reports that provides progress in respect of the implementation of recommendations from audits and inspections across the Health Board. The reporting of the 'Audit Tracker' reports is also listed on the ARAC work plan for 2024/25. A review of ARAC minutes confirmed scrutiny of the progress of audits recommendations overall by members including the identification of any issues or concerns.

In January 2024, the escalation status of Hywel Dda was increased to targeted intervention (TI) for the entire organisation due to concerns within all six domains of the *NHS Wales Escalation and Oversight Framework*. A streamline approach with newly defined assurance levels was introduced as part of the organisation's internal escalation process. This approach has also been incorporated into the 'Audit Tracker' reports with updates on the implementation of recommendations provided per directorate and service.

Audit Wales' Structured Assessment 2024 (issued November 2024) reported that "*the Health Board has maintained robust arrangements for tracking audit and review recommendations, with internal escalation arrangements used to strengthen operational audit tracking arrangements*". The report also corroborates the above arrangements in place for the tracking of recommendation in addition to providing a high-level summary of each directorate's escalation status on the governance domain, which includes managing audit and inspection recommendations, since October 2024.

A review of the audit tracker (as at 19 March 2025) highlighted continued good engagement with directorates and services with 80% of recommendations raised during 2024/25 noted as closed. We noted 16 (15%) open recommendation that are overdue did not have a revised completion date.

Outcomes of Ongoing Internal Audit Work

The Assurance and Risk Team have regularly engaged with Internal Audit throughout 2024/25 with dedicated meetings and ad hoc requests. These meetings focus on progress of actions including those that have implemented management actions and those where barriers have been identified that has delayed department or services addressing outstanding actions.

Internal Audit also attend regular sessions established by the Assurance and Risk Team with dedicated services, such as Estates and Facilities. These sessions allow the Assurance and Risk Team to obtain progress updates from the service and provide any support where issue or concerns are identified.

Throughout 2024/25, Internal Audit have independently reviewed implemented actions and supporting evidence on a total of 21 recommendations (2x High, 15x Medium and 4x Low). Where Internal Audit have deemed that further evidence or work is required for management to address the recommendation, this is communicated back to the responsible officers either through AMaT, via the Assurance and Risk Team or directly with the responsible officers.

During the course of this review and throughout the year, we identified some recommendations that have been signed off as implemented; however, no supporting evidence to corroborate the completion of the agreed management action had been uploaded on AMaT. Where supporting documentation has not been uploaded onto the AMaT, Internal Audit have communicated this back to the identified responsible officer via the system, whilst the Assurance and Risk Team would also support in communicating this to the service or directorate at their regular meetings.

Progress of Agreed Actions Not Fully Implemented

Falls Management: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status
3.1	**Risk Assessments** Senior Nurse Management teams to undertake independent checks to ensure the existence, timeliness (for example through WNCR reporting functionality) and quality of MFRAs, particularly in falls 'hot spots'. Independent checking controls have been observed at other Welsh Health Boards.	Head of Nursing & Senior Nurse Manager (PPH) 31 January 2025 *(second mgnt action not due until May 2025)*	High	**Partially Implemented** A falls audit tool has been developed but has not been rolled out for use across the organisation to date. The Deputy Head of Nursing confirmed that the roll out of this audit tool will commence in May 2025.

Nursing Management: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status
3.1	**Escalation of Unfilled Shifts** Ensure that unfilled shifts are escalated to agency in line with the new process effective 1 November 2024 and maintain an audit trail to demonstrate compliance with the standard operating procedure, where approval is obtained outside of the roster system. This could be achieved by including the Roster Team on approval correspondence which would provide oversight and enable a central record of approvals to be maintained. Determine approval requirements for the reallocation of agency shifts and consider whether this needs to be incorporated into the new standard operating procedure.	Head of Nursing for Professional Standards & Regulation 31 March 2025	High	**Not Implemented** A *Booking Registered Nurse or Health Care Support Workers Additional Hours, Bank, Overtime and Agency* procedure document that outlines the new approval process has been drafted but has not been formally approved to date. No evidence of peer-to-peer audits have been undertaken, whilst additional testing by Internal Audit identified continued non-compliance with escalated shifts not being submitted for approval to the Heads or Deputy Heads of Nursing.

Management of Bed Capacity: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status
2	**Established Core Bed Numbers** Following an exercise on the reconciliation of actual numbers of core beds with the WPAS system, this will be shared with other departments and services to ensure ward core bed numbers correctly aligned.	Deputy General Manager Carmarthenshire & Head of Information Services 31 March 2025	**High**	**Partially Implemented** A review of the 'Live Bed Capacity' numbers, which are linked to the WPAS figures, identified wards where core bed numbers did not accurately reconcile. A *Bed Complement Reconciliation* standard operating procedure (SOP) document has been produced outlining the requirement for senior nurse managers to submit core bed numbers for WPAS on a monthly basis. However, no evidence of the SOP sign-off or dissemination was evident.
3	**Consolidation of Core and Surge Bed Numbers** The triangulation of data in a central repository will be addressed as part of the implementation of the new *Pt-Flow* and *E-Obs* system – a hospital wide 'at a glance' summary is included in the deliverable system – for all staff that need access to this. In the meantime, appropriate staff will be trained on how to record opening of beds identifying them as surge on the WPAS.	Deputy General Manager Carmarthenshire 31 March 2025	**High**	**Partially Implemented** Informatics have undertaken training on approximately 75 employees to date to show them how to record opening of beds identifying them as surge on the WPAS. Staff have also been provided with a WPAS user guide for reference. The implementation of the *Pt-Flow* and *E-Obs* system continues to be on track for roll out by 31 December 2025, with the existing Power BI dashboard in place in interim.
4	**Service Changes Process** To ensure a consistent approach for service changes, the establishment of a change procedure to modify core bed numbers will be developed. This solution will be superseded following the implementation of the new *Pt-Flow* and *E-Obs* system.	Deputy General Manager Carmarthenshire 1 March 2025	**High**	**Partially Implemented** A *Bed Complement Reconciliation* SOP document has been developed detailing the process for the adjustment of core bed numbers. As noted above, no evidence of the SOP sign-off or dissemination was evident.

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status
				The implementation of the *Pt-Flow* and *E-Obs* system continues to be on track for roll out by 31 December 2025.
5	**Surge and Flex Beds** To confirm the consistent interpretation of surge beds and 'flex' beds, actions will be taken to as part of the new *Pt Flow* and *E-Obs* system development, to ensure a clear delineation of all the bed types on the hospital 'at a glance' view to be included.	Deputy General Manager Carmarthenshire & Head of Information Services 31 March 2025	**Medium**	**Partially Implemented** Informatics have undertaken training on approximately 75 employees to date to show them how to record opening of beds identifying them as surge on the WPAS. In addition, senior nurse managers are required to submit core bed numbers monthly. The implementation of the *Pt-Flow* and *E-Obs* system continues to be on track for roll out by 31 December 2025, with the existing Power BI dashboard in place in interim.

Estates Condition HDU-SSU-2324-03: Limited Assurance

Ref	Recommendation	Original Responsibility & Timescale	Priority Rating	Status
4.1	**Funding Strategy – Revenue Investment** A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity based on the current configuration of the estate - pre any redevelopment. Following this, a clear financial model for the revenue support needed in the estate should be developed.	Director of Estates, Facilities and Capital Management 1 July 2024	**High**	**Not Implemented** Following the outcome of the A Healthier Mid and West Wales strategy refresh, a review of workforce will be assessed and a paper will be tabled. No action on this review of workforce has taken place to date.
6	**Board Assurance Framework** The Board will be provided with assurances on the effectiveness of the identified controls to reduce the principal risk associate with the "Insufficient investment in facilities/equipment/digital infrastructure"	Executive Director of Strategy and Planning 1 December 2023	**High**	**Partially Implemented** Whilst the risk is contained on the Principal Risk Register within the Board Assurance Framework (Risk Ref. 1196), the implementation of the controls and actions has not progressed since 2021 with the risk score increasing in February 2025.

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	Substantial	**Follow up:** all recommendations implemented and operating as expected.
	Reasonable	**Follow up:** all high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited	**Follow up:** no high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory	**Follow up:** no action taken to implement recommendations.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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