Board Oversight
Final Internal Audit Report

October 2023

Hywel Dda University Health Board

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Executive Summary

Purpose

Review the arrangements in place to ensure adequacy of Board oversight of key risks and challenges.

Overview

We have concluded **substantial** assurance on this area with no significant matters for reporting in our review.

The Board has established an effective committee structure logically split by function. All committees have an approved terms of reference and workplan and regular reporting to the Board.

Planning objectives and risks are clearly aligned to Board committees and there is evidence of regular reporting on these in line with workplans.

We noted good practice in the use of standard templates for committee and Board reporting, to encourage consistency and clarity of reporting and key messages are clearly articulated.

We have identified one medium priority matter arising relating to the opportunity to further enhance the quality of reporting at committee level with reports tailored to the requirements of the recipient.

Full details are provided within appendix A.

Report Opinion

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	n/a

Assurance summary[1]

Objectives		Assurance
1	Design of governance structures and processes	Substantial
2	Escalation and reporting of governance, compliance, key risks and issues to the Board	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Committee Reporting	2	Operation	Medium

1. Introduction

1.1   The Board is responsible for the Health Board's overall system of governance and control, which includes robust risk management, and therefore must seek and be provided with assurance on the effectiveness of the systems and processes in place for meeting the Health Board's strategic and planning objectives.

1.2   The Board's ability to make well-informed and effective decisions is dependent on the information and assurance it receives via it's supporting committees:
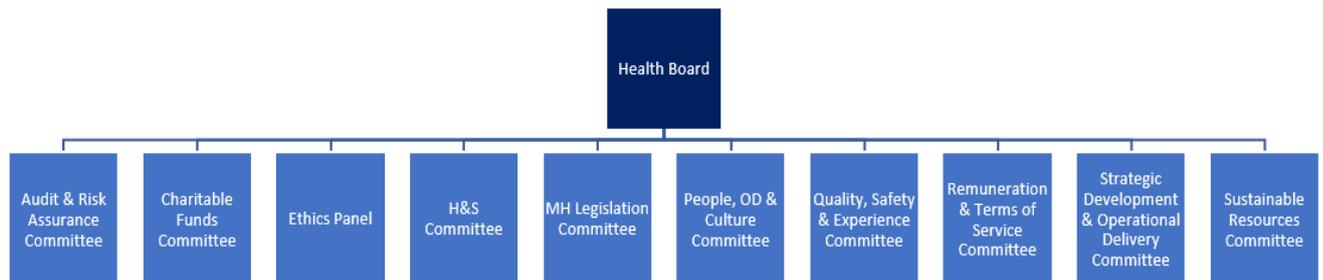
1.3   The associated risk considered in the review is that the Board is not sighted on or does not receive assurance in relation to key risks and issues, impacting on the organisations ability to achieve its objectives and potentially resulting in:

- ineffective decision making

- materialisation of key risks

- failure to achieve objectives

- reputational damage

1.4   The review has focused on the structures and processes in place to ensure adequate Board oversight of key issues. The review has not sought to confirm or provide assurance that the Board is sighted on everything it should be.

2. Detailed Audit Findings

Objective 1: Governance structures and processes are designed to ensure that the Board has adequate oversight of and assurance in relation to key operations, risks and issues pertinent to the achievement of the Health Board's objectives

Board & Committee Structure

2.1   The Board has an established committee structure satisfying the requirements of Standing Orders, with committees logically split by function.

2.2   All committees have a terms of reference approved by Board in July 2023 and an annual workplan for 2023/24.   Meeting frequency for 2023/24 to date was confirmed to be in line with the Board Committee Schedule, committee terms of reference and workplans.

2.3   Core committees report to each meeting of the Board, whilst the Charitable Funds, Mental Health Legislation and Remuneration & Terms of Service committees reporting by exception. Review of papers for four Board meetings held between March 2022 – July 2023 confirmed that reporting is in line with the Board workplan.

2.4   A number of Board committees are supported by sub-committees and/or groups as identified within the respective terms of reference and workplans. Review of the sub-committee and group reporting during 2023/24 to date confirmed that reporting is in line with workplans with no issues identified.

Alignment with Objectives & Risks

2.5   The Board has agreed 23 planning objectives (POs) for 2023/24 which are assigned an Executive lead and aligned to a Board committee. Responsibilities for POs are reflected in committee terms of reference and workplans.

2.6   Reporting on planning objectives in 2023/24 to date is consistent, with all committees provided with an update on 2022/23 POs, details of 2023/24 POs with a 'plan on a page' for each, and deep dive reviews in line with committee workplans.

2.7   The Board Assurance Framework (BAF) triangulates the Health Board's strategic objectives, principal risks, and POs. The Board has retained responsibility for all principal risks and updates are provided via the BAF four times a year.

2.8   Corporate risks are reported to the Board three times a year, most recently in September 2023. All 17 risks on the corporate risk register (CRR) are aligned to a Board committee. Committee papers for 2023/24 to date evidence reporting and monitoring of assigned corporate risks. The reports follow a standard template for consistency within and across committees.

Conclusion:

2.9   We have concluded **Substantial** assurance for this objective.

Objective 2: There is complete, accurate and timely escalation and reporting of governance, compliance, key risks and issues to the Board by its sub-committees

2.10 Arrangements for monitoring and reporting on planning objectives and principal/corporate risks are covered under objective 1.

2.11 Three topic areas were selected as tracers for the review:

　　　a. Reinforced Autoclave Aerated Concrete Planks (RAAC)

　　　b. Maternity

　　　c. Infection Prevention & Control

2.12 Papers of relevant committees as well as the Board were reviewed and in all cases reporting was considered to be timely, consistent, and accurate (where able to verify supporting data) with no significant issues identified.

2.13 Reports to committees were very detailed and we noted examples where the same report was discussed at multiple forums. Whilst this ensures consistency, there is opportunity to enhance the quality of reporting by tailoring reports to suit the needs of the recipient thereby allowing the committee to easily identify and focus on the key elements pertinent to their role and remit. **[Matter Arising 1]**

2.14 Nevertheless, onward reporting to the Board was appropriately focused in line with the committee remit. For example, in the case of RAAC, updates from the Health & Safety Committee focused on estates; Quality, Safety & Experience Committee focused on patient safety/experience; Sustainable Resources Committee focused on capital funding; and the Strategic Development & Operational Delivery Committee focused on operational service delivery implications.

2.15 We noted **good practice** in the use of standard templates for reporting to committee and Board, requiring information outlined in the table below to ensure consistency and clarity of reporting:

SBAR Report to Committee / Board	Committee Update Report to Board
Report purpose – i.e., for assurance, information, decision, or discussion	Summary of the key decisions and matters considered by the committee
Links to committee objectives	Matters requiring board level consideration or approval
Links to Health Board strategic, planning and wellbeing objectives	Key risks and issues/matters of concern
Links to domains and enablers of quality in line with the Quality & Engagement Act	
Impact in terms of finance, quality/patient care, workforce, risk, legal, reputational, privacy and equality	

2.16 We also noted **good practice** with the availability of templates and supporting guidance to ensure the completeness and consistency of directorate exception reporting to the Operational Quality, Safety & Experience Sub-Committee.

Conclusion:

2.17 We have concluded **Reasonable** assurance for this objective.

Feedback from Independent Members

2.18 We met with three Independent Members including the Chair of the health board, to seek their views on the timeliness and quality of information reported to committee and Board level. Feedback is generally very positive with praise for the "open and transparent culture" of the organisation and support provided by the corporate governance team.

Appendix A: Management Action Plan

Matter Arising 1: Committee Reporting (Operation)	Impact
Reports to committees are very detailed and we noted examples where the same report was discussed at multiple forums. Whilst this ensures consistency, there is opportunity to enhance quality of reporting by tailoring reports to suit the needs of the recipient thereby allowing the committee to easily identify and focus on the key elements pertinent to their role and remit.	Potential risk of: • The Board and its committees are not sighted on or do not receive assurance in relation to key risks and issues, impacting on the organisations ability to achieve its objectives

Recommendations		Priority
1.1	Committee level reporting should be tailored to the recipient and focused on the key information required by the committee to enable it to discharge its duties in line with the role and remit set out within terms of reference. To refine the level of detail, background / contextual information could be included within an appendix rather than the main body of the report to maintain spotlight on key messages.	**Medium**

Agreed Management Action	Target Date	Responsible Officer

1.1	The Director of Corporate Governance/Board Secretary or the Assistant Director of Assurance and Risk attend all Agenda Setting Meetings where the content of reports is agreed with the Committee Chair and Executive Lead. Where it is identified that reports relating to the same issue are being reported to more than one Committee during the agenda setting process, the relevant Committee Services Officer (CSO) will provide clarity on the content and structure of the report to the report authors and Executive Leads to ensure that the specific focus of the report is tailored to requirements and remit of each Committee. The CSO will also identify any issues with the report's content and structure during the quality assuring process prior to papers being issued. The SBAR provides a 'Background' section and should contain information relating to the background and context of the report being presented to the Committee, with the 'Assessment' section used to provide the information relevant to the Committee to make a decision or to take assurance from. This requirement will be: 1. Communicated to CSOs through our team meeting for them to communicate requirements for the report to authors and Executive Leads and to identify any issues with the report's content and structure during the quality assuring process. 2. Incorporated in the CSO's process map on our Teams channel. 3. Incorporated in the guidance we provide to authors when requesting committee reports. This matter will be reviewed at the Committee Chairs meeting.	Oct 2023	Assistant Director of Assurance and Risk

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. **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. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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