Hywel Dda University Health Board

Bronglais General Hospital Directorate Governance Review

(Follow Up)

Final Internal Audit Report

September 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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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.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

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1. Introduction and Background

The assignment originates from the 20/21 internal audit plan. The relevant lead Executive Director for the assignment was the Director of Operations.

The original internal audit (HDUHB-1920-26) considered the adequacy of the systems and controls in place for the directorate's governance arrangements, in order to provide assurance to the Audit & Risk Assurance Committee (ARAC) that risks material to the achievement of system objectives are managed appropriately.

A report rating of limited assurance was derived from this review. This audit has looked at the progress made by management to implement agreed actions to address the key findings identified in the previous report.

2. Scope and Objectives

The overall objective of this audit was to establish progress made by management to implement actions agreed to address key issues identified during the 2019/20 review of the adequacy of the systems and controls in place for the directorate's governance arrangements, in order to provide assurance to the ARAC that risks material to the achievement of system objectives are managed appropriately.

The scope of this audit was limited to the follow-up of action taken in response to issues raised in the last report.

3. Associated Risks

The following inherent risks were considered during this audit:

i. Governance structures, roles and responsibilities are not clear;

ii. Risks to achievement of the managed unit or Health Board objectives are not identified, managed or reported appropriately;

iii. Assurance against key areas of Directorate business, performance and compliance not received and acted upon;

iv. Incidents and concerns are not recorded and addressed;

v. Robust arrangements for financial management not in place; and

vi. Staff not managed appropriately; and

vii. Recommendations have not been addressed as agreed by management.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Bronglais General Hospital Directorate Review (Follow Up) is **Reasonable** assurance.

RATING	INDICATOR	DEFINITION
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.

The follow up audit work undertaken, has confirmed that positive progress had been made with the implementation of the agreed management actions from the previous audit, although some actions still need to be fully implemented.

In summary, progress against the five agreed recommendations that required implementation is as follows: **Priority rating**	**No of management responses to be implemented**	**Fully addressed**	**Partially addressed**	**Not addressed**
High	3	0	2	1
Medium	5	4	1	0
Low	0	0	0	0
Total	**8**	**4**	**3**	**1**

The BGH Directorate has made some progress since the original Internal Audit review undertaken in February 2020, including improvements in the financial performance, establishment and formal approval of terms of reference, and the declaration of intrests, gifts and hospitality both corporately and locally.

Of the eight findings identified in the original audit report, four findings had been fully addressed. Of the remaining findings, three findings in relation to the directorate's risk register, BGH Management Committee work plan and PADR forms had only been partially addressed; whilst one finding in relation to sickness absence management had not been addressed.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

		Assurance Summary*			
Audit Objective					
1	The Directorate has a clear organisational group structure with approved terms of reference			✓	
2	The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance				✓
3	A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated			✓	
4	Look for assurance that staff in department visited have an awareness of the requirements of the Declarations of Interest, gifts and hospitality policy.				✓

		Assurance Summary*			
Audit Objective					
	Review level and nature of declarations made				
5	The Directorate division has an appropriate and up to date scheme of delegation and a robust financial management arrangement are in place				✓
6	Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

6. Summary of Audit Findings

The progress of management actions against key findings identified in the original report are noted in the main body below.

OBJECTIVE 1: The Directorate has a clear organisational group structure with approved terms of reference

Retention of Documents

The original audit identified that due to long-term absence of an employee within the directorate, some committee papers and minutes were not readily available upon request. This situation has now been resolved with new staff appointments and a revised system of storing documents in a shared drive. We can confirm that committee minutes and papers were promptly received upon request by Internal Audit during this review.

Management action addressed.

BGH Management Committee Work Plan

The previous internal audit report highlighted that a work plan/cycle of business had not been implemented by the Bronglais General Hospital (BGH) Management Committee. Concluding discussions with the Hospital General Manager durng this follow up review, it was noted that a work plan had not been development. However, we can confirm enhanced arrangements had been implemented as the BGH Management Committee had redesigned their reporting arrangements to ensure all supporting group minutes and papers are regularly submitted at future meetings.

Whilst we note the steps taken to establish reporting completeness within the directorate, the further development of a BGH Management Committee work plan would ensure organisational business objectives and goals provided by supporting groups, committees and external sources are captured and reported.

Management action partially addressed.

OBJECTIVE 2: The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance

Terms of Reference

The original audit identified that groups and forums within the directorate did not have/ had incomplete terms of reference (TOR). Concluding testing, we can confim an approved TORs were now in place for the Quality Forum, Theatre Users Group and Professional Nursing Forum.

Management action addressed.

OBJECTIVE 3: A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated

Risk Register

On review of the risk register (as at July 2020) during this follow up audit, it was found that the register had been updated and was being regularly reviewed by the BGH Management Committee. We also noted the inclusion of Covid risks on the register.

We identified was one risk (Ref. 197) where all actions had been implemented yet the risk is ongoing and still included in the register. We were informed by the Hopsital General Manager that the risk is related to system and site flow, and are unable to close the risk through actions, some of which are long term monitoring and constant review.

Consideration should be given to identifying more actions to address the initial risk or closing the initial risk and raising more manageable risks that are able to be addressed.

We also identified that some actions do not have a set target date. We would recommend the inclusion of target dates against all outstanding actions.

Management action partially addressed.

OBJECTIVE 4: Look for assurance that staff in departments visited have an awareness of the requirements of the Declaration of Interest, gifts and hospitality policy

Declaration of Interests, Gifts & Hospitality Registers

Evidence was obtained that key directorate individuals identified in the *Standards of Behaviour Policy* had completed and submitted a declaration of interest form. In addtition, locally held declaration of interest records within departments were evident, such as the A&E Department. We also noted a number of recent entries on the corporate register of gifts, sponsorship and hospitality.

Management action addressed.

OBJECTIVE 5: The directorate division has an appropriate and up to date scheme of delegation and a robust financial management arrangement are in place

Directorate Financial Performance

The Month 3 financial performance summary noted an underspend of approximately £111k. The current underspend was due to a combination of closed capacity that has been offset by Covid spend and the removal of all agency doctor spend from the directorate.

Whilst we note that the directorate is reporting a break-even position at year-end, management should continue to work with finance colleague to ensure long-term financial balance is maintained.

Management action addressed.

OBJECTIVE 6: Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy.

Sickness Absence

A follow up sample of five periods of sickness was selected and tested to ensure appropriate actions have been taken and documented in line with the *NHS Wales Managing Attendance at Work Policy*. Concluding testing, we continued to note a lack of formal documentation of file including missing self and medical certificates and completed 'Return to Work' forms.

We did note a new approach currently being developed by the Head of Nursing, where compliance with the management of sickness absence forms a key component of a personal development plan for ward managers.

Management action not addressed.

PADRs

A sample of five PADRs were tested to ensure the objectives complied with the SMART principles set out in the *Performance Appraisal and Personal Development Plan Policy*. We noted that all set objectives tested were achievable and realistic. However, there were still a number of objectives that were not specific, measurable or timely.

Management action partially addressed.

Appendix A - Assurance Opinion and Action Plan Risk Rating

2020/21 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 has **no assurance** arrangements in place to secure governance, risk management and internal control, within those areas under review, which 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.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are 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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