

# **Hywel Dda University Health Board**

## **Records Management (Follow Up)**

### **Final Internal Audit Report**

**October 2020**

**Private and Confidential**

**NHS Wales Shared Services Partnership**

**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.

### **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 follow-up review of Records Management was completed in line with the 2020/21 Internal Audit Plan. The relevant lead Executive Director for the assignment was the Director of Operations.

The original internal audit review (HDHB-1819-33) considered the adequacy of the systems and controls in place for the management of records, in order to provide assurance to the Audit Committee 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 2018/19 review. The audit reviewed the adequacy of the systems and controls in place for the management of records, in order to provide assurance to the Audit Committee 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. Lack of corporate policies could lead to records being managed in an inappropriate manner;
- ii. Lack of records inventory resulting in the Health Board not being aware of what records are held or where they are held;
- iii. Records are created and not filed into the appropriate record keeping system;
- iv. Records are not stored securely and may not be protected from unauthorised access, theft or accidental damage;
- v. Records are not disposed of in line with WHC 00 (071) and NHS Code of Practice resulting in information not being available;
- vi. Records are stored in a non-secure environment which could result in inappropriate access;

- vii. Staff are not aware of their responsibilities in respect of records management; and
- viii. 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 the follow up review of Records Management is **Limited** assurance.

<b>RATING</b>	<b>INDICATOR</b>	<b>DEFINITION</b>
<b>Limited Assurance</b>		The Board can take <b>limited assurance</b> 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 <b>moderate impact on residual risk</b> exposure until resolved.

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit.

In summary, progress against the seven agreed recommendations that required implementation is as follows: <b>Priority rating</b>	<b>No of management responses to be implemented</b>	<b>Fully addressed</b>	<b>Partially addressed</b>	<b>Not addressed</b>
High	4	1	3	0
Medium	6	3	1	2
Low	0	0	0	0
<b>Total</b>	<b>10</b>	<b>4</b>	<b>4</b>	<b>2</b>





Since the audit in 2018/19, we note that management actions have been completed for three recommendations including the identification of all Information Asset Owners, the regular reviewing of Information Assets Registers, updating of the Health Records Management Policy and strategy, and the restart of the Health Records Committee in 2019.

We also noted the progress of work undertaken to address the storage and retention of health records and documents both within the organisation and with third party providers through the establishment of the Health Records Modernisation Programme with dedicated workstreams. However, due to the impact of Covid-19 the progress on five management actions have only been partially addressed.

In addition, we noted one management actions that has not be addressed to date in regard of the lack of a records management training module.

## 5. Assurance Summary

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

Audit Objective		Assurance Summary*			
					
<b>1</b>	Implementation of the Records Management Strategy		✓		
<b>2</b>	Storage, retention and destruction of records			✓	
<b>3</b>	Security arrangements in place with respect to records			✓	
<b>4</b>	Records management training and guidance		✓		
<b>5</b>	Audit of records management				✓

\* 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: Implementation of the Records Management Strategy

#### Corporate Records Management Strategy and Policy

An update provided to the Audit & Risk Assurance Committee (ARAC) in October 2019 stated that the *Corporate Records Management Strategy and Policy* would be reviewed and approved by December 2019. However, a discussion with the Head of Corporate Office confirmed that review and update of the *Corporate Records Management Strategy and Policy* remains outstanding.

**Management action not addressed.**

### OBJECTIVE 2: Storage, retention and destruction of records

#### Health Records Inventory

We can confirm that the identification of all Information Asset Owners (IAO) has been completed and captured on an IAO work plan. The identified IAOs are responsible to maintaining their designated Information Asset Registers (IARs). We can confirm that IARs were being regularly reviewed and reported to the Information Governance Sub Committee meetings that are held on a bi-monthly basis.

**Management action addressed.**

#### Storage Capacity

In October 2019, a Health Records Management Report was submitted to the Business Planning & Performance Assurance Committee providing an update on the progress made with the health records modernisation programme. The programme established a Health Records Management Group and five key workstreams.



The Health Records Management Report also provided an updated of the work being/to be undertaken with the key theme of storage capacity (and the reduction of manual records) running through the workstreams.

An update paper was submitted to the Executive Team meeting in March 2020 providing an update of the health record modernisation programme and also a request for additional resource to create a dedicated Programme Management Office Support to aid in the development of the workstreams.

However, since February 2020 the progress of the workstreams to address storage capacity within the organisation has been paused due to the impact of Covid-19.

### **Management action partially addressed.**

#### Retention & Destruction of Records

The previous report identified a disparity between department and services on the compliance of record retention and destruction. We can confirm that the Health Records Manager issued a reminder to all staff of their responsibilities to adhere to the *Retention and Destruction of Records Policy* in February 2019 via the global email system.

In addition, the retention and destruction of records was identified as a key theme within the workstreams established by the Health Record Modernisation Programme. However, as noted above, due to the impact of Covid-19 the progress of the Health Record Modernisation Programme was temporarily paused in February 2020.

### **Management action partially addressed**

## **OBJECTIVE 3: Security arrangements in place with respect to records**

#### Access to Health Records Policy

We can confirm that review of the *Access to Health Records Policy* has been undertaken and has been updated to reflect the introduction of the General Data Protection Regulations (GDPR). The policy was approved at the BPPAC meeting in August 2020, with the policy due for review in August 2023.

### **Management action addressed.**

#### Third Party Storage Providers

The previous report identified two recommendations for the finding of third party storage providers:



- To review the current storage arrangement with third party providers; and
- To establish what information is stored with third party storage providers and that retention and destruction of information is done within guidelines.

The storage of Health Board documents and records by third party providers was another key driver of the Health Record Modernisation Programme.

Whilst we noted the formation of the Health Record Modernisation Programme and workstreams to address this issue, since February 2020 this work has been paused due to the impact of Covid-19 on the organisation.

### **Management actions partially addressed.**

## **OBJECTIVE 4: Records management training and guidance**

### Records Management Training

The Health Records Manager confirmed that following a departmental review it was decided that Health Records employees did not require additional refresher training due to department induction and on job training.

The Welsh Health Records Management Group have had initial conversations on the production of an 'All Wales' training programme but it is still very much in its infancy with little progress made to date. In addition, there is no resource at present in the Health Board to deliver refresher/update training locally.

### **Management action not addressed.**

## **OBJECTIVE 5: Audit of records management**

### Record Management Practices Audits

We can confirm that the terms of reference for the Health Records Group has been updated to accurately reference the Health & Care Standards 2015. In addition, the *Health Records Management Policy and Strategy* had also been revised and approved by the Information Governance Sub-Committee in April 2019. However, the updated documents require uploading on the Health Board intranet site.

### **Management action addressed.**

### Health Records Committee

We can confirm that the Health Records Group (HRG) was restarted in 2019 and have met on four occasions with the last meeting held in November 2019. We


can also confirm that the Chair of the HRG is the Assistant Director of Informatics, with the group reporting directly to the Information Governance Sub-Committee as a standard agenda item.


However, due to Covid-19 the HRG has not yet met during 2020, but a meeting has been scheduled for the 26<sup>th</sup> October 2020.


**Management action 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
<b>High</b>	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*
<b>Medium</b>	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
<b>Low</b>	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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