Escalation Status Actions
Final Internal Audit Report

July 2023

Hywel Dda University Health Board

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Auditors:	Jennifer Usher, Principal Auditor
Executive sign-off:	Steve Moore, Chief Executive Joanne Wilson, Director of Corporate Governance/Board Secretary
Distribution:	Huw Thomas, Director of Finance
Committee:	Audit & Risk Assurance Committee

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.

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

Executive Summary

Purpose

To assess and provide independent assurance over the effectiveness of governance arrangements in place for the closure of targeted intervention (TI) and enhanced monitoring (EM) actions.

Overview

There were 28 closed actions on the most recent action log at the time of audit fieldwork and 20 of these were considered to have sufficient evidence to support closure.

We have concluded **Reasonable** assurance overall with two medium priority matters arising in relation to:

- Maintenance of the action log to ensure it provides an up to date and accurate reflection of action status and a clear line of sight to any associated actions; and
- Insufficient evidence to demonstrate completion and justify closure of actions.

Full details of all matters arising, and associated recommendations are provided at Appendix A on page 8.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	n/a

Assurance summary[1]

	Objectives	Assurance
1	TI and EM actions are only closed on approval of the TI Working Group on the basis that they are supported by: (i) sufficient appropriate evidence, or (ii) subject to business-as-usual monitoring arrangements with mechanisms to provide assurance over progress	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	Maintenance of the Action Log	1	Operation	Medium
2	Evidence to Support Action Closure	1	Operation	Medium

1. Introduction

1.1 In September 2022, the Health Board was escalated from 'enhanced monitoring' to 'targeted intervention' for finance and planning, due to the Health Board's failure to submit a balanced and approvable Integrated Medium-Term Plan (IMTP) or a finalised annual plan, and a growing financial deficit from £25m to £62m.

1.2 Governance arrangements have been established to manage and oversee escalation processes, which were approved by the Board in November 2022.

1.3 The potential risk considered in the review is that Targeted Intervention and Enhanced Monitoring actions are not completed or are closed prematurely, compromising the Health Board's response to and de-escalation from Targeted Intervention status.

1.4 The scope of this review was limited to considering the appropriateness of evidence to demonstrate completion of closed actions and did not consider the appropriateness of or assess progress in completing the actions identified.

2. Detailed Audit Findings

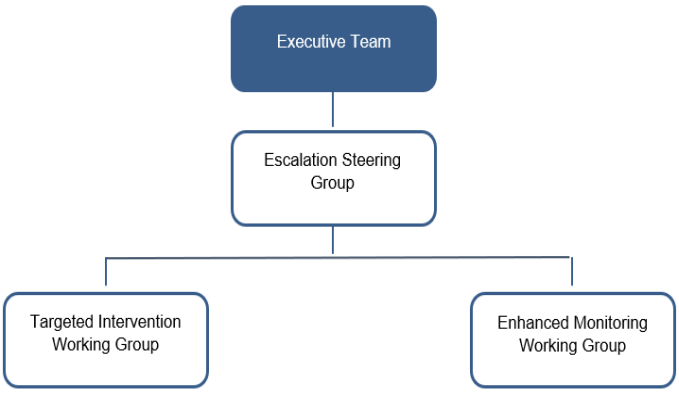
Objective 1: Targeted Intervention and Enhanced Monitoring actions are only closed on approval of the Targeted Intervention / Enhanced Monitoring Working Groups on the basis that they are:

i. **supported by sufficient and appropriate evidence demonstrating completion; or**
ii. **subject to alternative 'business as usual' monitoring arrangements with mechanisms in place to provide assurance over progress and completion.**

Background – Governance Arrangements

2.1 On the 2 November 2022, three working groups were constituted in order to deliver the Health Board's response to the increase in escalation status to targeted intervention (TI) for finance and planning and enhanced monitoring (EM) for specific quality and performance issues.

2.2 The *Escalation Steering Group (ESG)* was established to ensure oversight and coordination of the overall management of the Health Board's response and activity relating to the increased escalation status.



2.3 The *Targeted Intervention Working Group (TIWG)* and the *Enhanced Monitoring Working Group (EMWG)* purpose is to deliver the Health Board's response to the escalation status.

2.4 It was evident from a review of the ESG meeting minutes that the closure of actions and the adequacy of the supporting evidence was discussed, challenged, and scrutinised.

2.5 Whilst resource had been identified to co-ordinate evidence to support actions, arrangements were not sufficiently robust and have fallen down due to unplanned absence with alternative arrangements determined during the latter part of May 2023.

Evidence to Support Closed Actions

2.6 A review was undertaken of the 28 closed actions (15 TI and 13 EM) as recorded in the *TI Key Deliverables Closed Action Log* ('action log') as of January 2023 to establish whether sufficient appropriate evidence existed in support of the action closure. A summary of closed actions subject to review is included at Appendix B, and the results of our fieldwork summarised in the table below:

Findings	EM Actions	TI Actions	Total Number of Actions
Closure supported by satisfactory evidence	6	14	20
Lack of clarity regarding action status *Action References: 1.13; 8.2*	1	1	2
Insufficient evidence to support action closure *Action References: 4.2; 4.5; 4.6; 4.8; 5.6; 8.4*	6	0	6
Total number of closed actions	**13**	**15**	**28**

2.7 For six (five TI & one EM) of the twenty actions deemed satisfactory, evidence to support closure was provided on our request but had not been saved to the evidence folder. **[Matter Arising 2]**

2.8 According to the action log, action 1.13 (TI) had been closed on the basis that it would be addressed by action 1.14 (which remains open). We were advised that action 1.13 consists of two parts; the first part had been completed and evidence was provided to support this but had not been saved to the evidence file (per para 2.7 above); whilst the second part would be addressed by a 'master action'. This was not evident on the action log, and it is not clear which 'master action' it relates to. **[Matter Arising 1]**

2.9 Minutes of the ESG meeting (15 February 2023) note that it was agreed that action 8.2 (EM) would be re-opened, although this is not evident on the most recent action log (25 May 2023), where the action remained closed. **[Matter Arising 1]**

2.10 The remaining six actions (all EM) did not have sufficient evidence to support closure. In some cases, minutes of the ESG evidenced challenge of the action status and it was agreed that the actions should remain closed. We sought the views of the Director of Corporate Governance/Board Secretary who agreed with our assessment that the evidence provided is insufficient. **[Matter Arising 2]**

2.11 In April 2023, the ESG took the decision to consolidate a number of the open TI actions into seven 'master actions' split by directorate. Where this is the case, the original actions have been closed and mapped to the relevant 'master action'. With the exception of action 1.13 (see para 2.8 above), there is a clear line of sight from the original actions to the 'master actions'.

2.12 The action log is colour coded to distinguish between actions that are open, closed or moved to a 'master action'. The log has a status field but in many instances this is blank. The log could be further enhanced to record the date of the ESG meeting where action closure was agreed. **[Matter Arising 1]**

Conclusion:

2.7 The majority of closed actions had sufficient evidence on file to demonstrate completion and support closure, although we identified instances where evidence

was not saved to the evidence folder (but was provided on request) and instances where the action log did not accurately reflect the action status. Accordingly, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Maintenance of the Action Log (Operation)	**Impact**
The action log did not accurately reflect the status or rationale for closure of two actions: • TI Action 1.13 was noted on the log to be closed as addressed by action 1.14 however we were advised that 1.13 has two parts with the first part complete (with satisfactory evidence) and the second part to be addressed by a new 'master action'. The action log had not been updated to reflect this. • EM Action 8.2 was agreed at February ESG to be re-opened however it remained closed on the latest action log (25 May 2023). The action log is colour coded to distinguish between actions that are open, closed or moved to a master action. The log has a status column but in many instances this is blank. The log could be further enhanced to record the date of the ESG meeting where action closure was agreed.	Potential risk of: • TI and EM actions are not completed or closed prematurely, compromising the Health Board's response to and de-escalation from TI status.

Recommendations		**Priority**
1.1	Ensure that the *TI Key Deliverables Action Log* is updated on a regular basis and following each ESG meeting to reflect the decisions made in that meeting, to provide a complete and accurate reflection of the current status of each action including reference to associated actions where appropriate.	**Medium**
1.2	Use the 'status' field in the action log to record the date of the ESG meeting where action closure was agreed.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed that the action log will be updated following each ESG meeting to reflect the decisions made in that meeting.	July 2023	Project manager, ESG
1.2	Agreed that the status field in the action log will record the date of the ESG meeting where the action closure was agreed.	July 2023	Project manager, ESG

Matter Arising 2: Evidence to Support Action Closure (Operation)	**Impact**
For six actions (five TI & one EM) the evidence (deemed satisfactory) was provided on request is not stored in the central evidence folder to demonstrate completion of the action and justify closure. *(Actions 1.13; 2.4; 3.2; 5.4; 10.23 & 10.24).* A further six EM actions did not have sufficient evidence to support closure. In some cases, minutes of the ESG evidenced challenge of the action status and it was agreed that the actions should remain closed. We sought the views of the Director of Corporate Governance/Board Secretary who agreed with our assessment that the evidence provided is insufficient.	Potential risk of: • TI and EM actions are not completed or closed prematurely, compromising the Health Board's response to and de-escalation from TI status.

Recommendations		**Priority**
2.1	The six EM actions with insufficient evidence should be re-opened. Actions should only be closed where there is sufficient evidence presented at ESG to demonstrate completion.	**Medium**
2.2	Ensure that all evidence to support closure of an action is maintained on the central repository to maintain a robust audit trail demonstrating action completion.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed that the actions will be reopened and further evidence collected.	July 2023	Project manager, ESG
2.2	Agreed that the evidence will be captured using the same process as for TI.	July 2023	Project manager, ESG

Appendix B: Summary of Audit Findings

Ref	Action	Conclusion
Targeted Intervention Actions		
1.10	Implement frequent directorate accountability and performance management.	Satisfactory
1.13	The FDU will support the organisation in undertaking a review of financial management arrangements, identifying gaps, next steps and opportunities. This will incorporate the deterioration of the deficit, testing and reviewing the delivery framework and the opportunities framework.	Lack of clarity regarding status – see para 2.8
2.4	Provision of specialist planning and strategy advice from the Director of Planning at Welsh Government.	Satisfactory
2.6	Monthly progress review meetings incorporating check and challenge throughout the planning process.	Satisfactory
2.10	Specialist demand and capacity advice and support to the health board from Improvement Cymru with the roll out of RTDC (Real Time Demand and Capacity) programme.	Satisfactory
3.1	Establish an appropriate governance structure for Targeted Intervention including the appointment of an SRO and Independent Member for TI.	Satisfactory
3.2	Develop a planning maturity matrix through which the organisation could assess themselves against in order to identify the steps required to develop the planning processes.	Satisfactory
3.6	Commit to participating in and rolling out the RTDC model across all sites.	Satisfactory
6.3	Key deliverables agreed with the FDU and implementation plan in place, monitored and reviewed monthly.	Satisfactory *(addressed by 1.14)*
6.5	Presentation of speciality data reviews.	Satisfactory
6.7	Implementation of key deliverables, monitored and reviewed monthly.	Satisfactory
9.1	That Hywel Dda University Health Board is a data-driven organisation that ensures data is understood and utilised in decision making at all levels.	Satisfactory
9.2	To demonstrate a strong link between ensuring quality and performance improvement.	Satisfactory
10.23	KPMG Residual - Monthly reporting on HB performance to Board and committee.	Satisfactory
10.24	KPMG Residual - Expand forecast model to reflect 12-month actuals and 18 months forward.	Satisfactory
Enhanced Monitoring Actions		
4.2	Have a clear understanding of the challenges it faces across key planned care specialities to include general surgery and urology and the appropriate solutions agreed with the NHS Executive.	Insufficient evidence to support action closure

4.5	Undertake desk top reviews into cancer – overall picture with a focus on areas of concern.	Insufficient evidence to support action closure
4.6	Undertake desk top reviews into planned and unscheduled care focusing on areas of concern.	Insufficient evidence to support action closure
4.8	Review ambulance patient handover plans and implement the performance management framework.	Insufficient evidence to support action closure
5.1	Appoint an SRO for Enhanced Monitoring.	Satisfactory
5.2	Demonstrate Board ownership and oversight of the areas of concern.	Satisfactory
5.3	Submit an enhanced monitoring action plan by the 5 November 2022.	Satisfactory
5.4	Provide monthly progress reports against the enhanced monitoring action plan.	Satisfactory
5.6	On urgent and emergency care provide a focus on timely patient flow and discharge, engage with patients (and staff) on their experience in ED and focus upon reducing trolley waits and long waits for admission from ED.	Insufficient evidence to support action closure
5.8	Undertake a detailed analysis behind infection control with a focus on c-diff.	Satisfactory
8.1	Agreed approach and delivery over 6 months against planned care recovery actions.	Satisfactory
8.2	Consistency in urgent and emergency care over the next 6 months as highlighted in 12-hour performance and ambulance handovers.	Lack of clarity regarding status – see para 2.9
8.4	Evidence of actions implemented from identified within the speciality reviews, opportunities assessment and improvement plans and performance sustainably improved over 6 months.	Insufficient evidence to support action closure

Appendix C: 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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership