Directorate Governance – GGH Unscheduled Care

Final Internal Audit Report

August 2022

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

Review reference:	HDUHB-2223-12
Report status:	Final
Fieldwork commencement:	14 June 2022
Fieldwork completion:	21 July 2022
Debrief meeting:	14 July 2022
Draft report issued:	26 July 2022
Management response received:	15 August 2022
Executive sign off received:	18 August 2022
Final report issued:	18 August 2022
Auditors:	Rhian Jones, Principal Auditor
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Committee:	Audit & Risk Assurance Committee

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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

The purpose of the review is to establish whether the Directorate governance structures follow the principles set out in the Health Board's system of assurance and support the management of key risks.

Overview

We have concluded **Reasonable** assurance overall with one high priority matter arising:

- Lack of appropriate record keeping in relation to sickness absences, to demonstrate compliance with the Managing Attendance at Work Policy

We have also identified four medium priority matters arising relating to:

- No Terms of Reference or work plans for the Quality, Safety & Assurance Group and the Budget & Management Group.
- The risk relating to financial performance requires review and updating.
- A significant proportion of complaints are not responded to within the 30-working day target.
- Statutory and mandatory training compliance rates are below the Health Board target rate.

Full detail is provided in section 2 of the report, with a summary of matters arising and recommendation in Appendix A.

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	Governance Structures	Reasonable
2	Risk Management	Reasonable
3	Declarations of Interests	Substantial
4	Financial Management	Reasonable
5	Incidents & Concerns	Reasonable
6	Statutory & Mandatory Training	Reasonable
7	Sickness Absence Management	Limited

[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	Terms of Reference	1	Design	Medium
2	Financial Management	4	Operation	Medium
3	Incidents & Concerns	5	Operation	Medium
4	Statutory & Mandatory Training	6	Operation	Medium
4	Sickness Absence Management	7	Operation	High

1. Introduction

1.1 The review of the Directorate's governance structures considered areas including risk and financial management, incidents and concerns as well as sickness management and statutory and mandatory training compliance to provide assurance that there is management of key risks within these areas and that the Directorate's objectives are achieved.

1.2 The associated potential risks are:

- materialisation of risks due to poor risk management arrangements;
- the Health Board is unable to achieve its forecast financial position; and
- harm to patients or staff.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements are in place to monitor and provide assurance on key objectives and risk areas

2.1 The Directorate has two established management meetings namely the *Quality, Safety & Assurance (QS&A) Group* and the *'GGH Business & Management (B&M) Group'* which meet bimonthly and monthly respectively.

2.2 Terms of Reference (ToR) were not available for either group, so we were unable to determine the roles and responsibilities or assess whether meetings are quorate. However, from review of agendas and papers we can confirm that meetings were well attended by key members from across the Health Board and covered key areas expected. **[Matters Arising 1]**

2.3 Review of the QS&A Group papers for the period January to May 2022 confirmed key standing items had been identified and reports are presented around governance, health and safety, external reporting, incidents, concerns, and risks. Sufficient discussion, scrutiny and reporting against key standing items was evident. The General Manager advised that the QS&A Group reports by exception to the Health Board's Operational Quality Safety & Experience Sub-Committee (OQSEC). Evidence of such reporting was noted in the May 2022 meeting OQSEC papers.

2.4 Papers of the B&M Group for the period April to June 2022 demonstrate discussion, scrutiny and reporting in relation to finance, workforce sickness and performance.

2.5 We compared the QS&A agenda with the Health Board template agenda for Directorate Quality, Safety and Experience' meetings to ensure key areas of business are tabled for discussion. We noted the following areas are not included on the QS&A agenda: Research and Development; Safeguarding; NICE Guidelines;

Infection Control; Safety notices; and Written Control Documents for Consultation and Approval. **[Matter Arising 1]**

2.6 We also noted that there were no annual work plans for either group. Although not mandatory, audit would highlight that having work plans in place for the groups ensures matters for discussion are tabled effectively across the year and are not overlooked. **[Matter Arising 1]**

Conclusion:

2.7 There are no Terms of Reference or work plans in place for the QS&A and B&M groups, although minutes and papers demonstrate scrutiny and discussion of key areas including risk, finance, workforce, quality, and safety. Comparison of QS&A and B&M group agendas with the Health Board's standard template agenda for Quality, Safety & Experience meetings also identified additional areas for inclusion. Accordingly, we have concluded **Reasonable** assurance for this objective.

Objective 2: Risk management processes are effective to ensure that risks are identified, assessed, mitigated and escalated where appropriate

2.8 Directorate risk registers are a standing agenda item tabled at the bi-monthly QS&A meetings. Review of the minutes between January and May 2022 confirmed that the risk register had been presented for discussion together with updates on actions taken to mitigate risks.

2.9 A comprehensive review of the risk register has recently been completed and a paper was submitted at the May 2022 QS&A meeting detailing current risks at 'Corporate', Directorate' and 'Service' level.

2.10 We reviewed the risk register as at May 22 to establish whether actions to mitigate the risk are being progressed and closed. One risk was identified where the action completion date had passed (in March 2022) but no further update had been given and the current risk score still exceeds the target/tolerance. This related to finance – see para 2.20 for further details. **[Matter Arising 2]**

Conclusion:

2.11 Noting the above, we have concluded **Reasonable** assurance for this objective.

Objective 3: Declarations of interest are completed in line with the Standards of Behaviour policy where appropriate

2.12 In line with the Health Board's Standards of Behaviour Policy specified groups and senior members of staff are required to submit a declaration of interest form on an annual basis for inclusion on the Health Board register.

2.13 Sample testing of five senior members of staff within the Directorate confirmed that a declaration of interest form had been submitted for inclusion on the register in four cases, with one exception relating to a new starter in May 2022. This was highlighted to management to action during audit fieldwork.

Conclusion:

2.14 Noting the above, we have concluded **Substantial** assurance for this objective.

Objective 4: Appropriate arrangements are in place to monitor and manage the Directorates financial position and performance

2.15 The structure of the Directorate is based on the scheme of delegation set out in the Health Board Standing Orders and Standing Financial Instructions and budget holders' roles and responsibilities are defined within the Health Board Standing Financial Instructions.

2.16 The financial position is discussed by senior Directorate management together with the Senior Finance Business Partner on a weekly basis, these are informal operational meetings documented in the form of agreed actions rather than formal minutes.

2.17 The financial position is more formally discussed at the monthly B&M Group meetings. Scrutiny of the directorate's financial position, covering overall and service level status is discussed and evidenced within meeting minutes.

2.18 The Directorate receives a monthly report that details the financial position including actual and forecast spend, areas of overspend and other variances to the budget. The financial position for month 3 shows a slight improvement on month 2:

	Month 2	Month 3	Trend
In Month Variance	-£470k	-£347k	↑
Forecast Year End	-£6.3m	-£5.18m	↑
Annual Budget	£45.47m	£45.95m	↑

2.19 With a forecast overspend of £5.18m at year end, financial risk is reflected on the Directorate risk register:

Risk: 979	Identified: July 2020	
There is a risk that the GGH Directorate will fail to remain within their allocated budget over the medium term, caused by inability to: *1. Identify and deliver realistic recurrent savings plans* *2. Manage the impact of the COVID-19 pandemic within available funding* *3. Manage the impact of the underlying deficit of resulting non-delivery of the recurrent savings requirement* *4. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved* *This will lead to a significant long term detrimental impact on the Health Board's financial sustainability*		
Tolerance Score: 6	Current Score: 9	Target Score: 6

2.20 Actions have been identified to mitigate the risk, including a three-year financial training programme for budget holders, however this was paused due to the pandemic response. The risk was last reviewed/updated in March 2022 and should be reassessed based on financial performance in 2022/23 to date, with new actions identified to mitigate. **[Matter Arising 2]**

2.21 We understand that directorates have not been asked to identify specific savings schemes for 2022/23 in light of current pressures. Noted within the June 2022 B&M Group minutes are discussions and plans to monitor agency costs, one of the main drivers of overspend, and the need to ensure that there is effective rostering to reduce the need for agency.

Conclusion:

2.22 Noting the financial challenges faced by the Directorate, we have concluded **Reasonable** assurance for the arrangements in place for financial monitoring and management.

Objective 5: Incidents and concerns are promptly investigated and discussed at an appropriate forum to ensure themes/trends are identified and learning is shared

2.23 Incidents and concerns are standing agenda items on the Directorate QS&A Group meetings. Meeting minutes for the period January to May 2022 demonstrate that incidents and concerns are being discussed, monitored, and closed where appropriate.

2.24 Also evident within the papers are examples of learning from events reports in relation to incidents and concerns which have been submitted for discussion and information. The action plans show at what level of the organisation the action relates to, i.e. ward level/Directorate/HB wide.

2.25 The QS&A Group receive a report from the Patient Safety & Assurance Team in relation to incident reporting via the DATIX system. This provides substantial detail allowing for the identification of themes and trends, including an analysis by service areas of the number of incidents and concerns reported within the year, how many have been closed, and what areas/type of incident has occurred.

2.26 Senior Nurse Manager Assurance reports are also presented at each QS&A meeting which detail incidents and concerns within each service, including action taken to address.

2.27 Notes of the May 2022 meeting highlight the work ongoing since March 2022 to progress a number of incidents through to closure, although a significant number remain under management review or investigation. **[Matter Arising 3]**

Open Incidents @May 2022	
New Incidents	106
Under Management Review	271
Under Investigation	22
Awaiting Closure	423
Total	**822**

2.28 Concerns (complaints) are reported at each meeting by the Complaints Manager. At 9 May 2022, there were 57 open complaints with 41 exceeding the 30-working day response target. However, we note that work is ongoing to address open complaints and the position has improved since January 2022. **[Matter Arising 3]**

2.29 In addition, we note that Senior Nurse Manager Assurance reports are presented at each QS&A meeting which detail incidents and concerns/complaints within each service.

Conclusion:

2.30 Adequate arrangements are in place for monitoring incidents and concerns and there is evidence of shared learning from events. We recognise the ongoing effort to reduce open incidents and concerns, although there remains a significant number of incidents under management review/investigation. Accordingly, we have concluded **Reasonable** assurance for this objective.

Objective 6: Statutory and mandatory training compliance is in line with Health Board targets

2.31 The overall compliance rate for statutory and mandatory training for the Directorate stands at 75.34% (ranges from 62.5% - 81.77% by service area) as at the end of April 2022, which falls below the HB target of 85%. **[Matter Arising 4]**

2.32 The General Manager commented that many service areas are below target due to current service pressures and difficulty in releasing staff to undertake training. This is reflected in the Directorate risk register (Risk 1211) and review of the risk is expected end of September 2022.

2.33 It is noted within the minutes of the QS&A Group that the Senior Nurse Managers report on compliance within their Assurance Reports.

Conclusion:

2.34 Statutory and mandatory training compliance is below the Health Board target, and is reflected in the Directorate risk register. Accordingly, we have concluded **Reasonable** assurance for this objective.

Objective 7: Sickness absence is managed in accordance with the all-Wales Managing Attendance at Work policy

2.35 Sickness absence management is a standard agenda item at each monthly B&M Group meeting with a summary report detailing current rates across the service areas.

2.36 Sickness absence is also reported within the Senior Nurse Manager Assurance reports which go to the QS&A meetings bimonthly. These give a more detailed overview of types of sickness (long/short term) at service level and which staff grade are affected.

2.37 The Directorates' sickness absence rates are higher than the Health Board target, and table below outlines the current sickness absence rates for the Directorate in comparison to the overall Health Board rates:

Sickness Absence Rates - May 22		
Target:	4.79%	
Actual:	**Directorate**	**Health Board**
12 Month Rolling	7.44%	6.36%
Monthly sickness rate	5.68%	5.83%

2.38 The B&M Group papers for May 22 report and improving trend with a 1.96% reduction in sickness absence compared to April 22.

2.39 Testing was undertaken on a sample of 5 employees having had a sickness episode for the period Jan - May 2022 to ensure the absence had been managed in line with the All Wales Managing Attendance at Work Policy:

- only one provided documents relating to the sickness episode, however the supporting 'Fit Note' was missing;
- no evidence was received for three of the sample as the manager was unable to locate the documents in two cases, and one did not respond to our requests; and
- one had not completed the relevant documents as they were unaware that the requirements applied to COVID related absence.

[See Matter Arising 5]

Conclusion

2.40 Although there are adequate arrangements in place for monitoring sickness absence rates, we were unable to confirm that sickness is being managed in accordance with the all-Wales Managing Attendance at Work Policy. As a result of the testing carried out, we have concluded **Limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Terms of Reference (Design)	**Impact**
Terms of Reference (ToR) were not available for the QS&A or B&M Groups, so we were unable to determine the roles and responsibilities or assess whether meetings are quorate. We compared the QS&A agenda with the Health Board template agenda for Directorate Quality, Safety and Experience' meetings to ensure key areas of business are tabled for discussion. We noted the following areas are not included on the QS&A agenda: Research and Development; Safeguarding; NICE Guidelines; Infection Control; Safety notices; and Written Control Documents for Consultation and Approval.	Potential risk of: • Lack of monitoring and reporting on key business areas, potentially resulting in issues not being identified and addressed, which could lead to the materialisation of risks including poor financial performance and harm to patients or staff

	Recommendations	**Priority**
1.1	Develop Terms of Reference for both the Quality, Safety and Assurance Group and the Budget & Management Group, with due regard to the Health Board's template agenda for Directorate Quality, Safety & Experience groups.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer/s**
1.1	Terms of reference to be developed for all Management meetings.	30 September 2022	Sarah Perry, General Manager Unscheduled Care, and Olwen Morgan, Hospital Head of Nursing
	Review template agenda for Quality, Safety and Assurance Group.	31 August 2022	Olwen Morgan, Hospital Head of Nursing

Matter Arising 2: Financial Management (Operation)			Impact
The financial position is reflected on the Directorate risk register. Actions have been identified to mitigate the risk, including a three-year financial training programme for budget holders, however this was paused due to the pandemic response. The risk was last reviewed/updated in March 2022 and should be reassessed based on financial performance in 2022/23 to date.			Potential risk of: • Lessons are not learned from incidents and concerns resulting in harm to patients or staff • Reputational damage
Recommendations			**Priority**
2.1	The risk relating to financial performance should be reviewed and reassessed based on current performance and forecast outturn for 2022/23, with new actions identified to mitigate.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Revised savings plan across Carmarthenshire system to be in place which will be reviewed at monthly finance operational meeting.	30 September 2022	Sarah Perry, General Manager Unscheduled Care

Matter Arising 3: Incidents and Concerns (Operation)	Impact
At 9 May 2022, there were 57 open complaints with 41 exceeding the 30-working day response target. We note the work ongoing since March 2022 to progress a number of incidents through to closure, although a significant number remain under management review or investigation.	Potential risk of: • Lessons are not learned from incidents and concerns resulting in harm to patients or staff • Reputational damage

	Recommendations	Priority
3.1	Ensure that complaints are investigated and a final response provided within 30 working days where possible.	**Medium**
3.2	We would recommend that continued effort is made to clear all outstanding incidents.	**Low**

	Agreed Management Action	Target Date	Responsible Officer
3.1	Weekly meetings with Concerns Team & DHoN/SNM to escalate and progress with actions. Datix and Concern data is being feedback into Quality, Safety & Assurance meeting every other month.	30 September 2022	Iona Evans, Deputy Head of Nursing
3.2	Monthly review of outstanding incidents with Patient Safety & Assurance Team & DHoN agreeing timescales to action.	30 September 2022	Iona Evans, Deputy Head of Nursing

Matter Arising 4: Statutory and Mandatory Training Compliance (Operation)			**Impact**
Statutory and Mandatory figures for the Directorate stand at 75.34% as at the end of April 2022. This falls below the Health Board target of 85%.			Failure to achieve statutory and mandatory training targets, potentially resulting in non-compliance with related policies and procedures
Recommendations			**Priority**
4.1	The directorate should target areas with low compliance rates and set a deadline for achieving the Health Board target compliance rate of 85%.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Statutory and Mandatory Training Compliance being reviewed within Sister/Charge Nurse & SNM 1:1 on a monthly basis. Plans to be devised to work towards compliance rate of 85% by November 2022. To monitor compliance through monthly Budget & Management meeting – and target areas of non-compliance (also looking at allocated staff time/flexible working to support). Review individual statutory & mandatory compliance through PADR (especially with implementation of pay progression PDR).	30 November 2022	Sarah Perry, General Manager Unscheduled Care Olwen Morgan, Hospital Head of Nursing

Matter Arising 5: Sickness Management (Operation)	Impact
Testing was undertaken on a sample of 5 employees having had a sickness episode for the period Jan- May 2022 to ensure the absence had been managed in line with the All Wales Managing Attendance at Work Policy: • only one provided documents relating to the sickness episode, however the supporting 'Fit Note' was missing; • no evidence was received for three of the sample as the manager was unable to locate the documents in two cases, and one did not respond to our requests; and • one had not completed the relevant documents as they were unaware that the requirements applied to COVID related absence	Potential risk of: • Non-compliance with the Managing Attendance at Work policy • Sickness absence is not appropriately managed, which could impact on availability of staff resource and reliance on agency use

Recommendations		Priority
5.1	Line managers to be reminded of the requirements of the All-Wales Managing Attendance at Work Policy. Evidence of Return-to-Work Interviews, self-certificates and fit notes must be retained on the individuals personal file to demonstrate compliance with the policy.	**High**

Agreed Management Action		Target Date	Responsible Officer
5.1	Workforce are undertaking a peer review of the sickness absence for the 5 top areas at the moment - Cadog, Steffan, Teifi, Padarn and Towy. This will be a piece of work we will filter through to all areas eventually to see what support/training etc. is needed to best manage this going forward. Also, will identify key reasons of absence so we can see any themes and how to address this.	October 2022	Iona Evans, Deputy Head of Nursing

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.
	**No 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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