Directorate Governance – WGH Unscheduled Care

Final Internal Audit Report

October 2022

Hywel Dda University Health Board

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

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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 due to finance matters not being discussed or monitored at an appropriate Directorate-level forum.

We identified a further five medium priority matters arising:

- Workforce matters are discussed at the QS&E Group, but this is not reflected in the ToR, which are in line with Health Board requirements.
- A recent annual review with the Assurance & Risk Team identified new actions to mitigate risks, with the exception of the finance risk which has not been updated since December 2021.
- A significant proportion of open incidents remain "under management review", and 70% of complaints are not responded to within the 30-working day target.
- Statutory and mandatory training compliance rates are below the Health Board target and actual rate.
- Delays in completing return-to-work documentation following a period of sickness absence.

Full detail is provided in section 2 of the report, with a summary of matters arising and recommendations 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	Limited
5	Incidents & Concerns	Reasonable
6	Statutory & Mandatory Training	Reasonable
7	Sickness Absence Management	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	Finance Monitoring Arrangements	4	Design	High
2	Workforce Governance Arrangements	1	Design	Medium
3	Risk Management	2, 4	Operation	Medium
4	Incidents & Concerns	5	Operation	Medium
5	Statutory & Mandatory Training	6	Operation	Medium
6	Sickness Absence Management	7	Operation	Medium

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 an established management meeting namely the *Quality, Safety and Experience (QS&E) Group* which meets on a bimonthly basis.

2.2 The Directorate has adopted the Health Board standard Terms of Reference (ToR) and agenda for QS&E groups. Review of the QS&E Group papers confirmed that key standing items are presented around governance, health and safety, external reporting, incidents, concerns, and risks. Sufficient discussion, scrutiny and reporting against these items was evident in the minutes.

2.3 The Group reports by exception to the Health Board's Operational Quality Safety & Experience Sub-Committee (OQSEC), evidenced in the May 2022 OQSEC papers.

2.4 There is no designated forum for the discussion and monitoring of workforce and finance matters/performance. Whilst papers of the QSE Group demonstrate discussion, scrutiny and reporting in relation to workforce, this is not in line with the ToR and there was no evidence that finance matters are considered. The impact of this is dealt under Objective 4 (see para 2.18). The same audit for Glangwili noted that workforce and finance matters are considered at a separate business/performance forum. **[Matters Arising 1 & 2]**

2.5 There is no annual work plan for the QS&E Group. Although not mandatory, an annual work plan would support the effective discharge of the groups role and responsibilities as set out in the ToR.

2.6 We also note inconsistency in the title of the QSE group per the ToR, agendas and papers, with interchangeable use of 'QSE Group' and 'Quality & Governance Group'.

Conclusion:

2.7 We have concluded **Reasonable** assurance for this objective on the basis that governance arrangements within the Directorate are generally robust, with the

QS&E Group operating in line with Health Board mandated requirements. Whilst Workforce related matters are dealt with at QS&E Group, albeit outside of the ToR, finance is not discussed at a directorate-level forum. The impact of this is reflected in the assurance rating for the finance-related audit objective (4).

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 QSE meetings. Review of the minutes between March and May 2022 confirmed that the risk register had been presented for discussion.

2.9 We reviewed the risk register as of August 2022 to establish whether actions to mitigate the risk are being progressed and closed. The review date for all risks had lapsed (see table 1 below), most within 1-2 months. However, two risks relating to training compliance and the Directorate's ability to remain within its allocated budget, had lapsed review dates of July and December 2021.

2.10 Actions have been identified to mitigate risks, however the implementation dates had also lapsed in many cases (see table 1 below), with one dating back to November 2021.

Table 1: Summary of Risks

	Red	Amber	Yellow	Total
Number of Risks on Register	7	4	1	12
Number of Risks with Lapsed Review Date	7	4	1	12
Number of 'Additional Risk Actions Required' identified on Register	18	9	1	28
Number of 'Additional Risk Actions Required' with Lapsed Completion date	10	7	1	18

2.11 The General Manager confirmed that management are aware that the risk register requires updating. The register was subject to an annual review in August 2022 with the Director of Operations, Director of Nursing and Assurance & Risk Team. New actions have been identified to mitigate each risk with a three-month deadline for completion. At the time of review, no actions had been identified for the finance risk as this was awaiting input from the Finance team – see para 2.20 under Objective 4 for further details. The risk register also requires updating to reflect these new actions and timescales. **[Matter Arising 3]**

Conclusion:

2.12 We have concluded **Reasonable** assurance for this objective. At the time of fieldwork all risks on the register had lapsed review dates, and in many cases action due dates had also lapsed. However, we acknowledge that the Directorate is working with the Assurance & Risk Team to address these issues, with new actions identified for implementation within three months. The finance risk is an exception to this, and is reflected in the assurance rating for audit objective (4).

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

2.13 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.

2.14 Sample testing of five senior members of staff within the Directorate confirmed that a declaration of interest form had been submitted for each for inclusion on the register.

Conclusion:

2.15 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

2.16 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.

2.17 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 and are not documented.

2.18 As highlighted in paragraph 2.4 above, there is no designated forum for the discussion and monitoring of finance matters/performance at Directorate level. We understand that Senior Management meet monthly for the 'Directorate Utilisation of Resources Meeting – Pembrokeshire System' with the purpose of reviewing the service on a county basis as a whole including key drivers, mitigations, risks and saving opportunities going forward. Outcomes of these meetings are summarised and presented at Executive Team meetings. **[Matter Arising 1]**

2.19 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 four shows a slight improvement on month three:

	Month 3	Month 4	Trend
In Month Variance	-£496k	-£327k	↑
Forecast Year End	-£4.96m	-£4.86m	↑
Annual Budget	£33.97	£34.06m	↑

2.20 With a forecast overspend of £4.86m at year end, financial risk is reflected on the Directorate risk register:

Risk: 980	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

2.21 Whilst actions have been identified to mitigate the risk, including a three-year financial training programme for budget holders, this was paused due to the pandemic response and actions are overdue for implementation. The risk has not been reviewed by the Directorate since March 2022 and therefore requires updating to reflect the 2022/23 position. Although the Directorate risk register has been subject to a recent annual review with the Assurance & Risk Team, the finance risk has not been updated and is awaiting input from the Finance Team to identify and agree new actions to mitigate. **[Matter Arising 3]**

2.22 As of August 2022 directorates must begin to identify savings schemes for 2022/23. The Directorate has identified three potential savings schemes detailed in the 'Finance Dashboard' report presented to the Health Board Executive Team. These schemes are yet to be formally recognised and savings realised.

Conclusion:

2.23 Whilst the financial position for month 4 is slightly improved, the Directorate is facing significant financial pressures with a forecast deficit of nearly £5m for 2022/23. There is no designated Directorate-level forum for the monitoring and scrutinising financial performance, and whilst finance risk is appropriately reflected on the Directorate risk register, it has not been reviewed since March 2022 and actions are overdue. Accordingly, we have concluded **Limited** 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

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

2.25 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.

2.26 The QS&E 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 area of the number of incidents and concerns reported within the year by incident type, and how many have been closed/remain open.

2.27 DATIX identifies 484 open incidents as at August 2022, with 64% of these currently under management review:

Open Incidents @Aug 2022	
New Incidents	33
Under Management Review	309
Under Investigation	15
Awaiting Closure	127
Total	**484**

2.28 An overview of concerns (complaints) is reported at each QS&E Group meeting. Comparison of open complaints reported at the last two QS&E Group meetings is noted as follows:

Date	12/08/22	25/05/22
No of Open Complaints	77	61
% of Complaints Exceeding 30 Days	70%	80%

2.29 Weekly reports are received from the Patient Safety & Assurance Team detailing all complaints and are scrutinised by Senior Management. The General Manager acknowledged that the number of open incidents and concerns is higher than it should be due to staffing pressures and senior ward staff not having protected time for administration. **[Matters Arising 4]**

Conclusion:

2.30 Whilst action is required to reduce the number of open incidents improve complaint response times, we are satisfied that the arrangements in place for monitoring incidents and concerns are adequate, with evidence of shared learning from events. 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 80.14% (ranges from 27.78% - 95.83% by service area) as at the end of June 2022, which falls below the HB target of 85%. **[Matter Arising 5]**

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 1005) which needs review and updating, as reported at Objective 2 above.

Conclusion:

2.33 Statutory and mandatory training compliance is below the Health Board target. This is recognised by management and 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

2.34 Sickness absence management is a standard agenda item at each QS&E Group meeting with a summary report detailing current rates across the service areas. Detailed within the report is an overview of types of sickness (long/short term) and the number of whole time equivalents the sickness relates to at service level.

2.35 The Directorates' sickness absence rates are higher than the Health Board target and actual sickness rates:

Sickness Absence Rates - June 22		
Target:	4.79%	
Actual:	**Directorate**	**Health Board**
12 Month Rolling	7.34%	6.36%
Monthly sickness rate	7.42%	5.83%

2.36 A report to the QS&E Group in July 22 highlighted an improving trend over the last three months:

April 22	May 22	June 22
9.15%	7.52%	7.42%

2.37 Testing was undertaken on a sample of five employees with a sickness episode during the period January - June 2022, to establish whether the absence had been managed in line with the All Wales Managing Attendance at Work Policy. We identified two instances where there was a delay of 1-2 months in conducting the Return to Work interviews and completing the required form.

[See Matter Arising 6]

Conclusion

2.38 Adequate arrangements are in place for monitoring sickness, however sickness absence levels within the directorate remain above the target and Health Board-wide rates. Whilst sickness absence is generally managed in line with policy, delays

in the completion of required documentation were identified. We have therefore concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Finance Governance Arrangements (Design)			Impact
Finance matters/performance are not discussed or monitored at an appropriate Directorate-level forum, which is particularly significant in light of the financial pressures and forecast deficit. We note that for Glangwili finance (and workforce) matters are considered at a separate business/performance forum.			Potential risk of: • Finance matters/performance are not monitored or discussed, resulting in issues not being addressed or escalated which could impact on the ability of the Directorate to operate within its allocated budget.
Recommendations			**Priority**
1.1	Determine an appropriate forum for the monitoring and scrutiny of finance related matters/performance.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Reinstate the business/ performance forum to include scrutiny of finance related matters/ performance	31 October 2022	Janice Cole-Williams, General Manager

Matter Arising 2: Workforce Governance Arrangements (Design)			Impact
Whilst papers of the QSE Group demonstrate discussion, scrutiny and reporting in relation to workforce, this is not in line with the ToR, which are consistent with the Health Board mandated requirements. We note that for Glangwili workforce (and finance) matters are considered at a separate business/performance forum.			Potential risk of: • Lack of clarity regarding the arrangements for monitoring and reporting workforce related matters, which could result in issues not being escalated or addressed, and the materialisation of associated risks.
Recommendations			**Priority**
2.1	Determine the most appropriate forum for the monitoring and scrutiny of workforce related matters and ensure arrangements are formalised in ToR.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Reinstate the business/ performance forum to include scrutiny of workforce related matters with a formalised ToR.	31 October 2022 (Complete)	Janice Cole-Williams, General Manager

Matter Arising 3: Risk Management (Operation)	Impact
Management acknowledge that risk review and action implementation dates have lapsed. The register was reviewed in August 2022 with the Director of Operations, Director of Nursing and with support from the Risk and Assurance department. New actions have been identified and agreed to mitigate each risk with a three-month deadline for completion. At the time of review, no actions had been identified for the finance risk as this was awaiting input from the Finance team. The risk register also requires updating to reflect these new actions and timescales.	Potential risk of: • Lessons are not learned from incidents and concerns resulting in harm to patients or staff • Reputational damage

Recommendations		Priority
3.1a	Identify actions to mitigate the finance risk (ref 980), seeking input from the Finance Team where appropriate.	**Medium**
3.1b	Update the risk register to reflect the new actions agreed following annual review, and ensure that these are completed within the stipulated timescales.	

Agreed Management Action		Target Date	Responsible Officer
3.1a	Update financial risk to include mitigation and main drivers for year to date and end of year projected overspend.	31 October 2022	Andrew Spratt, Deputy Director of Finance
3.1b	Risk Register to update to reflect current position, agreed actions with revised timescales.	31 October 2022	Janice Cole-Williams, General Manager

Matter Arising 4: Incidents and Concerns (Operation)			**Impact**
At August 2022, DATIX identified: • 484 open incidents with 309 under management review and 127 awaiting closure; • 77 open complaints with 54 exceeding the 30-working day response target.			Potential risk of: • Lessons are not learned from incidents and concerns resulting in harm to patients or staff • Reputational damage
Recommendations			**Priority**
4.1	Develop an action plan and timeline to improve the Directorate position for incidents and complaints.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Continue to support and promote daily oversight and transfer to 'make it safe' of incident reports, including escalation of increasing outstanding report investigations to Triumvirate management team to support resolution. Action plan to be developed to support the continued reduction in outstanding incident reports.	30 September 2022 (Complete) 24 October 2022	Janice Cole-Williams, General Manager Janice Cole Williams, General Manager

Matter Arising 5: Statutory and Mandatory Training Compliance (Operation)			Impact
Whilst the overall statutory and mandatory training compliance rate for the Directorate is only slightly below the Health Board target of 85%, compliance varies by service area with the lowest noted as 27.78%. We understand the difficulty in releasing staff for training due to service pressures but areas with particularly low compliance need to be addressed as a priority.			Failure to achieve statutory and mandatory training targets, potentially resulting in non-compliance with related policies and procedures, and harm to staff or patients.
Recommendations			**Priority**
5.1	Identify and prioritise service areas with the lowest training compliance rates (relative to staff numbers) and set a reasonable deadline for improving compliance, allowing staff protected time to complete mandatory training.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Continued review of nursing compliance rates and monthly scrutiny. Service Delivery Manager to develop action plan with consultant leads to improve mandatory training compliance for medical staff.	30 September 2022 30 November 2022	Carol Thomas, Head of Nursing Bethan Andrews, Service Delivery Manager

Matter Arising 6: Sickness Management (Operation)	Impact
Testing was undertaken on a sample of five employees with a sickness episode during the period January - June 2022, to establish whether the absence had been managed in line with the All Wales Managing Attendance at Work Policy. We identified two instances where there was a delay of 1-2 months in conducting the Return-to-Work interviews and completing the required form.	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
6.1	Line managers to be reminded of the requirements of the All-Wales Managing Attendance at Work Policy.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
6.1	Updated version of Management at Work Policy to be circulated to all Dept leads reinforcing policy requirements.	4 October 2022	Janice Cole-Williams, General Manager

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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