Follow-up: NICE Guidance
Final Internal Audit Report

February 2024

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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Acknowledgement

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Executive Summary

Purpose

This review has sought to establish progress made by management to implement agreed actions arising from the previous internal audit [report HDUHB-2324-14 refers], which concluded limited assurance.

Overview of findings

Significant progress has been made by management in addressing the control weakness identified in the original report, with all actions having been implemented.

The review of a sample of new and updated guidance confirmed that they had been disseminated to service leads in a timely manner.

The new process introduced of assigning a member of the Clinical Effectiveness Team as guidance lead and disseminating every guidance to a service lead has satisfactorily addressed the weaknesses previously highlighted.

Evidence was provided to verify that the monitoring and reporting arrangements have been reviewed and strengthened. We conclude that regular reporting to key groups is now in place.

Follow-up Report Classification

		Trend
Substantial 	**Follow up:** All recommendations implemented and operating as expected	

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1.1	Guidance Dissemination	Medium		Closed
2.1a/b	Nominated Leads	High		Closed
3.1	Compliance Monitoring & Assurance Reporting	Medium		Closed
3.2	Compliance Monitoring & Assurance Reporting	High		Closed

1. Introduction

1.1 This audit sought to establish the progress made by management in implementing agreed actions to address the issues identified in the original review (report HDUHB-2324-14 refers).

1.2 The original review identified three high priority matters arising requiring immediate attention relating to:

a. The need to identify nominated contact(s) for each clinical/service area for the Clinical Effectiveness Team to disseminate new/updated NICE guidelines to, and with responsibility for identifying and nominating a lead for each guideline.

b. Stipulation of a deadline for identifying a nominated lead when disseminating guidelines and monitoring and following up guidelines without a nominated lead.

c. The need for the CSGG to receive regular reporting on the number of new/updated NICE guidelines in order to fulfil its terms of reference and provide assurance to ECPAP and ultimately the Board.

Two medium priority matters were identified requiring management action within one month relating to:

a. Determining an appropriate timescale for the dissemination of NICE guidelines following publication within AMAT.
b. A review of the governance reporting arrangements, including the role of the OQSESC, to ensure they are efficient and fit for purpose.

1.3 The potential risks considered in the original review were:

- Poor quality services provided to patients, resulting in patient harm and/or negative patient experience,
- Reputational damage to the Health Board; and
- Financial loss to the Health Board.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	3	3	0	0
Medium	2	2	0	0
Low	0	0	0	0
Total	**5**	**5**	**0**	**0**

2.2 Full details of recommendations that have been implemented are provided in **Appendix A**.

Appendix A: Previous Matters Arising Now Closed

Previous Matter Arising 1: Guidance Dissemination (Operation)		
Original Recommendation		Original Priority
1 Determine an appropriate timescale for the dissemination of NICE guidelines following publication within AMAT.		**Medium**
Management Response	Target Date	Responsible Officer
A new process has been introduced from the 1st August 2023 to disseminate newly published and updated NICE guidance weekly upon receipt of the AMaT Roundup every Monday.	1st August 2023 (complete)	Donna Edwards, Clinical Effectiveness Coordinator
Current findings		
A review of newly published and updated guidance within AMAT during the period August to December 2023 found that there has been a significant improvement in timeliness of guidance dissemination since the new process has been introduced. The sample of guidelines we reviewed had all been disseminated in a timely manner apart from one guideline where a suitable service lead is still being sought. We were advised that this case will be escalated to and discussed at the next CSGG meeting.		
Conclusion		
Action Completed		

Previous Matter Arising 2: Nominated Leads (Operation)		
Original Recommendations		Original Priority
2.1a Identify appropriate/nominated contact(s) for each clinical/service area for the Clinical Effectiveness Team to disseminate new/updated NICE guidelines to, and with responsibility for identifying and nominating a lead for each guideline.		**High**
2.1b When disseminating guidelines, the Clinical Effectiveness Team should stipulate a deadline for identifying a nominated lead. Guidelines without a nominated lead should be monitored and followed up by the Clinical Effectiveness Team, with regular reporting of those outstanding to the CSGG.		**High**
Management Response	Target Date	Responsible Officer
2.1a A new approach has been introduced to disseminate new and updated NICE guidance directly to the Service Lead within AMaT, identified by the Clinical Effectiveness Team, with the ability of the Service Lead to reallocate within AMaT. The Clinical Effectiveness Team will become Guideline Lead in order to maintain oversight and support collation of Health Board statement of compliance. To allocate the Directorate Quality and Governance Lead as Stakeholder for all relevant guidelines.	1st August 2023 31st December 2023 (depending on meeting dates to present the SBAR)	Donna Edwards, Clinical Effectiveness Officer
2.1b Recommendation not applicable as process has changed as per response to 2.1a.	Not Applicable	Not Applicable

Current findings
We reviewed a sample of new and updated guidelines to confirm that they are now being disseminated directly to a Service Lead, with a member of the Clinical Effectiveness Team assigned as guidance lead. The follow up testing confirmed that the new process has been implemented and the new system satisfactorily addresses both recommendations 2.1a and 2.1b.
Conclusion
Action Completed.

Previous Matter Arising 3: Compliance Monitoring & Assurance Reporting (Design/Operation)	
Original Recommendations	Original Priority
3.1 Review the governance reporting arrangements, including the role of the OQSESC, to ensure they are efficient and fit for purpose.	**Medium**
3.2 In order to fulfil its responsibilities per the terms of reference and facilitate assurance reporting to ECPAP (and ultimately the Board), the CSGG should receive regular reporting on the number of new/updated NICE guidelines: - published by NICE and included in AMaT - disseminated to clinical/service leads - awaiting identification of a nominated lead to complete the statement of compliance - where compliance statements are not started/in progress/overdue/complete	**High**

When there is sufficient progress with compliance assessments and therefore data available within AMaT, this reporting should be extended to include the compliance status of each guideline, the completion of baseline assessments and action plans to achieve/improve compliance.		
Management Response	**Target Date**	**Responsible Officer**
3.1 To conclude the current review of governance arrangements, discussing the role of the ECPAP, OQSESC and QSEC, alongside the Directorate Quality and Governance Groups; and amend the Terms of Reference accordingly. To develop an SBAR outlining the new reporting arrangements and recommending adoption. To present the SBAR outlining the new reporting arrangements to the following: - Directorate Quality and Governance Groups (dependent on scheduled dates) -OQESC (8 th November 2023) - ECPAP (5th September 2023) - CSGG (7 th November 2023)	4th September 2023 4th September 2023 31st December (dependent on meeting dates to present the SBAR)	Lisa Davies, Head of Effective Clinical Practice and Quality Improvement
3.2 From 1st August the following reports will be generated from AMaT and provided to CSGG and ECPAP at every meeting: - published by NICE and included in AMaT - disseminated to clinical/service leads - where compliance statements are not started/in progress/overdue/complete (Reporting on New/Updated NICE guidelines awaiting identification of a nominated lead to complete the statement of compliance will no longer be applicable due to the change in process per response to matter arising 2.1a).	1st August 2023	Donna Edwards, Clinical Effectiveness Officer

Current findings
3.1 Governance arrangements have been reviewed and a revised reporting structure put in place. We can confirm that a SBAR detailing the new arrangements was developed and presented to the Directorate Quality and Governance groups, CSGG, ECPAP and OQSESC. In addition examples have been seen of the reporting arrangements operating in practice. 3.2 A review of the latest CSGG and ECPAP meeting papers confirmed that presentation of the recommended reports is now taking place. Presentation of these reports to OQSESC will commence in March 2024.
Conclusion
Action Completed.

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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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