Hywel Dda University Health Board

Closure of Actions

Final Internal Audit Report

February 2021

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.

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1. Introduction and Background

The review of closure of improvement and learning actions was completed in line with the Hywel Dda University Health Board Internal Audit Plan for 2020/21. The relevant lead Executive Director for this review was the Director of Nursing, Quality & Patient Experience.

2. Scope and Objectives

The overall objective of the review was to ensure adequate arrangements are in place for the closure of improvement and learning actions in order to provide assurance to the Health Board that risks material to the achievement of the system's objectives are managed appropriately.

The review encompassed closure of agreed improvement and learning actions identified for implementation. These actions may have resulted from a range of sources including reviews (both internal and external), incidents, complaints or claims relating to the quality and safety of patient care.

The areas that the review sought to provide assurance on were:

- There are appropriate arrangements in place for the capture and recording of agreed improvement and learning actions;
- Appropriate arrangements are established for the implementation of the agreed improvements and learning actions and the ongoing monitoring of these actions; and
- Progress and completion of actions are reported to appropriate groups, committees and the Board.

3. Associated Risks

The potential risk considered in this review were as follows:

- Identified weakness are not addressed by implementation of agreed actions; and
- Lack of scrutiny by the Health Board resulting in identified inherent risks remaining in place.

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 Closure of Actions is **Reasonable** assurance.

RATING	INDICATOR	DEFINITION
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.

Overall, the controls in place to manage the closure of actions are of a reasonable standard. Adequate governance arrangements have been established with directorate/county governance groups reporting through to the Health Board via the Quality, Safety & Effectiveness Assurance Group. Furthermore, the introduction of the Listening and Learning Sub-Committee will provide clinical teams across the organisation with a forum to share and scrutinise learning arising from incidents, and to share innovation and best practice.

During this review we identified consistent standardised documentation in place with evidence of consistent monitoring and reporting. However, two medium priority findings were identified in relation to:

- Partial completion of 'Learning from Event Reports' for closed complaint cases; and
- Documentation and evidence to support the completed action of a redress case was not provided upon request during this audit.

5. Assurance Summary

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

		Assurance Summary*			
Audit Objective					
1	There are appropriate arrangements in place for the capture and recording of agreed improvement and learning actions.			✓	
2	Appropriate arrangements are established for the implementation of the agreed improvements and learning actions and the ongoing monitoring of these actions.			✓	
3	Progress and completion of actions are reported to appropriate groups, committees and the Board.				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for Closure of Actions.

Operation of System/Controls

The findings from the review have highlighted **two** issues that are classified as weaknesses in the operation of the designed system/control for Closure of Actions. These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

OBJECTIVE 1: There are appropriate arrangements in place for the capture and recording of agreed improvement and learning actions

Introduced during October 2019, the Learning from Events Report is used across NHS Wales by all Health Bodies to record and report incidents in relation to complaints, claims and redress cases; whilst a Closure Summary form is completed for serious incidents.

These reports provide a summary of the events and circumstances which led to the incident, together with the issues and findings identified during the investigation. The report also identifies the actions and interventions taken and the assurance plans which are in place, in order to reduce the risk of reoccurrences or mitigate the effects of repeat events. The action plans arising from each incident are developed and implemented within the relevant service/directorate area.

Testing covered a sample of 20 closed cases across the areas of redress, complaints, claims, serious incidents and other/external reports for the period April 2019 – August 2020.

The review identified that for the sample of 20 cases, 18 items had supporting Learning from Events Reports, Closure Summaries or equivalent reports which had been signed by both the Case Manager and the relevant Governance Lead or the Senior Representative within the service.

However, whilst Learning from Events Reports for two closed complaint cases were fully complete neither had not been signed by either the Case Manager or the appropriate Governance Lead. The current practice within the department is not to formally sign the Learning from Events Reports but rather add them to an Action Log.

See Finding 1 at Appendix A.

OBJECTIVE 2: Appropriate arrangements are established for the implementation of the agreed improvements and learning actions and the ongoing monitoring of these actions

Services and directorates are responsible for ensuring agreed actions are implemented, monitored and fully completed. However, additional arrangements have been established to capture the implementation and monitoring of actions throughout the Health Board.

- New procedure has been developed and implemented whereby the Complaints & Claims and Serious Incident teams are requiring supporting evidence to validate the implementation of completed actions. The evidence is retained on the Datix system.

- The Head of Quality & Governance team attends directorate/county governance group meetings to provide assistance with arising incidents and ensuring actions are being monitored and implemented in line with agreed timescales.

- A corporate process is maintained within the Health Board, with a register recording all recommendations arising from the various internal and external reviews and the relevant service contacted bi-monthly for an update on progress. Regular updates have been reported to the Board in relation to the outstanding recommendations from auditors, inspectorates and regulators during the COVID-19 pandemic, agreeing the changes to the process during the pandemic period and also acknowledging the current challenges with the pace of delivery of the actions.

- During June 2020, the Listening and Learning Sub-Committee was established with the aim of identifying learning points and changes to practice evolving from investigations, reviews of incidents, themes and trends, and the sharing of improvements, best practice and training requirements. Membership of the Sub-Committee comprises of a number of appropriate individuals from multiple functions from across the Health Board.

A review of the sampled 20 closed cases confirmed that appropriate agreed improvements had been recorded by service/directorate management and supporting evidence confirmed the implementation of the actions for 19 of the closed cases. However, supporting evidence for one redress case had not been provided upon request.

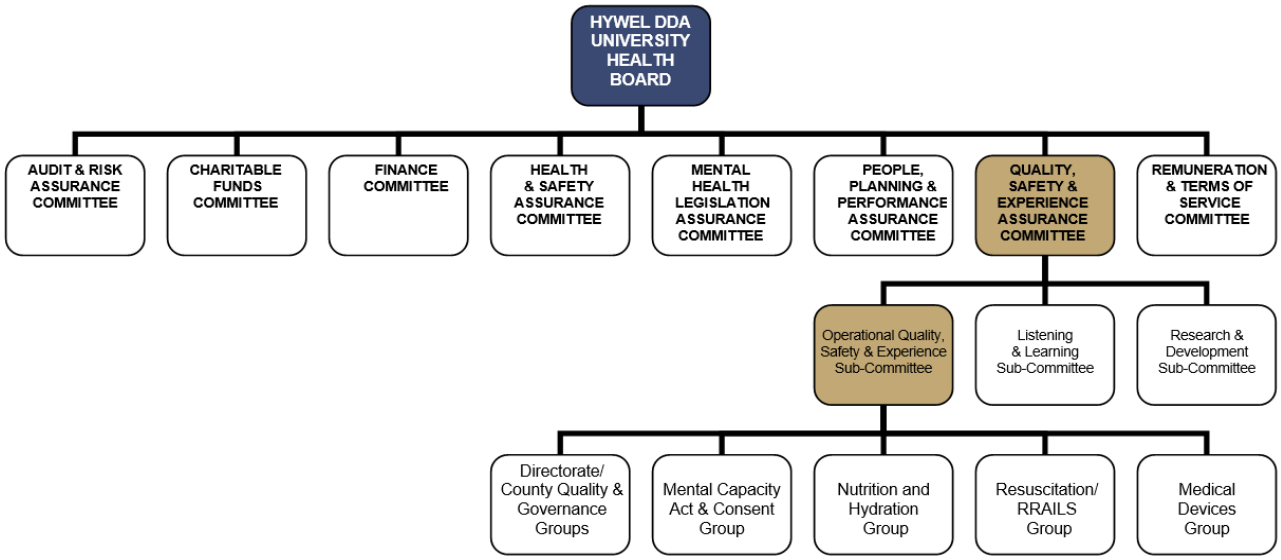
See Finding 2 at Appendix A.

OBJECTIVE 3: Progress and completion of actions are reported to appropriate groups, committees and the Board

From our review it was evident that action plans together with their current status are being reported and reviewed through a variety of channels, with governance structure in operation.

Actions are initially reported through the relevant Directorate/County Quality & Governance Groups where the incident arose. The minutes of these quality and

governance group meetings are reported through to the Operational Quality, Safety and Experience Assurance Sub-Committee before being progressed through to the Quality, Safety and Experience Assurance Sub-Committee (QSEAC) and Health Board.



Operational QSEAC Terms of Reference (October 2020)

In addition, a Listening and Learning Sub-Committee has been established to ensure that the learnings from all investigation of incidents (including serious incidents, complaints and claims, health and safety etc.) are shared with and communicated with a wider audience, including clinical teams, across the Health Board. The Listening and Learning Sub-Committee reports directly to QSEAC.

A review of the QSEAC meeting minutes for August 2020 noted the presentation of the Listening and Learning Sub-Committee meetings for July and August by both the Chair of the Sub-Committee and the Assistant Director of Legal and Patient Support. Furthermore, noted within the QSEAC minutes are regular progress reports submitted by the Head of Quality and Governance in relation to serious incidents and external/other reports.

It is evident from a review of the Health Board Committee meeting minutes that the papers presented to QSEAC from both the Listening and Learning Sub-Committee and the Quality and Safety Assurance Report are noted and acknowledged.

No matters arising.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**0**	**2**

Finding 1 – Approval of Learning for Events Report (O)	Risk
Of the 20 sampled closed cases reviewed, two closed complaints cases had fully completed Learning from Events Reports, however, both reports had not been signed by either the Case Manager or the appropriate Governance Lead. The current practice within the department is not to formally sign the Learning from Events Reports but rather add them to an Action Log.	Identified weakness are not addressed by implementation of agreed actions.
Recommendation 1	**Priority level**
Management should review the current practice to establish whether complaint cases recorded on the Learning From Events Report requires the physical sign-off by Case Managers and relevant Governance Leads.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
For complaints which do not progress through to redress, a learning from events report is not required, the relevant action plan must be completed and approved by the services(s) responsible. The new Datix system will provide a strengthened mechanism for which all approved action plans will be recorded and the issues in the case clearly identified for monitoring of themes and trends. Individual directorates via their governance arrangements are responsible for the identification and monitoring of lessons learnt actions relating to all concerns. Therefore corporate sign off by the case manager would not be required. This will be reinforced through the revised investigation management toolkit and guidance.	Head of Legal Services 1st April 2021

Finding 2 – Completed Action Supporting Documentation (O)	Risk
Concluding a review of closed cases, we identified one redress case where supporting evidence had not been provided upon request in order to corroborate the implementation of actions to mitigate the original incident.	Identified weakness are not addressed by implementation of agreed actions.
Recommendation 2	**Priority level**
Management should ensure evidence and relevant documentation are ascertained in order to support completed actions.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Since the time of the closure of the case referred to, Welsh Risk Pool has advised that every case must come with supporting documentation. Guidance has been provided on what is expected as supporting evidence to all health bodies. All Learning from Events submitted to Welsh Risk Pool from the Redress Team are provided with support for the action and assurance plans outlined in the document. Cases will not be accepted by the Welsh Risk Pool without the appropriate evidence supplied.	Head of Legal Services 8th February 2021

Appendix B - 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
High	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*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	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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