Hywel Dda University Health Board

Rostering

Final Internal Audit Report

March 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Committee:	Audit & Risk Committee

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.

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

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1. Introduction and Background

The review of rostering within Hywel Dda University Health Board was completed in line with the approved 2019/20 Internal Audit Plan.

Effective management of rosters across the Health Board is important to ensure that there is efficient use of organisation's resource. Management and staff are expected to comply with Health Board's Rostering Policy and following the arrival of the Nurse Staffing Levels (Wales) Act there is even more importance on effective roster management.

The lead Executive Director for the review was the Director of Workforce and Organisational Development.

2. Scope and Objectives

The objective of the audit was to ensure that Hywel Dda UHB has appropriate structures and processes in place to adequately manage the production of staff rotas, in order to provide assurance to the Audit & Risk Assurance Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if appropriate processes and procedures are in place within the UHB to ensure that staff rotas are effectively planned and managed.

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

- The Health Board has appropriate processes and procedures in place for the drawing up of staff rotas;
- Staff rotas are drawn up to reflect correct skill mix and breaks; and
- Staff rotas in place ensure that staff work contracted hours.

For the purpose of the audit, we visited seven wards/departments from across the Health Board, as follows:

- Ceredig Ward BGH
- Meurig Ward BGH
- Ward 7 WGH
- CHRT (Carmarthen)
- Ward 3 PPH
- Ward6 PPH
- SCBU GGH

All the wards/departments visited use the e-roster system, RosterPro, to administer their rosters.

3. Associated Risks

The potential risks considered during this review were as follows:

- Staff rotas are not drawn up in advance;
- Shifts do not have the appropriate skill mix; and
- Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.

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 Rostering 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.

We deemed a reasonable rating fair for this audit based on the following:

- The majority of wards/departments were producing rosters in advance in line with policy timelines;
- Staff were found to have worked their contracted hours and apart from one member of staff, shifts had been assigned in line with guidelines; and
- Testing highlighted for some wards, the skill mix was not being maintained for all shifts worked over a set period.

5. Assurance Summary

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

		Assurance Summary*			
Audit Objective					
1	The Health Board has appropriate processes and procedures in place for the drawing up of staff rotas			✓	
2	Staff rotas are drawn up to reflect correct skill mix and breaks		✓		
3	Staff rotas in place ensure that staff work contracted hours				✓

** 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 **two** issues that are classified as weaknesses in the system control/design for Rostering. These are identified in the Management Action Plan as (D).

Operation of System/Controls

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

6. Summary of Audit Findings

Testing was carried out as detailed below and the key findings are reported in the Management Action Plan at Appendix A.

OBJECTIVE 1: The Health Board has appropriate processes and procedures in place for the drawing up of staff rotas

Discussions with the managers highlighted that they were all happy with the level of support they received from the Health Board's Rostering team in terms of training and advice.

Training is available from the Rostering team if and when required and many of the teams also conduct in-house training for new starters. Good practice was observed on Ward 7 WGH whereby they had a designated 'Champion' to help with any local issues encountered.

The Health Board's 'Rostering Policy' (No. 436) was reviewed to ensure that the latest version available to staff was in date. The latest version dated 19/11/19, is available on the Health Board intranet site, however we did note that the link on the intranet page had not been updated to reflect the new version.

See Finding 4 in Appendix A.

OBJECTIVE 2: Staff rotas are drawn up to reflect correct skill mix and breaks

For each of the wards/departments, the staffing skill mix was reviewed to ensure that it was reflected in the rosters being produced.

It was established that the e-Roster system is set up to the requirements of each individual ward/department therefore ensuring that the correct skill ratios are in place for each shift being worked.

A review was undertaken to ensure that the skill mix for each ward/department was adhered to for each shift worked over a set period (27/5/19 to 23/6/19). Testing highlighted the following number of shifts during the period that were not compliant:

	No. of Shifts in Week Not Compliant with Skill Mix (Inclusive of Qualified and Unqualified Staff)			
	w/c 27.5.19	**w/c 3.6.19**	**w/c 10.6.19**	**w/c 17.6.19**
Ceredig Ward	12	10	9	7
Meurig Ward	1	1	0	1
Ward 7 WGH	9	4	9	7
Ward 3 PPH	0	0	2	1
Ward 6 PPH	17	17	23	24
SCBU GGH **	2	2	4	7
CHRT (Carm) **	6	4	10	5

** Not subject to the Nurse Staffing Levels (Wales) Act

The staffing skill mix for the above wards became statutory as of April 2018 under the Nurse Staffing Levels (Wales) Act. It is noted that both Ceredig Ward and Ward 7 WGH carried a high number of shifts which were not compliant with the set skill mix. Discussion with both managers highlighted that they carry a high vacancy rate and sickness rate.

For Ward 6, the majority of the shifts noted above related to unqualified staff and again there was some sickness noted during the period.

See Finding 1 in Appendix A.

OBJECTIVE 3: Staff rotas in place ensure that staff work contracted hours

In line with Health Board policy, rosters should be produced with a minimum of 4 weeks' notice to staff. Discussions conducted with the ward/department managers highlighted that apart from CHRT (Carmarthen), all produced rosters in advance of 4 weeks with most producing them 6 to 8 weeks in advance. Managers commented that they saw great benefits from this practice as staff are more prepared; and the need for bank and agency can be factored in, in readiness, especially on wards which have been experiencing high sickness and vacancy rates.

Audit would recommend that the Rostering policy be updated to reflect this good practice, which would be in line with the 'Audit Tool' published as part he 'Interim Guidelines to Support Effective Rostering for Nurses and Midwives Appendix of Rostering Policy' which recommends that rosters are available 6 weeks in advance for staff to view.

See Finding 5 in Appendix A.

Discussion with the CHRT manager confirmed that rosters in their department were only being produced up to 3 weeks in advance.

See Finding 2 in Appendix A.

All the wards/departments sampled use e-rostering, which has an in-built hierarchy of authorisation which does not allow self-certification. We confirmed across the sample wards/departments tested that the staff responsible for producing and verifying the rosters had their own shifts verified by their senior managers.

Rostering of Annual Leave
We concluded that the rostering of annual leave followed similar processes for all the wards/departments visited.

Staff are requested to submit their preferred leave dates for the forthcoming year by the end of January. The persons responsible for producing the rosters will then have a clear vision of who is off and when in order to create a fair, roster which is in line with staffing requirements.

We did note that there were 'local' variants in place in relation to how much leave is required to be booked in advance. Some of the wards requested staff to book 2 weeks off whilst another requested that all bar one day's annual leave was booked in advance. Discussions with the managers highlighted that the management of leave was what had evolved and suited the requirements of the service and staff, however, there is leeway to adjust leave applied for, as long as the rosters being produced are in line with the required skill mix.

The Health Board should consider requesting that the wards/departments formalise their annual leave arrangements to ensure transparency of working practice across the organisation.

See Finding 6 in Appendix A.

Review of Rosters
Testing was carried out to ensure that the production of rosters across the sample wards/departments were being prepared and adhered to the Health

Board's 'Agreed Rostering Rules & Parameters'. For each area visited, a sample of five members of staff was selected from their rosters. For the set roster period 27th May 2019 - 23 June 2019 (4-week period) the shifts worked by the sample of staff was reviewed to ensure that they had worked within regulations.

Results of the testing highlighted one employee from Ward 7 WGH had worked outside of regulations during 3 weeks of the 4-week period reviewed.

See Finding 3 in Appendix A.

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	**1**	**2**	**3**	**6**

Finding 1 – Maintaining Required Skill Mix (O)	Risk
Review of the required skill mix for each shift on each ward/department was undertaken for the period 27/5/19-23/6/19. Whilst it is noted that every effort is made to fulfil the requirements of the ward by the managers, a number of shifts (as detailed in the main body of the report) were not compliant with the required skill mix (as defined by the NSL (Wales) Act 2016 were applicable). It was highlighted that many have and still are encountering high levels of sickness and vacancy rates.	Shifts do not have the appropriate skill mix.
Recommendation 1	**Priority level**
The required staffing skill mix should be maintained at all times. When a shift cannot be suitably filled, ward staff should ensure that senior management are fully informed as per policy.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Reinforce through senior nurse management structure the importance of maintaining the required staffing skill mix, unfilled shifts to be recorded and reported through risk assessment for regular review. Roll out of allocate E-Roster system will improve real-time visibility of skill mix, this will enable managers to intervene in a timely manner.	Director of Nursing, Quality & Patient Experience 01/06/2020

Finding 2 – Rosters Made Available in Advance (O)	Risk
Testing on the CHRT (Carmarthen) rosters highlighted that they are not being prepared and made available within the recommended timeframe of 4 weeks in advance as per policy. At the time of audit, the department were only working to a roster completed for 3 weeks in advance.	Staff rotas are not drawn up in advance.
Recommendation 2	**Priority level**
Management should ensure that the rosters for the CHRT (Carmarthen) are being produced and made available with a minimum of 4 weeks of notice in order to comply with Health Board policy.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Roster team are tracking issues around roster publication and supporting the operational nurse. Advice and guidance has been provided to MHLD. Director of Mental Health aware and ensure delivery of recommendations.	Service Delivery Manager MHLD 01/10/2020

Finding 3 – Review of Rosters (O)	Risk
Review of the roster period 27th May 19 - 24th June 19 highlighted the following occurrences on Ward 7 WGH: <u>Ward 7 WGH</u> the same employee was noted to have worked the following shifts: W/C 27.5.19 - 2 Long Days worked followed by 2 night shifts overtime, which does not observe the rule that there should be a break of 2 days between working long days and night shift in a week. W/C 3/6 - 2 Long Days were worked followed by an Early and Night in the same day and followed by 2 Night shifts which does not observe the rule that there should be a break of 2 days between working long days and night shift in a week. W/C 10/6 - Worked 5 Night shifts in a row which does not observe the rule that is not permissible to allocate 2 overtime Night shifts after working 3 Night shifts in a row. It is recognised that there were several overtime shifts worked in the above, however working such hours could cause detrimental effects.	Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.

Recommendation 3	Priority level
Management should be reminded of the Health Board's 'Agreed Rostering Rules and Regulations' to ensure that staff are working within policy and the law.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
The Ward Manager will ensure agreed roster rules are complied with for future rosters.	Ward Manager 01/05/2020

Finding 4 – Policies and Procedures (O)	Risk
The Health Board intranet page has yet to be updated to reflect the updated, approved version of the Rostering Policy (436). (Details on the intranet state that the policy is under review; dated 30.9.18)	Current policy information may not be relayed to staff.
Recommendation 4	**Priority level**
The Health Board need to update their intranet page to reflect that the rostering policy has been updated.	**LOW**

Management Response	Responsible Officer/ Deadline
Intranet Page has been updated with the new policy 08/01/2020.	Senior Workforce Manager (Bank & E-Roster) 08/01/2020

Finding 5 –Rosters are Available in Advance (D)	Risk
The Rostering policy states that rosters should be made available 4 weeks in advance for staff to view. However, good practice across some of the ward highlighted that rosters were being produced 6-8 weeks in advance.	Staff rotas are not drawn up in advance.
Recommendation 5	**Priority level**
The Rostering policy should be updated to reflect the good practice observed of rosters being produced 6-8 weeks in advance. (This would also align the policy with what is detailed in the 'Audit Tool' of the 'Interim Guidelines to Support Effective Rostering for Nurses and Midwives Appendix of Rostering Policy').	**LOW**
Management Response	**Responsible Officer/ Deadline**
Policy to be updated in line with Allocate rollout June 2020	Senior Workforce Manager (Bank & E-Roster)

	30/06/2020

Finding 6 – Rostering of Annual Leave (D)	**Risk**
Testing highlighted that there is a variance across wards/departments to the management of how much annual leave is applied for in advance.	Staff rotas are not drawn up in advance.
Recommendation 6	**Priority level**
The Health Board should consider that ward/departments are asked to formalise their annual leave arrangements to ensure transparency of working practice across the organisation.	**LOW**
Management Response	**Responsible Officer/ Deadline**
Workforce and Nursing are creating an abstraction overview to track all unavailability including annual leave, this will allow senior managers to pick up incorrect variance across wards and departments and will allow workforce to report. Introduction of Allocate will also allow dashboards for all managers to easily identify issues. (Leave rules will be created in Allocate to warn managers when going over leave allowance) Date completion end of 2020.	Senior Workforce Manager (Bank & E-Roster) 31/12/2020

Appendix B - Assurance Opinion and Action Plan Risk Rating

2019/20 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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