Therapies Directorate Review
Final Internal Audit Report

November 2021

Hywel Dda University Health Board

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Review reference:	HDUHB-2122-23
Report status:	Final
Fieldwork commencement:	6 September 2021
Fieldwork completion:	22 November 2021
Draft report issued:	23 November 2021
Debrief meeting:	28 September 2021 (interim) & 23 November 2021 (final)
Management response received:	25 November 2021
Final report issued:	26 November 2021
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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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Executive Summary

Purpose

The purpose of the review was to confirm that Directorate governance structures follow the principles set out in the Health Board's system of assurance and support the management of key risks and achievement of the Directorate's objectives.

Overview

We identified one high priority issue relating to the management of incidents, due to the volume of historic incidents requiring completion of investigation and closure. Two medium priority matters arising were also highlighted – these are detailed in Appendix A.

Report Classification

		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]

Assurance objectives		Assurance
1	Governance Structures	Reasonable
2	Risk Management	Reasonable
3	Declarations of Interest, Gifts, Hospitality and Sponsorship	Reasonable
4	Financial Management	Reasonable
5	Incidents and Concerns	Limited

Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Governance Arrangements	1, 4	Design	Medium
2	Declaration of Interests	3	Operation	Medium
3	Incidents and Complaints	5	Operation	High

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

1. Introduction

1.1 The governance review of the Therapies Directorate was completed in line with the 2021/22 Internal Audit Plan. The relevant Executive Director lead for the assignment was the Executive Director of Therapies and Health Science.

1.2 The following inherent risks were considered during this review:

- the directorate is not appropriately governed;
- risks are not identified or addressed;
- the financial position is not met; and
- lessons learned are not captured and addressed.

2. Detailed Audit Findings

Objective 1: The Directorate has appropriate governance structures, with key meetings having approved terms of reference, agendas, and work plans to provide assurance on key objectives and risk areas

2.1 The Therapies Directorate is comprised of seven service areas as follows: Physiotherapy, Speech & Language Therapy, Nutrition & Dietetics, Occupational Therapy, Podiatry & Orthotics, Lymphoedema and Community Neuro-Rehabilitation.

2.2 Prior to September 2021 there was no overarching governance structure for the directorate, with each service having its own governance arrangements. This was in part due to reorganisation of the Directorate, as the service areas previously sat within the locality structures before the directorate was established.

2.3 The directorate Quality, Safety, Experience & Risk (QSER) Group was established in September 2021 to focus on learning and information sharing across the directorate. Terms of Reference (ToR) were approved in September 2021 and state that the group reports by exception to the Health Board's Quality, Safety & Experience Assurance Committee via the Operational Quality, Safety and Experience Sub-Committee (OQSESC).

2.4 The Group has oversight of and is responsible for:

- monitoring identified actions resulting from concerns, risks and patient experience feedback; and
- identifying and sharing best practice and escalating as appropriate to the OQSEC or for staff matters to the appropriate Sub-Committee of the Health & Safety Assurance Committee.

2.5 Meetings are held bi-monthly with a meeting schedule in place to ensure appropriate coverage of the agenda categories on a rotational basis. At the time of reporting, two QSER meetings had been held in September and October 2021, and the agendas collectively covered all categories outlined in *table 1* below. Meetings are not formally documented although an action log is maintained, and we observed meeting papers relating to governance, risk and patient safety.

Table 1: Agenda Categories	**September 2021**	**October 2021**
A: Patient Experience		√
B: Quality, Safety & Clinical Practice		√
C: Quality, Improvement, Clinical Effectiveness and R&D		√
D: Health & Safety		√
E: External Inspections / Reports		√

F: Directorate & Department Risks	√	

2.6 With the QSER Group operating as the directorate's main management group, there is no formal group for other key areas such as workforce, finance and performance. We were advised that the Clinical Director of Therapies meets with the seven heads of service collectively on a twice weekly basis and individually on a monthly basis. The focus of these meetings is fluid, but typically includes discussion around risks, finance, workforce and quality and safety. Meetings are operational in nature and not formally documented.

2.7 Workforce performance reporting in relation to absence management metrics and training compliance was included on the Quality, Safety & Clinical Practice agenda section in October. Responsibilities for workforce matters are not reflected in the QSER Group ToR. **[See Matter Arising 1 at Appendix A]**

2.8 We selected a sample of service areas for review to establish the local governance arrangements in place, in the absence of a directorate governance group prior to September 2021: Podiatry, Occupational Therapy and Speech and Language Therapy (SLT).

Service Group / Forum	ToR	Meeting Frequency	Meetings Documented	Example Items Discussed
Occupational Therapy Service Leads Group	Yes	Monthly	Agendas	Quality & Safety Workforce Risk Management Patient Experience Concerns Expenditure
Podiatry Service Leads Group	No	Monthly	No	Clinical Updates Workforce
Speech & Language Therapy Adult Services Childrens Services	 No No	 Bi-Monthly Monthly	 No No	Service Delivery Workforce Safeguarding Patient Experience

2.9 The Service level groups reviewed are relatively informal in nature, with no ToR for Podiatry or Speech & Language Therapy, and meetings are not documented. These groups are not reflected in the QSER ToR so reporting and accountability arrangements are not clear, although we recognise that Heads of Service will be members of both.

Conclusion:

2.10 Prior to September 2021 there was no overarching governance structure for the directorate, although informal arrangements existed at service level with regular (albeit informal) Head of Service meetings with the Clinical Director. The directorate QSER is now in place however, the reporting and accountability

arrangements between the service level groups and QSER are not clear. On the basis of the new governance arrangements with the QSER established in September 2021, we have concluded **Reasonable** assurance for this objective.

Objective 2: A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, and escalated.

2.11 A cursory review of the risk registers for Occupational Therapy, Speech & Language Therapy and Podiatry at the outset of the audit identified:

- 24 risks assigned to Occupational Therapy (11), Speech & Language Therapy (5) and Podiatry (8);
- a small number of instances where target dates (in 2020 and 2021) for actions delayed (for example due to the pandemic response) had not been updated;
- one risk relating to mapping of capacity and demand within Occupational Therapy where the target date for action has been delayed since 2018; and
- in some cases the current status of the risk was unclear.

2.12 There was little evidence of risk management featuring within the service level governance groups sampled for review. However, directorate and service level risks are now a standing agenda item on the meeting schedule for the newly established Therapy Directorate QSER Group. The first meeting held in September 2021 was attended by the Health Board's Assurance & Risk Officer and focused on the review and update of the directorate risk register, with a further workshop planned for the end of November 2021 to review all service level risk registers.

Conclusion:

2.13 Recognising the action ongoing to review and update risk registers, no further recommendations have been raised. We have concluded **Reasonable** assurance for this objective.

Objective 3: The requirements of the declaration of interests, gifts, hospitality, and sponsorship policy has been implemented within the Directorate.

2.14 We undertook a review of the 2020/21 Health Board's registers of Staff Interests and Register of Gifts, Hospitality and Sponsorship to identify whether the Directorate had actively contributed to them.

2.15 The Health Board's *Standards of Behaviour Policy* identifies staff groups working in 'high risk' areas required to submit a declaration of interest form on an annual basis, with a 'nil return' where there is nothing to declare. Therapies staff are included within the *Senior Non-Medical/Nursing Clinical Staff* category, although policy does not stipulate which individuals (in terms of role or band) the requirement applies to. We therefore reviewed the Declaration of Interests Register maintained by the Head of Corporate & Partnership Governance to establish

whether the Clinical Director and Heads of Service have completed a return. Returns had not been completed by the recently appointed Head of Physiotherapy or Joint Head of Dietetics. **[See Matters Arising 2 in Appendix A]**

2.16 A review of the Register of Gifts saw two entries for Occupational Therapy in 2019, these were accepted and approved on the basis that one was for the benefit of patients and the other fell below the £25 threshold. There were no entries on the Health Board's Register of Hospitality, Sponsorship and Honoraria for Therapies Directorate staff – the Heads of Service we spoke with confirmed that there has been nothing to record.

Conclusion:

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

Objective 4: Appropriate financial management arrangements are in place within the Directorate, including compliance with an up-to-date scheme of delegation.

2.18 We can confirm that the structure of the Directorate is based on the scheme of delegation set out in the Health Board Standing Orders and Standing Financial Instructions (SFIs) and budget holders' roles and responsibilities are defined within the SFIs.

2.19 The Clinical Director of Therapies and Heads of Service have access to QlikView for real-time budget monitoring, with the ability to drill down to transaction level. We were advised that the financial position is discussed at the regular Heads of Service meetings, and individual Head of Service meeting where there is a specific financial impact, with any queries addressed to the Finance Business Partner on an informal, ad-hoc basis. As noted at paragraph 2.6, there is no formal group for monitoring and reporting of key areas such as workforce, finance and performance. **[See Matter Arising 1 at Appendix A]**

2.20 The financial position as at month 7 is £306,280 underspent:

Service	Annual Budget	YTD Budget	YTD Actual	YTD Variance
Dietetics	£2,833,072.	£1,640,575.	£1,466,244.	(£174,332.)
Lymphoedema	£735,050.	£427,333.	£266,057.	(£161,276.)
Neuro & Stroke	£309,820.	£180,231.	£140,343.	(£39,888.)
Occupational Therapy	£4,897,530.	£2,853,840.	£2,656,196.	(£197,644.)
Physiotherapy	£8,803,869.	£5,119,300.	£5,227,112.	£107,812.
Podiatry	£2,976,847.	£1,734,039.	£1,632,610.	(£101,429.)
Speech & Language	£2,364,953.	£1,369,416.	£1,325,924.	(£43,491.)
Management & COVID	(£170,695.)	(£94,375.)	£209,593.	£303,968.

Directorate	**£22,750,446.**	**£13,230,360.**	**£12,924,080.**	**(£306,280.)**

Conclusion:

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

Objective 5: The Directorate has appropriate processes in place to ensure actions are taken as a result of incidents and concerns.

2.22 The Heads of Service individually review and scrutinise all incidents and complaints recorded on the Datix system. Very few complaints are received. For the three service areas reviewed, a total of four complaints had been received since April 2021 and all were closed at the time of audit.

2.23 Incidents and complaints are discussed as part of the Patient Experience agenda for the QSER Group. The comprehensive *Therapies Governance Report* presented at the October 2021 meeting highlighted:

- The Health Board implemented the new All Wales Datix system in April 2021 so reported data is split by data in the old system (up to 31 March 2021) and data in the new system (from 1 April 2021).
- In the old system, there were 43 open incidents as at August 2021.
  - Two date back to 2019 and a further 32 date back to 2020, with 21 incidents open for more than one year.
  - 25 incidents were classed as "awaiting final review" indicating that they have been reviewed. The remaining 15 have not been reviewed, one of which dates back to 2019. **[See Matter Arising 3 in Appendix A]**
- There were 37 incidents reported between 1 April 2021 – 31 August 2021, all resulting in 'no harm' to 'moderate harm'.

Conclusion:

2.24 Noting the above, we have concluded **Limited** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Governance Arrangements (Design)		**Impact**
With the QSER Group operates at the directorate's main management group, there is no formal group for other key area's such as workforce, finance and performance. We were advised that the Clinical Director of Therapies meets with the seven heads of service collectively on a twice weekly and individually on a monthly basis. The focus of these meetings is fluid, but typically includes discussion around risks, finance, workforce and quality and safety. Meetings are operational in nature and not formally documented. Workforce performance reporting in relation to absence management metrics and training compliance was included on the Quality, Safety & Clinical Practice agenda section in October. Responsibilities for workforce matters are not reflected in the QSER Group ToR.		Potential risk of: • the directorate is not appropriately governed • workforce, finance and performance related issues are not appropriately monitored, reported or escalated where appropriate
Recommendations		**Priority**
Formal monitoring and reporting arrangements for workforce, finance and performance matters should be established.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**

A dedicated workforce meeting is in place on an alternate week process as part of the bi-weekly heads of service meeting, and includes attendance of the dedicated Workforce & Employee Relations Officer and the assistant Director of Therapies & Health Sciences. This dedicated meeting covers areas such as employee relations, agency usage, apprenticeship programme, workforce commissioning and development. However, we accept that these arrangements require formalisation with an agreed terms of reference and action log. Monthly finance meetings will also been established from 14th Dec 21 as part of the twice weekly meetings, this will be reflected in the terms of reference and incorporated into the action log.	December 2021	Clinical Director of Therapy Services

Matter Arising 2 : Declaration of Interests (Operation)		**Impact**
We reviewed the Declaration of Interests Register maintained by the Head of Corporate & Partnership Governance to establish whether the Clinical Director and Heads of Service have completed a return. Returns had not been completed by the recently appointed Head of Physiotherapy or Joint Head of Dietetics.		Potential risk of: • the directorate is not appropriately governed.
Recommendations		**Priority**
In line with the Standards of Behaviour Policy, all senior managers within the Directorate should submit a declaration of interest form (including a nil return if appropriate) for inclusion on the declaration on interests register.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
All appropriate senior managers and clinicians within the Directorate will submit an annual declaration of interest form (including a nil return if appropriate) for inclusion on the declaration on interests register.	March 2022	Clinical Director of Therapy Services. Heads of Service

Matter Arising 3: Incidents and Complaints (Operation)		**Impact**
There are 43 open incidents dated prior to 1 April, as at August 2021. Two date back to 2019 and a further 32 date back to 2020, with 21 incidents open for more than one year. 25 incidents were classed as "awaiting final review" indicating that they have been reviewed. The remaining 15 have not been reviewed, one of which dates back to 2019.		Potential risk of: • Lessons are not learned from incidents or action taken to prevent reoccurrence
Recommendations		**Priority**
Management must prioritise the review and closure of open incidents predating April 2021.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
All open incidents have been reviewed at QSER Group meeting on 29th of October 2021 and identified areas for review tasked to Heads of Service to have been actioned by January meeting. Some of these were attributed to turnover in the Head of Service posts with delays in reassigning responsibilities for open incidents. Bi-monthly directorate review structure in place to monitor open incidents in addition to Head of Service responsibility.	January 2022	Clinical Director of Therapy Services. Heads of Service

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.