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Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

FINAL INTERNAL AUDIT REPORT 2018/19

ABM University Health Board

Princess of Wales Delivery Unit Governance Review

(ABM-1819-036)

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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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. EXECUTIVE SUMMARY

1.1 Introduction and Background

This assignment originates from the 2018/19 internal audit plan.

The Health Board's Service Delivery Units became operational from October 2015. Whilst this was the case, Princess of Wales Hospital had been managed already as a separate unit from February 2014 under the direction of a previous hospital director. An internal audit review undertaken in June 2015, assessed the governance arrangements in place up to that point and reported a *limited* assurance rating. The new Unit Service Director (the current post holder) who had recently taken up post at that time agreed action to address key findings raised.

1.2 Scope and Objectives

The objective of this review is to confirm the Unit governance structures follow the principles set out in the Health Board's current system of assurance, and support the management of key risks and the achievement of the Unit's objectives.

The approach taken was a desktop review of the terms of reference, work plans/programmes, agendas, minutes & action logs documented of key Unit management groups with the aim of confirming a clear framework had been put in place within which to manage the Unit's business.

1.3 Associated Risks

The following inherent risks were considered during this audit:

- Governance structures, roles and responsibilities are not clear or not operating effectively;
- Risks to achievement of the managed Unit or Health Board objectives are not identified, managed or reported appropriately.

2 CONCLUSION

2.1 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 level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the governance structures and arrangements within the Princess of Wales Hospital Service Delivery Unit (POWH SDU) is **Limited** Assurance.

RATING	INDICATOR	DEFINITION
Limited assurance	 - + Amber	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

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.

Prior to the commencement of fieldwork the Unit Head of Patient Experience, Governance & Planning submitted his resignation following extended sick leave which commenced in February 2018. Within the governance structure of the Unit this is a key role. We acknowledge the valuable contribution made by the Unit Nurse Director in taking on responsibilities within this area in the intervening period.

This audit has been undertaken in the context of these challenges and a number of the findings of this report reflect these circumstances. In considering our findings we reflect on how they have will have affected the maturing of governance arrangements within the Unit.

Following the closure of fieldwork we note that the revised post of Head of Quality & Safety has been advertised, and the position will now report directly to the Unit Nurse Director.

3 KEY FINDINGS & RECOMMENDATIONS

3.1 Key Findings

The Patient Experience & Governance team have provided comprehensive supporting arrangements and information within the Princess of Wales Hospital Unit to Service Group Managers and Unit Directors aiding in the focus on patient Quality and Safety.

The key issues identified during this audit:

- The Unit Quality & Patient Safety (QPS) committee meetings held experienced poor clinical attendance (medical representatives and senior nurses). Additionally, four meetings were cancelled in the period April 2017 – March 2018.
- The QPS committee terms of reference were reviewed but were not subsequently revised. They require redrafting to ensure they reflect current Q&S priorities and reporting arrangements.
- The QPS has no workplan. A workplan would contribute to improved monitoring of Unit Q&S business in the event of the disruption of meeting cancellations. We noted gaps in the reporting of Unit quality and improvement plan management, health & care standards progress, formal progress against the HIW improvement plans, and work of the Unit Health & Safety Committee. A workplan would also contribute to strengthened reporting from groups such as Spot the Sick patient and Nutrition and Hydration which have not reported to QPS within the last year.
- Good communication between the Patient Experience Team and Service Group Managers was evident in respect of risk register management, though a number of risks were identified as overdue for review. However the reporting of risks to Hospital Management Committee (HMC) and the Unit QPS committee require improving. The HMC has not received the full risk register and the QPS had not done so for a period of September 2017 – June 2018.

In addition to the above, a number of additional observations and recommendations have been made to improve the recording of ongoing unit business.

3.2 Design of System / Controls

The findings from the review have highlighted 7 that are classified as weaknesses in the system/control design.

3.3 Operation of System / Controls

The findings from the review have highlighted 8 that are classified as weaknesses in the operation of the designed system/control.

3.4 Summary of Recommendations

The audit findings and recommendations are detailed in Appendix C 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	**2**	**13**	**1**	**16**

4 AUDIT FINDINGS

Audit findings are reported below. Full details with associated improvement recommendations are provided in Appendix C.

4.1 UNIT GROUP STRUCTURE

The Princess of Wales Hospital Delivery Unit was established as a managed unit in February 2014. The current management arrangements were established following the appointment of the current Unit Service Director in August 2015. The Unit's senior leadership team is made up of the Unit Service Director, Unit Medical Director and Unit Nurse Director.

The most senior operational management group at the Unit is the Hospital Management Committee (HMC). It is supported by a Unit Quality & Patient Safety Committee (QPS) to review, manage and provide assurance on quality and safety matters. The Unit's organisational structure comprises four service groups: Medicine & Care of the Elderly, Surgical Services, Clinical Support Services, and Emergency Care & Hospital Operations – each has its own local governance arrangements. In respect of quality & safety, there are a number of groups that address individual subject areas. This audit has not reviewed all of these groups. The focus of our review has been on the Hospital Management Committee and the Quality & Patient Safety Committee – the two key groups of which each of the Unit Directors are chairs or members. Limited work has been undertaken and reported in other areas where appropriate.

4.1.1 Princess of Wales Hospital Delivery Unit Board

The Princess of Wales Hospital Delivery Unit has an established Hospital Management Committee (HMC – previously known as the Hospital Management Board). Whilst we were provided with documented terms of reference (TOR), we could not see that they had been received or agreed at the HMC and the membership requirements of the HMC within the ToR were in need of refreshing. During fieldwork the Unit Service Director indicated that updated TOR would be included in the agenda for the July 2018 HMC meeting. At its close he confirmed verbally that revised ToR had been agreed at the HMC and forwarded a copy.

The HMC does not have a formal work plan. Standard agenda items include the key areas of finance, workforce, service performance, Unit Nurse Director update, Unit Medical Director update and quality & safety. Service improvement reports were noted from the service

groups, though the frequency of this varied significantly between services: From September 2017, four papers were received from Medicine and Care of the Elderly, whilst only one was received from Emergency Care & Hospital Operations (September 2017). A high-level comparison against routine subjects reported within the Health Board's Business Cycle did not identify any gaps in coverage. Whilst this is the case the HMC may benefit from introducing a workplan to spread some subjects that may not be required at every meeting (in order to spend more time on fewer at each meeting) and to ensure that less frequent items are not overlooked (eg service group improvement plans, TOR review, risk register (see later)).
Finding 1 at Appendix C

We reviewed attendance at meetings of key members set out in the ToR including the management and clinical leadership for each service area, taking into account the current structure of the Unit, and its corporate business partners. We can report a good level of representation from Finance, Workforce and the Unit's Service Group Managers. Whilst some of the medical leadership attended all meetings for which notes were available, it was variable for others and two had not attended at all – the Medicine and Care of the Elderly clinical directors (September 2017 – March 2018).
Finding 2 at Appendix C

The previous Internal Audit review of the Unit (ABM-1516-003) identified areas where recordkeeping and administrative procedures required improvement. We note that there had been an improvement made following the original review; however a recent deterioration was noted, particularly in respect of the maintenance of action logs which had not been recorded from December 2017 onwards, and so there was no dedicated follow up of recorded actions within the minutes of meetings. This was discussed with the Unit Service Director who indicated that there had been gaps in administrative support for the meetings from December 2017 arising from personal issues affecting one of the administrative team.
Finding 3 at Appendix C

4.1.2 Unit Quality & Patient Safety Committee

The Unit Quality & Patient Safety Committee (QPS) remit is to review, manage and provide assurance on quality and safety matters.

<u>Terms of Reference</u>
The terms of reference (TOR) for the Unit's QPS committee were due for review in September 2017. Minutes note that amendments were

required however this was not added to the action list and there was no evidence that a refreshed document had been presented at a later meeting.
See Finding 4 in Appendix C

Frequency of meetings & attendance
The extant QPS TOR note that it should meet monthly however we note that four meetings were cancelled in the 12 month period sampled. Informal feedback has suggested that this was due to the meetings not being quorate. Clinical attendance (medical staff and senior nurses) at the committee has been poor across a number of specialties including Medicine, Orthopaedic and Emergency Medicine.

The Unit Directors indicated that they were considering a revision to the current format of the QPS committee in order to improve attendance. They indicated that at July's HMC a paper would be presented to consider the future format - one option at the time of fieldwork was the introduction of alternate monthly 'business' and 'learning' meetings, the latter to be attended by medics. Following the close of fieldwork, the Service Director indicated that ToR had been reviewed and approved at HMC, but they were to be subject to further discussion and agreement at the QPS subsequently.
(Finding 4 in Appendix C refers)

Subject Coverage
The Unit QPS committee does not have a documented work plan, scheduling subject reports to be received or matters to be discussed over the year. A review of QPS committee papers against the expectation of its TOR identified some gaps in coverage expected:

- *"Promote and manage a Quality and Improvement Plan for the Princess of Wales Hospital";*
- *"Receive and act on reports from the POWH H&S committee"*;
- *"Review the progress of the POWH services against the Health Care Standards for Wales"* (this was on the agenda for February 2018, but the meeting was cancelled. There was no detail in the March minutes.)

Additionally, the TOR referred to three initiatives first implemented in response to the Trusted To Care report (2014), which have not featured in the papers in the form suggested in the TOR:

- *"Receive and act on reports from the POWH Dignity Forum"*;
- *"Review the work of the Professional Standards Taskforce"*;
- *"Receive and act on in information provided by the Care Barometer"*.

These aspects of the TOR may be out of date. Conversely there are other groups, eg the Spot the Sick Patient Group which are taking forward quality & safety initiatives which do not periodically report in. **See Finding 5(a) & (b) in Appendix C**.

We also compared the coverage to selected key subjects listed in the Health Board Quality & Safety Committee work plan (we excluded clinical audit, recognising that the Health Board policy was revised in late 2017/18 – there is a separate review in the internal audit plan to consider this). Most subjects were reflected either within dedicated papers or as elements of summary papers. One subject not evident was the work of the Unit Nutrition & Hydration Group. The terms of reference (TOR) for this group suggest that it has been set up as a sub-group of the corporate group and do not specify any reporting arrangements within POWH. Unit Directors were clear that wherever possible they try to reflect corporate quality & safety structures within local arrangements. Whilst this group has been set up to address matters arising from the corporate group, we would suggest that its TOR be reviewed by the Unit Directors to ensure that they are clear and reporting arrangements be amended to include the POWH Quality & Safety Committee in addition to any corporate arrangements.
See Finding 6 in Appendix C

4.1.3 Taskforce

We also note that the Unit Directors meet with the Patient Experience & Governance team to review quality & safety reports in a weekly 'Taskforce' meeting. The reports are shared with Service Group Managers. The reports include data relating to:

- Incidents: New serious incidents (including Datix detail); numbers under investigation; hot spot wards; rolling trends; incident themes; and incidents requiring external reporting, including never events. Falls and pressure ulcers are detailed separately also.
- New or recently closed complaints
- Redress
- Inquests
- Claims
- Patient liaison report.

These meetings are not formally documented through minutes or action lists (we have received some rough, handwritten notes). Brief action notes recording attendance and actions agreed would assist demonstrate the Unit Directors' regular review of these particular quality & safety measures.
See Finding 7 in Appendix C

4.1.4 Unit Service Groups

The POWH Delivery Unit has four service groups established to manage delivery of services: Medicine & Care of the Elderly, Surgical Services, Clinical Support Services, and Emergency Care & Hospital Operations.

We note that the Hospital Management Committee does not as a matter of course receive and approve terms of reference (TOR) from these groups, so we requested copies from service group managers. Of the four service groups operating within the Unit Internal Audit received TOR for the Medicine and Care of the Elderly and Surgical service groups only. No TOR were supplied for Clinical Support Services or Emergency Care & Hospital Operations service groups. The documentation of TOR and agreement amongst service group members would promote a common understanding of group purpose, membership and expected operating arrangements for members.
See Finding 8 in Appendix C

Whilst TOR were not provided for all, minutes of meetings were available for three of the four service groups; however, we note that one group, ECHO has not held a management board meeting since May 2017 (the last highlight report to HMC was September 2017). The Service Group Manager informed Internal Audit that he was aware of the arrangements in place for other groups and was in the process of re-establishing the meeting.
See Finding 9 in Appendix C

We were informed that each service group manager has weekly or fortnightly meetings with the Patient Experience & Governance (PEG) team to review performance issues across areas including complaints and significant incidents. It was also indicated that these meetings were used as an ad hoc opportunity to address overdue risk register entries (see later section for promptness of review). Meetings are frequent and operational so notes are not taken formally. Example agendas containing complaint and incident data for discussion were forwarded in support of their existence.

Service group managers attend HMC on a regular basis and provide updates through highlight reports or Service Improvement updates (see earlier in respect of frequency of reporting).

4.1.5 Monitoring of Current Issues/Risks

We sampled five areas presenting issues/risks currently to confirm they were subject to active review by management:

Infection Control

The Unit has a weekly Infection Control meeting chaired by the Unit Nurse Director. It includes a review of Tier 1 targets (C.Diff, MRSA, MSSA, and E Coli) with actions for proposed improvements. Whilst action are recorded in notes for staff, follow up at subsequent meetings is not always recorded clearly – the Unit Nurse Director may wish to consider this for future meetings, seeking assurance from those tasked that actions have been completed.

The Unit's annual infection control plan is not monitored at the meetings. A review of weekly meetings papers established that most subjects within the plan have been covered in some way with two exceptions: the review of inter-ward patient transfers, and the audit of bed capacity for adequate isolation facilities (the availability of sufficient single rooms with en suite facilities). The Unit Nurse Director provides infection control reports to HMC, QPS and the Health Boards Infection Control committee. Our testing noted the reports reflected areas covered by the team.

See Finding 10 in Appendix C

Ward Cleaning

The weekly infection control meeting receives updates from Support Services. A report is submitted noting any discrepancies in the completion of paperwork for recording cleaning and fridge temperature checks done within the ward kitchen areas. Additionally, information is provided on number of ward cleaning hours. In discussion with the Unit Directors, they highlighted concerns around cleaning hours/standards, highlighting that they considered hours were not enough. We were able to identify this had been raised via papers to the Health Board Infection Control Committee.

The review of equipment and environmental cleanliness are elements of POINT reviews undertaken by matrons. The outcomes have not been reported to the QPS during the year. The reporting of outcomes of the corporate Quality Assurance Framework which is being rolled out across ward areas this year to the Unit QPS would enhance assurance.

See Finding 11 in Appendix C

Staffing Establishments

The HMC received a report from the Unit Nurse Director indicating the implications of the Nurse Staffing Act in March 2018. Within the report a risk assessment was embedded, listing the compliance status of each qualifying ward with explanation, identifying actions being taken within the Unit to manage the risk and escalating some issues for corporate support (eg electronic information systems).

The HMC received a further update as part of the Nurse Director's report in June.

External Inspections

At the time of fieldwork POWH unit had received two recent external inspections, one from HIW and a Health Board wide review of the management of Serious Incidents undertaken by the NHS Wales Delivery Unit.

In January 2017 HIW inspected the POWH Emergency Department and Ward 10. The action plan was presented to QPS for review in April 2017 and was noted to be in need of further monitoring. Due to meeting cancellations it was not brought to the committee again. In March 2018, as part of a programmed review of Surgical Services, including Main Theatres and Ward 10, HIW issued an immediate improvement notice highlighting a number of issues in respect of Thromboprophylaxis Risk Assessment and treatment, one of which – the initial completion of risk assessment documentation at Ward 10 had been highlighted at the previous inspection in January 2017. Whilst this was the case and we have highlighted a gap in the monitoring of the improvement plan agreed following the original visit, we note that the QPS has received quarterly Pharmacy & Medicines Management reports which included audits of the initial completion of risk assessment documentation, which provided information on the level of compliance across all wards. The January 2018 position (which would have been reported to the February 2018 meeting had it not been cancelled) indicated 100% compliance at Ward 10.

See Finding 12 in Appendix C

The Delivery Unit report was scheduled for QPS in April 2018, but that meeting was cancelled. It did not appear on the agenda for the following meeting in May 2018.

This is noted for management information and future agenda-setting.

Significant Incidents/Never Events

Prior to field work commencing, seven 'Never Events' had been recorded in POWH for the period September 2017 – March 2018. Internal Audit have noted that never events are included within the information presented within the serious incident reporting to the Unit Directors TaskForce meetings. Brief, handwritten notes have been supplied by Patient Experience & Governance team. However while these provide a brief outline of topics covered they do not provide the fuller assurance that formalised Action lists could do.

At the time of fieldwork the process of investigation and agreement of action had not been completed for any of the seven never events reported up to the end of March. We note though that the Unit Medical Director wrote to colleagues in June emphasising the need to adhere to safety arrangements with respect to Theatres. Additionally, the Service Director informed us that on 18th July a shared learning event took place within the lecture theatre at POW Hospital, led by staff involved in each incident. Further "human factors" training is intended.

We have noted some administrative discrepancies between the total number of never events recorded and the numbers summarised within the main body of the Unit Highlight Reports submitted to the Health Boards Assurance & Learning group. These coincided with the departure of the Head of Patient Experience & Governance and the total numbers were embedded more deeply within the document.

4.2 UNIT RISK REGISTER

4.3.1 Risk Register Monitoring

The current process for updating the Unit risk register is through regular liaison between each Service Group Manager and the Patient Experience & Governance (PE&G) team. The Team were critical of the Datix system reporting functionality and we note the Service Group management meetings do not receive extracts of the Unit risk register detailing their risks.
See Finding 13 in Appendix C

We were informed that the full register would be presented to the QPS committee on a quarterly basis with risk managers being prompted to update any overdue risks ahead of the meeting. At any other QPS meeting a report would be prepared listing the overall total including a breakdown of number by grade. A review of papers notes that the register itself has not been included in QPS papers since

September 2017. As fieldwork was being completed the QPS meeting scheduled for 19th June 2018 received the full register for scrutiny.

The HMC receives a similar headline risk total but does not review the register as a whole. There is evidence of the Unit Service Director scrutinising some risks on an ad-hoc basis but there are no formal records to demonstrate the ongoing systematic monitoring of risk register content. The Health Board's Risk Management Policy states that Unit Boards should receive the register on a quarterly basis. Scheduling dates within a HMC workplan would support this end. In between quarterly full reports, receipt of information on changes would support shared awareness and review of new risks.
See Finding 14 in Appendix C

4.3.2 Risk Register Management

In discussion with the Patient Experience & Governance team we were informed that on occasion risks will be updated by the handler but that the date of next review might not be amended to reflect this. Testing noted 23 high or significant risks requiring review and one which had been updated but not closed. Towards the end of fieldwork and ahead of the June QPS meeting where the full register was to be received the above risks were reviewed again to note progress. The number of outstanding high or significant risks requiring review had decreased to 14. This was communicated to Unit Directors as part of the mid audit briefing.

The previous Internal Audit review of Princess of Wales (ABM-1516-003) included recommendations for the management of the Unit's risk register. These included recording of progress updates, recording of actions and correct use of terminology. There has been improvement made in all of the highlighted areas.
No further recommendation made (HMC monitoring of register should assist with promptness of update)

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** that arrangements to secure governance, risk management and internal control, within those areas under review, 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.

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.