# Mental Health & Learning Disabilities Service Group Governance

## Final Internal Audit Report

July 2024

Swansea Bay University Health Board

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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 Chartered Institute of Public Finance & Accountancy in April 2023.

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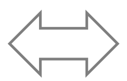
# Executive Summary

## Report Opinion

| | | Trend |
|---|---|---|
| Reasonable | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. | <br>2019/20 |

## Assurance summary[1]

| | Objectives | Assurance |
|---|---|---|
| 1 | Service Group Organisational Structure | Reasonable |
| 2 | Service Group terms of reference and work programmes | Reasonable |
| 3 | Divisional arrangements in support of the Service Group | Reasonable |
| 4 | Mechanisms to provide oversight and assurance of key risks and issues. | Reasonable |

### Purpose

To review the governance and risk management arrangements implemented within the Mental Health and Learning Disabilities Service Group (MHLDSG).

### Overview

We have issued reasonable assurance on this area. We found that the Service Group has a clear leadership structure with established governance arrangements to support the delivery of services and agreed priority areas. Service Group representatives highlighted the impact of the number of internal, corporate, regional and national forums where attendances and contributions are required, on individuals and teams capacity for service delivery.

The matters requiring management attention include:

- Terms of reference for some key groups within the Service Group are overdue for review, and were in draft only for the sampled division, indicating a gap in regular receipt and approval processes.
- Reporting requirements for some groups are unclear or not in operation, resulting in gaps in onward reporting.
- Poor medical attendance at Quality and Safety group noted, and instances of meetings not quorate. To mitigate high medical vacancy rates, Clinical leads have undertaken additional clinical duties, limiting capacity to attend Service Group meetings.
- Escalation reporting by exception has been identified within the Service Group structure, Divisions and Directorates provide regular quality and safety reports, however there could be enhancements to ensure clarity of issue, escalation reason, or support required.
- Performance monitoring arrangements through scorecard review could be evidenced, and generally we could identify targets being met, however a gap (October 2023 – February 2024) in scorecard receipt and discussion was identified.
- Declarations of interest are not obtained from Divisional Senior Management Teams.

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

- Limited discussion of risks noted at Service Group Management Board, and the intention for future risk register monitoring requires strengthening.
- There is no formal mechanism for escalation between the Service Group Management Board and Corporate Management Board, although we note regular meetings with the COO take place.

| | Key Matters Arising | Objective | Control Design or Operation | Recommendation Priority |
|---|---|---|---|---|
| 1 | Key Group Terms of Reference | 1, 2 | Design | Medium |
| 2 | MHLDSG Reporting structure | 2, 3 | Design | Medium |
| 3 | Attendance & quoracy at MHLDSG groups | 2 | Operation | Medium |
| 4 | Clarity of key reports | 2, 3 | Operation | Medium |
| 5 | Performance monitoring and reporting | 2, 3 | Operation | Medium |
| 6 | Declarations of Interest | 2 | Design | Medium |
| 7 | Learning Disabilities Business Meeting Terms of Reference | 3 | Design | Medium |
| 8 | MHLD Risk Management Arrangements | 3, 4 | Design | High |
| 9 | Management Boards linkage | 4 | Design | Medium |

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

# 1. Introduction

1.1 In 2021/22 Swansea Bay University Health board ('the health board') undertook a review to consider the quality governance arrangements within its Service Groups. The timing of this piece of work coincided with Audit Wales review of Quality Governance arrangements which reported 'significant weaknesses in arrangements both corporately and within operational teams', and an internal audit review of the health board's implementation of its Quality and Safety Framework which assigned it 'limited' assurance.

1.2 In responding to the above, the health board has identified a number of actions to be progressed at Service Group level. This included a Quality Management System task and finish group, chaired by the Chief Executive Officer, with a remit to '*ensure a robust quality governance structure is in place for each of the Service Groups*.' In concluding its work in March 2023, it identified that while some consistent approaches were in place, no Service Group's arrangements mirrored the corporate structure or each other's. An Audit & Assurance review in 2022/23 of the health board's Quality and Safety Framework noted progress assigned 'reasonable' assurance, and the more recent review of progress in 2023/24 of progress in implementing a Quality Management System also assigned 'reasonable' assurance.

1.3 The health board has outlined its intention to develop each acute site into a centre of excellence and work continues to progress these. This includes Morriston designated the centre for urgent and emergency care, regional complex services and specialist care; and Singleton and Neath Port Talbot sites focusing on planned care and rehabilitation services.

1.4 Our review of Service Group governance has coincided with an Audit Wales review comparing governance arrangements across all four Service Groups at the health board. The scope for both Internal Audit and Audit Wales reviews considered the arrangements for overseeing finance, performance and quality and safety of services, alongside flows of assurance to the Board and its committees. We have held discussions with Audit Wales to understand the themes arising from their *Review of Operational Governance* as it concluded.

1.5 The Mental Health and Learning Disability Service Group provides services on both a local and regional basis, structured across three divisions of Mental Health, Learning Disabilities, and Secure Service and Recovery. This review included review of arrangements within the Learning Disabilities division.

1.6 The key risks considered in this review included the clarity of governance structures and roles and responsibilities, impacting operating effectiveness of the Service Group and its ability to meet key objectives.

1.7 Fieldwork for this review has coincided with the Audit & Assurance review of health board *Risk Management & Assurance* which included detailed sampled testing of

risks held by all four Service Groups and corporate risk escalation. This review has considered MHLDSG risk management reporting arrangements but has not undertaken testing of risk content or escalation to the health board Risk Management Group.

# 2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

| | Recommendation Priority | | | Total |
|---|---|---|---|---|
| | High | Medium | Low | |
| Control Design | 3 | 11 | - | 14 |
| Operating Effectiveness | - | 5 | - | 5 |
| Total | 3 | 16 | - | 19 |

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

**Objective 1: The Service Group has a clear organisational structure, with approved terms of reference and work programmes.**

2.3 The Mental Health and Learning Disabilities Service Group (MHLDSG) has a structure of key groups supporting the MHLDSG Management Board (SGMB) which has oversight of performance, finance, and quality. Detail of the group structure is included within **Appendix B**.

2.4 Terms of reference (ToR) were provided for all groups within SGMB structure (inclusive of the SGMB), with the exception of the Weekly Business Meeting (WBM). The WBM is an operational senior management team meeting which rotates its agenda across finance, workforce and continuing healthcare, alongside weekly divisional updates and periodic divisional performance reviews. Review of key groups ToR identified that three of the six had passed their review date. **See Matter Arising 1** Agendas provided for key groups did not contain work programmes or business cycles. **See Matter Arising 2 & *Audit Objective 2* for further detail on group operation.**

2.5 The Service Group is led by a leadership team of Service Group Director (since January 2024 a job shared role), Nurse Director, and Medical Director. We were provided with a hierarchy setting out the operational senior management across the MHLDSG. This included the medical, nursing, psychology & psychological therapies and operational management structures to divisional and directorate/service level. A small number of interim or vacant posts featured within the hierarchy suggesting the Service Group has retained a stable leadership team.

Conclusion:

2.6 The Service Group has an established organisational structure setting out the key groups which support the SGMB. While ToR could be provided for nearly all groups, the majority were overdue for review. A Service Group and divisional/directorate management hierarchy was also available containing few interim or vacant posts, such demonstrating the stability of the leadership team at the date of the review. We assign this objective **reasonable** assurance.

**Objective 2: The Service Group terms of reference and work programmes are constructed in alignment with key objectives and health board priorities.**

2.7 We reviewed details of ToR for the SGMB, Service Group Quality and Safety Committee (SGQSC), and undertook a high-level review of format for the remaining five groups reporting to SGMB listed within the group structure (**Appendix B**). Discussion with Service Group representatives highlighted the challenges, both in terms of attendance and effectiveness of meetings, due to the number of internal, corporate, and regional forums where contributions are required. The national Strategic Programme for Mental Health also requires Service Group representation, its structure contains 14 network or steering groups, requiring a range of operational and clinical attendees from the Service Group. The capacity of individuals, and teams, to deliver required improvements is noted in this context.

SGMB.

2.8 ToR were recently reviewed and approved in May 2024, and contain detail of its constitution, remit/objectives, membership, frequency of meetings, quorum, administration and reporting. We note that SGMB's remit is aligned with the Health Board Management Board (HBMB), subject to some minor gaps identified. Additionally, the frequency of meetings, and list of subgroups do not reflect current arrangements. **See Matter Arising 2.** The SGMB ToR also includes that it should '*establish any issues that need escalation to the Health Board Management Board*'. Our audit work within ***audit objective 4*** includes escalation arrangements and notes that there is no formal feedback mechanism between HBMB and SGMB to facilitate this. **See Matter Arising 9**

2.9 The SGMB membership includes the SG Directors, Divisional management teams, Head of Operations, Heads of Therapies, and representation from Workforce, Finance, Planning, and trade unions. Meetings are held on a monthly basis, with the exception of August and December, review of attendance for the period July 2023 – February 2024 noted that two meetings in the period were not quorate. **See Matter Arising 3**. Review of SGMB papers also noted that the board did not receive reports from all of the subgroups listed within its ToR. **See Matter Arising 2**.

SGQSC.

2.10 ToR was approved in January 2023 reflected changes made to the quality and safety structure to align with the revised corporate arrangements, and the

introduction of divisional quality and safety reporting. The ToR contain detail of purpose, aims/objectives, membership, frequency of meetings, quorum, administration and reporting. The ToR was due for review in January 2024, but we could not confirm this had taken place. **See Matter Arising 1**

2.11 The SGQSC membership includes the SG Directors, Head of Nursing – Quality Governance & Improvement, Divisional management teams, Heads of Therapies, Quality and Safety Manager, Pharmacy lead, Quality Improvement Nurse Manager, and Expert by Experience representative. A review of attendance for the period September 2023 – March 2024 identified one meeting cancelled due to number of apologies (December 2023), and two not quorate. Medical attendance was also noted to have decreased across the period reviewed, as per para 2.26 the medical vacancy rate for the Service Group currently exceeds 40%, we were also informed of extended absences within the Service Group Medical leadership group within the time period reviewed. **See Matter Arising 3**

2.12 The supporting quality and safety structure is included within its ToR, but the frequency and formality of updates received from some subgroups varied. **See Matter Arising 4** Template reports from Divisions were introduced in early 2023, and we noted these were regularly submitted, although staff absences within the Mental Health division had contributed to some exceptions (para 2.23 contains further detail on divisional QS reporting). **See Matter Arising 4**

Other key groups.

2.13 Summary review of other key groups ToR highlighted that there is not a standardised approach in format or content. Two did not include detail of onward reporting arrangements. **See Matter Arising 1**

Alignment of priorities and objectives within Terms of Reference.

2.14 As per para 2.4, work programmes do not feature within Service Group meetings. Noting this we reviewed the standing agenda against areas contained within the SGMB and SGQSC ToR, and content within the Health Board Business Cycle, Health Board Quality and Safety Committee, and Performance and Finance Committee work programmes. There were some areas not set out within SGMB or SGQSC ToR; - SGMB does not contain reference to Welsh Language Standards and Partnerships; SGQSC similarly does not reference Patient Stories and Infection, Prevention and Control. However, we were able to confirm receipt of related papers at these groups (or within the WBM), therefore no recommendation is raised.

Alignment with key objectives and Health Board priorities: MHLDSG Planning.

2.15 As part of the health board 2023/24 IMTP planning process Service Groups were required to develop system visions which aligned with those of the health board and its strategic priorities. Evidence to demonstrate Service Group senior management engagement in their development was provided.

2.16 In 2023/24 the Service Group delivered 31 of 40 Goal Method Outcome (GMO) milestones, with the availability of funding impacting a number of those not delivered. Review of the 2024/25 MHLDSG GMOs identified inclusion of those not

completed within the prior year, and we noted engagement with both internal divisions, and the health board's wider planning process, in developing entries.

2.17 Following approval of the health board Recovery and Sustainability plan in March 2024, the SGMB received it's final 2024/25 GMOs at its April 2024 meeting. This contained a total of 46 milestones, which included four external GMOs (for a Corporate Directorate and other Service Group) for which the MHLDSG leads are responsible for delivering, and seven GMOs not included within the health board plan but seen as important for future MHLDSG planning which are to be monitored locally.

Alignment with key objectives and Health Board priorities: MHLDSG Performance.

2.18 The MHLDSG has an established performance monitoring approach, using divisional and directorate performance scorecards which are produced on a monthly basis. Whilst including some customisation to reflect the type of service/care provided, there is consistent inclusion of service user feedback and quality indicators, workforce metrics, financial analysis, and operational indicators across access, capacity and patient flow. Review of content identified that there was often use of RAG ratings to support analysis, but use of comment boxes to offer further explanatory narrative did not feature in all scorecards. **See Matter Arising 5**

2.19 Scorecards are received at WBM, however we noted a gap in their receipt between October 2023 – February 2024. We are informed there is intention to enhance scrutiny arrangements through establishing quarterly performance reviews for Divisions which will include review of scorecards. **See Matter Arising 5**

2.20 SGMB also receives an Activity and Access report, which presents performance and trends against national targets such as Mental Health Measure (Wales) compliance, outpatient and therapies waiting list performance. We identified discussion, escalation, and risk register entries across a number of areas where achieving required performance levels is a challenge. Generally, reports reviewed highlighted performance was meeting targets expected, although Child and Adolescent Mental Health Services performance remains inconsistent following repatriation from CTMUHB. Historic performance issues prompted the return of the service which features within Welsh Government Targeted Intervention arrangements. Performance against the Psychological therapies 26-week target (95%) has deteriorated over the past two years to around 70% as a result of increased demand (125% increase between 2021 – 2023), the WBM received a paper in November 2023 setting out actions to realign team resource, but acknowledged continued clinical risks due to the extended waiting times and further resource would be required to address this.

2.21 However, we did note a WBM request for escalation of a risk relating to Mental Health Division nursing establishment which had not been actioned (risk management arrangements are considered within ***audit objective 4)***. The recent Audit & Assurance review of *Mental Health 111 Press 2 Service* (SBUHB-2324-15)

provided limited assurance, highlighting gaps within performance, assurance and risk reporting.

Alignment with key objectives and Health Board priorities: MHLDSG Quality and Safety.

2.22 The 2023/24 Audit & Assurance review of the health board's Quality Management System received reasonable assurance, recognising the continued progress made by the health board in developing and implementing its wider quality management system. It has taken the health board time to establish its quality governance arrangements and they are continuing to embed, and there is also recognition that there needs to be more scrutiny and strengthening of existing structures.

2.23 As per para 2.12, Divisions provide reports to SGQSC using template reports, and our review noted consistent use of these to provide information of incidents, falls, medication incidents, patient experience indicators, complaints/complements, and quality improvement activities. The Service Group has experienced significant challenges in addressing incidents within datix, the February 2024 position was reported as 2183 open. The Service Group Quality and Safety Team is supporting Divisions in addressing the backlog through prioritisation, and the Service Group has agreed actions as part of a Corporate Task and Finish Group to a thematic approach to incident closure at the SGQSC in March 2024.

2.24 Divisional reports also include a 'key message' field. As minuted at the January 2024 SGQSC meeting, direction was received from the Service Group Director and Service Group Nurse Director that *'reports should contain clearer outline of escalation areas',* however review of subsequent reports noted this continues to be a challenge. Divisional reports also include quality and safety risks; and we noted the completeness and detail provided on risks submitted varied. **See Matter Arising 4** Divisional reports are reliant on collation of data from a number of sources, including datix, and the monthly frequency of reporting is a resource heavy requirement on divisional management capacity. The development of the health board Quality Dashboard may assist in addressing these pressures.

Alignment with key objectives and Health Board priorities: MHLDSG Workforce.

2.25 In October 2023, in recognition of a number of workforce challenges, the MHLDSG established a dedicated workforce group to complement the existing nursing, and medical workforce groups. Discussion at the initial meeting of the group identified that a workplan or output would need to be developed, and the groups ToR includes that it will provide a highlight report to the SGMB, but we were not able to identify these being in place (although the SGMB continues to receive a dedicated workforce report at each meeting). **See Matter Arising 2**

2.26 The SGMB receives a workforce report at each meeting, which contains detail on key workforce metrics (sickness absence/mandatory training/PADR – see table 1 below noting performance broadly in line with that of the wider Health Board) whilst also noting some success in overseas recruitment campaigns. Despite these, there remain challenges in filling vacancies with the May 2024 SGMB report noting medical vacancies at 46% and nursing at 9.5%. Individual modernisation

workstreams are underway within both the Mental Health Division and the Learning Disabilities Division, containing actions for the development of new roles and pathways within each.

*Table 1 Comparison of workforce indicators*

| Workforce Indicator | Sickness Absence | Statutory & Mandatory Training | PADR |
|---|---|---|---|
| MHLDSG – May 2023 | 5.36% | 88% | 75% |
| MHLDSG – March 2024 | 8.04% | 90% | 74% |
| Health Board – May 2023 | 7.60% | 87% | 68% |
| Health Board - March 2024 | 6.67% | 90% | 73% |

Alignment with key objectives and Health Board priorities: MHLDSG Finance.

2.27 The MHLDSG 2023/24 financial budget was approved at SGMB in April 2023, and the approach and methodology for its delivery had been subject to discussion within finance agendas of the WBM. The MHLDSG 2024/25 budget followed the same process. The SGMB receives a financial report at each meeting, and the WBM's agenda includes focus on finance twice a month. Review of papers identified these included updates on savings delivery, monthly positions and review of IMTP cost pressures.

2.28 The MHLDSG savings target for 2023/24 was £3.363m (inclusive of 2022/23 savings shortfall of £0.795k). The MHLDSG savings plan was reviewed as part of Audit & Assurance review of *Savings Programme* (SBUHB-2324-009 - Reasonable assurance – October 2023) which included sample testing of the Cost Improvement Plans. Financial reporting for end of year indicated the savings target had been delivered, despite an overall overspend of £1.899m (1.38% of the MHLDSG budget). The same savings target is in place for 2024/25 and circa a third of the target had been identified by April 2024, with a deadline of September 2024 in place for confirming the remainder.

Alignment with key objectives and Health Board priorities: MHLDSG Policies.

2.29 The MHLDSG has a Policy Review Group responsible for oversight of policies, and this reports through the MHLDSG QSC structure. MHLDSG policies are available to staff through the health board's Clinical Online Information Network (COIN). Fifteen of the 17 policies listed were in date (or had only recently past their review point), as were the 15 operational procedures and protocols also available on COIN. For the two policies past their review dates, explanatory notes within a policy tracking document offered context to the extended period and noted assignment of new review leads. **See Matter Arising 2**

Alignment with key objectives and Health Board priorities: MHLDSG Declarations of Interest.

2.30 Section 6.4 of the health board's Standards of Business Conduct Policy ('the Policy') states that Service Group Directors are responsible for maintaining and reviewing registers of declarations of interest (D.O.I). D.O.I returns were available for Service Group Directors, but not for the Divisional Management team reviewed within ***Audit Objective three***. **See Matter Arising 6**

2.31 The policy also requires all consultants to complete a standard D.O.I, with an additional declaration required when undertaking private practice (s.18.2). We were informed this is considered as part of the annual job planning process, and a review of records within one directorate within the LD Division (Cwm Taf Morgannwg directorate) confirmed that additional employment and practice are recorded within the job planning software, however standard D.O.I. forms are not retained. **See Matter Arising 6**

Conclusion:

2.32 The Service Group has an established structure, and approaches for operational oversight of planning, performance, quality, finance and workforce are in line with health board objectives and priorities. We have identified a number of areas which require strengthening, including in relation to reporting, attendance/quoracy at SGMB and SGQSC; and the operation of a performance monitoring mechanism. We provide **reasonable** assurance for this objective.

**Objective 3: Divisional arrangements support the Service Group delivery of key objectives, and operate in accordance with terms of reference and work programmes.**

2.33 The Learning Disabilities (LD) division provides specialist adult learning disability services across the Swansea Bay, Cwm Taf Morgannwg, and Cardiff and Vale University Health Boards. These are delivered through health board aligned directorates comprising of community multi-disciplinary teams, specialist behaviour and support teams, acute admission units, and specialist residential services (also known as complex care units).

2.34 The LD division's organisational structure includes a Divisional Manager, Head of Nursing and Clinical Director. Directorates align to health board footprints, and each have a Directorate Manager and Lead Nurse, all noted as substantive with one exception. The structure also includes a LD Nurse Consultant and receives support from a Deputy Finance and Business Partner, and Assistant Workforce Business Partner.

Learning Disabilities Division Business Meeting

2.35 The LD Division has a monthly Business Meeting (LDBM) for which an undated draft ToR was provided. We note the ToR reflected a previous rotational agenda approach focusing on workforce, finance and quality and safety, and did not reflect the current agenda (standing agenda of finance & workforce, quality & safety, service development, planning and performance), or contain objectives outside of those rotational subject areas. It does not have a work programme, and we noted omissions against expected subject coverage. **See Matter Arising 7**

2.36 Review of LDBM minutes for the period July 2023 – December 2023 identified good attendance, although we noted the Clinical Director attended only two meetings in the period. We are informed that the LDBM clashed with clinical commitments, but there has been recent agreement to amend the scheduling of the meeting to

minimise the clash with such as well as other MHLDSG meetings. **See Matter Arising 3**

LD Division – Quality & Safety

2.37 The LD Division does not have a separate quality and safety meeting, instead there is a quality and safety heading within the LDBM. Directorates have established individual quality and safety meetings which receive reports from inpatient sites and services, and provide a highlight report to the LDBM. The Division submits its own report to the MHLDSG QSC.

2.38 Review of LDBM papers for the period July – December 2023 confirmed the receipt of directorate quality and safety reports, although some exceptions were noted for Swansea Bay directorate during a period of staff changes. The Directorate Reports offer detailed narrative information, but we noted often the key messages and discussion at LDBM, related to environmental concerns, or staffing pressures rather than being solely quality focussed. **See Matter Arising 4**

2.39 Performance scorecards provide some data relating to patient safety indicators, although we note the nature of the services provided are to provide support in addressing health inequalities and challenging behaviours, which do not make comparisons to wider services easy. Trends in incidents are reported by frequency and site within the scorecard, with focus on violence and aggression incidents. The impact of poor estate conditions was noted to be a factor within performance, and in April 2024 one site (Rowan House) was temporarily closed to enable repairs to be made. LD Divisional reports to the SGQSC highlighted the need to improve the feedback received from patients, and we noted little use of patient feedback indicators within scorecards. The recent establishment of a Patient Experience Group within the Division may help assist in this area.

LD Division - Planning

2.40 Recognising changes in population, policy and practice, challenges in recruitment, and that the current inpatient facilities do not support the delivery of modern specialist learning disability services, there has been development of a three-year LD Modernisation Programme ('the programme'). The initial programme identified actions to develop new methods of both service provision and staffing roles in community services, alongside repurposing the current estate and securing funding for a new purpose-built facility. Additional actions have since been added to develop a service specification, reflecting detail of the programme, to be agreed with commissioning health boards by the end of quarter two 2024/25. We could identify clear alignment between the Divisional GMOs (see para 2.16) and the actions within the programme.

2.41 A programme tracker is maintained and is presented to the Joint Adult Learning Disability Commissioning & Performance Strategic Group. At April 2024, 28 of the 51 actions were complete, but some delays against original timescales were evident. Challenges in accessing capital funding are noted, but we could see the Service Group has had success in targeting Regional Partnership Board capital

funds in the West Glamorgan area, and has intention to do so within the commissioning health boards equivalent RPBs.

2.42 The LD Divisional Manager highlighted intention to review the format of the Programme tracker (para 2.40) to provide a more robust capture of date movement and progress updates. Review of the LD divisional GMOs demonstrated alignment with the Modernisation Programme, and this will provide an additional mechanism for monitoring, alongside ongoing reporting to the Joint Adult Commissioning and Performance Strategic Group (para 2.40). However, we noted there is no risk on the divisional risk register relating to the capacity for programme delivery or impact should it not be delivered. **See Matter Arising 8**

LD Division – Performance

2.43 As per para 2.18 the LD Division has a monthly performance scorecard and is regularly included within the agenda of the LDBM. Review of minutes for our sample period (see para 2.36) did not identify detailed discussion of the scorecard contents taking place. Discussion with the LD Divisional manager highlighted that the scorecard is widely distributed across the division and there is awareness of its purpose, review of meeting minutes did include recognition of its use by MHLDSG Directors as a performance management tool.

2.44 Within the period reviewed, compliance with the Mental Health (Wales) Measure Part Two (that patients have a valid care and treatment plan (CTP)), dropped to below target level within the Cardiff and Vale Directorate. Action to address this has led to improvement in performance, however we noted that performance for all Directorates is not reported at SGMB. **See Matter Arising 5**

LD Division - Workforce

2.45 The case in support of the Modernisation Programme (para 2.40) referenced the challenges faced in recruitment, and the programme contains actions to develop non-clinical care navigator roles, restructuring specialist team models into community teams and, where possible, the co-locating of teams.

2.46 The LDBM receives a division workforce report including performance against key indicators (sickness absence, PADR, Mandatory training) for which actions and progress updates were provided. Verbal updates on nursing, therapies, and medical workforce issues were also provided at each LDBM. Table 2 provides a comparison of divisional performance within the MHLDSG, particular workforce challenges and actions are captured in para 2.47.

*Table 2 Comparison of workforce indicators by division*

| Workforce Indicator Division/month data | Sickness Absence | Statutory & Mandatory Training | PADR |
|---|---|---|---|
| LD Division - June 2023 | 6.78% | 92% | 78% |
| LD Division - January 2024 | 8.70% | 90% | 74% |

| | | | |
|---|---|---|---|
| Secure Services and Recovery Division - June 2023 | 6.58% | 88% | 89% |
| Secure Services and Recovery Division - January 2024 | 7.07% | 88% | 85% |
| Mental Health Division - July 2023 | 5.97% | 86% | 79% |
| Mental Health Division - January 2024 | 8.53% | 91% | 67% |

2.47 Capacity issues are prevalent within the Swansea Community Learning Disabilities Team (CLDT), where vacancies and absences have resulted in reductions in registered nursing to over 50% of establishment. While there has been a delay in piloting the non-clinical care navigator role (while the job evaluation details are worked through) at the close of audit fieldwork, we were informed that the rebasing of the Swansea CLDT with the Neath CLDT was being progressed to ensure the availability of continuing support. However, we noted no risk relating to the workforce challenges of the team had been raised. **See Matter Arising 8**

LD Division - Finance

2.48 The Service Group receive a direct allocation of funding for learning disabilities services, and in previous years any underspend was retained. We note this has recently changed and from 2023/24 onwards funds not spent will be returned to commissioners, a minor overspend did not require any return this year. No CIP was assigned to the Division for 2023/24, however a target has been agreed for 2024/25, and has established a separate finance meeting outside of the LDBM to allow further scrutiny of divisional and directorate positions. The LDBM minutes included discussion of finance, reflecting key messages on spend and increased detail provided on the pressure areas of continuing healthcare and pay.

Conclusion:

2.49 The LDBM requires agreed ToR to reflect its current operation. We identified areas to be addressed in meeting attendance, clarity of reporting, and consideration of risks, but note these were consistent with those identified within the wider Service Group. The Division has embarked on a Modernisation Programme, and there is evidence of progress, but the risk to delivery has not been captured. We assign this objective **reasonable** assurance.

### Objective 4: The Service Group has mechanisms to provide oversight and assurance regarding key risks and issues.

Risk oversight and assurance

2.50 The health board's Risk Management Policy states that '*Service Group Boards are responsible for management of its operational risks, will establish processes for the review of new risks, and oversight of those accepted onto risk registers'*. While the policy is not prescriptive of reporting arrangements, within Appendix A it states '*Boards should consider the risk register with a focus on most significant risks (typically scoring 12 or above)'*. The MHLDSG ToR includes that it is responsible for oversight of risks and will undertake an annual review of its register.

2.51 Review of SGMB papers for the period July 2023 – March 2024 noted deferral of a risk paper (including copy of the Service Group risk register) in November 2023, and subsequent inclusion of datix report extracts with no accompanying narrative in February and March 2024. Minutes did not identify discussion at the SGMB of the risks provided. **See Matter Arising 8**

2.52 Subsequent SGMB risk updates in April and May 2024 included intention that risks registers would be scrutinised through divisional quality and safety arrangements, with a focus on those risks scoring 16+. Our review of divisional reporting to the SGQSC (para 2.24) identified that reporting had improved for some divisions but there remained areas where detail included varied. Within the SG Quality and Safety report provided to the SGMB for the period October 2023 – March 2024 there is reference to only one high scoring quality and safety related risk. The risk report introduced at the May 2024 meeting provides a narrative outline of Service Group register status, including score changes, actions for higher scoring risks, and updates from the health board Risk Management Group. Service Group management confirmed that the SGMB will continue to receive dedicated risk reports alongside any changes in monitoring arrangements. **See Matter Arising 8**

2.53 Our analysis of the MHLDSG risk register also identified 24 risks registered as Service Group wide, rather than divisionally owned. The arrangements for ownership and scrutiny of these would also require confirmation should responsibility for risks be devolved to divisions (para 2.52), whilst recognising this is to ensure greater divisional ownership of risks within the Service Group. **See Matter Arising 8**

2.54 The Audit & Assurance review of *Risk Management & Assurance* (SBUHB-2324-001) included sample testing of risks within the MHLDSG risk register, and this identified four risks which had not had risk review dates updated. Review of LD Divisional risk entries identified the same theme of narrative updates provided against risks, but review dates unchanged. No recommendation is raised in relation to this noting the wider health board risk management review undertaken.

Escalation of key issues

2.55 Through the review of arrangements within ***audit objective two and three***, we could identify the mechanisms in place to allow escalation from Directorates and Divisions through the Service Group structure, this included:

- The use of the WBM by Divisional Senior Management as a forum for highlighting operational pressures and concerns.
- SGQSC and receipt of divisional reporting, is now established, and a reporting thread from Directorates, through Divisional arrangements, to the Service Group level could be evidenced, although the clarity of key messages could benefit from refinement. The Service Group wide quality and safety report to SGMB for February 2024 and March 2024 reports did not include any key messages from divisional reports. **See Matter Arising 4**

- Performance scorecards offer oversight of activity, quality, workforce and finance indicators, however, some enhancements to frequency and format should be considered. Whilst these arrangements are well established as per 2.21 the Audit & Assurance review of *Mental Health 111 Press 2 Service* (SBUHB-2324-15) identified gaps within performance, assurance and risk reporting. **See Matter Arising 5**

2.56 As per para 2.8, the SGMB ToR references the need to establish issues which require escalation from the Service Group to HBMB. MHLDSG Directors are members of HBMB, and we understand there are routine meetings between Service Group Directors and the COO in relation to performance, however there is no formal mechanism or reporting which links the two forums. **See Matter Arising 9** The Service Group also receives quarterly reviews through Executive Director led performance reviews, and we could identify the highlighting of challenging performance areas referenced within ***audit objective two*** (para 2.20) within the review papers.

2.57 Review of HBMB papers for the period April 2023 – April 2024 identified four occasions where an action was raised for Service Group completion, the monitoring of re-admission data within Service Group quality and safety meetings was noted, however we could not evidence this being reviewed within SGQSC. **See Matter Arising 9**

2.58 Through the review of HBMB papers (para 2.57) we could identify ad hoc papers and reports being submitted by the MHLDSG, and these includes actions to address external inspections, the recent temporary closure of an LD facility Rowan House due to environment and estate concerns, and for the approval of the LD Modernisation Programme.

2.59 There are also a number of health board committees which receive reports from Service Group representatives:

- Mental Health Act Legislation Committee - the Mental Health Act, and Mental Health Measure monitoring reports received at each meeting.
- Quality and Safety Committee – Quality and safety highlight reports presented on a rotational basis, recently including additional reporting of health and safety issues.
- In 2024/25 Service Groups will provide financial status reports to the Performance and Finance Committee.

Conclusion:

2.60 Our review identified the mechanisms for escalations within the Service Group, which are embedded but could benefit from enhancements, and some gaps in these arrangements were noted as highlighted within our recent review of Mental Health 111 press 2. There is evidence of the Service Group using the HBMB for escalation and awareness of issues, however a lack of formal link between the groups appears to be a gap. The effectiveness of risk reporting to SGMB has been impacted by the deferral of papers, and format of information shared which may contributed to the

limited discussion of risks noted. There is intention to adopt an alternative approach to the oversight of risks, however there would need to clarification of ownership and reporting mechanisms in undertaking this. We assign this objective **reasonable** assurance.

# Appendix A: Management Action Plan

| **Matter Arising 1: Key Group terms of reference review (Design)** | **Impact** |
|---|---|
| Terms of reference (ToR) were requested for the key groups included within the Service Group Management Board (SGMB) structure. Review dates or periods had passed for the following groups, all noted as requiring annual review:<br>• Quality and Safety Committee (last approved January 2023)<br>• Complex Case Panel (last approved July 2022)<br>• Mental Health Act Operational Group (July 2020)<br>Review of SGMB meetings July 2023 – March 2024, did not identify the submission of ToR to the SGMB from its supporting groups.<br>The ToR for the MHLD Health and Safety Group, and Complex Case Panel, did not include onward reporting within the Service Group.<br>The Weekly Business Meeting/Senior Management Team (WBM/SMT) does not have ToR. The WBM membership includes Service Group directors, divisional managers and heads of nursing, and leads from therapies, planning, finance and workforce. Its agendas include rotational focuses across finance, workforce, and continuing healthcare, and regular divisional performance reviews and updates. | Potential risk of:<br>• Lack of up to date, or incomplete, terms of reference could undermine the shared understanding of members, and assurance taken from the groups. |

| **Recommendations** | | **Priority** |
|---|---|---|
| 1.1 | Service Group management should ensure any overdue terms of reference are reviewed. Sub-group terms of reference should be agreed by their parent group. | **Medium** |
| 1.2 | SGMB could include receipt of key groups terms of reference on an annual basis. | |

| | | | |
|---|---|---|---|
| 1.3 | Management should introduce terms of reference for the Weekly Business Meeting, to be received and approved by the SGMB. | | |
| 1.4 | The ToR for the SG Health and Safety Group and Complex Case panel should be updated to include onward reporting requirements within the MHLDSG. | | |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 1.1 | A work programme will be developed by the Service group, outlining all the governance meetings, details re ToR's (including review and sign off dates), and reporting schedule/frequency. All ToR's will be reviewed, standardised and quorate membership identified in the next scheduled subgroup meeting, and signed off at the parent group, prior to ratification and tabled for SGMB. | September 2024 | Head of Operations, MHLDSG |
| 1.2 | Once ratified in the relevant group, the SGMB will received the ratified ToR. | October 2024 | Head of Operations, MHLDSG in conjunction with the Chair of MHLDSG Management Board |
| 1.3 | Develop ToR for the WBM. This will need to be ratified and then approved by the SG Management Board once signed off in the WBM. | September 2024 | Head of Operations, MHLDSG |
| 1.4 | ToR's for the SG H&S Group and Complex Case Panel will be updated to reflect the recommendations and H&S to report into Board with a quarterly report. A monthly CHC report is already included in WBM and SGMB agendas. | September 2024 | Head of Operations, MHLDSG in conjunction with the Continuing Health Care Directorate Manager |

| Matter Arising 2: MHLDSG Reporting Structure (Design) | Impact |
|---|---|
| Review of MHLDSG key groups ToR and review of papers and operation identified inconsistencies in group reporting lines. We noted: | Potential risk of:<br>• Unclear governance structure could impact the effectiveness of reporting, and the flow of assurance within the Service Group. |

| Group | Issue |
|---|---|
| **SGMB** | The SGMB list of subgroups includes the Learning & Development Steering group and Medical Workforce group which have alternative reporting arrangements within the Service Group structure. |
| | A MHLDSG governance structure plan lists the Health and Safety Committee and Information Governance group as direct subgroups of the SGMB however we could not identify any reporting from either to the SGMB. |
| | The recently established Workforce Group is included within the SG Governance plan, and its terms of reference includes highlight reporting to SGMB, however we note the format of the SGMB workforce report has not changed to incorporate this. |
| **SGQSC** | We noted no reporting from the SG Safeguarding Group to the SGQSC in period October 2023 – April 2024. |
| | The Physical Health group reporting to SGQSC (October 2023-April 2024) was verbal only, and minutes included the need to establish a group or agree the submission of a formal report to the SGQSC. |
| | The MHLDSG Policy Review Group sits within the SGQSC structure, but we could not identify any policy review timetable or schedule provided for oversight. |
| **Mental Health Act Operational Group** | The Mental Health Act Operational Group is listed as a subgroup of both the SGMB and SGQSC, but we could not identify onward reporting to either within papers reviewed. |

| Recommendations | | Priority |
|---|---|---|
| 2.1 | The Service Group should address the inconsistencies identified to ensure that subgroup reporting is accurately reflected within terms of reference and Service Group governance structures. | **Medium** |
| 2.2 | The Service Group should introduce work programmes or business cycles for the SBMB and SGQSC to ensure subgroup reporting is in achieved in line with agreed frequencies. | |

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 2.1 | Update the SGMB ToR to reflect the correct reporting sub-groups incorporating the new reporting structure i.e. for RDIIaL, Medical Workforce & Health & Safety.<br><br>Other subgroups reporting into SGMB & SGQSC i.e. Information Governance/Safeguarding Committee/MHA Legislative Operational Group are identified and included on the reporting work programmes. Ensuring timely submission of quarterly reports.<br><br>Review the reporting template for Workforce and ensure it incorporates all requirements for reporting into SGMB.<br><br>Review current scope and purpose of the Physical Health Group with Head of Nursing, Secure Services & Recovery Division and agree if group to become an overarching item for SGQSC (similar to the Patient Safety & Compliance reporting).<br><br>Policy Review Group currently reports into RDIIaL and a reporting database is readily available.<br><br>A quarterly briefing report on policies will be tabled for SGQSC and this will be identified in the work programme in action 1.1. | September 2024 | Head of Operations, MHLDSG, in conjunction with the Head of Nursing – Quality, Governance and Improvement. |
| 2.2 | Service Group to construct a work programme which will include all governance groups and will outline the ToRs, the reporting structures and frequencies, and any other periodic reviews/additions. | September 2024 | Head of Operations, MHLDSG, in conjunction with the Head of Nursing – Quality, Governance and Improvement. |

<table>
<tr><th colspan="2">Matter Arising 3: Attendance and quoracy at MHLDSG groups (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2"><u>SGMB</u><br><br>SGMB ToR quorum requirements are 'one Service Group Director, one representative per Division and one staff side representative.'<br><br>Two meetings in the period were not quorate, October 2023 (no Divisional representation from Learning Disabilities), and February 2024 (no trade union representation).<br><br><u>SGQSC</u><br><br>SGQSC ToR quorum requirements are Chair or Co-chair, a Head of Nursing, a Clinical director (HoN or CD can also be the Divisional representative), and a Divisional Representative from each Division.<br><br>Two meetings were not quorate due to gaps in membership (no Mental Health Division representative – January 2024, & no Chair or Vice Chair in attendance February 2024); and one meeting was cancelled due to a number of apologies (December 2023).<br><br>Clinical attendance outside that of the Clinical Director (Secure Services and Recovery) (attended 4/6) was noted as poor: the Service Group Medical Director attended once (September 2023) and no attendance from the Clinical Directors of Learning Disabilities, and Mental Health. We note that the medical vacancy rate for the Service Group currently exceeds 40%, we were also informed of extended absences within the Service Group Medical leadership group within the time period reviewed, which will have impacted capacity for attendance at group meetings with the prioritisation of clinical duties.</td><td>Potential risk of:<br><br>• The purpose and effectiveness of meetings may be reduced where quoracy is not met.<br>• The effectiveness of meetings may be reduced without representation from medical leads.</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>3.1</td><td>Service Group management should consider strategies, including the frequency of meetings and deputisation where appropriate, to address attendance issues and enable members to participate in meetings as required.</td><td>Medium</td></tr>
</table>

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 3.1 | As per action 1.1 above – all SG ToR's to be reviewed, updated, and to reflect correct membership, quorum, reporting requirements, frequency and deputising arrangements. | October 2024 | Head of Operations, MHLDSG, in conjunction with the Head of Nursing – Quality, Governance and Improvement. |

<table>
<tr><th colspan="2">Matter Arising 4: Clarity of key reports (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">

<u>SGQSC Reporting</u>

Divisions provide reports to SGQSC using template reports and our review noted consistent use of these to provide information of incidents, falls, medication incidents, patient experience indicators, complaints/complements, and quality improvement activities.

Divisional reports also include a 'key message' field, in January 2024 SGQSC minutes included direction from the Service Group Director and Service Group Nurse Director that reports should contain clearer outline of escalation areas, review of subsequent reports noted this continues to be a challenge. The SGMB also includes a standing item Service Group wide quality and safety report, and for February 2024 and March 2024 reports it did not include any key messages from divisional reports.

Divisional reports also include quality and safety risks, we noted the completeness and detail provided on risks submitted varied.

<u>LD Division Quality & Safety Reporting</u>

A standardised quality and safety meeting ToR was provided relating to Directorate meetings, which included template meeting agendas and standardised reports. The Directorate Reports offer detailed narrative information, but we noted often the key messages and discussion at LDBM, related to environmental concerns, or staffing pressures rather than being solely quality focussed.

</td><td>

Potential risk of:

- Groups / committees may not receive regular reporting / information required to discharge their responsibilities.
- Lack of consistency in reporting may impact the ability to scrutinise or support escalation requests.

</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>4.1</td><td>The Service Group should review the format of current reports to ensure there is clear capture of escalation issues, impact, and any support required.</td><td>Medium</td></tr>
</table>

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 4.1 | Reporting templates into the SGQSC and the SGMB will be reviewed and streamlined to include the required information. Noting that a focus is required for the sections for key messages, risk and learning and a new section for items for escalation, impact and any support required. | September 2024 | Head of Operations, MHLDSG, in conjunction with the Head of Nursing – Quality, Governance and Improvement. |

| Matter Arising 5: Performance monitoring and reporting (Operation) | Impact |
| --- | --- |
| <u>Service Group</u><br><br>The MHLDSG has an established performance monitoring approach through the use of divisional and directorate performance scorecards which are produced on a monthly basis. Whilst including some customisation to reflect the type of service/care provided, there is consistent inclusion of service user feedback and quality indicators, workforce, finance, operational indicators across access, capacity and patient flow.<br><br>Our review of content identified that there was often use of RAG ratings to support analysis or trend/averages included, but use of comment boxes to offer further explanatory context or mitigating actions did not feature in 3/6 scorecards reviewed, similarly 3/6 scorecards did not include a slide capturing actions associated with previous reporting.<br><br>Scorecards are received at WBM, however we noted a gap in their receipt between October 2023 – February 2024. We are informed there is intention to establish regular quarterly divisional performance reviews.<br><br><u>LD Division</u><br><br>The LD Division receives a monthly performance scorecard, and is regularly included within the agenda of the LDBM. Review of minutes for July 2023 – December 2023 did not identify detailed discussion of the scorecard contents taking place. We are informed the scorecard is widely distributed across the division, and meeting minutes did include recognition of their use by MHLD SG Directors as a performance management tool.<br><br>We also noted some inconsistencies in how compliance with the Mental Health (Wales) Measure Part Two (care and treatment plan (CTP)) is reported as LD CTP compliance reported to SGBM provided information on Swansea Bay directorate performance, but not that of commissioned health board directorates, and within the period reviewed we did see periods where the Welsh Government 90% target was not achieved within one. | Potential risk of:<br><br>• Lack of regular discussion of scorecards in an appropriate forum could reduce their effectiveness as a performance management tool.<br>• Lack of consistency in the reporting of key indicators may reduce their effectiveness. |

| Recommendations | | Priority |
|---|---|---|
| 5.1 | The scorecard format should be reviewed for all Divisions and Directorates to include fields for the service to provide context or any ongoing actions. Format should include a log for capture of actions, with leads and timescales. | **Medium** |
| 5.2 | Activity and Access papers to SGMB should include CTP performance for LD directorates in commissioned health boards. | |

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 5.1 | The performance scorecard format will be updated prior to the next Executive Team Performance Review.<br><br>Divisional performance meetings (quarterly) have been re-scheduled and prioritised. One WBM a month (fourth Thursday), will have the performance scorecards (with a focus on the preceding months performance) on the agenda for comment and monitoring for each Directorate | October 2024 | Specialist Data Analyst, in conjunction with Divisional General Managers |
| 5.2 | Activity and Access report to include the CTP performance for the commissioned HBs and ensure that the LD Division is reporting and recording this information. | September 2024 | Specialist Data Analyst, in conjunction with Learning Disabilities Divisional General Manager |

| **Matter Arising 6: Declarations of Interest (Design)** | | | **Impact** |
|---|---|---|---|
| The health board Standards of Business Conduct Policy ('the Policy') section 6.4 includes that Service Group Directors are responsible for the review of registers of declarations of interest (D.O.I). D.O.I returns were available for Service Group Directors, but none were available for the LD Division Senior Management Team.<br><br>The policy also requires all consultants to complete a standard D.O.I, with an additional declaration required when undertaking private practice (s.18.2). We were informed this is considered as part of the annual job planning process, and a review of records within one directorate within the LD Division (Cwm Taf Morgannwg directorate) confirmed that additional employment and practice are recorded within the job planning software, however standard D.O.I. forms are not retained. | | | Potential risk of:<br><br>• Undisclosed conflicting interests compromise the Health Board's integrity, impartiality and transparency. |
| **Recommendations** | | | **Priority** |
| 6.1 | Declarations of interest should be completed by senior management teams within the Service Group on an annual basis, and included within a register for Service Group Director review. | | **Medium** |
| 6.2 | Declarations of interest should be completed by consultants and retained by divisions, as required by the health board policy. | | |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 6.1 | Divisional compliance registers will be constructed to evidence all senior staff (8A and above) have completed an annual D.O.I. and regularly reviewed by Service Group Director. This will be included in the work programme in 1.1. | October 2024 | MHLDSG Director, in conjunction with Divisional General Managers |

| | | | |
|---|---|---|---|
| 6.2 | Consultant compliance registers will be constructed to evidence all consultants have completed an annual D.O.I – this can be amalgamated with the divisional register for ease of access. | October 2024 | Divisional General Manager - Mental Health<br>Divisional General Manager – Learning Disabilities<br>Divisional General Manager – Secure Services and Recovery |

| Matter Arising 7: Learning Disabilities Business Meeting (Design) | Impact |
|---|---|
| The LD Division has a monthly Business Meeting (LDBM) for which an undated draft ToR was provided. We note the ToR reflected a previous rotational agenda approach focusing on workforce, finance and quality and safety, and did not reflect the current agenda (standing agenda of finance & workforce, quality & safety, service development, planning and performance), or contain objectives outside of those rotational subject areas. It does not have a work programme, and we noted omissions against expected subject coverage:<br>• operational performance;<br>• relationship to subgroups/directorates;<br>• oversight of Recovery and Sustainability plan Goal, Method, Outcomes; and<br>• the groups role in receipt and oversight of risks/risk register.<br><br>Review of agendas and papers identified that subject areas above were mostly present with the exception of the risk register. A recent Divisional general managers meeting included receipt of LD risks, however the membership of this group is operational only with no medical, nursing or therapies representation.<br><br>Additionally, while environmental and estates issues have frequently been discussed at LDBM, and feature heavily within directorate quality and safety reports, we noted that there was no receipt of status for divisional sites annual health and safety assessments, fire assessments, or ligature assessments. | Potential risk of:<br>• Lack of up to date, or incomplete, terms of reference could undermine the shared understanding of members, and assurance taken from the groups. |

| Recommendations | | Priority |
|---|---|---|
| 7.1 | Terms of reference which detail the responsibilities, membership, quorum, and operation of the Learning Disabilities Business meeting should be developed and ratified at an appropriate forum. | **Medium** |
| 7.2 | The Learning Disabilities Business Meeting should develop a work plan to ensure all relevant information and subject areas are addressed on a periodic basis. | |

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 7.1 | Learning Disability Divisional Management team will review Terms of Reference to reflect current purpose and responsibilities including:<br>• operational performance;<br>• relationship to subgroups/directorates;<br>• oversight of Recovery and Sustainability Plan (Goal, Method, Outcomes); and<br>• the group's role in receipt and oversight of risks/risk register.<br>The revised Terms of Reference will be signed off at the Learning Disability Business Meeting and shared with MHLD service group Weekly Business meeting. | August 2024 | Divisional General Manager – Learning Disabilities |
| 7.2 | As part of the revised Terms of Reference, there should be a schedule for reporting across all relevant topics that are required through the Business Meeting for assurance. This will include expected frequency of reporting, whether this is monthly, quarterly or annually. | September 2024 | Divisional General Manager – Learning Disabilities |

**Matter Arising 8: MHLDSG Risk Management arrangements (Design)**

Review of risk reporting within the Service Group noted :

| Group | Issue |
|---|---|
| SGMB | A risk management paper (including a copy of the SG risk register) was deferred in November 2023. The paper did not return at subsequent meetings until May 2024. Datix extracts were included within the February and March 2024 agendas.<br>Minutes did not identify discussion of the risks provided within the Datix or risk reports. |
| SGQSC | Secure Services and Recovery division reported that its risk register was under review in November 2023, and this status had not changed through to April 2024. |
| | Learning Disabilities division provided a full listing of risks with Datix references but no information on scores, controls or review dates. |
| | Within the Service Group Quality and Safety report provided to the SGMB October 2023 – March 2024, we noted the inclusion of only one high scoring quality and safety related risk (Court of Protection). |
| LD Division | Review of risks held by the LD Division found the majority held evidence of recent review, and contained outline of mitigating controls. We did identify that the division did not hold a risk relating to the workforce challenges noted within the Community Learning Disability Team, and that while there is a risk held on the need for modernising inpatient services, there is no risk relating to the modernisation programme as a whole and the associated risk should the programme fail to be delivered. |

In May 2024 the SGMB were informed that in future the risk register would be scrutinised through divisional quality and safety arrangements, with a focus on those risks scoring 16+. Our analysis of the MHLDSG risk register also identified 24 risks registered as Service Group wide, rather than divisionally owned.

The arrangements for ownership and scrutiny of these Service Group wide risks would require confirmation should responsibility for risks be devolved to divisions. As noted within the table above the reporting of quality and safety risks from SGQSC to SGMB has been limited in detail provided, however management has confirmed that dedicated risk reporting would continue at SGMB with a new template report focussing on new risks, and actions to mitigate the highest scoring risks.

**Impact**

Potential risk of:

- Risks and monitored effectively with inconsistent escalation of key risks that impacts adversely
- Risks may not be discussed in a forum with appropriate membership impacting scrutiny and oversight.

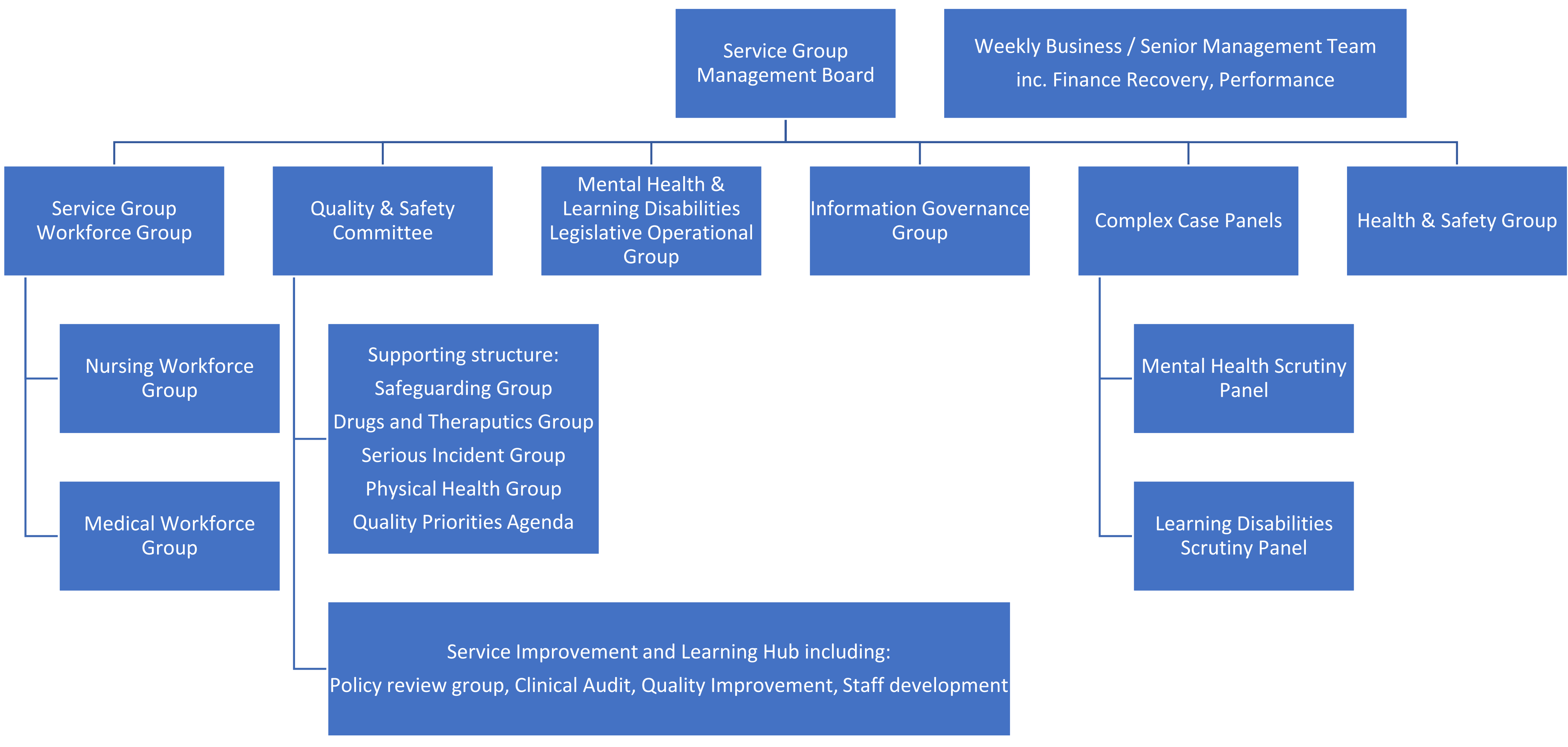
| Recommendations | | Priority |
|---|---|---|
| 8.1 | Service Group management should finalise arrangements for oversight of the risk register including frequency of receipt and include identification of the process by which the full register is reviewed. | High |
| 8.2 | Management should clarify risk monitoring arrangements for Service Group wide risks which are outside of divisional risk registers. | |
| 8.3 | The LD Division should develop risk register entries for the LD Modernisation Programme, and the workforce challenges within the Swansea CLDT. | |

| Agreed Management Action | | Target Date | Responsible Officer |
|---|---|---|---|
| 8.1 | Risk Register Report will be tabled monthly at SGMB highlighting any changes. | September 2024 | Head of Operations, MHLDSG |
| 8.2 | Bi-monthly Service Group Risk Register Scrutiny Meetings to be set up with senior management in attendance. Risk Register Report will be tabled monthly to SGMB highlighting any changes, and presentation of Service Group Wide Risks. | September 2024 | Head of Operations, MHLDSG |
| 8.3 | The Divisional Manager will oversee the development of risk assessments in relation to: -<br>• The infrastructure and capacity of the Division to deliver on the agreed LD Modernisation Programme, and<br>• The workforce challenges within the Swansea CLDT<br>These will be entered on DATIX as new risks for the risk register by the target date for review within the Service Group. | August 2024 | Divisional General Manager, Learning Disabilities |

| **Matter Arising 9: Management Board linkage (Design)** | | | **Impact** |
|---|---|---|---|
| The SGMB ToR references the need to establish issues which require escalation from the Service Group to HBMB. MHLDSG Directors are members of HBMB, and we understand there are routine meetings between Service Group Directors and the COO in relation to performance, however there is no formal mechanism or reporting which links the two forums.<br><br>Review of HBMB papers April 2023 – April 2024 identified a small number of occasions where an action was raised for Service Group completion. One exception was identified, at the 15 November 2023 Management Board Service Groups were tasked with the monitoring of re-admission data within Service Group quality and safety meetings. We could not evidence this being reviewed within MHLDSG groups. | | | Potential risk of:<br><br>• Effectiveness of escalation may be impacted by lack of formal mechanisms.<br>• Delegation of actions may be missed where no formal record is maintained. |
| **Recommendations** | | | **Priority** |
| 9.1 | The Service Group should engage with the wider health board to determine if formal route for reporting or escalation is required between management boards. | | **Medium** |
| 9.2 | The SGQSC should include readmission data as an area for review within the groups work programme. | | |
| **Agreed Management Action** | | **Target Date** | **Responsible Officer** |
| 9.1 | Service Group Director MH&LD to escalate to SBUHB Director of Corporate Governance.<br><br>As per 4.1 Reporting templates into the SGQSC and the SGMB will be reviewed and streamlined to include the required information with a new section for items for escalation, impact and any support required. | September 2024 | Service Group Director, MHLDSG |

| | | | |
|---|---|---|---|
| 9.2 | Readmission data will be included on the directorate performance scorecards and reported into WBM on the fourth Thursday of the month and into the quarterly divisional performance meetings. | August 2024 | Specialist Data Analyst, MHLD in conjunction with Head of Operations, MHLDSG |

# Appendix B: Mental Health & Learning Disabilities Service Group structure



# Appendix C: 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:

| Rating | Definition |
|---|---|
| **Substantial assurance** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
| **Reasonable assurance** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
| **Limited assurance** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
| **Unsatisfactory assurance** | Action is required to address the whole control framework in this area.<br>**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.<br>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.<br>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.<br>Some risk to achievement of a system objective. | Within one month* |
| Low | Potential to enhance system design to improve efficiency or effectiveness of controls.<br>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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