



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



Meeting Date	12 December 2019	Agenda Item	4.1
Report Title	Internal Audit		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A		
Report Sponsor	Helen Higgs, Head of Internal Audit, NWSSP A&A		
Presented by	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A		
Freedom of Information	Open		
Purpose of the Report	To advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports.		
Key Issues	<p>The Audit Committee looks to other Board Committees to monitor the effectiveness of action taken in response to risks and issues raised in internal audit reports.</p> <p>Key audit reports for Quality & Safety Committee consideration are:</p> <ul style="list-style-type: none"> • Nursing Quality Assurance (Interim Follow up) <p>HTA Mortuary (Part II)</p>		
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Recommendations	<p>Members are asked to:</p> <ul style="list-style-type: none"> • NOTE the summarised findings and conclusions presented, and the exposure to risk pending completion of action by management. • CONSIDER any further information or action required in respect of the subjects reported. 		


AUDIT & ASSURANCE ASSIGNMENT SUMMARY REPORT

1. INTRODUCTION

The purpose of this report is to advise the Quality & Safety Committee of the outcomes of finalised Internal Audit reports to support monitoring of action and the provision of assurance to the Board.

2. BACKGROUND: REPORTS ISSUED

Since the last meeting of the Quality & Safety Committee the following audit assignments have been reported:

Subject	Rating ¹
Internal Audit	
Nursing Quality Assurance (Interim Follow Up) (SBU-1920-027)	No rating applied
HTA Mortuary (Part II) (SBU-1920-045)	

The overall level of assurance assigned to reviews is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

Audit report findings and conclusions are summarised below in Section 3. A full copy of the report can be made available to Committee members on request.

Actions have been agreed with Executive Directors in respect of audit recommendations made for Final reports issued. Progress against agreed actions is input into an online database by lead officers and visible to Executive Directors for monitoring. The Director of Finance's team analyses and summarises the status for Audit Committee meetings as a matter of routine.

¹ Definitions of assurance ratings are included within Appendix A to this report

Audit & Assurance undertake follow-up reviews on key issues within areas deriving limited assurance ratings as part of its agreed plan of work for subsequent years. Additional follow up reviews may be undertaken at the request of the Audit Committee. The timing of follow up work is planned in liaison with Executive Directors.

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 NURSING QUALITY ASSURANCE (INTERIM FOLLOW UP) (SBU-1920-027)

No rating
applied

Board Lead: Director of Nursing & Patient Experience

3.1.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

The Quality Assurance Framework was launched in June 2018. An Internal Audit review of its implementation (ref ABM-1819-027) reported *Limited* assurance in March 2019 and recommended a review of the "Toolkit" and how it was used. Additionally, as part of a review of its impact, audit visits to wards had highlighted issues with the completion of controlled drugs registers and the recording of resuscitation trolley checks. Action was agreed to address all issues raised.

When planning to follow up the above, a review of the recorded status of management action indicated that actions agreed with Units to address immediate controlled drug and resuscitation trolley issues were addressed at the end of June 2019; however, there was work ongoing to complete the review of the Quality Assurance Framework, the target date for which had been revised to 20th October 2019. Recognising that additional time would be required following its revision before an effective assessment could be made of its implementation, we agreed that an interim audit would be undertaken of those actions agreed to address controlled drugs records and resuscitation trolley checks in order to provide independent assurance to the Board in respect of progress. We agreed with the Director of Nursing & Patient Experience that a full follow up audit incorporating review of the implementation of the revised Quality Assurance Framework be considered for inclusion within the audit plan for 2020/21.

The overall objective of this audit was to provide assurance in respect of action taken at Unit level to address issues raised previously in respect of controlled drugs records and resuscitation trolley checks at ward level.

The audit scope considered the following:

- Controlled drugs register completion

- Resuscitation trolley check records.

The scope of the audit was limited to a review of action taken in response to key recommendations made in the last report issued by Audit (ref ABM-1819-027). The audit work comprised unannounced visits to those ward areas where issues were previously raised in order to determine improvements made. Additionally, we reviewed minutes & papers of unit nursing groups for consideration of the unit peer reviews conducted following the original Internal Audit review.

3.1.2 Overall Opinion

Recognising that this is an interim follow up audit, comprising a partial review of action reported to address issues previously raised (so not directly comparable with the original review), it was agreed with the Director of Nursing & Patient Experience that an assurance rating would not be assigned at its conclusion. Instead, a narrative commentary would be provided with details of any remaining issues for management action as appropriate. These have been summarised below:

We were informed that the Health Board's Controlled Drugs Accountable Officer has expressed concern to the Chief Executive in respect of the way controlled drugs are managed at ward level. Our testing at wards found continued instances of non-compliance with the dual-signature requirement for drug records, and entries being crossed out in the CD Register. At one ward it was suggested that agency staff may not be aware of requirements. There was a need to take further action to address the causes of non-compliance in this area.

Improvement was evident in the completeness of resuscitation equipment checks at the Singleton wards, though there was scope for further improvement. At Morriston, whilst there was some improvement in resuscitation equipment checks on Ward R, further improvement was recommended within wards visited.

It was positive to note the reporting of peer review outcomes within the Singleton Unit nursing groups. However, we recommended enhancements to the checks undertaken as part of this process (findings reported did not include the review of drug error corrections), the approach to reporting the incidence of issues found, and the recording of action to address remaining issues.

Whilst 'First Thursday' inspections and the programme of matron checks was discussed at groups within the Morriston unit, the peer view of CD controls and resuscitation equipment was not evident within nursing or quality & safety meetings. The Interim Unit Nurse Director undertook to address this in October 2019. The findings and recommendations of this report should be considered as part of that process.

The majority of actions have been agreed with the Director of Nursing and Patient Experience to address issues raised by the end of November 2019.

3.2 HTA MORTUARY (PART II) (SBU-1920-045)



Board Lead: Chief Operating Officer

3.2.1 Introduction, Scope and Objectives

This assignment originates from the 2019/20 internal audit plan.

Internal Audit began preparation for an audit review of this subject in April 2019, at the point at which the initial findings of the management self-assessment against the Human Tissue Act Post Mortem Examination: Standards & Guidance had been reported to the Deputy Director. Recognising that issues had already been highlighted for attention that included several areas of non-compliance and improvement, we issued an interim report with advisory recommendations aimed at supporting her to ensure effective management of the changes needed ahead of a forthcoming inspection by the Human Tissue Authority (HTA) in June 2019, and beyond.

The Human Tissue Act 2004 (the Act) came fully into force on 1st September 2006. The aim of the Act is to provide a legal framework regulating the storage and use of human tissue from the living and the removal storage and use of tissue from the deceased. It introduces regulation of other activities such as post mortem examinations, and the storage of human material for education, training and research. It is intended to achieve a balance between the rights and expectations of individuals and families, and broader considerations, such as the importance of research, education, training, pathology and public health surveillance to the population as a whole.

This audit aims to provide assurance on the arrangements operating to ensure improvements are made following the HTA inspection and the recommendations they reported.

The overall objective of this audit was to review the effectiveness of the arrangements in place to ensure the implementation of changes required to address issues arising from management self-assessment and HTA inspection, and to provide assurance regarding the same.

The audit scope considered the following:

- The Health Board has a plan of action that includes actions to address all key issues raised;
- Progress against plan is monitored effectively and there is a clear line of assurance to the Board;
- A programme of management audit has been implemented to provide ongoing assurance in respect of compliance with key aspects

of the Act, and there is a clear line of assurance via management to the Board.

The internal audit review has not replicated the comprehensive compliance assessments undertaken by management or the HTA inspectors.

3.2.2 Overall Opinion

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 following key findings were identified:

- A self-assessment was undertaken to present a management view of compliance against each of the areas in the HTA guidance as they relate to each of the sites managed by Swansea Bay UHB under the Morriston Hospital HTA licence 30015, including the mortuary it manages at Princess of Wales Hospital. The assessment indicated that there were several key areas of non-compliance and many more indicated as requiring improvement. However an action plan has not been created to address the shortfalls the self-assessment identified.
- The terms of reference for the HTA Oversight Committee were amended in July 2019 to reflect recommendations made by the previous internal audit review. However further updates are required, in particular to current membership.
- The Health Board have a schedule of audits in place as per the HTA guidance under standard GQ2. It was noted during the review that although the audits are being undertaken, the audits or their outcomes are not being reported into the HTA Oversight Committee.

Action has been agreed with the Chief Operating Officer to be completed by the end of February 2020.

4. RECOMMENDATION

4.1 The Committee is asked to note:





- **The internal audit findings and conclusions**
- **The exposure to risk pending completion of agreed management actions**

4.2 The Committee is asked to consider:

- **Any further information or action required in respect of the subjects reported, to support monitoring and assurance.**

AUDIT ASSURANCE RATINGS

APPENDIX A

RATING	INDICATOR	DEFINITION
Substantial assurance	 <p style="text-align: center;">- + Green</p>	<p>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.</p>
Reasonable assurance	 <p style="text-align: center;">- + Yellow</p>	<p>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.</p>
Limited assurance	 <p style="text-align: center;">- + Amber</p>	<p>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.</p>
No assurance	 <p style="text-align: center;">- + Red</p>	<p>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.</p>