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Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board



Meeting Date	24th October 2019	Agenda Item	5.1
Report Title	Audit & Assurance Assignment Summary Report		
Report Author	Neil Thomas, Deputy Head of Internal Audit, NWSSP A&A		
Report Sponsor	Paula O'Connor, Head of Internal Audit, NWSSP A&A		
Presented by	Paula O'Connor, 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"> • Prevention and Management of Inpatient Falls • Deprivation of Liberty Safeguards (Follow Up) • Morriston Hospital Cardiac Services • Hospital Sterilization & Disinfection Unit • Patient Environment 		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
			✓
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	
Prevention and Management of Inpatient Falls (SBU-1920-020)	
Deprivation of Liberty Safeguards (Follow Up) (SBU-1920-023)	
Morrison Hospital Cardiac Services (SBU-1920-035)	
Hospital Sterilization & Disinfection Unit (SBU-1920-037)	
Patient Environment (SBU-1920-038)	

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.

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.

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

3. INTERNAL AUDIT FINAL REPORT SUMMARY

3.1 Prevention and Management of Inpatient Falls (SBU-1920-020)



Board Lead: Director of Nursing & Patient Experience

3.1.1 Introduction, Scope and Objectives

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

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospitals are the most commonly reported patient safety incidents, with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day). Swansea Bay University Health Board's May 2019 Performance report indicated there were a total of 3,761 falls recorded during the 2018/19 year (over 10 per day).

The Health Board's extant Policy for the Prevention & Management of Inpatient Falls was endorsed by the Nursing & Midwifery Board in September 2016, with the expectation that it be used in conjunction with an inpatient falls pack ratified in October 2016. The policy has been reviewed since and a revised version was received and approved by the Quality & Safety Committee in August 2018. The new policy is intended to reflect recommended guidance from NICE and the recommendations from the 2017 National Inpatients Falls Audit. Whilst this policy has been revised, the Integrated Performance Report to the Board in May 2019 indicated that the policy had not yet been implemented but it was intended that once training had been completed within the Service Delivery Units it would be launched across the Health Board. The Deputy Director of Nursing & Patient Experience informed us during the planning of this audit that training levels had been monitored corporately and September 2019 was envisaged as the implementation date.

During 2017/18 a Falls Prevention and Management Group was in place, chaired by the Princess of Wales Unit Nursing Director. The Group was stood down in the later part of 2018 and the inaugural meeting of the Hospitals Falls Injury Prevention Strategy Group took place on 25th June 2019, chaired by the Neath Port Talbot Unit Nurse Director.

The overall objective of this audit was to review compliance with key aspects of Health Board Policies and Procedures.

As the Hospitals Injury Prevention Strategy Group was newly established we agreed that the scope of this audit would exclude the work of this group. Additionally, as the revised policy was not yet implemented formally, the audit did not review compliance with newly introduced requirements. However, there were some expectations which were common to both the current and revised policies, and others set out within wider Health Board

policies (e.g. incident reporting), which were considered within the scope of the audit.

The audit scope considered the following:

- Unit(s) performance of audits of compliance with falls policy, procedures and record-keeping, in particular the completion of falls risk assessments and care plans, in hotspot wards and departments.
- Compliance with policies for the investigation of falls classed as serious incidents (including fractured neck of femur).
- The effectiveness of the Unit Management Board(s) and/or Unit Quality & Safety Group(s) in monitoring and scrutinizing operational compliance with key elements of Health Board policy & procedures, in particular the completion of falls risk assessments and care plans reviewed within local falls audits and serious incident investigations.
- Evidence of actions outlined in Unit Risk Registers to address falls.
- Reporting of Unit(s) audits via Unit Nurse Director exception reports to the Health Board's Quality & Safety Forum.
- The steps being taken to strengthen the levels of falls management/prevention training in readiness for the launch of the new policy (recognizing that the extant policy does not stipulate specific training).
- The potential impact of work undertaken under the Gold Command implemented by the Executive Medical Director as a result of the Health Board appearing as an outlier for mortality in the National Hip Fracture Database audit 2018.

3.1.2 Overall Opinion

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.

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.

There were no key findings arising from the audit. However, action has been agreed to improve the reporting of the coverage and outcomes of nursing quality assurance visits within units, an element of which assesses compliance with falls risk assessment and care planning documentation.

The majority of actions have been agreed with the Director of Nursing & Patient Experience to be completed by the end of December 2019, with one action relating to the "gold command" due by the end of March 2020.

3.2 Deprivation of Liberty Standards (Follow Up) (SBU-1920-023)



Board Lead: Director of Nursing & Patient Experience

3.2.1 Introduction, Scope and Objectives

In accordance with the 2019/20 Internal Audit plan agreed with the Audit Committee in March 2019, a follow up review has been undertaken of management action in respect of the Deprivation of Liberty Safeguards audit report that was issued in September 2018.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provide protection for vulnerable people in care homes or hospitals who lack capacity to consent to the care or treatment they need. Within Swansea Bay UHB, DoLS apply to those who are considered to be deprived of their liberty within an inpatient hospital setting.

Internal Audit has completed two reviews previously of the Health Board's arrangements to comply with legislative requirements. On both occasions *limited* assurance reports were issued.

The overall objective of this audit was to confirm that action has been taken to address issues highlighted at the last audit review.

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-1819-026).

3.2.2 Overall Opinion

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.

Audit recognised that the Health Board continues to be challenged in meeting demands for DoLS assessments within the required timescales. While this was the case it was clear from our audit that action had been taken in key areas towards addressing issues raised previously and addressing capacity, and performance had been reported to the Mental Health Legislative Committee. The development of a central shared database, and appointment of two full-time dedicated best interest assessors to support the administration and conduct of assessments, are noted in particular, though there is more to do to maximise the benefit of the former. We note that the Committee paper analyses success so far and explores options for further improvement.

The previous audit made 11 recommendations, of which five were high priority and five were medium priority, with one low priority. Concluding testing of 10 agreed actions, we can confirm that 4 recommendations had been addressed, whilst 6 were partially addressed.

The following key findings were noted:

- Policies & procedures (for the approval of new best interest assessors, and for processing payments) and the Service Level Agreement had not been formally approved. Review of each indicates that improvements are required, and the engagement of colleagues within Workforce, Finance and Procurement is advised to ensure the content is sound before adoption.
- Payments have been made to some external best interest assessors without all the documentation required (though we recognise that there was other documentation present relating to assessments undertaken).
- DoLS breaches are not being uploaded onto DATIX. The process for recording breaches has recently changed to be recorded via the new SharePoint Dashboard, however no Standard Operating Procedure had been approved yet at DoLS Improvement & Support Group or communicated to all Service Delivery Units.
- Not all units have been granted access to the new DoLS Dashboard.

Actions have been agreed with the Director of Nursing & Patient Experience to address issues raised by the end of January 2020.

3.3 Morriston Hospital Cardiac Services (SBU-1920-035)



Board Lead: Chief Operating Officer

3.3.1 Introduction, Scope and Objectives

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

The Morriston Hospital Unit Risk Register contains a large number of high level risks associated with Cardiac Services. In response to an Internal Audit review of Unit Governance arrangements, management agreed actions including the development of a Risk Register Standard Operating Procedure and the enhancement of Service Group reporting on their management of risk.

The overall objective of this audit was to review the risk management arrangements within Cardiac Services.

The audit scope considered the following:

- Review of the Risk Register Standard Operating Procedure
- Effectiveness of the Cardiology Service Board (CSB), Cardiothoracic Surgery Service Board (CSSB) and other unit and service level management processes, where documented, for scrutinising and monitoring risks
- Completeness and currency of the Service Risk Register considered by the Service Boards
- Management of high level risks
- Reporting to Morriston Quality & Safety Group and Management Board

3.3.2 Overall Opinion

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.

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.

Despite the gap in Cardiology Board meetings in the period December 2018 – May 2019 we noted that through the Unit Directors' Risk and Assurance meetings and the support from the Q&S Lead Surgical Services that there has been effective management of the service risk register.

This reflects the progress in addressing some of the weaknesses in risk register management identified during previous audits of Unit governance. There remains a need to develop a standard format of reporting to ensure information provided within the Surgical Service Group is consistent and timely.

Action has been agreed with the Chief Operating Officer to be completed by the end of September 2019.

3.4 Hospital Sterilization & Disinfection Unit (SBU-1920-037)



Board Lead: Chief Operating Officer

3.4.1 Introduction, Scope and Objectives

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

The Health & Care Standards require that suitable and sustainable systems, policies and procedures are in place for medical device decontamination by competent staff in an appropriate environment. Within Swansea Bay UHB, the central function performing these services is the Hospital Sterilisation and Disinfection Unit (HSDU). The function has departments within Singleton and Morriston Hospitals, and is managed within the Morriston Hospital management structure. In addition to the service it provides for those sites, it also performs this service for other hospital sites and some community services.

The head of service indicated that the HSDU operates in accordance with ISO13485 and is inspected and accredited by an external organisation SGS. Monthly, documented Business Governance meetings address governance and risk management requirements.

The overall objective of this audit was to review the governance arrangements in place that provide senior management and the Board with

assurance in respect of compliance with external directions and health board policies & procedures.

Recognising that the ISO requires a programme of management audit and monitoring arrangements, and that technical inspection and accreditation are performed via an external organisation, the internal audit review of compliance focused on the operation of these arrangements.

The audit scope considered the following:

- Business Governance meetings are documented and operate effectively, receiving information with which to monitor and manage the quality of services provided.
- A planned programme of audit is implemented to determine whether the quality management system conforms to documented requirements, and the findings and remedial actions are monitored by senior management.
- Action is agreed to address issues of non-conformance identified during external inspections, and monitored to completion by senior management.
- The Unit uses its risk register dynamically and in accordance with Health Board strategy, to record, assess, manage, monitor and report on risks.
- Key issues & assurances are reported within the Morriston Hospital Unit management structure, and to the Quality & Safety Committee / Board via a clear reporting line.

In reviewing the above, consideration was given to the compliance of audits and information provided against the requirements of agreed management policies & procedures, including:

- Time to re-processing
- Cleaning validation & continuous monitoring
- Tracking & traceability
- Training & competency of HSDU staff
- Incident / defect reporting

3.4.2 Overall Opinion

The Board can take **reasonable** assurance that arrangements to secure governance, risk management and internal control, within those areas under audit, 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.

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.

HSDU has established operating procedures, audit and performance monitoring and a reporting line to its service group (Clinical Support Services). The most recent external inspection resulted in continued

accreditation with only two minor issues raised. There had been changes in leadership and quality functions. The new management had identified areas for improvement and we noted evidence of progress (NB management of the HSDU has changed again following the completion of the audit review).

Whilst we identified no fundamental system weaknesses, the following have been raised for further attention:

- There was no mechanism to monitor time from close of procedure in theatres to re-processing in HSDU;
- There was scope to improve the monitoring of closure of actions identified following internal quality audits;
- External inspections were not included in the corporate risk team's "External Inspections" report to the Quality and Safety Committee.
- Additionally, we noted work undertaken to cleanse and refresh the HSDU risk register. We have highlighted the need to continue periodic review to incoming management.

Action has been agreed with the Chief Operating Officer to be completed by the end of October 2019.

3.5 Patient Environment (SBU-1920-038)



Board Lead: Chief Operating Officer

3.5.1 Introduction, Scopes & Objectives

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

Healthcare Inspectorate Wales (HIW) has been delegated powers of inspection and investigation by the Welsh Assembly, and provided with rights of access to NHS bodies, rights to require documents and information, and the access to interview both staff and patients of Welsh NHS organisations. Following inspections, HIW provides the Health Board with reports on its findings with recommendations for improvement, and it has been critical previously of the lack of learning where it has found issues similar to those raised at earlier inspections.

Community Health Councils (CHCs) are statutory bodies set up to represent the public's interest in local NHS services. Regulations provide their members with the right of access and inspection of Health Board and primary care contractors' premises in order to undertake their duties. They furnish the Health Board with reports on their activities, including inspections, which may also highlight issues and areas for improvement.

Concerns in respect of the patient environment have featured across several reports.

The overall objective of this audit was to review arrangements in place to address issues identified by Healthcare Inspectorate Wales, and other inspections, with regard to environmental matters that may impact upon the safety of service users.

The audit scope considered the following:

- All reports and notices issued following external inspections are recorded centrally and reported at Board or Committee level;
- Where issues are highlighted actions, responsibilities and timescales to address them are agreed and documented;
- Clear arrangements are in place to monitor progress and confirm the completion of all actions agreed, or to escalate appropriately to senior management/executive level;
- Systems are in place to disseminate reports and notices to wider Unit Management Teams, and to obtain assurance that key issues are addressed at other locations;
- The Board is assured via its Committees that issues raised during external inspections are addressed.

3.5.2 Overall Opinion

The Board can take **reasonable** assurance that arrangements to secure governance, risk management and internal control, within those areas under audit, 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.

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.

Currently, there is no overarching policy that outlines how external regulator or inspection reports should be managed across the Health Board. As a result there is variation in process for the management of CHC and HIW reports and the methods used for providing assurance to the Health Board.

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

4. RECOMMENDATION

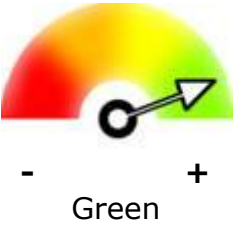
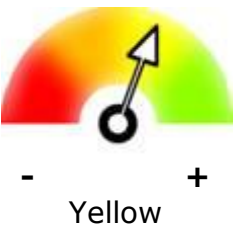
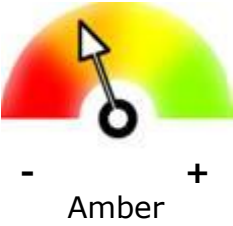
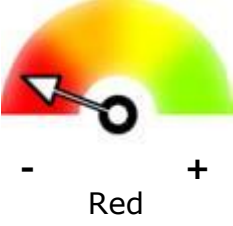
4.1 The Committee is asked to note:

- **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

RATING	INDICATOR	DEFINITION
Substantial assurance		<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>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>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>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>