FINAL INTERNAL AUDIT REPORT

Hywel Dda Health Board

Review of Clinical Audit

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS

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Committee	Audit Committee; Q&S Committee

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

1. EXECUTIVE SUMMARY

1.1 Introduction and Scope

In accordance with the risk based 2013/14 internal audit plan agreed by the Audit Committee, a review of the Clinical Audit function within Hywel Dda Health Board was undertaken.

As per the NICE definition, Clinical Audit (CA) "is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the review of change. Aspects of the structure, process and outcome of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery".

The review considered the arrangements in place within the Health Board regarding the processes for reporting and monitoring of CA recommendations.

The objective of the review is to gain assurance that the processes in place within the Health Board are robust and that recommendations arising from the work of CA are reported and monitored in a timely manner. The latest edition of the Audit Committee Handbook tasks the Audit Committee with seeking this assurance.

1.2 Opinion and Key Findings

The level of assurance given to this review is Limited Assurance.

Limited assurance	 Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

There was one high priority issue identified during the review which is further detailed in the Management Action Plan at Appendix A.

2. INTRODUCTION

In accordance with the risk based 2013/14 internal audit plan agreed by the Audit Committee, a review of the CA function within Hywel Dda Health Board was undertaken.

The outcomes of this review can be linked or contribute to the Board's Assurance Framework and also Standards 6 – "Participating in Quality Improvement Activities" and 7 – "Safe and Clinically Effective Care" of the Standards for Health Services in Wales.

In October 2012 an external review of the CA function within Hywel Dda was undertaken by the Clinical Audit & Effectiveness Manager, ABMU Health Board. The purpose of the review was to examine the structure and functions of the CA department in order to identify ways to facilitate improved departmental working and performance management. As a result, a report – "Diagnostic Visit to the Clinical Audit Department at Hywel Dda Health Board" – was produced in November 2012. One of the objectives of this review therefore is to assess progress against the recommendations made in that report.

3. AUDIT APPROACH AND SCOPE

The approach to audit assignments is risk based, where the risks are identified with the lead manager. The importance of CA within the Health Board cannot be under-estimated and it is essential that recommendations arising from the work of CA are reported and monitored in a timely manner.

The main areas that were reviewed are:

- To assess progress against recommendations made in the "Diagnostic Visit to the Clinical Audit Department at HDHB" report of November 2012;
- To assess whether there is a Clinical Audit Plan in place for 2013/14, which is based on risk and approved by the relevant committee;
- To ascertain whether adequate governance structures exist within the CA department;
- Ensuring that the CA teams in each of the three counties work in a consistent fashion;
- To establish how results are shared throughout the Health Board and the wider NHS if required; and
- To confirm that the CA function has adequate reporting lines to the Audit Committee.

The risks considered in the review are as follows:

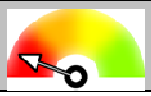
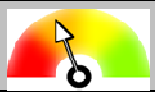
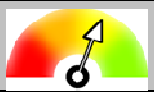
- The Clinical Audit Plan is not based on risk and has not been agreed by the Health Board;
- The Clinical Audit Plan is not adequately monitored and recommendations from the individual audits are not put into practice in a timely manner;
- The CA department is inadequately supported by the Health Board in terms of resources; and
- Adequate structures are not in place to inform the Health Board of the efficacy of the CA department.

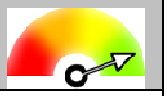
The audit assignment has been allocated an assurance rating, dependant on the level of assurance Internal Audit are able to provide. There are four potential levels of assurance available, along with three recommendation priorities and these are described in Appendix B and C.

4. SIGNIFICANT AUDIT FINDINGS

4.1 Assurance Summary

The summary of assurance given against the individual risk / themes / objectives is described in the table below:

	ASSURANCE SUMMARY				
	Audit Scope				
1	To assess progress against recommendations made in the external report of November 2012.			✓	
2	To assess whether there is a Clinical Audit Plan in place for 2013/14, which is based on risk and agreed by the relevant committee.		✓		
3	Adequate governance structures exist within the Clinical Audit department.			✓	

	ASSURANCE SUMMARY				
	Audit Scope				
4	Ensuring that the Clinical Audit teams in each of the three counties work in a consistent fashion.		✓		
5	To establish how results are shared throughout the Health Board and the wider NHS if required.				✓
6	To confirm that the CA function has adequate reporting lines to the Audit Committee.				✓

4.2 Design of System/Controls

The findings from the review have highlighted 4 issues that are classified as a weakness in the system/control design for the management of the Clinical Audit function. These are identified in the Management Action Plan as (D).

4.3 Operation of System/Controls

The findings from the review have highlighted 1 issue that is classified as a weakness in the operation of the designed system/control for the management of the Clinical Audit function. This is identified in the Management Action Plan as (O).

4.4 Summary of Audit Findings

The key findings by the individual risk/themes/objectives are reported in the section below with full details in Appendix A:

4.4.1 To assess progress against recommendations made in the external report of November 2012

Internal Audit are satisfied that the CA department is making good progress in regard to the recommendations contained in this report. A significant number of recommendations (around 68%) have already been resolved or, in some cases, such as the production of an Annual Report for 2012/13, a decision taken not to implement the recommendation.

All of the remaining recommendations are currently work in progress. These include the following areas:

- amending and updating policies, strategies, terms of reference etc;
- agreeing the 2013/14 Audit Plan;
- standardising reporting processes;
- improved monitoring against the mandatory national audit programme;
- encouraging greater communication between the county committees;
- completion of review of job descriptions within the CA department;
- updating the departmental website; and
- standardisation of teaching packages and presentation templates.

All of the above have timely completion dates – the aim is to implement all by early 2014.

One of the key recommendations in the report was the appointment of a Clinical Audit Manager, who commenced in post in July 2013, reporting to the Head of Clinical Effectiveness. Internal Audit recognises the considerable work undertaken by the CA Manager and the positive progress made in implementing a substantial number of recommendations in a short space of time.

4.4.2 Clinical Audit Plan for 2013/14

At the time of the audit, a Clinical Audit Plan for 2013/14 had not been finalised and approved by the relevant committee. However, as part of the "Situation, Background, Assessment, Recommendation" (SBAR) process, a paper regarding the production of a Clinical Audit Plan for 2013/14 went to a meeting of the Clinical Effectiveness Audit Committee (CEAC) on 7th October 2013. As a result, the aim is to submit a formal plan for approval to the CEAC by December 2013.

The Clinical Audit Manager explained that the CA department is responsible for creating the structure of the Plan, whereas the Plan is actually populated by the clinicians, population health groups, national audits etc. Thus the content of the Plan is led by the clinicians, so they are accountable for the Plan. The intention is that the Plan will be flexible – new areas can be added at any time.

Risk and safety concerns are always taken into account when putting the Plan together. The Assurance, Safety & Improvement (ASI) team, comprising the Quality Improvement Managers, pass on any identified risks to the CA department. Anything that is considered a risk is automatically included on the Plan.

The aim is to introduce a 12 month rolling programme. After the Plan has been approved by CEAC it will be put on the Health Board intranet.

4.4.3 Governance structures within the Clinical Audit department

Each individual audit on the Clinical Audit Plan will have single ownership by a clinician (senior staff), or by a committee (as requested and agreed by CEAC in the SBAR). Every audit should have an action plan which will contain individual action points.

In addition, each national audit has a Clinical Audit Facilitator who is responsible for monitoring progress. For these audits, the Health Board are in effect the monitoring body as the audits are determined at a national level.

It is part of the CA department's process to monitor the action plans by asking for updates on the individual action points. They will then report to a Clinical Audit Support Committee (each county has one) – these Committees are chaired by clinicians.

No assurance ratings are currently used within the CA department, but the Clinical Audit Manager would like to introduce these.

The Clinical Audit Manager also confirmed that there is no formal process for chasing responses to action points at present, but this will be introduced.

4.4.4 Clinical Audit teams in each County work in a consistent fashion

An example of good practice in this area is that standard documentation is used in undertaking and reporting clinical audits across the Health Board. A standard "Process Approval Documentation" form has to be completed. This form is then approved by one of the three county Clinical Audit Support Committees (CASC), or a virtual committee for Mental Health audits.

In addition, the audit year differed across the Health Board – some were for a financial year whilst others were for a calendar year. This has now been harmonised throughout the Health Board.

However, further consistency is required. It is unclear whether reporting requirements to the County Audit Committees are different and also whether the committees effectively communicate with each other. Thus there is a need to standardise the reporting format and the unification of working processes/systems/activities (as previously referred to in 4.4.1).

The time given for managers to respond to CA recommendations also appears to differ across the counties, but the Clinical Audit Manager is aiming to introduce standard response times across the Health Board.

4.4.5 How results are shared throughout the Health Board and the wider NHS

Results are disseminated via the Whole Hospital Audit meetings which are held to share learning. These meetings are facilitated by the CA department. Another way of communicating results is via the CA intranet site. Ultimately however, it is up to the clinicians to communicate the results.

With regard to the wider NHS, the mandatory National Clinical Audits produce annual reports for this purpose. Communication can also be made via conferences, clinicians' professional journals etc.

The results of the national clinical audits are compared across Wales, and all mandatory audits have been quality approved at a national level e.g. by the Royal Colleges.

4.4.6 Clinical Audit department reporting lines to the Audit Committee

The CA department reports to the CEAC, the NICE Implementation Group and also to the three county CASC's who meet bi-monthly. In effect therefore, the CA function within Hywel Dda are accountable to the CEAC who report to the Quality & Safety (Q&S) Committee, who in turn report to the Board.

The CA Annual Report for 2013/14 will be signed off by CEAC. The CA Manager stated that it is important to note that the CA department is responsible for monitoring, facilitating and quality control, but cannot enforce clinicians to provide documentation to give assurance.

At present, the CA function does not perform any self assessments. However, in the future the emphasis may be more about how the CA department "monitors, facilitates and quality controls" rather than against criteria set out in the Audit Committee handbook.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the management arrangements in place for the Clinical Audit function. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

Limited assurance	 Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

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

It should be acknowledged however, that following the external review of Clinical Audit carried out in October/November 2012, and the subsequent appointment of a Clinical Audit Manager, the department has made good and steady progress in implementing the suggested improvements within the report.

5.2 Audit Recommendations

A range of recommendations have been made to address the issues identified and these have been accepted by management. A summary of these recommendations by priority is outlined overleaf:

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**2**	**5**

The full audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

OBJECTIVE 1

Finding 1 (O)	Impact
Although the majority of the recommendations within the external report have been satisfactorily addressed, a number remain as "work in progress" (as outlined in 4.4.1).	Failure to implement the outstanding recommendations could impact on the continued progress and effectiveness of the department.
Recommendation 1	**Priority**
In order to continue the good progress already made, it is important that the outstanding recommendations are addressed within the projected timescales.	**Medium**
Management Response	**Responsible Officer/ Deadline**
There are a total of 9 outstanding recommendations from the external review of the Clinical Audit Department. 3 of these have already been completed by the time of this report. 5 of the recommendations will be tied in with the production of the Clinical Audit Programme as they revolve around reporting of progress against the plan. The remaining recommendation involves the standardisation of teaching packages which is currently not possible due to the differences in the Postgraduate delivery of teaching to junior doctors across the four sites. Sites with similar teaching formats have a standardised teaching package. The action plan will be updated and information passed on to Internal Audit once the actions have been implemented.	Ian Bebb, Clinical Audit Manager. Ongoing – final recommendation to be completed April 2014.

OBJECTIVE 2

Finding 1 (D)	Impact
At the time of the audit, a Clinical Audit Plan for 2013/14 had not been finalised and approved by the relevant committee, although a paper regarding the production of the Plan went to the CEAC in October 2013.	The Clinical Audit Plan may not be risk based and adequately monitored.
Recommendation 1	**Priority**
The Clinical Audit Plan should be finalised, based on risk and approved by the CEAC as a matter of priority.	High
Management Response	**Responsible Officer/ Deadline**
The Clinical Audit Programme is currently in development. A draft of the programme will be taken to CEAC on 04.02.14 for approval. The population of this plan will develop over time to ensure that all priorities for the Health Board and key areas of risk are being audited appropriately. The programme will initially be a 12 month rolling plan to ensure flexibility as the programme will have a significant impact on the prioritisation and support of Clinical Audit activity throughout the Health Board.	Ian Bebb, Clinical Audit Manager, in conjunction with clinicians across the Health Board. Draft plan population to begin in January 2014.

OBJECTIVE 3

Finding 1 (D)	Impact
No assurance ratings, in terms of actions arising from individual audits, are currently used within the CA department. The introduction of an appropriate rating system would enable the prioritisation of recommendations.	Possible failure to prioritise recommendations.
Recommendation 2	**Priority**
Consideration should be given to the introduction of an appropriate assurance rating system for audits contained within the Clinical Audit Plan.	Low
Management Response	**Responsible Officer/ Deadline**
This is under consideration. Talks will take place between the Clinical Audit Manager, the Head of Clinical Effectiveness and the Clinical Lead for Audit. This type of classification system is not typically implemented for Clinical Audits. A decision will be made once the Clinical Audit Programme has been implemented.	Ian Bebb, Clinical Audit Manager. March 2014.

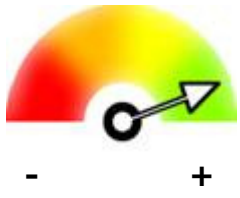
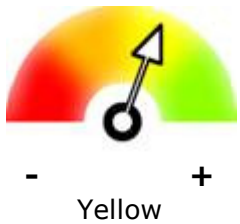
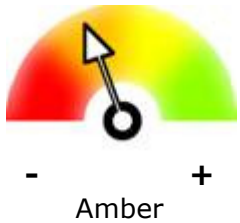
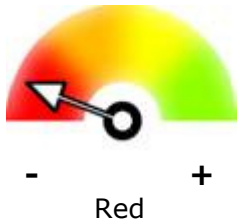
OBJECTIVE 3

Finding 2 (D)	Impact
There is currently no formal process within the CA department for chasing responses to action points from individual audits.	Action points may not be satisfactorily addressed.
Recommendation 2	**Priority**
A formal process should be introduced within the CA department for chasing responses to action points, after a specified length of time.	**Medium**
Management Response	**Responsible Officer/ Deadline**
This is a key priority for the Department and will be included in the Clinical Audit Policy. The policy will go to CEAC for comments in February 2014, and then to the Clinical Policy Review Group for final approval. The time frame is beyond the one month limit due to the approval required from both CEAC and Clinical Policy Review Group (CPRG). Draft policy to CEAC. Final approval of policy.	Ian Bebb, Clinical Audit Manager. February 2014. CPRG – April 2014.

OBJECTIVE 4

Finding 1 (D)	Impact
At present, the time given for managers to respond to CA recommendations appears to differ between the counties, however the Clinical Audit Manager is aiming to introduce standard response times across the Health Board.	Possible inconsistent working practices within the county CA teams across the Health Board.
Recommendation 2	**Priority**
Standard response times to CA recommendations should be introduced on a Health Board wide basis as soon as practicable.	**Low**
Management Response	**Responsible Officer/ Deadline**
As above. This is also a key priority for the Department and response times will be outlined in the new Clinical Audit Policy. The time frame is beyond the three month limit due to the approval required from both CEAC and CPRG. Draft policy to CEAC. Final approval of policy.	Ian Bebb, Clinical Audit Manager. February 2014. CPRG – April 2014.

2013 Audit Assurance Ratings

RATING	INDICATOR	DEFINITION
Substantial assurance	 - + Green	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 - + Red	The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Timeframe for commencement of management action
High	Poor key control design OR widespread non-compliance with key controls PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or mis-statement	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls PLUS Some risk to achievement of a system objective	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls These are generally issues of good practice for management consideration	Within Three Months*

* unless a more appropriate timescale is identified / agreed at the assignment.

Confidentiality

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

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

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

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

Responsibilities

Responsibilities of management and internal auditors:

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

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

Hywel Dda Health Board
Review of Clinical Audit

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