NHS
Dumfries
& Galloway

Internal Audit

FINAL REPORT

DELEGATED AUTHORITIES

A-01-19

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Summary of Audit Findings

The table below summarises the grades of audit recommendations as they sit against each of the audit objectives.

Audit Objective	Recommendations			
	A Low risk	B Medium risk	C High risk	D Very High Risk
By confirming that the appropriate level of governance is in place that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of authority in a manner that enforces the significance of the responsibility	-	2	-	-
By verifying that there is a structured framework in place that maps each delegated level of authority to the appropriate level of officer to ensure business continuity, whilst maintaining strong governance	-	4	4	-
By confirming that there is sound training and awareness provision to support each nominated officer's ability to conduct their respective responsibilities in the most appropriate manner	-	1	-	-
By ensuring there is a process for capturing changes within the levels and personnel assigned to authority roles on an ongoing basis to ensure the information held on all Authority Lists is as accurate and current as possible	-	1	-	-

Level of assurance	**Moderate**

Introduction

1. Audit Scope

To provide assurance that authority delegated by the Board is being managed in accordance with the most current version of the Code of Corporate Governance, the Scheme of Delegation and the Standing Financial Instructions

2. Audit Objectives

2.1 By confirming that the appropriate level of governance is in place that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of authority in a manner that enforces the significance of the responsibility.

2.2 By verifying that there is a structured framework in place that maps each delegated level of authority to the appropriate level of officer to ensure business continuity, whilst maintaining strong governance.

2.3 By confirming that there is sound training and awareness provision to support each nominated officer's ability to conduct their respective responsibilities in the most appropriate manner.

2.4 By ensuring there is a process for capturing changes within the levels and personnel assigned to authority roles on an ongoing basis to ensure the information held on all Authority Lists is as accurate and current as possible.

2.5 By confirming all recommendations raised following a review of practices by internal or external agencies have been implemented and maintained

3. Overview

A key element to a sound system of control is ensuring that all duties are carried out in accordance with a regulatory framework delegated down from the Chief Executive and the Board through to nominated officers in a secure and controlled manner. This framework should demonstrate the boundaries and limits assigned to named individuals, against specific roles that may be further delegated to ensure day-to-day operations are efficient and effective. In addition there should be a clear pathway linking delegated roles to the assurances required.

The Schemes of Delegation and approved associated lists should be capable of being accessed quickly and easily so that authority levels can be tracked without unduly delaying operational duties. Therefore any list should be provided via a platform that is available to all relevant staff and be kept as up to date as possible.

This audit aims to deliver assurance to the Board that delegation of authority is completed in accordance with Board policy and procedure. The audit has been completed as part of the 2018/19 audit plan approved by the Audit and Risk Committee.

4. Approach

Following initial research a risk matrix was designed to reveal what was regarded as expected practice in this field. Risks were formalised under the main headings listed in the scope and against which control objectives were identified and testing developed to assess the practices of the departmental service.

We undertook a series of discussions inviting all members of NHS Board, Integration Joint Board (IJB) and their respective Standing Committees to provide insight on delegation matters from their perspective. There was a good take up of this request from the Health side; however discussion was limited from the IJB Side.

We then gathered key documentary evidence which was either available on on-line or provided by departmental staff. Once processes were evaluated we confirmed the steps taken to complete these by undertaking transactional testing.

Previous Audit

5. Previous Findings

A number of audits have been conducted in recent years that are linked to this process; one being directly linked and others within the range of Governance Arrangements reviews that have aspects that could be linked to this process. We have reviewed each to establish what actions were raised and whether these relate directly to this process and confirm they have been resolved satisfactorily. The following audits were identified:

- **A-05-13 Authorised Signatories (8 recommendations)**

  This audit was undertaken to provide assurance that there is a structured process in place for identifying and monitoring the appropriateness of individuals who hold delegated powers of authorisation in accordance with the most current version of the Code of Corporate Governance, the Scheme of Delegation and the Standing Financial Instructions.

This audit raised 8 actions relating to specific roles on the Scheme of Delegation and the Authorised Signatory List at an operational level. None of the actions were implemented at their due date; however 7 were closed within the same calendar year and one was closed at a later date in line with a higher level process change.

This audit is directly relevant to the current process being audited. However the actions raised were based on testing which was at a focussed operational level, with a financial emphasis which has not been undertaken during this process review.

- **A-01-17 Governance and Control Framework (5 recommendations)**

  This audit was undertaken to provide assurance that the Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

  This audit raised 5 actions relating to failure to recognise specific roles within the Scheme of Delegation, lack of awareness of non-executives within the assurance process and failure to obtain Information Assurance Committee approval for the annual report on Information Governance prior to formal issue. Four of the five actions have been implemented beyond their original target dates and one remained open at the time of this audit, relating to IAC annual reporting, which is being overseen through Information Assurance Committee agenda.

  One of the actions can be related directly to this process in respect of non-executive awareness. This was resolved by undertaking awareness sessions in 2016 and 2017 and this action was closed.

- **A-01-18 Board Governance and Decision Making Structures (6 recommendations)**

  This audit was undertaken to provide assurance that the governance framework within the board contributes to effective and informed decision making.

  This audit raised 6 actions, 3 of which have been closed. Of the 3 that are open two have future target dates at the time of writing this report.

  From these actions we would consider that one action is directly relevant to the current process under review which required streamlining of committee paper templates. Supporting evidence was provided and this action was closed in line with its target date. The current status of this action has been reviewed and detailed in section 6.2.3 below.

- **IJB-01-17 IJB Governance Arrangements (9 recommendations)**

  This audit was undertaken to provide assurance that the governance, assurance, risk and performance management arrangements for the Integration Joint Board meet relevant guidance and providing required assurances.

  This audit raised 9 actions, 5 of which have been closed. Of the 4 that are open one has a future target date at the time of writing this report.

  From these actions we would consider 1 action is directly relevant to the current process under review which highlighted a failure to align committee business between IJB and NHS. This action remains unresolved at this time and we have commented upon the status of this action in section 6.2.

Current Audit

6. Audit Findings

6.1 Governance

6.1.1 Guidance

In respect of NHS Board operations the overarching legislation for Health and IJB governance are the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and 2016, the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Act 2014 (no 285). This legislative framework has been supplemented over the years with various Scottish Office/Scottish Government publications which interpret how this should be applied within the NHS in Scotland. However MEL 1994(80) remains one of the most comprehensive pieces of guidance in this area.

The regulations stipulate the requirement for Standing Orders from which delegated authority is formalised. Both the Health Board and the IJB have Standing Orders; those for the Health Board are contained within the Code of Corporate Governance, whilst those for IJB are in a self named standalone document. Each document is subject to review, which has been undertaken in line with expected target dates.

In terms of delegation, each body has defined a number of Standing Committees that are charged with undertaking specific duties on behalf of its Board, and for which Terms of Reference have been established. These are further supported by Schemes of Delegation.

6.1.2 Policy Framework - Health

Code of Corporate Governance

In order to meet the regulatory requirements and demonstrate achievement of the published outcomes, Board business must be conducted within robust decision making and governance arrangements. The Code of Corporate Governance is the primary document setting out how the business is organised and includes the following information:

Section A - How the Business is Organised
Section B - Members' Code of Conduct
Section C - Standards of Business Conduct for NHS Staff
Section D - Fraud Policy and Action Plan
Section E - Standing Financial Instructions
Section F - Scheme of Delegation
Section G - Risk Management

Sections A – C lay down the standards and Sections D – G are full versions of some key governance policy documents. In respect of this audit Sections A and F are considered the most relevant as they contain the directives surrounding delegation. Section A of The Code shows that the Board has established 8 committees, 5 of which are considered standing governance committees and a sixth is a sub-committee to one of the 5.

1. Audit and Risk Committee
2. Healthcare Governance Committee
3. Performance Committee
4. Person Centred Health and Care Committee
5. Staff Governance Committee

6. Remuneration Sub Committee
7. Area Drug and Therapeutics Committee
8. Pharmacy Practices Committee

The Code states that each of the 8 committees will provide scrutiny and additionally 6 will provide a level of assurance. It further describes how each committee will be setup, what the membership should be, the quoracy requirements and also provides a summary overview of the role and function with full versions of the Terms of Reference (ToR) being provided within annexes for the Standing Committees. There are no overview summaries or ToRs described for either the Area Drug and Therapeutics Committee or the Pharmacy Practices Committee and it is therefore unclear what the Board requires their function to be. In addition we could find no reference of the delegated duties provided to the Strategic Capital Programme Board and where its assurances should be received within The Code.

Whilst The Code is relatively clear on Board requirements there is no reference to any specific guidance that may also affect committee setup. For example the work undertaken by the Audit and Risk Committee is governed by the Audit Committee Handbook and the work undertaken by Staff Governance Committee is underpinned by a national guidance framework. The Code should be updated to include reference to any regulatory requirement in relation to all Standing Committees. (**Recommendation NHS1**)

Section A of The Code states that the Standing Committees '*may seek approval to appoint sub-committees'* that must be approved by the Board. In this respect the Remuneration Committee is named as a sub-committee of the Staff Governance Committee and a series of 6 sub committees have also been recognised in association with the Healthcare Governance Committee. No other sub committees are named as being associated with any other of the Standing Committees; the implication being that no other sub-committees have been formally recognised and approved through the Board.

The Code of Corporate Governance undergoes a full review every two years, which according to the Document Control table was last due in May 2017. Review of the meeting agenda for the Board meeting in December 2017 and the subsequent minutes found that this review was undertaken and approved, albeit slightly later than expected. The Board Agenda Matrix shows that a review of The Code was due for a further review in June 2018; however this did not take place, bearing in mind a review took place in December 2017 this appears to be reasonable.

Scheme of Delegation

Section F of The Code contains the Scheme of Delegation which itemises all the powers reserved for the Board in addition to individually listing each area of responsibility delegated from the Board. The Scheme is attached to The Code as an appendix but is not referred to within Section A of the Code itself and therefore the significance of its importance is not captured. Inclusion of a paragraph within Item 3 of Section A of The code should be included to reinforce this policy requirement

The Scheme of Delegation undergoes a full review every two years, which according to the Document Control table was due in March 2018. This review invites participation through all the lead officers and is managed by Finance Department who prepare the submission to the Board for approval. The Board Agenda Matrix for 2017 and 2018 did not show this document as part of the review cycle specifically; however we can confirm that cyclical review is undertaken with the most recent review being presented to the Board in August 2018.

We would ask management to ensure the Agenda Matrix for future years captures review dates for The Code and the Scheme are re-aligned so that the review cycle does not become fragmented.

6.1.2 Policy Framework - IJB

Integration Scheme - IJB

As part of Health and Social Care Integration an Integration Scheme was drawn up in 2015 for the IJB incorporating responsibilities and delegations for NHS Dumfries & Galloway and Dumfries & Galloway Council. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes in accordance with Strategic Plans agreed by the Scottish Government. Achievement of the outcomes is to be delivered operationally by named officers either jointly or individually from each partner agency who will then provide assurance through the IJB committee structure.

Standing Orders

The Standing Orders for the Proceedings and Business of the D&G Integration Joint Board are the primary policy document that sets out how the IJB is organised. This document includes the membership, the appointment of key officers, how meetings will be managed and how they will be minuted. In terms of delegation the Standing Orders clearly lay out which matters are reserved for the IJB and the fact that Committees will be created to manage the delegated matters it deems appropriate.

The version of the document posted on-line found it is reviewed annually and was last reviewed in November 2018.

Scheme of Delegation

The Standing Orders are supplemented by the D&G Integration Joint Board Scheme of Delegation to Committees. The Scheme of Delegation for the IJB lists the duties that have been delegated to each of its standing committees. The standing committees are:

- Audit and Risk Committee
- Clinical and Care Governance Committee
- Performance and Finance Committee

This document was last reviewed in June 2017 and should be revised annually. However we could not identify a more recent revision through the IJB committee agenda framework and so this has now passed its target date. This document should now be reviewed to ensure it continues to reflect the requirements of the IJB Board (**Recommendation IJB1**).

6.2 Structure & Framework of Delegation

The framework of delegation should include formally approved criteria that specify the level of management, up to and including the board of directors, who must review and approve decisions taken or being considered by employees and management in the business units. All delegated authority should be assigned to a named individual, job role or committee with any further delegation being permitted in accordance with formalised approval standards. We would expect that this framework would also identify potential misalignment between strategy and workforce capability and capacity in delegated roles.

There is an outstanding action from a report on IJB Governance Arrangements in 2017 which was expected to be implemented by March 2018 but has yet to be resolved. The action highlighted:

'*There is a risk that assurances are not being delivered to the appropriate forum where committee business has not been aligned between the IJB and the NHS. This also poses a risk of duplication*.

The IJB and NHS committees should be reviewed and their roles aligned to ensure that the appropriate information is being reported to the appropriate forum in accordance with the delegation of functions. It must also be ensured that while agendas may be amended, that assurance mechanisms are established to ensure the necessary feedback to partner agencies as set out by the Integration Scheme'.

This action should be revisited by both Health Board and IJB in conjunction with the actions from this report and a joint solution achieved.

6.2.1 Committee Terms of Reference

Health

We have seen in section 6.1 that the Board has established a number of Standing Committees through which it expects to receive assurance. We have also seen that some of the committees have approved sub-committees who undertake additional oversight to enhance the assurance process. The Code describes '*How Committee meetings must be organised*' and states that '*The Board shall delegate to such Committees those matters it considers appropriate. The matters delegated shall be set out in the Terms of Reference of those Committees*'.

We have confirmed that there are Terms of Reference in place for each of the Standing Committees and comparison of the detail included in the ToRs found them broadly to agree to the Code of Corporate Governance. However in section 6.1.2 we referred to the failure of The Code to recognise any external guidance affecting Committee activities. This should also be extended to the ToRs for the respective Committees.

Review of Standing Committee Terms of Reference is undertaken and approved by the committees themselves and there is no current expectation for review of ToRs to be referred back to Board for approval. Although ToRs are expected to be reviewed on an annual basis the timelines for review are different for each of the Standing Committees. The fact that the ToRs for the Standing Committees are reviewed annually is at odds with the fact that The Code is reviewed bi-annually.

Whilst The Code does not expressly state that ToRs should be submitted back to Board for approval, changes that occur independently without reference to the committee structure as a whole could undermine the Board's oversight of delegation, particularly where this review is not synchronised with that of the Code. This lack of coordinated review may represent a gap in the delegation process and result in assurances that cannot be provided or delivered. We would ask that this position is reviewed and the requirements of ToR review and approval in the Code are clarified (**Recommendation NHS2**).

IJB

The Integration Scheme clearly states the areas in which operational delivery is to be provided and from this the IJB has established three committees that will receive

assurance. These requirements have been included within the Scheme of Delegation for the IJB, listing the remit and powers for each of the standing committees along with the membership stipulations and frequency of meetings.

Each committee referred to in the Scheme of Delegation has a Terms of Reference that has been approved by the IJB, in accordance with the IJB Standing Orders. However we have not seen any revised version of the initial ToRs since 2015 and feel that this should be introduced as a cyclical event and submitted to the IJB for approval.

In addition to the standing committees we have also identified Terms of Reference for the Integrated Professional Advisory Committee that provides support to the NHS Board, Local Authority and Health & Social Care Partnership. Whilst ToRs were approved by IJB in 2015 we have seen no further submission from this group. As it is not listed within the IJB Standing Orders or the Scheme of Delegation it is unclear if assurances are required from it. This should be clarified within the Scheme if this is the case.

In respect of Assurance we have seen annual reports submitted to the IJB from the Health and Social Care Management Team. However we have not noted any Terms of Reference that requires this assurance and this is not referred to in the IJB Standing Orders or the Scheme of Delegation. This should be clarified to ensure the Scheme captures what duties are required from this group in terms of delegation for which assurance should be provided (**Further refer to Recommendation IJB1**).

6.2.2 Agenda & Agenda Matrices

NHS Board, IJB and their Standing Committees each have formal agendas which advise members of the business of each meeting. Agendas have been standardised for each committee and commonly have standing items in addition to ad hoc business.

Health

In December 2016 the Board approved the introduction of a suite of formal documents to '*ensure clarity around the administrative requirements for Board and Board committees'* as best practice. One of these documents was an Agenda Matrix which would indicates the proposed work of each committee meeting over a given year and influences the content of the agenda for individual meetings.

At the time of the audit only the Board, Audit & Risk Committee and Performance Committee had adopted the agenda matrix. The content of each can be matched back to their respective ToRs and forward through the committee agendas for the year as well as linking forward to the assurances at the year end. The other Standing Committees have not adopted the matrix and therefore there is no transparent view of how their individual committee business should progress in any given year, hindering prompt tracking when determining assurances. This lack of consistency fails to demonstrate that the full extent of approved business the Board requires is being captured within the annual calendar.

The Agenda Matrix should be now be made mandatory across all Standing Committees and should be aligned with each Terms of Reference. Both documents should be presented together at any time of revision for Board validation of appropriateness and for approval (**Recommendation NHS3**).

IJB

Agendas have also been standardised for each committee and commonly have standing items in addition to ad hoc business.

Agenda matrices are not used within all of the IJB committees therefore there is no transparent view of how individual committee business should progress in any given year or how this is consolidated into an IJB view. This hinders prompt tracking when determining assurances.

This lack of consistency fails to demonstrate that the full extent of approved business the IJB requires is being captured within the annual calendar. The IJB should consider the introduction of agenda matrices for each of its committees **(Recommendation IJB2)**.

6.2.3 Committee Papers

All papers submitted to the NHS Board, IJB and Standing Committees are required to be presented using a formal committee paper template. These templates have been introduced to ensure agenda items are consistently presented.

We reviewed a range of papers in an attempt to understand how each was aligned to the delegated roles and ToRs for each committee and to see how each contributed to providing the assurances required back to the respective committee members. We also asked for the views of committee members in how the papers helped in achieving this goal.

Health

A new template was introduced in response to a previous report action and includes instruction on how each section should be completed. Review and discussion found that papers submitted to Board and Standing Committees have now improved, either presenting the papers for noting or for some level of approval, which is in line with the intentions of the revised standards.

For the most part the new template is being used and there is now a streamlined approach to presenting information to each committee. We found however that there still appears to be minor levels of misunderstandings in how the template should be used, especially in the completion of the monitoring form where the authors commonly fail to align back to corporate risk and corporate objectives, which was the subject of our previous findings. This is not entirely being addressed by committee secretariat or committee chairs.

During conversation we learned that the titles of the papers did not always clarify how the subject ties back to the approved committee business, thereby questioning relevance. In addition the exact same papers could be presented at a range of Board and Committees without any change to their content or emphasis, resulting in duplicated conversations. From review we also have a concern that many of the papers are for ‘noting’ which does not require any action from the committee members and it is not always clear what outcomes are expected or what assurances are being delivered by receiving these papers.

Whilst there are occasions where the Board and or Standing Committees have made a direct request for a paper, or where an ad hoc subject requires additional review most papers should be specifically relevant to each committee’s business and tie in with the ToR and agenda matrix. Authors should be required to clarify the reasons for submitting papers and committee members should question situations where papers cannot be tied back to

agreed committee business. It should further be clarified when papers have already been through a process of review through a sub-committee, programme board or group.

The adoption of this revised template has been in place for some time and has improved the information provided. However there is now the opportunity to review this process and enhance it further. Board should consider how papers could now be developed to enrich the assurance process by ensuring each is more aligned to the respective committee's business and whether the action of 'noting' could be superseded by more. This would contribute to providing an ongoing level of assurance from each committee, building up to the assurances provided annually (**Recommendation NHS4**).

IJB

All papers submitted to the IJB Committees are required to be presented using a formal committee paper template, which has developed since the creation of the IJB in 2015.

We reviewed a range of papers in an attempt to understand how each was aligned to the delegated roles and ToRs for each committee and to see how each contributed to providing the assurances required back to the respective committee members. We also asked for the views of committee members in how the papers helped in achieving this goal.

In the main, papers can be tied back to the ToRs, however the absence of an agenda matrix makes it difficult to confirm all committee business is being discussed without reviewing each of the agendas and papers individually.

6.2.4 Committee Minutes

All activity within the Health Board, IJB and their respective Standing Committee meetings is supported by minutes and action plans, in keeping with the Code. Once Standing Committees have approved their minutes they should be submitted to the Board to support the activity they have undertaken.

A key principal of demonstrating Board performance within public services is that of accessibility, openness and transparency and how papers of the Board and its Standing Committees are presented is of the utmost importance to drive this forward. Board should determine how best to receive ongoing assurance from each Standing Committee, whether this should be a verbal update from the respective committee chair or a briefing that summarises recent committee activity as well as capturing all previous approved papers.

Health

Standing Committee minutes are submitted once they have been approved by their respective members, which can be some months after the original meeting. For example the Board meeting in October 2018 was presented with papers from Standing Committee meetings from April and June 2018. These papers are commonly on the last agenda item and although they appear to have been discussed, it is difficult to appreciate how meaningful this conversation bearing in mind the date each meeting may have taken place. In addition review of minutes presented in 2017/18 found two papers had failed to be presented for one Standing Committee representing a gap in assurance for the Board.

None of the papers submitted to Board appear to encompass the current status of the entire business conducted by any of the Standing Committees and the current agenda set-up does not lend itself to this type of reporting. Were the Board to receive a summarised committee brief from each Standing Committee Chair this would provide a more operational

view of more recent committee business and provide the opportunity to adapt focus relatively quickly where gaps are identified in the level of assurance received. Submission of approved minutes could form part of the overall update as appendices to this update (**Recommendation NHS5**).

IJB

Similarly activity within IJB and Standing Committee meetings is supported by minutes and action plans, in keeping with Standing Orders. Once Standing Committees have approved their minutes they should be submitted to the IJB to support the activity they have undertaken.

In 2018 the minutes from Standing Committees have been submitted to the IJB haphazardly and we could not verify that a copy of each meetings minutes had been received by the IJB. Review of the agendas for 2017 IJB meetings could not find a consistent submission of these minutes either. As previously reported it is crucial to ensure that each Standing Committees activities are communicated to the controlling Board.

IJB should determine how best to receive ongoing assurance from each Standing Committee, whether this should be a verbal update from the respective committee chair or a briefing that summarises recent committee activity and ensures all previous approved papers are captured (**Recommendation IJB3)**

6.2.5 Sub-Committees

Health

The Code states that '*committees may seek the approval of the Board to appoint Sub-Committees for such purpose as may be necessary*'.

Review of Standing Committee ToRs found that only Staff and Healthcare Governance Committees make reference to specific affiliated groups, which is in keeping with The Code. In general the ToRs from these committees are discussed at their respective Standing Committees but do not appear to be presented to the Board to gain formal approval in the way suggested within The Code.

Review of all Standing Committee papers found there are other sub-committees or groups that were affiliated to each Committee and provided various levels of assurance from performing more focussed activity. For example the Audit and Risk Committee receives assurances from Information Governance Committee and Risk Executive Group through quarterly updates from the work undertaken by two sub-groups and Staff Governance takes assurance from work undertaken by the Corporate Health and Safety Group. These groups are not specifically referenced by name within the Standing Committee ToRs.

Assurances from affiliated groups is commonly provided by the submission of summary activity reports, that may or may not be supplemented by copy minutes or action notes to verify the content of the meetings taking place. This is inconsistent practice.

The Code should be revised to include clarity on what the Board expects in terms of groups affiliated to all Standing Committees; this should include a naming convention to differentiate what is a committee as opposed to a group or a programme board. In addition each Standing Committee's ToRs, agendas and agenda matrices should list all affiliated groups and committees to demonstrate how activities will be governed and what assurances will be provided (**Further refer to Recommendation NHS1**).

IJB

Sub-groups are in place that report directly to Clinical Care Governance Committee and reflect locality and directorate activity. Review of the ToR for the CCGC within the Scheme of Delegation makes no detailed reference to sub groups and therefore expectations are not clear. Review of the agendas for the CCGC could not immediately confirm that minutes for sub-groups are being received on a regular basis.

This area of governance should be strengthened within the Scheme of Delegation and any corresponding Terms of Reference to ensure al sub group activity is captured for monitoring purposes and can be included within assurance provision (**Further refer to Recommendation IJB1**).

6.2.6 Scheme of Delegation

As reported within section 6.1 the Code of Corporate Governance and IJB standing Orders clearly state the roles preserved for Board oversight and those delegated to the current Standing Committees. In support of this a Scheme of Delegation is in place that captures these responsibilities in addition to listing a range of other functions that have been further delegated to named officers or to other groups or committees aligned to the Standing Committees.

Health

The Scheme of Delegation is a document that has evolved over time to its current format and is easy to follow, describing the range of duties in 16 general areas of responsibility. Each duty has a nominated lead, an authorised deputy structure and constraints are applied where appropriate. This document also refers to further examples of onward delegation that ensures duties can be managed operationally such as Authorised Signatory Lists for budget management, bank signatories and stock management. These lists are managed by Finance Department and in relation to budget management is refreshed on an ongoing basis and republished monthly via the intranet for operational access.

The format and presentation of the Scheme of Delegation in its current format is satisfactory and appropriate. If, however, this was to be enhanced, Board should consider delegating each section to one Lead Director and aligning each section to a specific Standing Committee for oversight or through line management performance review. This could then be added to each Standing Committee agenda to receive assurance on their respective section. This already happens within the A&RC Committee whereby a Finance report provides assurance on various activities within the Scheme as well as exception reporting where Standing Financial Instructions have been breached or have been waived.

IJB

As previously reported the Scheme of Delegation is a standalone document for the IJB containing the delegated terms for its Standing Committees.

Comparison to the Integration Scheme found that it did not reflect the named officers who have been identified as being responsible for specific areas within the partner agencies. We can confirm that those named officers from the Health Board are listed within its own Scheme; however to provide further clarity the IJB should determine what additional delegated duties should be clarify within the Scheme and what assurances are required from these officers as individuals (**Further refer to Recommendation IJB1**).

6.2.6 Assurance Map

Health

In December 2016 the introduction of a Board Assurance Framework was proposed to the A&RC to support the governance process as follows:

> *One of the key elements of the governance and assurance process is for the committee to review risk within the Health Board and to provide assurance to the NHS Board members that appropriate processes and procedures have been put in place and are regularly reviewed to ensure all risks are identified and added to the risk register for each key area within the Board.*

It was reported that this framework would be produced in stages starting with a framework for corporate risks. It was intended that this would be reviewed on a quarterly basis by the A&RC developing this framework to capture a board wide assurance map. During 2018 a revised Audit and Assurance Committee Handbook was issued by the Scottish Government which explicitly identified the requirement for Boards to have an Assurance Framework in place.

Our review has found that updates on the Corporate Risk Assurance Framework are not presented on a quarterly basis as initially intended but an update was provided within the annual Risk Management report for 17/18. However the framework has not yet been developed on a wider scale at the time of writing this report.

In undertaking this audit it has become clear that the creation of a board wide assurance framework should now be progressed using the delegated duties to form the basis. This framework can then be mapped to corporate objectives and corporate risks to reinforce their suitability, highlight any gaps and to demonstrate how assurance can be delivered through the Standing Committees back to the Board. Once in place for the Standing Committees this can then be filtered down through the directorates to complete the oversight process (**Recommendation NHS6**).

IJB

We have not been able to tie back delegated authority activity to an assurance map either by committee or across all committees as no assurance mapping is currently in place. An assurance mapping process should be devised that links the national outcomes, IJB risks and committee activity to reinforce their suitability, highlight any gaps and to demonstrate how assurance can be delivered through the Standing Committees back to the IJB (**Recommendation IJB4**).

6.3 Training and Awareness

We have undertaken a range of discussions with the majority of NHS Board members and limited number of additional IJB members to understand their level of awareness in respect of Delegated Authorities.

Health

We have confirmed that, in general, awareness is good and each member understands their role in the various committee meetings they attend. The majority of Board and committee members have been with NHS D&G for some time and so awareness has been

built up over a number of years. This has been supplemented with workshops and awareness sessions when new members have been appointed.

Discussion revealed that new appointees may take a number of months to be completely familiar with their delegated roles especially when they attend a large number of committees. There is perhaps a perceived expectation that personnel at a senior level should be automatically familiar with their roles and there is therefore little in place to assist in a more detailed level of familiarisation.

There is no 'training package' as such that provides a detailed awareness of committee life and is also difficult to understand what this 'training package' would look like if it were to be drawn up. However the lack of initial awareness is a potential gap in this process and management should consider how this can be overcome for any future new appointees (**Recommendation NHS7**).

IJB

In respect of the IJB the committee set-up is fairly new, having been first introduced in 2015 and differs from both Health and Council committee frameworks. Members revealed that following initial cultural differences awareness is continuing to develop and they have been provided with a range of workshops to enhance their knowledge and build on their general awareness.

6.4 Capturing of Change within Delegated Authority

Health

We have reported in previous testing the process of reviewing the corporate documents such as the Code and the Scheme of Delegation on a 2 yearly cycle. There is also the opportunity to make minor revisions within this period to ensure the relevance of this information is maintained at a current status at all time. Whilst this opportunity does exist we have seen little evidence of minor changes, this could be because there were no changes or that this process is not widely used.

ToRs for the Standing Committees are largely reviewed and revised on an annual basis which is captured through the individual committees. As reported previously these changes are not necessarily referred back to the Board either for approval, for information or to demonstrate the change was in accordance with Board requirements. This is also a lack of consistency in respect of committees or groups that are affiliated to the Standing Committees whereby ToRs are not always referred back to gain approval for any revisions.

Operational lists such as the Authorised Signatory List (ASL) and Changes to Bank Signatories have defined processes in place to make changes as and when they occur, which are managed by Finance. In respect of the ASL, changes are received on an ongoing basis and a revised list published on a monthly basis. This process works well and has been established for many years, although the Authorised Signatory Procedure is not currently available to view on Beacon (**Recommendation NHS8**).

In respect of bank signatories, changes are captured immediately in respect of staff leaving roles and all new appointees are submitted to Audit and Risk Committee for approval. These processes have not been subject to focussed testing during this audit but are intrinsic in audits of a financial nature. We can confirm that changes to bank signatories are advised to the Audit and Risk Committee; however we have not noted any cyclical

assurance being provided on the effectiveness of the Authorised Signatory List in the same way. This should be considered (**Further refer to Recommendation NHS1**).

Computer management systems are used to undertake a vast range of operational tasks and as such access should be managed in accordance with strict logon protocols as directed by IT policies. The various levels of access are effectively a delegated authority whereby activities are conducted in accordance with areas of expertise and the hierarchical structure of the relevant process. As such all computer management systems should be managed by System Administrators that oversee these aspects. We have not undertaken any detailed review of this process; however we have noted in previous audits that there is a potential gap in the assurances being provided whereby System Administrators are not required to confirm that access levels remain appropriate and relevant. This subject will be reviewed in detail during the IT Security audit that is running concurrently with this.

IJB

Change requirements within the IJB process is restricted to the governance documents of Standing Orders and the Scheme of Delegation and this is undertaken as previously reported in section 6.2.5.

7. Conclusion

This review confirms that both the Health Board and IJB have a formalised framework that specifies the levels of authority, up to and including the respective Boards. The frameworks detail who must review and approve decisions taken. All delegated authority is assigned to a named individual or job role with any further delegation being permitted in accordance with formalised approval standards. In addition further levels of delegated authority have been defined for a small number of tasks where greater flexibility should be considered for operational reasons.

The Code of Corporate Governance is the primary document that states how levels of authority from the Chief Executive as Accountable Officer and the Board are delegated and this is supported in greater detail by the Scheme of Delegation. Both documents are revised on a bi-annual basis and any changes are itemised, presented to the Board for Approval and then placed on the internal website, Beacon for ease of access. The most recent update to the Code and the Scheme of Delegation was made in May 2017 in accordance with expected timescales.

A number of actions raised within this report have highlighted a need for clarity within The Code and Standing Orders around what the NHS Board and IJB requires in terms of approval or what detailed assurance is required for the roles it has delegated. The remainder of actions highlight the need to build upon the streamlining of the administrative side of committee business to ensure that all papers are presented in a consistent format and contain information that is meaningful and relevant to the respective committees.

Key documents such as the Code, Committee, Terms of Reference and the Scheme of Delegation are reviewed in a fairly timely manner; however the review deadlines are not coordinated and so a ‘whole process review’ cannot be completed at the same time. The lack of an assurance map limits how we demonstrate that the range of delegated duties tie together with the assurances and confirm that they adequately support the governance process as a whole. This risks gaps in expected assurance, risks failing to coordinate the focus of scrutiny and thereby may fail to confirm that the delegated duties are appropriate.

8. Acknowledgements

We would like to acknowledge with thanks the help and co-operation of all staff during the course of this audit.

9. Glossary of Terms

The following details the abbreviations and associated terms encountered throughout the course of this audit report.

Abbreviation	Term
A&RC	Audit and Risk Committee
ASL	Authorised Signatory List
Beacon	NHSD&G Intranet
HB	Health Board
IJB	Integration Joint Board
IT	Information Technology
NHS D&G	NHS Dumfries and Galloway
SoD	Scheme of Delegation
TOR	Terms of Reference

10. Management Action Plan

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
NHS1	**Finding Group: Governance** **Finding Type: Policy** The Code of Corporate Governance does not contain sufficient detailed information in relation to: • the duties delegated to all the named committees consistently • all sub-committees affiliated to Standing committees and • the role the Scheme of Delegation plays in the delegation process. This lack of clarity within The Code fails to provide comprehensive terms of reference under which all roles have been delegated and risks the Board failing to ensure scrutiny is then performed and assurances can be delivered.	The Board should review the level of delegation to each committees it refers to in The Code of Corporate Governance and through named individuals. The Code should then be updated to reflect this requirement	**C**	A review of the Terms of Reference for each of the Standing Committees will be undertaken to demonstrate clear links to the delegated authority for the committee through the Scheme of Delegation. A paper is due to be presented to the NHS Board in October 2019 which will demonstrate a full review of all standing committee structures and the sub committees that are linked to each standing committee. It should be noted that although changes will be made to the standing committee Terms of References, the National Corporate Governance Committee are reviewing all Terms of Reference as part of the implementation of the Corporate Governance Blueprint and they will be issuing a single template that all Boards are required to implement to supersede all current Terms of Reference Templates. It is thought the templates will be available from September 2019, but no firm date has been issued of the release as yet. **Evidence Required** We require sight of the revised and approved Terms of Reference for each of the Standing Committees and confirmation that these changes have been reflected within the Code of corporate Governance.	Laura Geddes	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
NHS2	**Finding Group: Governance** **Finding Type: Policy** Terms of Reference for the Standing Committees are not referred back to the Board for review and approval. Changes that occur independently without reference back could undermine the Board's rationale for delegation, particularly where this review is not synchronised with those of the Code. This lack of coordinated review may represent a gap in the delegation process and result in assurances that cannot be provided or delivered.	The Board should clarify its position in respect of approval of Terms of Reference for its Standing Committees and reflect this within the Code of Corporate Governance	**C**	A paper was taken to NHS Board in June 2019 highlighting that as part of the Board's delegated authority within the Scheme of Delegation the Board is required to formally approve all Terms of Reference documents for the standing committees. All 5 committee terms of reference documents were taken to Board to approve as the current versions. All standing committee terms of references will be reviewed at the committee and then submitted to the Board for formal approval going forward. **Evidence Required** We have had sight of the paper presented to the NHS Board in June 2019 and confirmed the ToRs for each of the standing committees were presented and approved.	Laura Geddes	Closed upon issue of final report
NHS3	**Finding Group: Governance** **Finding Type: Procedural** The Agenda Matrix introduced as Best Practice within Health is not being used across all Standing Committees. This lack of consistency fails to demonstrate that the full extent of approved business the Board requires is being captured within the annual calendar.	The Agenda Matrix should now be made mandatory across all Standing Committees and should be aligned with each Terms of Reference. Both documents should be presented together at any time of revision and presented to the Board for approval	B	A paper will be taken to Management Team to request the formal adoption of the agenda matrix for all standing committees, with the potential adopt the matrix further to the sub committees that report in to the standing committee also. **Evidence Required** We would expect to see decision-making within Board regarding the formal adoption of the Agenda Matrix across all standing committees.	Laura Geddes	31/12/19

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
NHS4	**Finding Group: Governance** **Finding Type: Monitoring** Titles of the papers did not always clarify how the subject ties back to the approved committee business, thereby questioning relevance; added to which the exact same papers could be presented at a range of Board and Committees without any change to their content or emphasis, resulting in duplicated conversations. In addition many of the papers are for 'noting' requiring no action from the committee members and it is therefore occasionally unclear what outcomes are expected or assurances are being delivered from receiving these papers. This fails to demonstrate how assurances are being delivered	Board should consider how papers could now be developed to enhance the assurance process by ensuring each is more aligned to the respective committees business and whether the action of 'noting' could be superseded by a request to accept a level of assurance for example	B	A paper will be taken to Management Team to request the formal adoption of the agenda matrix for all standing committee. Once adopted the agenda matrices for the committees will be brought back to Management Team, twice yearly to ensure that there is no duplication in business being taken through each of the committees and Board. The wording within the monitoring forms on the Board / Committee paper template will be amended to clarify that the consultation section must be completed to demonstrate where the paper has been reviewed and what the outcome of the review was. **<u>Evidence Required</u>** We would require receipt of the paper clarifying committee business and related paper submission that has been reviewed and approved by board. In addition we require sight of the amended monitoring template showing the change to consultation section and an example of how this has been used in practice.	Laura Geddes	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
NHS5	**Finding Group: Performance** **Finding Type: Monitoring** It is unclear what assurances are being provided from receipt of minutes from committees that are some months old. Two committee papers were not presented to the Board in 2017/18. Additionally no covering paper was included provide a level of current status of the entire business conducted by any of the Standing Committees. This fails to demonstrate that the Board is being provided a current and more operational view of the most recent committee business and provide the opportunity to adapt focus relatively quickly, where there are gaps in assurance.	Board should determine how best to receive ongoing assurance from each Standing Committee, whether this should be a verbal update from the respective committee chair or a briefing that summarises recent committee activity	C	At each NHS Board Meeting the Chairman introduces the committee minutes to Board Members and asks the Committee Chair or lead Director for the committee to give an update on the key points of interest from the meeting. The two sets of minutes that were noted as not having been presented to NHS Board were taken to the June 2019 Board meeting. To ensure that all committee minutes are taken through NHS Board a supporting paper will be presented with a matrix of all committee dates and which Board meeting the minutes were taken to either in draft or approved by the committee. **<u>Evidence Required</u>** We require sight of the supporting paper showing the matrices of committee dates and confirmation that all required papers have been submitted to Board for 18/19.	Laura Geddes	31/12/19
NHS6	**Finding Group: Governance** **Finding Type: Monitoring** A board wide Assurance Framework has not yet been implemented in full to NHS Board. This fails to provide assurance to the NHS Board members that delegated functions are operating effectively and are regularly reviewed to demonstrate they	A board wide assurance framework should now be progressed using the delegated duties to form the basis. This framework can then be mapped to corporate objectives and risks to reinforce their suitability, highlight any gaps and to demonstrate how assurance can be delivered through the	C	An Assurance Framework is in the process of being developed and will be taken through Management Team for review before being presented in its final draft to Audit and Risk Committee for formal approval, along with a process on how it will be updated going forward and how often it will be brought back to Audit and Risk Committee as part of the Risk Management Quarterly Update.	Laura Geddes / Laura Douglas / Julie Watters	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	deliver assurance.	Standing Committees back to the Board		**Evidence Required** We require sight of the finalised and approved assurance framework. In addition we require sight of the first quarterly update provided to the Audit & Risk Committee.		
NHS7	**Finding Group: Governance** **Finding Type: Training & Awareness** There is no formal awareness process in place for new appointees that captures committee familiarisation and their expected roles particularly when membership is requires across a range of groups and committees. This risks a failure of committed participation and failure to meet the requirements of membership	A committee familiarisation process should be drawn up for all future new appointees	B	The national Corporate Governance Committee, in conjunction with Scottish Government, are in the process of developing a single induction programme for all new Non-Executive Board members that will be implemented across all NHS Boards in Scotland, which will include an overview of the Non-Executive member and details of a local induction. This programme will ensure a consistent approach to Board Member Induction whether as a Non-Executive Board Member or an Executive Director. It is thought that the induction programme will be released for implementation by December 2019, but no date has been confirmed as yet. **Evidence Required** We require sight of the finalised and approved committee formalisation process. In addition we would require sight of inductions provided to any new Executive and/or Non-Executive employed by the Board in the intervening period.	Laura Geddes	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
NHS8	**Finding Group: Governance** **Finding Type: Procedural** The Authorised Signatory List Procedure is not available to view on Beacon which fails to provide adequate guidance to staff.	The Authorised Signatory List Procedure should be reposted onto Beacon	B	Noted – this will be uploaded on Beacon **Evidence Required** We have received confirmation that this action has been completed.	Susan Thompson	Complete upon issue of final report

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
IJB1	**Finding Group: Governance** **Finding Type: Policy** The IJB Scheme of Delegation did not capture the complete range of duties stated within the Integration Scheme and the Standing Orders. This included ToRs of sub-committees, and duties of named officers. In addition the Scheme of Delegation has not been reviewed in line with its target date. This risks the IJB failing to ensure all activities are being monitored, scrutiny is complete and assurances are being delivered in line with IJB expectations.	The IJB should ensure the levels of delegation to its sub-committees and through named individuals is stated within the Scheme of Delegation.	**C**	The Scheme of Delegation is under review and the updated version will be presented to the IJB on the 24th July for sign off. **Evidence Required** We require confirmation that the Scheme of Delegation has been revised and approved through the requisite committee and require sight of the finalised document.	Alison Warrick	30/09/19
IJB2	**Finding Group: Governance** **Finding Type: Procedural** The Agenda Matrix is not being used within the IJB Committee structure. This lack of consistency fails to demonstrate	The Agenda Matrix should now be made mandatory across all IJB Committees and should be aligned with each Terms of Reference. Both documents should be	B	The Agenda Matrix is now used consistently across the Partnership. Governance Officer is now responsible for updating all Action Lists for the IJB and its Committees and for	Alison Warrick	30/09/19

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	that the full extent of approved business the IJB requires is being captured within the annual calendar.	presented together at any time of revision and presented to the IJB for approval		ensuring actions are completed timeously. **<u>Evidence Required</u>** We require sight of the Agenda Matrices for each of the IJB committees. In addition we require confirmation that each committee has had sight of their respective matrix and it is being included on agenda of business.		
IJB3	**Finding Group: Performance** **Finding Type: Monitoring** Review of historical papers could not support that all standing committee papers had been received by the IJB during the years 2016/17 & 2017/18. This fails to demonstrate that all levels of assurance are being fully captured.	A mechanism for tracking receipt of all standing committee minutes should be created.	B	As outlined in the revised Scheme (which will be presented to the IJB in July), Minutes for each committee are now forwarded to the IJB for Noting once approved by the relevant committee. **<u>Evidence Required</u>** We require sight of the tracking system used to confirm all required minutes are being presented from each standing committee.	Alison Warrick	30/09/19
IJB4	**Finding Group: Governance** **Finding Type: Monitoring** An Assurance Framework is not in place for the IJB. This fails to provide assurance to the NHS	An assurance map should be introduced for the IJB.	C	The Chief Officer presented a Governance paper to the IJB Performance and Finance Committee on the 28th April, following this some changes were required and this is	Julie White	31/12/19

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	Board members that delegated functions are operating effectively and are regularly reviewed to demonstrate they deliver assurance.			currently being reviewed. **<u>Evidence Required</u>** We require sight of the complete and approved assurance map.		

NHS Dumfries & Galloway

Internal Audit

FINAL REPORT

DIGITAL HEALTH

A-05-19

Audit Completed:	August 2019
Preliminary report issued:	12/09/19
Management Action Plan to be returned by:	10/10/19
Management Action Plan returned:	17/09/19
Final report issued:	15/10/19

Auditor:	Sandra Thompson
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	Julie White

Summary of Audit Findings

The table below summarises the grades of audit recommendations as they sit against each of the audit objectives.

Audit Objective	Recommendations			
	A Low risk	B Medium risk	C High risk	D Very High Risk
To confirm that the appropriate levels of governance are in place incorporating any relevant guidance or legislation into policy, procedure, risk management and delegated authority that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of management and staff.	-	-	2	-
To confirm that the digital technology strategy is being implemented locally in support of and to enhance how health and social care services that is defined and measurable.	-	-	-	-
To confirm that monitoring and reporting of assurances within the process is relevant, accurate and consistent at every level in the organisation up to and including Board and is accurately represented in any external reporting.	-	-	2	-

Level of assurance	**Moderate**

Introduction

1. Audit Scope

To provide assurance that digital technology is encompassed across the range of health, social care and wellbeing services within NHS Dumfries & Galloway to meet the Digital Health and Care Strategy for Scotland.

2. Audit Objectives

2.1 To confirm that the appropriate levels of governance are in place incorporating any relevant guidance or legislation into policy, procedure, risk management and delegated authority that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of management and staff.

2.2 To confirm that the digital technology strategy is being implemented locally in support of and to enhance how health and social care services that is defined and measurable.

2.3 To confirm that monitoring and reporting of assurances within the process is relevant, accurate and consistent at every level in the organisation up to and including Board and is accurately represented in any external reporting.

3. Overview

In 2005 the Scottish Government issued its report Delivering for Health that set out an action plan for improving health services in Scotland. This included a section on their eHealth Strategy as well as the plan for the creation of the Scottish Centre for Telehealth which was achieved in 2006.

In 2007 the Scottish Government published the Better Health, Better Care Action Plan which highlighted that *High quality information is crucial to the delivery of safe and effective health care.* This resulted in the production of a more detailed eHealth Strategy for 2008 - 2011 which was updated for the period 2011 - 2017 and was further refreshed in 2014.

The themes of Better Care, Better Health were progressed in 2016 to include Better Value within the publication of the Health and Social Care Delivery Plan that detailed what would be delivered by 2021. Part of this plan was that *a review of the approach to digital health, use of data and intelligence, would be undertaken*, which resulted in Scotland's Digital Health and Care Strategy that was published in April 2018.

This strategy had two main aims:

1. *To empower citizens to better manage their health and wellbeing, support independent living and gain access to services through digital means. We know this is leading to a shift in the balance of care by using the tools and technologies that we are already increasingly using for all other aspects of our lives, and*
2. *In order to achieve this at scale, we need to put in place the underpinning architectural and information governance building blocks for the effective flow of information across the whole care system that will enable the transformational ambitions of the Health and Social Care Delivery Plan, including public health and social care reform priorities.*

This audit aims to provide assurance that the digital activities undertaken within NHS D&G are in keeping with Scotland's Digital Health and Care Strategy and we are on course to deliver the requirements of the plan.

4. Approach

To understand how the process worked we issued a questionnaire to management and requested a range of information to be provided prior to commencement of the audit. In addition, discussions were held to verify the information provided and ascertain the current processes in place.

Previous Audit

5. Previous Findings

The Digital Health and Care Strategy is newly formed and therefore no previous audits have been undertaken by the Internal Audit team of this strategy as a whole. However Internal Audit has performed a range of audits on Information Governance and IT Security that are key elements of this strategy. These audits include:

- A-03-09 - Information Governance & Security
- A-07-14 - Records Management

- A-12-15 - Change Fund – Putting You First
- A-04-18 - Information Governance and Security Improvement Measures DL(2015)17
- A-04-19 - IT Security

Where relevant these audits will be referred to in the main body of the report.

Current Audit

6. Audit Findings

The Scottish Government have been working towards delivering a Healthcare Strategy since 2005 that included use of improved technology in some form. Since that time this has included:

- **eHealth Strategies** - Since August 2008 the Scottish Government has issued three eHealth Strategies covering the periods 2008-2011, 2011-2014 and 2014-2017. The purpose of these strategies was to set a national direction through a common vision and set of key aims. These strategies reflected on the developments and set out a clear eHealth vision for 2020 which was supported by seven aims.
- **Change Fund Putting You first** - The Reshaping Care for Older People Programme was a Scottish Government initiative established in 2011 to '*optimise independence and wellbeing for older people at home or in a homely setting*' that would be achieved by 2021. It was recognised that the process of introducing this programme had financial implications as it recognised there would need to be fundamental changes from current practices to develop more '*anticipatory and preventative approaches to achieve and sustain better outcomes for older people*'. One of the strands of work included Delivering Innovative Modern Services (DIMS) capturing improvements to Telehealth and Telecare as well as improved technologies to support care provision in a home setting.

In April 2018 Scotland's Digital Health Care Strategy was issued which builds upon the previous eHealth strategies and brings together Telecare, Telehealth and eHealth under one combined strategy. This strategy supports the principal aim which is to improve outcomes through better coordination of care. The way this strategy aims to achieve this is by "*empowering citizens to better manage their health and wellbeing and support independent living and gain access to services through digital means. In order to achieve this however recognition has been made that underpinning architectural and information governance building blocks for the effective flow of information across the whole care system need to be put in place".*

To deliver on the ambitions of the strategy the Digital Health First Standard must be applied using 22 criteria across three themes that aims to make sure that services in Scotland are continually improving and that users are always the focus, with co-production built in. All future developments must follow these principles. To enable the strategy to be implemented, six domains have been established which are:

- A - National Direction and leadership
- B - Information Governance, Assurance and Cyber Security
- C - Service Transformation
- D - Workforce Capability
- E - National Digital Platform
- F - Transition Process

This section reports the current status of each of these domains at a local level.

6.1 A - National Direction and Leadership

The strategy emphasises clearly that there is a need for strong leadership due to this being a joint strategy across national government, local government and the NHS and so to achieve this by *July 2018 a national decision making Board made up of Executive representatives of the Scottish Government, Local Government and the NHS, with additional support and advice from industry, academia and the third sector will be created.*

6.1.1 Policy & Procedure

Within NHS D&G there are currently no formal policy directives in place on the subject of Scotland's Digital Health and Care Strategy as a whole process. Recognition has been made, that in order to implement the key areas identified within the strategy issued, a local Digital Health and Care overarching Strategy would be required. During the course of this audit, work was underway to develop this local strategy and its intention is to include participation from public focus groups to influence the direction of the strategy. The draft will be produced for review by the Digital Health Programme Board in August and approved by Health and Social Care Senior Management Team by September 2019.
(**Recommendation 1**)

Whilst no overarching strategy exists there are elements of the process that are supported by standalone pre-existing policies and strategies. Once such example of an existing local strategy is the NHS D&G eHealth Strategy that has been in place since 2008. In December 2018 this document was entitled Digital Health and Care Delivery Plan 2018/19 encompassing the ongoing previous national and local eHealth Strategies, and has aligned this work to the key domains listed within SG Digital Health Care Strategy.

Other examples of policy direction will be highlighted in further sections of this report.

6.1.2 Risk Management

NHS D&G has 17 corporate risks that recognise the risks of delivery across a range of activities, two of which recognise digital or IT as a risk to delivering services. The first risk, entitled Infrastructure, recognises the impact of failure to deliver the Digital Health Strategy within Health and states it is currently mitigated using a draft eHealth Workplan for 2019/20 but will further mitigate the risk by establishing a Digital Health Strategy by June 2019. The second risk, entitled Information Security, recognises the risks associated with the use of IT systems and the information held within them and how these will be mitigated or managed. None of the other corporate risks refer to information technology and the impact of not using it effectively to deliver current services or develop its use to enhance services in the future.

We note that no further risks at a tactical or operational level have been developed through Datix, however we anticipate progress is made with overall governance of the process driven by the Information Security corporate risk.

The IJB has three strategic risks that are primarily concerned with the failure to deliver services in accordance with IJB direction, with the expectation that each partner agency will have the required level of risk recognition to deliver the services required. At a tactical level the Health and Social Care Senior Management Team have 12 risks on their register none of which recognise the risk or impact of failure to implement Digital Health in any level of detail.

We would recommend that all risk is considered and assessed in more detail at a corporate/strategic, tactical and operational level to ensure the impact of failing to maximise the use of digital technology within health and social care activity is captured. This would provide a more comprehensive assessment demonstrating how opportunities are taken forward for future delivery within NHS D&G and our partner agencies. **(Recommendation 2)**

6.2 B - Information Governance, Assurance & Cyber Security

Scotland's Digital Health and Care Strategy recognises that there are assurances required that personal information is being handled appropriately, safely, securely and in an approved and controlled way in line with previous guidance such as GDPR and alignment with ISO 27001. To address this there is a commitment that by *2020 there will be clear arrangements in place to deliver a simplified and consistent national approach for Information Assurance which will take into account the different needs of users and citizens, and provide clarity around information sharing across health and care.*

Previously, the Scottish Government issued DL 17(2015) Information Governance and Security Improvement Measures 2015-2017 which replaced the previous NHSS Information Assurance Strategy 2011-2015. The Directors Letter (DL) set out actions for Boards to implement over a two year timescale with a view to improving Board level information governance and security arrangements by working towards demonstrating compliance with an Information Security Policy Framework (ISPF) aligned with ISO 27001. In 2018 this framework has been developed to include additional requirements.

6.2.1 Information Governance

In NHS D&G Information Governance is managed by the Head of Information Governance IM&T Directorate within Health Services. Policy directives for this process are described within the Confidential & Data Protection Policy and the Information Security Policy, both of which have undergone recent reviews. These policies are intended to be supported by a range of procedures and guides which are currently being revised; however this is yet to be completed at the time of writing this report. Regular alerts are issued via e-mail and Information Governance is being rolled out for discussion as an agenda item throughout the standing committees, associated groups and more informal meeting network.

Review of the status of compliance with the Information Security Policy Framework is being worked through. An initial response has been made to over 400 lines of requirements which will be enhanced by more detailed review by members of the IM&T directorate and senior management. This will require commitment and input from other areas across the board which is being identified and requested. This subject is being reviewed within the A-04-19 IT Security audit which is being undertaken concurrently with this review.

6.2.2 Assurance

For NHS D&G assurance for Information Governance is overseen by the Information Assurance Committee that provides updates on activities to the Board through the Audit and Risk Committee. This work is supported by more detailed review undertaken by groups such as the eHealth Board and the IT Security Group.

The IAC meet on a quarterly basis and receive updates on a range of activities defined by a recently revised Terms of Reference and in accordance with an agenda matrix. Quarterly updates are provided from IAC to the A&RC in addition to an annual report that is produced

in accordance with the Governance Framework of NHS D&G. The quality and quantity of information provided to IAC was the subject of an action raised in a previous audit. This provision is continually improving and was considered sufficient to close this action.

IJB assurance is due to be provided through the Digital Health and Care Programme Board. Terms of Reference have been created and approved through IJB and updates from the Programme Board activities will be provided through the Health and Social Care Management Team and the IJB Clinical and Care Governance Committee, both as required, but twice a year as a minimum. No such reporting had commenced at the time of writing this report.

6.2.3 Cyber Security

NHS D&G continue to address Information Governance, Assurance and Cyber Security through a number of initiatives to improve the cyber security and ensure that all data held within the systems is secure. This has involved obtaining Cyber Essentials status and working towards Cyber Essentials Plus. Also Firewall technology has been introduced to GP practices to improve protection. Penetration testing of specific applications which are connected to the internet is carried out to ensure that the data is protected. Fairwarning has also been re-launched to monitor and take action against inappropriate behaviours in accessing records. These activities are now being reported through IAC as part of the quarterly updates.

6.3 C - Service Transformation

The strategy recognises that local services will require to transform the way in which they are currently delivering in order to implement this strategy and so *by the end of 2018 there was a commitment that there would be a clear national approach to supporting local co-designed service transformation with clearly identified leads.*

In NHS D&G the biggest transformation occurred when the new hospital opened with the opportunity being taken to ensure digital technology was at the centre. The NHSD&G ICT Delivery Plan reports that there have been a number of systems that have been developed and implemented over 2018/19 that bring about improvements that help meet the aims of the Digital Health and Care Strategy. The report provided detailed information to the IAC in April 2019 under the following headings:

- Business/Strategic Priorities – Local and national
- ICT in year priorities – systems under development/being implemented
- ICT in year priorities – core infrastructure
- ICT in year priorities – Integration of Health and Social Care TEC Initiatives
- ICT in year priorities – Systems Life Cycle
- ICT in year priorities – Business as usual support services
- Regional Working
- Funding

In previous years the work streams of the Putting You First programme included a number of programmes developed in relation to Telehealth and the development of technology to assist with delivering services. This included providing health services at a distance using a range of digital and mobile technology.

6.4 D - Workforce Capability

The underpinning factor in the success of the uptake and use of digital technologies largely relies on the capabilities of the workforce in using such technology and therefore knowledge and skills must be developed in order to support and deliver the key digital transformations that are required. Scottish Government committed that by *September 2018, NHS Education for Scotland, the Local Government Digital Office and the Scottish Social Services Council will have in place a clear approach to developing the modern workforce and the necessary leadership to drive change*.

From the information we have received and reviewed workforce capability has not been identified as a subject as such. However NHS D&G is currently focussing on Workforce Sustainability as a priority across all operations at which all directorates are represented on the membership.

6.5 E - National Digital Platform

A national digital platform is being created that will allow real time data and information from health records to be available to those who need it, when they need it, wherever they are in a secure and safe way.

In the D&G Health and Social Care Strategic Plan (2016-2019) one of the ten priority focus areas refers to making the best use of technology. It was recognised that digital technology was critical in delivering sustainable health and social care now and in the future. We have been provided with a copy of the DG ICT Delivery Plan for 2018-19 which details the systems that were developments to core infrastructure and Technology Enabled Care (TEC) Initiatives and how these initiatives link with the six domains of the national strategy.

NHS D&G have recognised the Microsoft Cloud Computing Strategy, adopted by the Scottish Government, as the new key infrastructure component that will have a significant impact on the way services are delivered in the future. This development should greatly assist the delivery of the Digital Health and Care Strategy however new workgroups will be required to be created to ensure that this programme is embraced and implemented in the best way possible to have the maximum effect.

6.6 F - Transition Process

It is recognised within the strategy that transition will be challenging, will take time and will require significant input from delivery partners and so *Scottish Government will work with eHealth and clinical leads, NHS NSS and Local Government Digital Office to plan and manage the transition process and through our new governance, will review existing projects and investment to ensure best value and alignment to future direction.*

Within NHS D&G and the IJB assurance pathways are being developed to ensure and confirm the transition process is aligned with SG guidance. Representation will also be made available to attend national meetings of the Scottish Government Transition Board and Microsoft Cloud Computing Strategy Board.

6.6.1 Digital Health and Care Programme Board

Recently the Digital Health and Care Programme Board has been set up in order to provide strategic and operational oversight for scaling up digital technology across health and social care in Dumfries & Galloway as well as making recommendations to relevant committees and Boards with regard to the development of services and decisions regarding investment

and prioritisation. The scope of this Board is to develop and maintain a shared vision of digital health and care in D&G. It will meet bi-monthly and report to The Health & Social Care Management Team as well as the IJB Clinical and Care Governance Sub-Committee. The first meeting took place in June 2019, with the next meeting planned for August 2019.

Terms of Reference and reporting templates have been established and presented to the IJB who approved them in July 2018, but no updates had been noted at the time of writing this report.

A number of sub-groups have been identified as providing specialised updates to the Digital Health Programme Board such as the eHealth Board. The Programme Board should ensure that the Terms of Reference for each of the groups is current and relevant and is clear on how the reporting arrangements and assurance provision through both Health and IJB is to be provided, and to further consider links onto other Transformation work being undertaken within the Board. **(Recommendation 3)**

6.6.2 IJB

The Scottish Government's Digital Health and Care Strategy was presented to the IJB in July 2018. The IJB was asked to note the recommendations, consider the implications and approved the direction for the development of a local Digital Health and Care strategy and delivery plan. Board Members:

- Noted the recommendations contained within the recently published Scotland's Digital Health and Care Strategy
- Considered the implications of the national Digital Strategy for health and social care
- Approved the direction for the development of a local Digital Health and Care Strategy and delivery plan for the Dumfries and Galloway Health and Social Care Partnership

The direction given was to:

> *Develop a digital health and care strategy and delivery plan for Dumfries and Galloway Health and Social Care Partnership to ensure that people who use services are offered the choice of digital services in all NHS services and Adult Services provided by the Council, Third and Independent Sectors.*
>
> *This will also be in line with the delivery of key outcomes in the national Digital Health and Care Strategy and the IJB Strategic Plan*

This had a review date of April 2019 but we cannot see any review being taken back through the IJB as there is no overall record kept through the IJB of Directions and their updated status. **(Recommendation 4)**

7. Conclusion

The Digital Health and Care Strategy for Scotland was issued in 2018 since when all NHS Boards have been tasked with rolling out its implementation and build on the requirements of earlier guidance. We can confirm that this strategy is being taken forward although it is too early to measure its success or appropriateness.

We have seen that technology has been encompassed across a range of health, social care and wellbeing services within NHS Dumfries & Galloway however the monitoring

arrangements for this and the assurance framework require to be enhanced to determine their effectiveness.

8. Acknowledgements

We would like to acknowledge with thanks the help and co-operation of all staff during the course of this audit.

9. Glossary of Terms

The following details the abbreviations and associated terms encountered throughout the course of this audit report.

Abbreviation	Term
A&RC	Audit and Risk Committee
Datix	Risk Management system
IAC	Information Assurance Committee
ICT	Information Communication and Technology
IJB	Integration Joint Board
NHS D&G	NHS Dumfries and Galloway
TEC	Technology Enabled Care

10. Management Action Plan

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
1	**Finding Group: Governance** **Finding Type: Policy** The Digital Health Strategy was not yet in place which fails to provide direction at a local level for the application of guidance issued in 2018.	The Digital Health Strategy should be finalised, approved and published in accordance with Health and IJB requirements	C	The local strategy is under development and planned to be completed by the end of the year after which it will be presented for review and approval. **Evidence Required** Sight of the completed strategy which has been presented through the appropriate committee for approval.	Ruth Griffiths	31/03/20
2	**Finding Group: Risk Management** **Finding Type: Policy** The impact of failing to meet the national Digital Health Strategy has not yet been sufficiently assessed at all risk levels and therefore fails demonstrate in detail the opportunistic element of risk will be managed within the Board and IJB	Risk assessments should be developed to recognise the impact of and/or opportunities presented by the Digital Health Strategy and Strategic, Tactical and Operational levels.	C	A schedule of risks have been formalised for the Digital Health Strategy and are being developed which when approved will become a standing agenda item at Digital Health Programme Board. **Evidence Required** Sight of the completed risk assessment schedule and evidence that this has been approved by the Digital Health Programme Board.	Ruth Griffiths	31/03/20
3	**Finding Group: Governance** **Finding Type: Reporting** The Terms of Reference for the sub groups reporting into the Digital Health Programme Board may not capture any additional requirements of the new board and therefore lack clarity in respect of assurance and reporting pathways.	The reporting lines and assurance provision for each sub group/committee should be reviewed to confirm delivery expectations for each reporting structure. The Terms of Reference for each should then be updated to reflect these	C	The Terms of Reference for each sub group will be reviewed, updated and presented to Digital Health Programme Board for approval **Evidence Required** Sight of the revised terms of	Ruth Griffiths	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
		requirements.		reference for the sub groups and evidence of approval by Digital Health Programme Board.		
4	**Finding Group: Governance** **Finding Type: Policy** The Direction issued by the IJB to develop a Digital Health Strategy was due to be reviewed in April 2019, which did not take place. Thereby failing to receive a status update and/or assurance that the directive had taken place.	The IJB should ensure that the Direction entitled '*The development of a local digital strategy and delivery plan for Dumfries and Galloway Health and Social Care Partnership'* is reviewed.	C	An update on the direction was provided in April 2019 and was presented to the IJB in July 2019. **Evidence Required** Internal Audit has received the supporting papers confirming the review of the Direction	Ruth Griffiths	Closed upon issue of Final Report

NHS Dumfries & Galloway

Internal Audit

FINAL REPORT

PATIENT ACCESS AND WAITING TIMES

A-08-19

Audit Completed:	August 2019
Preliminary report issued:	01/10/19
Management Action Plan to be returned by:	29/10/19
Management Action Plan returned:	21/11/19
Final report issued:	27/11/19

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Summary of Audit Findings

The table below summarises the grades of audit recommendations as they sit against each of the audit objectives.

Audit Objective	Recommendations			
	A Low risk	B Medium risk	C High risk	D Very High Risk
To confirm that the appropriate levels of governance are in place incorporating policy, procedure and risk management processes.	-	1	2	-
To confirm that processes are in place to ensure that the patient management system cannot be inappropriately changed	-	-	1	-
To confirm that processes are in place to ensure patient records are accurate.	-	-	2	-
To confirm that monitoring and reporting within the process is relevant, accurate and consistent at every level in the organisation up to and including Board.	-	-	-	-

Level of assurance	**Moderate**

Introduction

1. Audit Scope

To provide assurance that there are robust processes in place to ensure that patient access and waiting times arrangements are managed in accordance with national guidance.

2. Audit Objectives

2.1 To confirm that the appropriate levels of governance are in place incorporating policy, procedure and risk management processes.

2.2 To confirm that processes are in place to ensure that the patient management system cannot be inappropriately changed

2.3 To confirm that processes are in place to ensure patient records are accurate.

2.4 To confirm that monitoring and reporting within the process is relevant, accurate and consistent at every level in the organisation up to and including Board.

2.5 Recommendations from external bodies and internal reporting have been fully implemented and maintained in accordance with agreed action plans.

3. Overview

In 2007 New Ways of Defining and Measuring Waiting Times guidance was issued. This was superseded by CEL 33 (2012) - Delivering Waiting Times. The CEL refers to three directives which are the NHS Scotland Waiting Time Guidance, NHS Scotland National Access Policy and Effective Patient Booking for NHS Scotland which Boards are expected to use to assist them in delivering the national waiting times standard.

In October 2018 Scottish Government issued a Waiting Times Improvement Plan that sets out clear deliverables over the next 30 months supported by funding and detailing how implementation will lead to improvements.

This audit forms part of the 2018/19 audit plan approved by the NHS Audit and Risk Committee in March 2018 and aims to provide assurance that the management of the Patient Access and Waiting Times process is being undertaken in accordance with guidance.

4. Approach

Following initial research a risk matrix was designed to reveal what was regarded as expected practice in this field. Risks were formalised under the main headings listed in the audit objectives against which control objectives were created and testing developed to assess the practices of the service. We identified the staff whose main role is to manage Patient Access and Waiting Times from the acute perspective and gathered key documentary evidence which was either available on Beacon or provided by staff. This does not include waiting times within Mental Health Directorate.

To understand the process we issued a self assessment questionnaire and requested a range of information to be provided. Discussions were then held to verify the information provided and confirm the status of current processes, following which we undertook focussed testing to verify processes.

Previous Audit

5. Previous Findings

5.1 Review of NHS Waiting Time Arrangements Audit – A-08-13

In 2012 inappropriate use of unavailability codes by an NHS Board was found to have distorted the figures reported to the Scottish Government. Following a review by Pricewaterhouse Coopers LLP (PwC) into Waiting Times Management at that board, the Scottish Government instructed the Internal Audit functions in other boards to conduct a review based on pre-set criteria to determine the activity within their own Board and to provide assurance that the same level of inappropriate use of unavailability codes was not present. This work reviewed activity from January to June 2012 and focussed on how Waiting Times lists were being managed. The results of the audit were presented to each Boards' Audit Committees and Boards before being presented to the Scottish Government in December 2012.

At the time of our previous audit we were able to provide a Significant Assurance level that waiting lists were being managed appropriately within NHS Dumfries and Galloway. Although this assurance could not be absolute we were able to conclude that from the data

provided and the period reviewed the large scale of inappropriate use of unavailability codes reported was not evident within this Board.

The audit of waiting times was a national process. This resulted in

- A local report (NHS D&G) – 12 recommendations
- An Audit Scotland Report – 9 recommendations
- And a Public Audit Committee Report – 14 recommendations

The Scottish Government then requested a follow up review by Internal Audit to verify actions from each of the reports had been implemented. We were able to provide assurance at that time that all recommendations from our Internal Audit had been implemented with the exception of the recommendation relating to IT systems which had an approved extended implementation date of August 2013, which was subsequently fulfilled.

The current status of each of these historical actions will be reviewed in line with current testing and will be reported on individually in section six.

5.2 Internal Audit of Patient Access Systems – A-08-16

We undertook an audit to provide assurance that Patient Administration Systems within NHS Dumfries & Galloway are managed within a secure and transparent environment and their use meets relevant legal, regulatory and operational requirements. This audit gave a Significant level of assurance and resulted in 10 actions of which 6 of these have been closed and 4 of these remain open with their due dates having passed in 2016. This will be reviewed in line with system integrity section 6.2.1.

Current Audit

6. Audit Findings

In a change to our normal practices we issued a self assessment form and requested a range of information to assist in planning our any audit work. This information included the supply of current guidance, policy and procedural documentation, in addition to risk evaluations and assurance pathways.

We can confirm that a good level of information was provided in general however there were gaps in what was provided in relation to linking corporate risk to known operational risk and what route the assurance for ongoing activity was being provided.

Further detail will be provided as this report progresses.

6.1 Governance

6.1.1 Guidance

There are a number of pieces of guidance around waiting times which have been introduced over the years. This is an area that is becoming increasingly more robust as greater obligations are placed on NHS boards to meet targets around waiting lists. This is an area that is closely monitored at the highest levels with performance across specialties being the subject of a great deal of scrutiny.

New ways of defining and measuring waiting times - Applying the Scottish Executive Health Department Guidance Version 3.0 (December 2007)	Superseded
18 Weeks - The Referral to Treatment Standard, Principles and Definitions Issue 2.0 (January 2009)	Superseded
CEL 33 (2012) Delivering Waiting Times	Current
Waiting Times Improvement Plan (October 2018)	Current

NHS Scotland Waiting Time Guidance

This document sets out the high level principles that should be adhered to. This guidance is to ensure that patients who are waiting for appointments are managed fairly and consistently across NHS Scotland and that NHS Scotland has clear and consistent guidance.

> *"This document is for the use of all staff in NHS Scotland and particularly those involved in collecting and recording information for patients on the following:*
>
> - *18 weeks Referral to Treatment for 90% of patients;*
> - *12 weeks for new outpatient appointments;*
> - *6 weeks for the eight key diagnostic tests and investigations; and*
> - *The legal 12 week Treatment Time Guarantee."*

NHS Scotland National Access Policy

This guidance states the following

> *"This policy sets out principles that will help ensure that systems are in place to optimise the use of facilities and available capacity in order to deliver high quality, safe patient care in a timely manner.*
>
> *Boards should ensure that they have systems, processes and resources in place to deliver the responsibilities described in the National Access Policy and that Standard Operating Procedures (SOPs) are established to ensure delivery of the requirements of this Policy.*
>
> *Each board will also provide a Local Access Policy setting out the details of how these principles apply to their local services, e.g. possible and reasonable service locations.*
>
> *Each Local Access Policy must be developed with patient participation, be open and transparent, be approved by the board in open session and be made widely available. This includes publication on the board's website*."

Effective Patient Booking for NHS Scotland

In the Effective Patient Booking for NHS Scotland the guidance around the booking models details three main models that are in operation across Scotland. NHS Dumfries & Galloway currently have two models that are used which are Patient Focussed Booking and Direct Booking these are in line with the models mentioned in the guidance except Direct Booking is entitled Implied Acceptance. There are eight principles of effective Patient Focussed Booking Practice that NHS D&G should endeavour to apply. These are

1. Clear communication with patients from the outset, outlining their responsibility for their appointment including booking, attending and advising of any changes to their availability. This should take place at the point of referral and within any booking dialogue between the patient and service.
2. A referral process which facilitates the transfer of information about the patients' equality needs and availability to attend.
3. All staff involved in booking and appointing working to standard operating procedures to ensure equity in appointing patients.
4. Booking processes must facilitate timely engagement and offer a single, reliable point of contact for patients.
5. Booking processes must offer patients real choice through active dialogue including dates and times of available appointments, following Treatment Time Guarantee and Waiting Times guidance.
6. Patients must be reminded of their appointment close to the date of agreed attendance.
7. The process must order the waiting list so patients are seen in turn, allowing for clinical priority.
8. The process must ensure ongoing validation of the waiting list to reduce wasted slots.

Waiting Times Improvement Plan October 2018

SG is providing additional funding of *£535 million to make a substantial and significant step change on waiting times.* Over the next 30 months the improvement plan will make a phased improvement in the experience of patients waiting to be seen or treated with phased implementation targets of October 2019, October 2020 and Spring 2021. This action is being taken in parallel with mental health waiting times but this is not included within the scope of this audit.

6.1.2 Policy

In our audit of Waiting Times in 2013 we highlighted that the Patient Access Policy had not been approved and during the follow up review in 2014 confirmation was received that this had been resolved and a revised version of the document was provided to close the action.

We have been provided with a copy of Version 1.3 of the Patient Access Policy which is considered the current version in relation to this process.

Review the policy provided found that this was not the version used to close the previous action, but was an earlier version and consequently did not reflect that the target date of the next review was in October 2014. We also noted that the version provided had sections that were incomplete and included paragraphs with comments requesting facts be checked. This version is published on the external website and so members of the general public are accessing out of date information. (See section 6.3 for further comment on content)

The incomplete version of the Patient Access Policy should be removed from the external website. It should also be reviewed to confirm the accuracy and appropriateness of its content and to incorporate any further revisions resulting from the issue of the 2018 Improvement Plan. In addition an Equality Impact Assessment (EQIA) should be undertaken. Once the review is complete the document should be submitted for approval in line with the Document Development and Approval Policy. **(Recommendations 1)**

6.1.3 Procedures

In our previous audit of Waiting Times in 2013 we were provided with a range of procedures and "How To" guides that were used across all areas within the Patient Access process. At the commencement of this audit the self assessment included a *Procedures and New Start Training Pack* document that is issued to new starts within the department. This document now incorporates many of the documents previously referred to and has created a more comprehensive and appropriate level of information for staff to reference across three sections; Procedures, Training Checklist and the Patient Access Policy.

Upon review of the procedural element of the document it was found to be relevant and current to this process however some pages remained blank with information relating to these areas of the process still requiring to be completed or further developed. The document also sets out variations to the process within differing consultants and/or specialism's such as details of clinic days. The training pack element consists of a checklist that is used as a training confirmation. The expectation is that all new staff will read the procedures, together with their line manager and then sign off the document as each section is completed; thereby confirmation training has been undertaken.

The presentation of the document is not in the standard format set out in the Document Development and Approval Policy and so we cannot determine when a review of this document is expected. However as the previous review was undertaken in 2016 we would anticipate that processes have moved on and should therefore have been reviewed by the time this audit commenced. **(Recommendation 2)**

In a previous audit of the Patient Administration Systems (A-08-16) we made similar observations in relation to procedural documents that had not been reviewed in line with target dates. This was originally due to have been completed by March 2017 but the date was extended following a management review in August 2018 and a new target date was set of 31st December 2019. The documents in question are not duplicated within the range of documents referred to in the Waiting Times audit but are closely linked as they relate to the computer systems used within Patient Access processes. We would ask operational management to consider participating in reviewing all documents to ensure the process as a whole is appropriately captured. **(Refer to A-08-16 Action 1)**

The procedural pack is also supplemented by a series of leaflets and communication templates that are issued to patients. We have been provided with examples of those generated by the system and have seen the leaflets that are available on Beacon. Each appears to be current and appropriate.

6.1.4 Risk Management

Risk

The receipt of the self assessment included confirmation that no risk assessments had been undertaken for this process at a tactical or operational level and no corporate risk was identified as being relevant to this process. This position was confirmed by further discussion with line management and review of the Datix risk management system. It was also confirmed that no Business Continuity plans existed that demonstrated all risks had been captured for this process. From discussion it was clear that informal continuity processes existed however these have not been formalised and there was no definition of what constituted an invocation of any contingency plan.

As there are many elements to this process alignment to one main corporate risk is not likely, however we have identified that this process could be aligned to Quality of Care, Corporate Governance or Information Security risks. This would capture the requirements of ensuring patient health and care is the main focus, to ensure compliance with guidance, and also ensure information held is accurate, appropriate and secure.

Risk assessment of the process must be undertaken to take cognisance of the range of causes that would result in failing to meet national waiting time targets and what impact this would have on the patients, staff and the health board and then further include how impacts are mitigated and/or controlled to minimise inherent risk and monitored and/or managed to limit any residual risk. This process of assessment should be formalised by production of a business continuity plan in addition to risk assessments through Datix that should be pitched at a managerial level that reflects the degree of risk exposure. (**Recommendation 3**)

Incidents

The receipt of the self assessment included examples of incidents being logged through Datix. Of the 17 examples provided two remained open with the rest having been managed and closed effectively. Further discussion revealed that incidents of this nature may be logged within other categories and may not necessarily be attributed directly to waiting times and so identification can occasionally be an issue.

Our review has confirmed that incidents are triaged for the whole of the Acute Directorate on a weekly basis and discussed with the relevant management as they occur. Where found to be specifically for this process they are investigated in line with requirement and then taken through the various assurance groups linked to this process and scrutinised in more detail. This appears to be appropriate.

6.2 System Integrity

In 2016 we undertook an audit of the Patient Administration System that captures all information of the patients' journey from waiting time through to treatment. There are numerous systems that interface with each other that manage information however Topas is the primary system used to capture all data in respect of waiting times. This continues to be the case.

Systems Integration

In 2016 our review confirmed that all computerised PAS are integrated to enable information to be passed across or between, using automatic links managed within the IM&T environment. Monitoring is in place to identify and correct errors in relation to these links. Where systems fail or are being tested, communications are issued to ensure users are informed and contingency measures can be put into place.

Process mapping is also in place in relation to the SCI Store Architecture. This map presents a simplified diagram of all processes linked to SCI Store, incorporating the type of link or feed and what type of data is transferred between each. We reported that this was not available for the TOPAS system and we recommended that one was created and shared to demonstrate how the process works in the same way as that for SCI Store. This recommendation was implemented and the process map produced. This continues to be in place.

Coding Structures

In 2016 we confirmed that there were standard sets of coding within each system linked to the PAS process. These were either codes developed locally or codes driven by National requirement. For reporting purposes where codes used locally differ to national ones a matching exercise had been developed. Each set of codes could be accessed within each system using drop-down boxes and/or look-up tables. In addition there were various 'How to' guides that advice users what to input. This continues to be the case.

There continue to be various reasons for requiring an update to the system, ranging from the introduction of new services, system upgrading, as well as individual requests for local one-off changes. All access to make changes is restricted to members of the Information Services Team. System upgrades and major changes to the system are initially conducted by the supplier, which are updated into the test system in the first instance. A range of tests are then completed locally using scenarios of various patient journeys which follows the pathways through all respective systems to ensure the change is captured fully, prior to authorising the changes to be made to the live system.

We viewed a selection of individual examples of supported evidence and enquired as to whether any formal review takes place and found that individual confirmation is approved on an ongoing basis; however there is no periodic review conducted over all errors to assess quantity or identify common themes or reasons. We recommended that a process of review is introduced on which assurance can be placed that all amendment to standing data on the systems is accurate, appropriate and relevant. This recommendation has not yet been implemented and remains outstanding with a revised target date of 30th September 2019. **(Refer to A-08-16 Recommendation 7)**

System Access

In 2016 access to each system was found to be restricted at the required user level, to departmental employees who had been fully trained on all relevant operation and security protocols at the time access is provided. However we could not verify during the audit that there are processes in place to confirm the continued validity of current users. This meant that there were potentially a number of users who have transferred department or left the board who had not had their access to the system revoked.

We requested that a one off exercise be performed to cleanse the system and thereafter a cyclical check should be put in place to maintain the validity of access. IM&T were also asked to consider linking system access to completion of the mandatory training module, as previously reported, whereby failure to complete an annual review could result in a temporary suspension of user access. This would force users either to take the course and re-establish their access or provide a list which could be confirmed with HR as leavers or transfers where they can be removed permanently. We can confirm that whilst validity is now managed on an ongoing basis for new users we have not yet been advised that a one off exercise has been produced therefore this action remained unresolved at the commencement of this audit.

Internal Audit therefore undertook this task by obtaining lists of Topas users and matched them to the most recent staffing reports and then analysed the last time each user had access the system. The reconciliation process was relatively straight forward however there were some hurdles to overcome such as mismatching of names, whereby they could have been spelt differently within the system compared to Payroll and where the surname had changed on payroll but not on Topas. There still remained a number of users that could not be verified and these were passed back to IM&T for further investigation.

This exercise revealed:

Report 1

- 3088 users as at 11th April 2019
- 1639 (53%) were verified as current employees
- 1010 (32%) had left the boards employ and not been removed
- 111 (3%) were test (IM&T) users or generic log on IDs
- 27 (1%) could not be verified to the payroll
- 301 (9%) were unresolved queries

Report 2

- 3086 users as at 12th April 2019
- 376 (12%) had never logged into the system
- 1327 (43%) used the system in 2019
- 385 (12%) last used the system in 2018
- 998 (32%) last used the system between 2007 and 2017

The risks associated with raising this action have been borne out and now that the reconciliation has been performed there are a number of confirmed risk implications which require resolution:

- **Over 30% of Topas users have left the board employ and have not been removed from the system**.
  The issue has primarily been caused by line management failing to advise IM&T of employees leaving. However this could also have been identified centrally by analysing the last log on dates and querying those not logging on in a 12 month period or similarly highlighted by comparing user lists to the completion of the mandatory training module and querying those that have not been undertaken.
  These users should be removed immediately from the system and monitoring systems put in place to minimise or eliminate this recurring.
- **10% of users could not be verified to the payroll or remain unresolved queries**
  These user IDs should be temporarily suspended until further action has been taken and their validity confirmed.
- **9% of users names were spelt differently within the Topas system or had been transposed between forename and surname**.
  This should be corrected.
- **There are 53 examples of a generic user IDs being set up on the system**.
  Generic users are set up to accommodate access to the system to a temporary user such as a locum. Whilst this facilitates a smoother operational transition this does not provide for strong monitoring capability and can undermine Information Governance where access cannot be attributed to a specified user. This is particularly concerning in relation to Fair Warning whereby this can be circumvented by employees using a generic log on instead of their own.
  Generic logons should either be removed or have a transparent monitoring process to supervise their use.

It is the system administrator's responsibility to deliver assurance that access to any system is provided to valid users at a level that is appropriate to their job role. An integral part of this process is obtaining management confirmation that this is the case therefore management should be required to confirm on a cyclical basis that the users within their service still require access at a defined level. This confirmation should also include that users understand the implications of Information Governance and Information Security and have undertaken any mandatory training associated with the system. This information

should be summarised by the System Administrator so that assurance can be provided through the appropriate Information Governance pathway. Failure to manage user access contravenes control requirements within the NIS Information Security Policy Framework.

We propose to close the original action as the exercise has been completed but create a further recommendation to deal with the outcomes and monitor compliance. We would therefore ask operational management to work with IM&T to ensure that all user information within Topas is cleansed and then maintained as such going forward and until this is resolved a risk should be created within Datix that recognises the impact of failure to manage user access and introduces control measures to manage the risk on an ongoing basis **(Recommendation 4)**

Data Security

In 2016 we confirmed that back-up processes are in place for all systems, with defined protocols for each system within the PAS process in line with potential risk for loss of data. In addition detailed information alerts are issued through the e-mail system when system testing makes them temporarily unavailable. These alerts also provide reasonable levels of advice in relation to continuity of services. Other than to confirm this is still the case no additional testing was undertaken

6.3 Accuracy of Patient Records

The four key responsibilities set out in the NHS Scotland National Access Policy are

1. *To communicate effectively with patients.*
2. *To manage referrals effectively.*
3. *To manage waiting lists effectively.*
4. *To use information to support improvements in service provision.*

The Patient Access Policy provides an appropriate level of direction on how each of the key responsibilities will be implemented locally which is supported by more detailed procedural guidance on staff side and leaflets for patients where appropriate. Throughout these sections of the Policy there are clear processes that are measurable, reportable and can therefore be monitored to understand compliance, direct improvement or to gain assurance.

6.3.1 Communication

The Patient Access Policy directs how communication will be used to keep patients appropriately informed in relation to the care they are to receive. It lists 9 areas of responsibility for the board and for patients to heighten awareness. This information is also included within leaflets that are published on the board's external website and are also included within the written communications sent out to patients alongside their appointment confirmations.

6.3.2 Referrals

The Patient Access Policy directs how referrals will be managed through effective partnerships using defined documentation. The direction includes detail for each constituent job role and process element should progress. These areas include:

- Referrer
- Receiving Location
- Receiving Clinician

6.3.3 Waiting Lists

The Patient Access Policy directs how waiting times standards will be delivered. This area of responsibility encompasses a vast range of duties from managing the waiting lists through to explaining how data must be recorded. The areas include:

- Patient Transfer
- Managing waiting lists effectively
- Travel costs
- Use of information to support improvement in service provision
- Appointment/Admission Booking process
- Unavailability
- Managing appointments of patients who did not attend (DNA)

The majority of information is relevant and appropriate however there are only brief references to cancellations within the policy and the procedures only list who should be advised when sessions are cancelled. Neither document includes the board's cancellation policy for sessions, theatres and or appointments and nor do they describe how cancellations should be dealt with. This should be remedied **(Further Refer to Recommendation 1)**

6.3.4 Service Improvements

The Patient Access Policy defines service improvement will be measured using *good quality data* to *inform on performance and to indentify measures for improvement*. The following areas are those for which data will be produced:

- Factors influencing waiting times
- New to return ratios
- Benchmarking

The policy and procedure do not define the specific type of data being collated at a local level, the frequency of production, the target levels that have been applied and how expectations are measured against outcomes. This fails to link the policy through to the assurance group activities. **(Recommendation 5 & Further refer Recommendation 1)**

6.3.5 Activity Validation

There are a series of checks undertaken to inform how accurate patient records are. Following the exercise in 2013 the SG issued a monitoring format that boards were expected to implement and then oversee locally. This constituted a checklist of tests to be undertaken on a sample of patient journeys in addition to producing an assurance map of the waiting times controls.

It has been confirmed to us that an independent monthly review is undertaken of 20 patient journeys the results of which are reported upon to the PAGG. Each of the journeys is assessed against a range of questions and the errors are followed up with the local teams as required. A summary is produced of any errors identified and presented to the PAGG.

We requested examples of the checks undertaken and the control sheets used to support the summary information, and have determined that a checklist is not used as such. This fails to demonstrate exactly what checks were performed on each sample and fails to provide a basis for a summary of findings to be produced.

We have been provided with an example report from May 2019 and compared the information back to the original SG request. Whilst the report includes a list of errors and why they have been highlighted the report does not include any trends of error reporting built up from historical evidence, nor does it reflect resolution information to the errors identified. This does not conform to the audit methodology described in the SG guidance and should therefore be revised. **(Recommendation 6)**

6.4 Monitoring and Reporting

6.4.1 Patient Access Support Group (PASG)

Purpose of Group
The purpose of the group is to ensure that services and departments are developed and supported in order to deliver the improvements required to ensure Patient Access. This will include discussion on the challenges faced by each department, the training and development needs of the organisation and areas for service improvement. The group will report its progress to the Patient Access Governance Group.

Remit
The remit of the group is to ensure the organisation continues to support staff within the organisation to deliver on Patient Access obligations. Areas for discussion should include the following:

- *Challenges faced by departments when facilitating Patient Access*
- *Areas for improvement in the Patient Booking process*
- *Service Improvement opportunities*
- *Support and training needs for administrative staff*
- *Run downs of performance against the Treatment Time Guarantee*
- *Run downs of performance against the Referral to Treatment Target*
- *Report to the Patient Access Governance Group*
- *Finance – locum spend*

We have received examples of notes reflecting the discussion subjects and information provided each meeting of this group and can confirm that the reviews follow the remit described. Each of the 'Run downs' include separate agenda points for each speciality with information that is updated to reflect the current status on a weekly basis.

6.4.2 Patient Access Governance Group (PAGG)

Purpose of Group
The purpose of this group is to ensure that all aspects of Patient Access are performed in accordance with the relevant policies. This will include the identification and resolution of operational issues, improvement of patient booking processes, review of weekly waiting times performance and oversight of the actions of the Patient Access Support Group and the Theatre Utilisation Group.

Remit
The remit of the group is to ensure the organisation continues to perform its Patient Access obligations. Areas for discussion should include:

- *Performance against 12 week Decision to Treat target*
- *Performance against 18 week Referral to Treatment target*
- *Weekly Return outpatient waiting lists*
- *Monthly out-patient / in-patient trajectory*

- *Adherence to Patient Access Policies – data quality / patient validation*
- *Progress of the Patient Access Support Group*
- *Progress of the Theatre Utilisation Group*
- *Areas where group members feel support is needed*

The PAGG meets on a fortnightly basis but this is increased to weekly when required. The meeting is supported by a rolling action plan and action notes/minutes to reflect discussions in an appropriate level of detail. The PAGG receives a range of summary information that includes a weekly performance report from the PASG.

6.4.3 Scheduled Care Programme Board

The Scheduled Care Programme Board was established in December 2018 to provide assurance and support to the Health and Social Care Senior Management Team in relation to scheduled care activity. The terms of reference state the following purpose and objectives:

Purpose
To coordinate and support effective management of Scheduled Care within the Acute & Diagnostics Directorate ensuring the delivery of:

- *Treatment Time Guarantee (TTG)*
- *18 Weeks Referral to Treatment Target (RTT)*
- *Cancer Waiting Times (31 and 62 day target)*
- *Services within the financial and other resources available*

The SCPB will provide leadership, support and direction on strategic issues and matters escalated from the Directorate tactical groups.

The Directorate operates through distributed leadership with decisions being taken as close to the front line as possible.

Objectives
The SCPB will:

- *Provide strategic direction and guidance for the Directorate tactical and operational management teams*
- *Lead on overall issue escalation and management*
- *Drive and support service improvements to achieve national targets*
- *Monitor progress against set trajectories as set out in the National Waiting Times Action Plan*
- *Consider the Directorate, Organisation and Community wide implications of decisions taken*
- *Maintain and seek assurance in quality of service provided.*
- *Ensure delivery of all business within Finance / Resource limitations*

In relation to Patient Access and Waiting Times this Board takes assurance from the PAGG by receiving minutes of the meetings and performance reports as well as progress against the National Waiting Times Improvement Plan.

Since the commencement of this audit the Board has met 3 times and follows its standing agenda receiving the updates required and producing minutes to support the activities.

7. Conclusion

This review has confirmed that the correct guidance has been identified and incorporated within the policy and procedural documents. This information has been captured and is being used to support local training. However the process of reviewing these documents is lacking and consequently they have not been updated in accordance with their target date.

There is a lack of formal recognition of risk either individually at a tactical and operational level, or through production of a business continuity plan, that would demonstrate risk is being identified, assessed and then managed appropriately. This fails to meet the expectations of the Risk Management Strategy and fails to support corporate risks.

In an audit of PAS and the previous Waiting Times audit we highlighted the risks associated with failure to understand how valid the users are on the relevant computer systems and requested that a one-off exercise be performed so that the scale of issue could be confirmed. The action from the PAS audit has remained unresolved since 2016. Following our own review we have revealed a number of significant issues that have potential to impact on information governance and information security including a third of the users having left the board without having their access revoked. Until user access is resolved there is a gap in assurance specifically over system integrity and as such should be reflected as a risk in Datix.

In terms of service activity there are generally sufficient processes in place to direct staff in how to accurately record data within patient records. There are gaps in direction in that there is no cancellation policy and no inclusion of KPIs or monitoring information that should/could be produced to support compliance or effectiveness in application. When the range of KPIs, monitoring reports and/or tools are being formalised this should include user access.

Oversight is in place at all levels of operations, with activity being scrutinised, acted upon and then assurances provided through a range of groups firstly through the Scheduled Care Programme Board and then to the Health and Social Care Senior Management Team. Updates are then communicated to IJB and Health Management Team. This appears to be transparent and captures the majority of salient information expected; however because there is no defined list of what type of reporting supports the individual expectations this cannot be completely assured and consequently there is a gap in conforming to the reporting of monthly auditing information.

8. Acknowledgements

We would like to acknowledge with thanks the help and co-operation of all staff during the course of this audit.

9. Glossary of Terms

The following details the abbreviations and associated terms encountered throughout the course of this audit report.

Abbreviation	Term
CEL	Chief Executive Letter
Datix	Risk Management system
DNA	Did Not Attend
EQIA	Equality Impact Assessment
HR	Human Resources

IM&T	Information Management and Technology
IT	Information Technology
KPIs	Key Performance Indicators
NHS D&G	NHS Dumfries and Galloway
PAGG	Patient Access Governance Group
PAS	Patient Access System
PASG	Patient Access Support Group
PwC	Pricewaterhouse Coopers
RTT	Referral to Treatment
SCI	Scottish Care Information
SCPB	Scheduled Care Programme Board
SG	Scottish Government
SOP	Standard Operating Procedure
TOPAS	Patient Administration System
TTG	Treatment Time Guarantee

10. Management Action Plan

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
1	**Finding Group: Governance** **Finding Type: Policy** The Patient Access Policy has not been reviewed in line with target dates, which is contrary to the Document Development and Approval Policy.	The Patient Access Policy should be reviewed and approved through the appropriate channels, all of which should be accompanied by an EQIA	**C**	Patient Access Policy has since been reviewed and endorsed by Acute Management Board. Will forward on approved policy for it to be published on Beacon. **Evidence Required** We require sight of the updated patient access policy and to see it published on Beacon.	Lorri Kirkaldie	31/03/20
2	**Finding Group: Governance** **Finding Type: Procedural** Procedural documents have not been revised in line with target dates, which is contrary to the Document Development and Approval Policy.	All procedural documents should be reviewed and revised versions approved by departmental management.	**B**	A review will be carried out on the New Start Pack for Patient Access and Patient Focus Booking and updated. **Evidence Required** We require sight of the updated new start pack.	Lorri Kirkaldie	31/03/20
3	**Finding Group: Risk Management** **Finding Type: Procedural** Datix has not been populated with risk assessments consistently at a tactical and operational level demonstrating how Patient Access processes could fail and the mitigating controls that have been established to minimise adverse events and monitor those that cannot be avoided. This fails to support the Corporate Risks and is contrary to the risk Management	The identification of a risk(s) at a tactical and/or operational level across all directorates would endeavour to demonstrate how the risk to Patient Access process is being managed. Mitigating controls would include the monitoring role of the various oversight Groups that provides assurance to both Health and IJB standing committees.	**C**	A risk assessment will be carried out in relation to the patient access process to identify all risks and these will be recorded on Datix. **Evidence Required** We require sight of the risks and to see them on Datix.	Callum Ambridge	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	Strategy.					
4	**Finding Group: Information** **Finding Type: Logical Security** A review of Topas users found a number of issues in relation to the confirming the validity and appropriateness of access. This included use of generic user IDs, failure to be able to verify user ID back to the Payroll and numerous examples of users not logging on to the system recently or at all. This fails to demonstrate that system integrity is managed effectively and compromises Information Security protocols and legal requirements of DL (2015)17.	The Topas system should be cleansed of all non-current and non valid user IDs. In addition a risk assessment should be undertaken through Datix to quantify the impact of failures, determine what further control measures are required to resolve and manage user access ongoing, in addition to tracking through the resolution to the current situation. Once complete access should be monitored on an ongoing basis and assurance provided through an agreed monitoring group or committee.	**C**	Review of topas users will be carried out ensuring that all users who no longer require access are removed. A process will then be devised to ensure that all users remain current **<u>Evidence Required</u>** We require sight of the process for updating users as well as evidence to show that a review of current users has been completed.	Phil Bertram	31/01/20
5	**Finding Group: Performance** **Finding Type: Monitoring** There was no defined list of KPIs, monitoring tools or reporting used to confirm all aspects of the process are operating effectively at a local level and also to distinguish between the data provided to the different levels of scrutiny through the various groups and committees within the assurance pathway. This fails to demonstrate that all standards within the guidance and our local directives have been captured.	The processes defined within the Patient Access Policy and associated procedures should be mapped through to the data used for scrutiny and assurances purpose at each group/committee to demonstrate that each is captured. Following which a comprehensive list of KPIs and/or reports should be devised. As a minimum this should mirror those required at a national level.	**C**	Currently monitor the following KPI's which are discussed weekly at PASG and PAGG: TTG OP Diagnostics Cancer **<u>Evidence Required</u>** We require sight of minutes showing that the KPI's have been discussed.	Lorri Kirkaldie	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
6	**Finding Group: Performance** **Finding Type: Monitoring** The sample testing of the accuracy of 20 patients' pathways is not supported by completion of a checklist demonstrating what tests had been undertaken and what the outcomes were for each of the samples reviewed. This fails to demonstrate how we are complying in detail with an SG requirement to monitor compliance against Waiting Time Guidance and statutory TTG conditions using a checklist style audit methodology.	The Checklist provided by SG should be used to form the basis of a local audit monitoring form that should be approved by the PAGG. Once in place the checklist summary should be used to support the update report provided to PAGG.	**C**	A checklist will be created to provide a local audit monitoring form that will be approved by PAGG. This will be used when carrying out monthly audits and updates provided to PAGG. **Evidence Required** We require sight of the checklist, to see it is being used and evidence to show that it has been approved and monitored by PAGG.	Phil Bertram	31/03/20

NHS Dumfries & Galloway

Internal Audit

FINAL REPORT

EQUIPMENT BANK

TS-18-19

Audit Completed:	September 2019
Preliminary report issued:	03/10/19
Management Action Plan to be returned by:	31/10/19
Management Action Plan returned:	25/11/19
Final report issued:	27/11/19

Auditor:	Colleen Bowthorpe

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	Jeff Ace
	Grant Thornton

Summary of Audit Findings

The table below summarises the grades of audit recommendations as they sit against each of the audit objectives.

Audit Objective	Recommendations			
	A Low risk	B Medium risk	C High risk	D Very High Risk
To determine the adequacy of the governance arrangements relating to the Equipment Bank including policy, procedure, general awareness and risk management.	-	3	2	-
To confirm that transactions reflected in the computer management systems are processed securely, approved coding structures, by authorised users, within established timetables that and are free from loss or corruption.	-	-	-	-
To confirm the order process is controlled adequately for both manual and electronic systems, and that segregation of duties is observed within the order, receipt of goods and services and passing for payment process.	-	-	-	-
To ensure that standard stock management systems are in place, providing suitable and sufficient stock availability without being excessive and that write-offs are appropriate and authorised.	-	-	1	-
To verify that all equipment issued is authorised, prompt, appropriately prioritised, can be traced to the patient who is using them and systems are in place to identify and manage returns.	-	-	-	-
To confirm that service activity is appropriately monitored and that any relevant internal and external reporting is accurate and consistent	-	-	1	-
To confirm that recommendations from all internal and/or external audit reviews have been implemented and monitored for ongoing compliance	-	-	-	-

Level of assurance	Significant

Introduction

1. Audit Scope

To provide assurance that the systems in place for acquiring, holding, issuing and returning of equipment necessary for assisting patients to live in their own homes are operating adequately and efficiently and that the correct information is held at ICES to enable monitoring of Patients requirements; and that all associated activity is monitored effectively.

2. Audit Objectives

2.1 To determine the adequacy of the governance arrangements relating to the Equipment Bank including policy, procedure, general awareness and risk management.

2.2 To confirm that transactions reflected in the computer management systems are processed securely, approved coding structures, by authorised users, within established timetables that and are free from loss or corruption.

2.3 To confirm the order process is controlled adequately for both manual and electronic systems, and that segregation of duties is observed within the order, receipt of goods and services and passing for payment process.

2.4 To ensure that standard stock management systems are in place, providing suitable and sufficient stock availability without being excessive and that write-offs are appropriate and authorised.

2.5 To verify that all equipment issued is authorised, prompt, appropriately prioritised, can be traced to the patient who is using them and systems are in place to identify and manage returns.

2.6 To confirm that service activity is appropriately monitored and that any relevant internal and external reporting is accurate and consistent

2.7 To confirm that recommendations from all internal and/or external audit reviews have been implemented and monitored for ongoing compliance

3. Overview

Health Boards and Local Authorities have been required to provide equipment and adaptations since 1976 when *NHS Circular 1976 (GEN) 90: Provision By Health Boards And Local Authorities Of Aids And Equipment For The Disabled Living At Home And Adaptations To Their Homes* was issued. This guidance was superseded in 2009 by *CCD5/2009: Guidance on the Provision of Equipment and Adaptations*.

In response to this, the Integrated Central Equipment Store (ICES) was created and has been in place ever since and is a shared operation with Dumfries and Galloway Council which is now part of the IJB and managed within the Facilities Directorate. ICES is an integral part of the discharge process ensuring equipment is provided to enable patients to smoothly transition to living back at home or to remain at home rather than being in an acute or community hospital setting.

This audit aims to identify the processes in place and confirm whether they are operated within expected controls as part of the approved plan for 2018/19. The audit focussed on the processes surrounding the ordering, storage, maintenance, issue and recovery of equipment provided to patients for an identified need.

4. Approach

To understand the process we issued a self assessment checklist and requested a range of information to be provided by the manager. Discussions were also held to verify the information provided and ascertain the current processes in place, which we further validated undertaking focussed testing.

Previous Audit

5. Previous Findings

Internal audit undertook an audit of this process in 2011 providing a Significant level of assurance and raising 11 actions. The 11 actions had expected closure dates in 2011 and 2012 whilst none of the actions were closed within the expected timescales they were all closed by the end of 2015. Each of these actions will be reviewed to understand whether they continue to be in place and will be reported on where appropriate in section six.

Current Audit

6. Audit Findings

6.1 Governance

6.1.1 Guidance

The most recent guidance for this process "**Guidance on the Provision of Equipment and Adaptations"** was issued by the Scottish Government in 2009 and aimed to *assist Local Authorities and their NHS partners to modernise and integrate their equipment and adaptation services within their wider community care context.* Reference was made within this guidance to undertake a review within three years of its publication however this does not appear to have taken place and so this remains the most relevant.

In addition to the guidance stated above a good practice guide for the provision of community equipment services was issued in November 2009 by Joint Improvement Team on behalf of the Scottish Government. The aim of this guide is for it to be used as a checklist in order to benchmark and evaluate the equipment service that is being provided. In addition to the guide a self evaluation toolkit is provided which allows a number of topics to be assessed and scored which will then highlight the strengths and weaknesses allowing focus to be moved towards areas which require improvement. The evaluation has 10 sections which are

- Service Model
- Governance
- Partnership Arrangements
- Finance
- Communication
- Service User and Carer Involvement
- Assessment and Provision of Equipment
- Store Service
- Performance
- Training & Development

6.1.2 Policy

We have been provided a copy of the operational policy for Integrated Community Equipment Service. This policy was produced in September 2016 however does not appear to have gone through the correct process for approval and is not published on Beacon.

Review of the document found this more to be a procedural document rather than a policy and therefore consideration should be given towards whether this should be renamed to procedure. The policy details the scope of the ICES department and information around the service activity. This document should be reviewed in order to ensure that it captures all details of what ICES does to provide staff guidance on the service and then approved in the appropriate manner and published on Beacon. **(Recommendation 1)**

6.1.3 Procedure

Documented procedures should be in place to define working practices to ensure the processes are administered and controlled in a standard, consistent and proper manner, whether they are driven by electronic or manual means. Procedures should be reviewed at regular intervals and should incorporate any changes to the system and should be readily available and known to all relevant staff.

Our review and testing found:

- There are a number of procedural documents within the ELMS system which guides users through how to use all aspects of the system. Review of these found them to be relevant and appropriate and also easy to follow.
- We have not been provided with any processes regarding the work of the ICES manager and office staff and therefore implementing the use of formal checklists of routine tasks carried out should be considered. **(Recommendation 2)**

6.1.4 Risk Management

Risk

It was anticipated that a risk concerned specifically with the provision of equipment would have been identified at a tactical and/or operational level in support of the control measure identified in the corporate risk for Quality of Care. This would provide a more detailed assessment demonstrating what impact the failure to provide this service would have on enabling safe discharge to a home setting or minimising admission or readmission from a home setting. It would also describe what mitigating controls are in place and how assurances are being delivered within NHS D&G and beyond.

The return of the self assessment included a listing of all risks recognised in Datix for the service. All of the risk were at an operational level and did not include any tactical risks or link through to any corporate risks. Our review considers this most closely links to the corporate risk for Quality of Care. From the information we have been provided those risks at an operational level total 28 that have been assessed at a low or medium level which requires review on an annual or 6-monthly basis. None of the risks assessed through Datix have been assessed in accordance with their expected dates and none had been reviewed since 2015.

The subject of the operational risk assessments of Datix includes the use of hazardous materials, failure to deliver equipment and lone working but we have found none that capture such subject as:

- delaying discharge due to lack of required equipment
- failure to provide appropriate levels of trained and capable staffing resources to provide the required level of service
- failure to provide adequate transport to deliver equipment or
- failure to provide suitable property and conditions for storing stock in hand.

A review of all risk should be undertaken to understand the impact of failure to provide the expected levels of service activity, ensure Datix reflects this assessment accurately and is pitched at the correct level operational and/or tactically. All risk should then continue to be assessed cyclically in line with policy directives. **(Recommendation 3)**

Adverse Events

We understand from discussion that the level on adverse incident occurring is low. This appears to be borne out by the relatively low numbers seen through Datix whereby the only incidents we have been able to source are those that occurred within the Equipment Bank department or where the investigation was undertaken by the service manager.

The method of categorising incidents through Datix is varied and wide ranging and not necessarily highlighted as incidents caused by equipment we have provided from the bank or because equipment was not available and therefore either delayed discharge or caused a patient to be admitted for inpatient care. That being said, there are no specific categories set up in Datix to record against this type of incident either and so we cannot confirm that this low level of recording is entirely accurate.

From the evidence provided we have not seen any analytical information being made available for scrutiny in any discussions as a specific topic in any review meetings. This could be because there are none, but equally could be because we do not discuss this subject as a standing agenda item. Therefore we cannot report on the level of reviews or how lessons to be learned are acted upon. Management should consider how incidents of this kind are reported and how this is captured within Datix and once established should report them in a more transparent way through a recognised assurance route. **(Recommendation 4)**

Business Continuity

In our report of 2011 we commented upon A Disaster Recovery and Continuity Plan being available that had been drawn up in 2009. Review of the Continuity Plan found that it did not fully include or describe all scenarios or their potential resolutions and had not been reviewed since 2009. A revised Continuity Plan was drawn up in 2015 that met with the recommendation requirements.

As part of the self assessment we were provided with a copy of the BCP however this was not the one used to enable the previous action to be closed. We therefore reverted to the most recent copy we had and found the target date for review had passed and therefore required updating to ascertain if it is still current and relevant. The BCP template available of Beacon should be used to ensure a consistent level of information is assessed.

ICES are currently working with a limited number of staff resulting in a prioritised service being provided. In respect of this it is unlikely that ICES will be able to implement all processes as fully as would be possible should they have a full complement of staff. They have therefore invoked their BCP however wider communication with the Board informing them of this has not been escalated formally through line management or communicated to the wider organisation to raise awareness of the pressures that are being faced and the need for a prioritised service until the staffing situation improves. This should be done through the relevant risk assessment on Datix **(Recommendation 5).**

6.2 Service Activity

6.2.1 System Integrity

The electronic system ELMS, is used throughout the whole process of the equipment bank with very little manual records now being kept. There are various different portals which provide different systems in addition to various levels of access to the ELMS system

depending on the user. There is a restricted range of category of user that includes drivers, engineers and circa 400 referrers who have access levels relevant to their job roles. Each user has a unique username and password and the system requests that passwords are changed on a 4 weekly basis. All access is managed centrally by the ICES Manager and Deputy who have the System Administrator access.

All new requisitioners to the ELMS system are required to complete an online form to request access to the system which must be authorised by a confirmation email from their line manager. This form captures all the users details which are entered on the system. Only after confirmation from the line manager has been received will access be granted.

If there is inactivity on a users account for 60 days then the ELMS system automatically blocks users from the system and so should they require access again after this then another request will have to be made.

Users must ensure that their details are kept accurate and the system allows this as each user can amend and change their details such as name and base however ELMS keeps an audit trail of all changes that are made to allow investigations to be made should they be required.

There is an annual maintenance contract in place to support the ELMS system should any support be required in order to ensure smooth running and there are continuity plans in place that would allow for some manual working for a short period should the ELMS system ever fail.

The drivers use the mobile app via their iPhones or iPads which allow them to see what deliveries are required each day and also allows them to plan their route. The system provides detailed information around where the delivery is to go and also has capability to capture the signature in order to prove delivery was made. There is also how to guides on how to use the equipment attached should the driver need to refer to this when demonstrating the safe and correct use of the equipment.

The contracted engineers also have access however they cannot see any patient information and only have access to each piece of equipment and the service records of each in order to allow them to plan the maintenance required and log there service records.

Referrers are Health and Social Care professionals who assess the needs of patients and request equipment on behalf of their patient. Referrers have access that allows them to place the orders that are required for each client such as ordering equipment that is available in the ICES store by selecting the appropriate item and adding to the basket. Each item has an image attached in order that the referrer knows exactly what they are selecting. Once they have all the required items in the basket and select submit the order is then generated and someone within the ICES department will pick up for processing. This is an enhanced use of the system that has been rolled out since our last audit.

It is the system administrator's responsibility to deliver assurance that access to any system is provided to valid users at a level that is appropriate to their job role. An integral part of this process is obtaining management confirmation that this is the case therefore management should be required to confirm on a cyclical basis that the users within their service still require access at a defined level. This confirmation should also include that users understand the implications of Information Governance and Information Security and have undertaken any mandatory training associated with the system. This information should be summarised by the System Administrator so that assurance can be provided through the appropriate Information Governance pathway.

6.2.2 Equipment Management

Equipment Requests

All patients registered with a GP in NHSD&G are held within the database of ELMS where their record can be retrieved by entering search information such as CHI number, date of birth, name etc. Once retrieved any equipment provided to them from ICES is logged and attached to their records.

Equipment is issued upon receipt of an official electronic request from a professional assessor either from the Council or the Board. Each referrer searches for the client's information to ascertain if they already are in receipt of equipment. Should the client not have used the service before then a further search can be done in order to find the client and add them to the system. From this screen items that are required can then be added to the basket and submitted generating a delivery request which is then picked up by the drivers the next day where it is prepared and dispatched. A walkthrough of this system was provided and it appears to be working well.

Since our previous audit the enhanced functionality of the ELMS system is now fully in use and rolled out across all referrers. This has resulted in the removal of the paper requests and email requests resulting in a smoother process and reduction in the risk of orders going missing which may result in equipment not being delivered to clients. This has also resulted in requests being received immediately in the ICES department once the referrer presses submit which allows for the orders to be prepared in a timely manner ensuring fast and efficient delivery is made to clients.

Deliveries and Collections

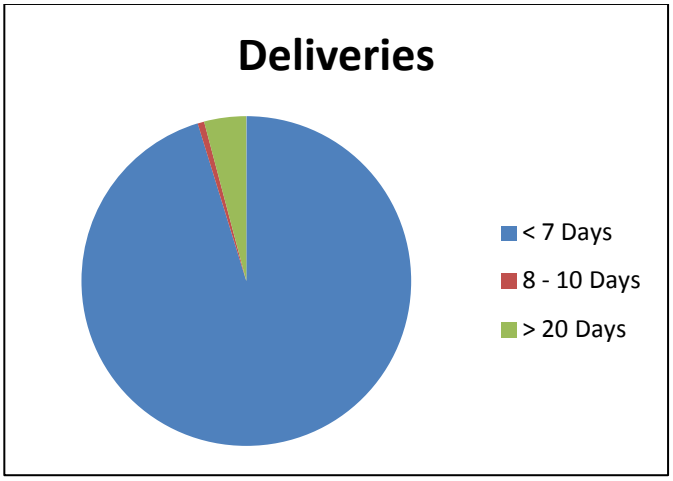
Deliveries are made each weekday across 5 planned routes. With use of the ELMS system drivers are able to see what is due for delivery and collection each day and plan the route accordingly. The GPS within the system allows the drivers to be directed straight to their destination. Upon delivery the drivers install and demonstrate the safe use of the equipment to the client after which they obtain signature as proof of delivery. Should they be required to leave the equipment in a safe place then a photo can be taken and uploaded onto ELMS as proof of delivery. The walkthrough of this system provided clarity around the process and it appears to be adequate.

Collections are made on equipment that is no longer required. This is dismantled and then loaded into the dirty section of the van before it is delivered to the decontamination unit for cleaning and repackaging ready for using again. At the decontamination unit the equipment is checked over thoroughly to ensure that it is still fit for purpose. If the equipment is no longer fit for purpose then this is recorded as to the reasons why and the date it was disposed of is recorded on manual records which are kept within the ICES department.

As part of our testing we requested information regarding the details of all referrals made and delivered for a period of time. Upon review of this information we found that for the period of August 2019 all referrals made were by an approved user on ELMS which was processed appropriately through the system in order to allow for prompt delivery of the equipment required.

Analysis of the data for the month of August, and as detailed in the chart below, revealed that 95% of the total deliveries made within the month were done so within 7 days or less, with the majority of these being with 0-2 days from referral and therefore demonstrates that

any referrals received are promptly dealt with and prioritised appropriately to ensure delays to the clients awaiting the equipment are kept to a minimum.



Review of the information provided also demonstrated that all patients contact details are maintained with details of each piece of equipment they hold, when this was delivered and the status of each to show whether it is in use, single use or has been returned. Once collection has been made then the data is updated to show the date collected and that the item is no longer in use. By maintaining this data it demonstrates that equipment is well managed and traced to the patients.

Drivers

The drivers are responsible for loading the vehicles with the deliveries for the day, delivering them to the specified location, assembling and demonstrating how to use the equipment as well as collecting equipment that is due for return. The drivers operate on a rotation schedule to ensure that the routes and mileage on the vehicles is evenly distributed.

Our testing confirms that there are no official regulations in place for the monitoring of drivers hours due to the vehicles that are used being less than 3.5 tonnes however the drivers must still comply with the Great British Domestic Rules for driving which states that the maximum amount of driving per 24hrs should be 10hrs. The working hours of 8-5 ensure that this is not exceeded. Discussions with the ICES manager confirmed that breaks are routinely encouraged however these are unable to be monitored to ensure drivers are taking appropriate lunch breaks.

Equipment Maintenance

The store manager is required to ensure there is sufficient equipment to meet the general needs of the patients/clients within Dumfries and Galloway, but also a responsibility to ensure that all equipment is appropriately serviced and maintained in line with the guidance.

The walkthrough of the system provided evidence that a well thought process exists in order to capture the routine maintenance that is required for each piece of equipment. The system allows tracking of what services are due and allows engineers to plan for future services. The ability to upload the service documents into ELMS allows a full audit trail on

each piece of equipment which allows the manager to review and raise any issues should there be any. This process appears to be efficient and adequate.

Each contractor provides a monthly report which details the services they have carried out during that month. This report is then compared with data downloaded from the ELMS system and a reconciliation is carried out to ensure that the suppliers invoice is accurate. Any discrepancies between the two are investigated as to the reasons why and appropriate action taken.

Equipment is returned via the decontamination unit where it is thoroughly cleaned and repackaged before it is sent back to the stores ready for re use.

Stock Control

All stock ordered in ICES is done via the Pecos system which only allows approved users to place orders. A database of all stock held is maintained within the ELMS system where regular monitoring of stock is carried out to determine the quantity and frequency of reordering.

We reviewed the information regarding all items that were delivered to ICES in August 2019. Review and testing of this information found that all orders were placed correctly through Pecos and approved by authorised users and coded appropriately to the ICES cost centre. Testing also confirmed that all orders received were receipted in a timely manner in the PECOS system as well as recording the delivery note numbers on the ELMS system allowing for tracking between the systems. We also tracked the orders through to eFinancials and found that all orders placed were in the financial ledger either as a purchase order or as an invoice once this had been received. From our testing it appears that the process of ordering is appropriate and sufficient.

Stock is issued from the stores in Nithbank and stock is returned to Nithbank via the Decontamination Unit at the Crichton site and there is a unique tagging system of each piece of equipment which ensures that all relevant information can be logged on the ELMS system. Equipment is 'loaned' to patients/clients to assist in recovery from an illness/accident, to provide a measure of comfort that would normally be provided in a hospital environment, or to provide an adaptation that eases day-to-day management of an infirmness or disability.

This equipment can range from a grab rail, to an air cushion through to a bed, mattress or hoist. The nature of some of the equipment requires it to be maintained which is completed to legal requirements within specified terms of contracts. From our testing and walkthrough of the system we can confirm that a robust and adequate system is in place to monitor stock levels and track where the loaned stock is. The reporting available on low stock level ensures that there is an adequate supply of stock maintained at all times preventing delays in equipment being delivered to clients homes which could result in delayed discharges.

There appears to be lack of formal procedures around stock taking and so this is required to be established either on a cyclical basis or annual stock take in order to comply with section 12.6 of the SFI's which states:

"*Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in stock at least once a year or by perpetual checks in main stores. A physical check shall involve at least one officer other than the Storekeeper, and the Director of Finance or his representative and internal and / or external Auditors shall be invited to attend. The stocktaking records shall be numerically controlled and*

signed by the officers undertaking the check. Any surplus or deficiencies revealed on stocktaking shall be reported to the Director of Finance immediately and she may investigate as necessary." **(Recommendation 6)**

6.3 Monitoring and Reporting

6.3.1 Local Monitoring and Reporting

KPI's

KPI's produced are only recorded at a local level and not national. We have been provided a copy of the stats recorded for Client orders in the month of April 2019. This report details the number of clients per age group and then how many deliveries and collections were made. We have only been provided with one month's information so unable to comment on any performance however can confirm that KPI's are produced and monitored regularly.

1 to 1's

Monthly 1 to 1's are held between the ICES Manager and the General Manager for Operational Services. There appears to be a standing agenda set for these meetings which cover 5 different areas. These are;

- **Service** – where the demand on the service and equipment issues are discussed around what is working well and where potential problems may arise. Also during this section the contracts that are in place for the servicing of the equipment are discussed and also the proposals that are being made for the future working of the ICES department such as the relocation from Nithbank.
- **People** – discussions are held around any potential staffing issues and what contingency plans are in place or require to be put in place to combat cyclical issues such as winter pressures and staff sickness. Mandatory training compliance is also discussed in this section.
- **Quality** – discussions include the contractual arrangement with the council and any reviews or issues as well as KPI's.
- **Finance** – discussions include any potential CRES savings that may have been identified or highlight any cost pressures that may have arisen due to legislation changes or unexpected costs occurring. Also updates on any bids for equipment that have been made as to how they are progressing are discussed.
- **Any Other Business**

Committee Reporting

Currently there are no formal arrangements in place for committee reporting however when requested information is provided such as the number of minor adaptations carried out in the year however this is produced via an excel spreadsheet and no formal report is written as well as this not being on a regular occurrence. Consideration should be made around attendance at a relevant standing committee. **(Recommendation 7)**

6.3.2 National Monitoring & Reporting

National Association of Equipment Providers

This group meets quarterly and is attended by various representations of health and social care partnerships for equipment banks across Scotland. They discuss areas of best practice and share issues that they are facing within their organisations in order to learn

and develop from each other. They also take the opportunity at these meetings to discuss proposals for future developments and improvements that could help with delivery of the service. Attendance at these meetings allows knowledge to be gained from a wider perspective that can assist in the development of the local service and allows for networking to build essential relationships. Demonstrations from suppliers also take place at these meetings allowing the newest pieces of equipment to be seen in action before making any decisions as to whether they should be introduced into the service or not.

7. Conclusion

Since our last audit of ICES in 2011, there continues to be clear processes in place to ensure a smooth delivery and collection service of equipment to clients. The use of the computerised system has resulted in clear audit trails and makes the processes easy to follow from picking deliveries through to the servicing of the equipment. The system allows for clear monitoring and tracking of all items.

Processes and procedures continue to be in place and working well however more formal procedures are required around routine administrative tasks and stock taking to ensure compliance with the SFI's.

From our review of the information received, there appear to be robust and adequate processes in place around the monitoring of equipment to ensure that any referrals made are done so by an approved person, dealt with promptly, prioritised appropriately and traced to the patient showing whether it is still in use or not.

From our testing of the information provided there appears to be adequate and sufficient processes in place for the ordering of stock to ensure sufficient levels are maintained within the ICES store. All orders tested were placed through Pecos, approved by authorised personnel and appropriately coded. All stock is then recorded and monitored on the ELMS system with delivery notes recorded as well as date of delivery to ensure sufficient tracking is maintained however there appears to be lack of formal procedures around cyclical stock taking.

At the time of writing this report there were staff shortages within the ICES team resulting in a reduced and more prioritised service being provided. This impacts results in increased workload for staff that are in attendance and can reduce morale. As a result of the staffing situation processes are not able to be implemented as fully as they would should a full complement of staff exist. The consequences of this should be captured in a risk assessment.

Whilst departmental monitoring is in place through line management, this has not been extended to delivering assurance on performance through the committee reporting structure and therefore this should be addressed.

8. Acknowledgements

We would like to acknowledge with thanks the help and co-operation of all staff during the course of this audit.

9. Glossary of Terms

The following details the abbreviations and associated terms encountered throughout the course of this audit report.

Abbreviation	Term
BCP	Business Continuity Plan
CCD	Community care Directorate
CRES	Cash Releasing Efficiency Savings
Datix	Risk Management system
ELMS	Equipment Loan Management System
GEN	NSS General Guidance
GPS	Global Positioning System
ICES	Integrated Central Equipment Store
IJB	Integration Joint Board
KPI	Key Performance Indicators
NHS D&G	NHS Dumfries and Galloway
SFI	Standing Financial Instructions

10. Management Action Plan

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
1	**Finding Group: Governance** **Finding Type: Policy** The Integrated Community Equipment Policy does not appear to have been approved through the correct process. In addition the policy appears to be overdue for review where consideration should be given to the content as well as whether this is actually a procedural document rather than policy. It also requires to be published on Beacon.	The Integrated Community Equipment Policy should be developed into an overarching process that captures the range of services ICES deliver and approved in line with the correct procedure.	**C**	Update and change to a procedural document , publish on Beacon **Evidence Required** Require to see sight of the updated procedural document and see it published on Beacon	Robert Mccallay	31/03/20
2	**Finding Group: Governance** **Finding Type: Procedural** There was little guidance in relation to office and management day to day duties. This fails to provide a basis on which the business continuity in the completion of any regulatory activities can be assured in the absence of one or more of the team	All aspects of the ICES department should have documented processes in place whether these are formal procedures or more informal checklists of routine tasks performed.	**B**	Departmental process document to be created covering daily/weekly tasks. Process flow flowchart **Evidence Required** Require to see sight of the process document and flowchart.	Robert Mccallay	31/03/20
3	**Finding Group: Risk Management** **Finding Type: Procedural** Datix has not been populated with risk assessments consistently at a tactical and operational level demonstrating how the ICES process could fail and the mitigating controls that have been	The identification of a risk(s) at a tactical and/or operational level across all directorates would endeavour to demonstrate how the risk to ICES process is being managed. Mitigating controls would include the	**C**	Risks to be listed on Datix capturing relevant areas of service provision. Most of the risks are captured on ICES business continuity plan	Robert Mccallay	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	established to minimise adverse events and monitor those that cannot be avoided. In addition current operational risks have not been reviewed in line with their current risk grading. This fails to support the Corporate Risks and is contrary to the risk Management Strategy.	monitoring role of the various oversight groups that provides assurance to both Health and IJB standing committees.		**Evidence Required** Require to see sight of these risks taken from BCP and put onto Datix and managed in accordance with guidance as per the Risk Management Strategy.		
4	**Finding Group: Risk Management** **Finding Type: Policy** The current set up of Datix does not provide for highlighting incidents that have an equipment related element in order to establish any incidents related to equipment provided by ICES department. In addition there also appears to be no reporting of incidents and so unable to review how lessons are learned and acted upon. This fails to comply with the Significant Adverse Events Policy	Datix should be amended in order to provide a category to capture equipment related issues and once established the information should then be gathered and monitored appropriately. **Suggested evidence to close** The "who else needs to be informed" box on Datix needs to be amended to include ICES Manager so that this field is available at the point the incident is being raised (contact Jean Wilson)	**B**	The "who else needs to be informed" box on Datix needs to be amended to include ICES Manager so that this field is available at the point the incident is being raised (emailed Jean Wilson on 13/11/2019 to update Datix) **Evidence Required** Require to see confirmation that this ICES Manager has been added to Datix as an option.	Robert Mccallay	31/03/20
5	**Finding Group: Risk Management** **Finding Type: Procedural** The business continuity plan provided has passed its target review date and therefore requires reviewed to ensure it is still appropriate and relevant.	A review of the business continuity plan should be carried out updating where required as well as all scenarios identified being risk assessed.	**B**	Revise Business continuity plan and ensure compliance **Evidence Required** Require to see sight of the revised Business Continuity Plan.	Robert Mccallay	31/03/20

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
	In addition the formal template has not been used and so therefore does not include risk assessments for the various scenarios and their impact. This fails to comply with the Business Continuity Framework.					
6	**Finding Group: Governance** **Finding Type: Policy** It was found that there are no formal stock taking processes in place either on a cyclical or annual basis. This fails to comply with the guidance of the SFI's.	A formal procedure should be established and implemented in order to ensure regular stock taking is performed in accordance with the SFI's.	**C**	Formal stock recording was dropped at the request of Finance dept as ICES stock was not on Boards Financial accounts balance sheet. Re-commence recorded and signed weekly / monthly stock check **Evidence Required** Require to see sight of regular completed stock checks.	Robert Mccallay	31/03/20
7	**Finding Group: Governance** **Finding Type: Regulatory** It was found that assurances were not being provided through any formal route to any standing committee which gives the Board or IJB overall assurance in the performance of ICES.	There is a need to establish formal reporting arrangements of ongoing ICES performance through the committee reporting structure.	**C**	Process started via David Bryson and George Noakes September 2019 – evidenced in 1:1 meeting minutes **Evidence Required** Require to see sight of the minutes showing the report and which committee it was discussed.	Robert Mccallay	31/03/20

NHS Dumfries & Galloway

Internal Audit

FINAL REPORT

SERVICES FOR OLDER PEOPLE

A-09-19

Audit Completed:	September 2019
Preliminary report issued:	28/10/19
Management Action Plan to be returned by:	25/11/19
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Summary of Audit Findings

The table below summarises the grades of audit recommendations as they sit against each of the audit objectives.

Audit Objective	Recommendations			
	A Low risk	**B** Medium risk	**C** High risk	**D** Very High Risk
To confirm that the appropriate levels of governance are in place incorporating any relevant guidance or legislation into policy, procedure, risk management and delegated authority that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of management and staff.	-	-	**1**	-
To confirm application of the standards can be demonstrated, whereby outcomes are supported by an appropriately detailed audit trail that has been communicated to all parties including the patient and/or carer.	-	-	-	-
To confirm that there is an ongoing process of review whereby application of the standards is monitored, shortcomings are being identified any corrective actions are implemented within an acceptable timescale.	**1**	-	-	-
Reporting on standards is accurate and consistent at every level in the organisation up to and including Board. These statistics are accurately reported in accordance with any related external requirements.	-	-	-	-
To confirm that recommendations from previous audit or inspection reports have been fully implemented.	-	-	-	-

Level of assurance	**Significant**

Introduction

1. Audit Scope

To provide assurance that NHS Dumfries & Galloway is meeting its responsibilities in relation to the services for older people in Scotland in accordance with the relevant guidance laid down by applying the standards consistently, measuring the success of their application, identifying shortcomings and implementing the appropriate corrective measures in a transparent and supported manner.

2. Audit Objectives

2.1 To confirm that the appropriate levels of governance are in place incorporating any relevant guidance or legislation into policy, procedure, risk management and delegated authority that is current, relevant, sufficiently detailed and has been communicated to all relevant levels of management and staff.

2.2 To confirm application of the standards can be demonstrated, whereby outcomes are supported by an appropriately detailed audit trail that has been communicated to all parties including the patient and/or carer.

2.3 To confirm that there is an ongoing process of review whereby application of the standards is monitored, shortcomings are being identified any corrective actions are implemented within an acceptable timescale.

2.4 Reporting on standards is accurate and consistent at every level in the organisation up to and including Board. These statistics are accurately reported in accordance with any related external requirements.

2.5 To confirm that recommendations from previous audit or inspection reports have been fully implemented.

3. Overview

Services for Older People are governed by a number of standards and pieces of guidance on areas that range from wide reaching professional practices to more focussed detailed day to day activities. These include:

- The Healthcare Quality Strategy which states;

  The Quality Ambitions
  Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

  There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

  The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

- The Scottish Patient Safety Programme (SPSP) Acute Adult which has been in place since 2008 and *aims to reduce harm and mortality for people in NHS Scotland's acute hospitals. SPSP Acute Adult works with clinical and improvement teams in NHS Scotland boards to develop, test and implement processes that will further improve reliable care delivery across a range of clinical areas. The Acute Adult programme supports boards to work on reducing harm from deterioration, including Sepsis and Acute Kidney injury, Falls, Pressure Ulcers and CAUTI*.

- The Excellence in Care report was issued following the publication of the Vale of Leven Hospital Inquiry Report. In 2015 the Cabinet Secretary for Health, Wellbeing and Sport announced that the Chief Nursing Officer would work with Nurse Directors to roll out care quality assurance programmes for nursing and midwifery within all hospitals and community settings. This included a commitment to developing a dashboard of measures around nursing care.

- Part 5 of the Public Services Reform (Scotland) 2010 which describes the key definitions of Social Care and Social Work Improvements and how they will be inspected. Inspections are conducted by Healthcare Improvement Scotland (HIS) and the Care Inspectorate.

- The Health & Social Care Standards introduced by Scottish Government in June 2017 replacing the National Care Standards published in 2002. The guidance states that the standards are expected to *'drive improvement, promote flexibility and encourage innovation in how people are cared for and supported'* and '*are*

applicable to the NHS, as well as services registered with the Care Inspectorate and Healthcare Improvement Scotland'.

- The Care of Older People in Hospital Standards were issued in 2015 by Healthcare Improvement Scotland (HIS) following a review and subsequent update of the Clinical Standards for Older People in Acute Care that had been in place since 2002. The document states that *Care of Older People in Hospital details 16 standards that all NHS Boards should use to assess their standards of care and identify areas for local improvements* with an expectation that NHS boards will *work towards achieving these standards*.

This audit aims to provide assurance that services for older people are provided in accordance with these standards and as such forms part of the audit plan for 2018/19.

4. Approach

To gain an oversight of the process we requested a range of information to be provided in the form of a checklist. Discussions were held to verify the information provided and determine the current processes in place. We then validated the discussions by undertaking focussed testing where appropriate.

We identified the personnel whose main role is to manage Services to Older People and gathered key documentary evidence which was either available on Beacon or provided by departmental staff.

Previous Audit

5. Previous Findings

5.1 Internal Audit

There have been no previous audits undertaken by Internal Audit.

5.2 External Reporting

Healthcare Improvement Scotland (HIS) inspection

In January 2017 Healthcare Improvement Scotland (HIS) carried out an unannounced inspection at DGRI on the Care of Older People in Acute Hospitals. The inspection focussed on the three national quality ambitions for NHS Scotland which aim to ensure that all care is person-centred, safe and effective.

This inspection was carried out prior to the move to the new DGRI and highlighted 6 areas of good practice as well as 12 areas for improvement

Following the inspection an improvement action plan was created in March 2017 setting out the actions that were planned, the timescale to meet each action and who was responsible. This was supplemented with 3 templates representing 3 levels of assessment that are conducted by nursing staff to confirm the status of each of the standards. This action plan was signed off by the Chairman and Chief Executive, prior to submission to HIS with ongoing improvement to be managed locally.

We can confirm that progress updates were provided and thereafter were linked and monitored through the Care Assurance Process.

Care Inspectorate

In October 2016 the Care Inspectorate carried out a joint inspection of Adult Health and Social Care services in relation to services for older people. The purpose of this inspection was to assess whether health and social work services improved outcomes for older people and their carers.

An assessment was made against the 9 quality indicators and 7 were found to be '**adequate**' which recognises "*strengths just outweigh weaknesses"* and 2 were found to be '**good**' which recognises "*strengths with some areas for improvement"*. The outcome resulted in 10 recommendations requiring improvement.

An improvement plan was developed in December 2016 based on five themes of;

- Governance
- Performance Management
- Leadership & Communication
- Quality & Delivery of Services
- Learning & Development

The improvement plan was created in accordance with report requirements and status of implementation was reported to the Chief Officers Group and the Clinical and Care Governance Committee of the Integration Joint Board. We can confirm that progress updates were provided and thereafter were linked and monitored through the Health & Social Care Management Team.

Current Audit

6. Audit Findings

6.1 Governance

6.1.1 Guidance

As stated in section 3 above, there are a range of initiatives and other pieces of guidance that are linked to care of older people. We have been provided with Scottish Government Health & Social Care Standards and Healthcare Improvement Scotland Care of Older People in Scotland Standards, which are considered to be the principal pieces of guidance.

Health & Social Care Standards

The Health & Social Care Standards were issued by the Scottish Government in June 2017 replacing the National Care Standards published in 2002.

The standards set out what service users should expect when using health and social care services and seek to provide better outcomes for everyone. These standards are now applicable to the NHS as well as services registered with the Care Inspectorate and Healthcare Improvement Scotland. From the 1st April 2018 these standards were taken into account by Care Inspectorate, Healthcare Improvement Scotland and other scrutiny bodies in relation to inspection and registration of health and care services. The key outcomes for service users are:

- I experience high quality care and support that is right for me.
- I am fully involved in all decisions about my care and support.

- I have confidence in the people who support and care for me.
- I have confidence in the organisation providing my care and support.
- I experience a high quality environment if the organisation provides the premises.

Care of Older People in Hospital (COPH) Standards

The Care of Older People in Hospital (COPH) Standards were introduced in 2002 and were revised in June 2015 by Healthcare Improvement Scotland to recognise the integration of Health and Social Care. When creating these Standards the document quotes 64 pieces of current legislation, programmes, initiatives and standards that have been referred to and in respect of inspections should be used alongside other standards such as:

- Standards of Care for Dementia in Scotland
- Standards for Food, Fluid and Nutritional Care and
- Best Practice Statement for the Prevention and Management of Pressure Ulcers

Healthcare Improvement Scotland is the body that supports NHS boards in the delivery of safer healthcare. Scottish Government have issued the NHS Scotland Healthcare Quality Strategy and the 2020 Vision in addition to a range of other guidance and legislation such as the Equality Act 2010, however Care of Older People in Hospital remains the key guidance in this process.

6.1.2 Policy & Procedure

The range of programmes, initiatives and standards regulate how all care should be delivered and must be followed by NHS Dumfries and Galloway. In order to draw all initiatives together we introduced a Care Assurance Framework. This framework was developed from the COPH standards, working on the belief that if these standards are applied (where appropriate) to all those in receipt of services they will receive high levels of care. These standards include Care of Older People in Hospital 2015, Food Fluid & Nutritional Care 2014, Complex Nutritional Care 2015 and the Dementia Care Standards Framework

The aims and objectives of the Care Assurance system are:

- To act as a means to ensure consistency in the delivery of high quality standards of care which has a positive impact on people who use the health care services in inpatient settings within Acute, Community and Cottage Hospitals.
- To reflect national and local priorities.
- To identify and celebrate good practice and promote the dissemination of good practice throughout the organisation.
- To identify areas of practice not meeting the locally agreed Standards and understand where this may be Board wide.
- To provide support to continuously improve using knowledge and information gained from the Care Assurance Report for each area and across the Board.

A series of templates were created to enable three levels of assessment to be undertaken. Level 1 is undertaken weekly in each area by a senior charge nurse along with a registered nurse and Level 2 should be undertaken monthly by a nurse manager along with a registered nurse. Level 3 is a 6-8 month check that is undertaken by nominated assessors who will make unannounced visits to verify how the standards and weekly checks are being maintained.

Whilst this is not a policy, as such, all areas of the relevant guidance have been captured and the documents are used as procedural as well as having monitoring arrangements. This local version of implementation was endorsed through Healthcare Governance Committee for Health and via the Clinical Governance Committee and Health and Social Care Management Team for the IJB.

6.1.3 Risk Management

Risk

We were advised through the assessment response that all risk is captured within the directorate risk registers however no link was provided to any corporate risks. We have reviewed the risks on Datix and found that at a corporate/strategic level the most relevant risk is 2399 - Quality of Care. This risk assesses the '*Failure to assure and improve the quality of care and services*' and refers to the development of the Care Assurance process as one of its current control measures. This appears to be the most appropriate risk in respect of services for older people.

It would be expected that a risk concerned specifically with care assurance would be identified at a tactical and/or operational level across all Health Services directorates in support of the control measure identified in the corporate risk for Quality of Care. This would provide a more detailed assessment demonstrating how services including those for older people are driven and how assurances are being delivered within NHS D&G and beyond.

At a tactical level we have identified a number of risks within the Community that have assessed the potential for risk failures within the care services provided within home, care home and the cottage hospital settings, all of which incorporate older people. We have not found a similar level of risk assessment within any of the other directorates.

At an operational level there are a number of risks that can be associated with this process. Those within the Community are more directly relevant, are fully detailed and have been reviewed in line with target dates. Risks identified from other directorates are not as well described and some have not been reviewed for a number of years and so the relevance or current status cannot be supported.

In general the perpetual checking and monitoring taking place within the Care Assurance Process is not being used as a control measure in any risk assessment on Datix other than the corporate risk. We would ask that all risk is assessed in more detail at both a tactical and operational level to further support the mitigating controls within the existing corporate risk. **(Recommendation 1)**

Adverse Events

The method of capturing incidents through Datix is varied and wide ranging and not necessarily categorised under a heading 'Services for Older People'. However the sections listed within the Care Assurance assessment process are mirrored within the reporting categories available within Datix and are therefore reportable.

The process for reviewing adverse events in an acute setting is the same whatever the cause or categorisation. All new incidents are triaged on a weekly basis, discussed and escalated where appropriate, added to which a further weekly review is also undertaken by the Patient Safety Group, where risk is assessed based on specific topics.

As part of the Care Assurance templates, questions are asked to staff around incidents to ensure that staff are aware of the ongoing issues and what the lessons learned have been. The information captured from these assessments informs these conversations such as falls and pressure ulcer data. This ensures that all staff in each area are aware of the common themes and can all take steps to make improvements.

6.2 Service Activity

We previously referred to a range of activities that are undertaken that are not exclusively age related but are undertaken to improve or better understand care in relation to Services for Older People.

6.2.1 Examples of Care Programmes

Dementia Champions

The Board has a number of dementia champions trained across a wide range of clinical and non clinical departments. There is also a dementia framework that has been agreed between the NHS, local authority, 3rd Sector and Independent Sector Partners. The framework is overseen by a multi agency Dementia Strategy Steering Group which reports through Healthcare Governance Committee.

In 2016 there were circa 140 trained Dementia Champions across the region. Refresher training is delivered regularly to ensure that the knowledge is kept up to date and is the most relevant and appropriate.

Frailty at Front Door

Healthcare Improvement Scotland introduced Frailty at the Front Door in December 2017 which saw five NHS Boards work together to test the potential approaches to improving care coordination for people with frailty who present to Unscheduled Acute Care Services. NHS D&G were part of this pilot.

Prior to this initiative being introduced NHS D&G had no routine frailty screening or screening tool, no frailty pathway and no data to compare and monitor performance. Since working with HIS there is now a frailty screening tool in place and an icon is available on Cortix to identity Frailty. A frailty interest group has also been established however data collection is still being developed.

One Team Approach

Nithsdale Locality is piloting the development of a one team approach which is a model that focuses on a proactive rather than a reactive approach. The overall aim is to focus approaches which support people to live as independently and as safely as possible at home making the best use of tools that are available such as Anticipatory Care Planning.

The one team sees GPs, DGRI and Community Social Work working together in order to establish the best pathways of care. This was initially started off with two Dumfries Practices and collaboration with Ward 18 in DGRI in 2016 before this was planned to be rolled out further.

This is Me

"This is me" is a passport that has been produced locally for use in health care environments. It is for anyone receiving professional care who is living with dementia or experiencing delirium or other communication difficulties. It is a simple passport that encourages the person to complete details around their lifestyle, routine and what is important to them. It is designed to help health professionals understand better who the person is that they are treating in order to deliver more person centred care and in return reduced distress for people with dementia.

As part of the self assessment it was highlighted that sometimes the "This is me" documents can be removed from bedsides when in acute settings rather than being with the person so all health professionals can read it. There were also concerns from care homes around sending the leaflets in due to them not being returned upon patients discharge. The use of these passports is monitored through the Care Assurance Framework.

5 MUST Do's

The "5 MUST Do's" is a practical approach that was introduced in order to ensure person centred care is being delivered. The 5 MUST Do's are;

- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me without me
- Personalised Contact

These 5 questions should be asked upon admission to ensure that the care provided is the most relevant and appropriate to the patient that is being treated. The performance of this being carried out is monitored within all the levels of the Care Assurance Framework that are completed.

6.2.2 Care Assurance Framework

The Care Assurance Framework templates were introduced in 2016 in order to review the care that patients are receiving and identify any further actions that require to be put into place. There are 3 levels of care assurance templates that require to be completed;

At Level 1 the Senior Charge Nurse alongside a Registered Nurse will undertake 4 reviews, 1 each for 4 different patients, during the course of a week. In addition a Level 2 assessment is carried out by the Nurse Manager together with a Registered Nurse for 1 patient. One template is used to record Level 1 and 2 assessments and reviews a patient's experience of the healthcare they are receiving as well as assessing whether they know what the next steps of treatment, care and support journey are. It then requires reviews of the patient's records to ensure all relevant documents related to their care have been captured and are up to date and accurate. Levels 1 and 2 consider care across 10 categories;

- Patient Engagement
- Medicines
- Deteriorating patient/Sepsis/Think Delirium
- Food, Fluid & Nutrition
- Invasive Devices

- CAUTI
- Falls
- Pressure Ulcers
- Communication
- Person Centred Care

Once the level 1 and 2 assessments have been completed then the results are reviewed. This is done by the nurse managers for each area. After the results have been reviewed an action plan is created which details the action required to be taken, the target date for achieving the outcomes set and the persons responsible for ensuring the action is completed.

We undertook a walkthrough of the process and were shown a number of action plans for various wards and community hospitals and can confirm they appear to be robust and monitored regularly.

Level 3 assessments are carried out every 6-8 months for each ward, cottage hospital and community hospital, are unannounced and are undertaken by a number of assessors at different times in order to give a view of the hospital over a period of time. The assessment is undertaken by independent assessors who work through the set criteria on the template together with 5 patient's currently receiving care. The standards assessed are across a range of categories and are complemented with a set of general and care observations in relation to:

- Falls
- Pressure Ulcer Care
- Food, Fluid & Nutrition
- Person Centred Care: "What and Who Matters to Me", maintaining dignity and privacy
- Cognition: Delirium, dementia, assessment and prevention of decline in cognition, depression, decision making, consent and capacity.
- Pharmaceutical care and medicine management.
- Patient pathway and flow, pre-discharge planning, Care Transitions and Rehabilitation.
- Skills mix and staffing levels.
- Infection control.

There are currently 8 independent assessors who are available to undertake these assessments. The target is for each area of ward and hospital to have completed level 3 care assessments twice yearly, however due to staffing difficulties within the wards and the continuing roll out of this process, the target is not currently being achieved. There is also a target of a 4 week return of the assessments however it is taking 8 weeks currently in some areas which is also hindering the ability to perform the assessments twice annually.

The level 3 assessments are made up of a bank of core questions however there is the ability to include a number of questions relating to specific topics such as pressure ulcers and adverse incidents. These optional topics are selected by the senior charge nurses in order to address key issues that they feel are ongoing within their wards.

As part of our focussed testing we undertook a walkthrough of the process where we spoke to the lead for the project in order to gain an understanding of the process. During this time we were shown a variety of completed level 3 assessments across a range of hospitals and wards. The information appeared to be well populated and scored consistently. The results are then analysed and scored in order to establish whether the area is working

towards bronze, silver or gold. 3 consecutive gold awards results in an exemplary award being issued. Currently the majority of areas are continuing to work towards achieving the bronze award.

The scores from each report are then collated and compared across all areas in order to establish any trends and common themes that require to be addressed. These issues can be addressed by inserting some of the optional questions into the standard template. Currently each section is compared across areas however developments are underway in order to record the scores for each individual question and analyse the trends and key questions that are bringing the overall scores down. We were shown these monitoring spreadsheets and compared the information with the hospital reports and they appear to be accurate and consistent.

A report is produced regularly for Health Care Governance Committee with the results of all the level 3 assessments that have been completed in order to establish any trends and common themes that may need addressed. We have seen examples of completed care assessments and compared the results tables to the figures presented in the report and confirm they appear to be consistent.

The process is still being rolled out across all areas and so at this stage not all wards and hospitals have completed a level 3 care assurance assessment. We have seen a spreadsheet that monitors which areas have completed assessments and when they were completed however there is currently no database to monitor the areas that the process is still to be rolled out to.

This audit is focussing on services for older people however these care assurance assessments cover all areas of healthcare and the process is currently being rolled out across Women and Children's' Services as well as District Nursing.

6.2.3 Older People in Acute Hospitals Self Evaluation

This evaluation has been produced by HIS and was revised to reflect the updated Healthcare Improvement Scotland's Care of Older People in Hospital: Standards (2015) and other related national standards and guidance. It contains the key elements of the older person's journey within the hospital setting from admission to discharge and recognises essential supporting outcomes such as the knowledge and competence of staff, effective leadership and accountable management to support effective patient care.

The self evaluation was designed to provide a clear structure in which to demonstrate strengths as well as identifying areas for improvement. This assessment should be reviewed, updated and submitted alongside a folder of evidence on a 6 monthly basis.

The self evaluation looks at 12 outcomes which are;

- Screening and Initial Assessment
- Person Centred Care Planning
- Long Term Conditions
- End of Life Care
- Cognitive Impairment
- Food, Fluid & Nutrition
- Falls
- Pressure area care
- Care Transitions
- Skills and accountability

- Leadership & management
- Communication

As can be seen above there is duplication in the areas reviewed within these individual frameworks. We have been provided with the initial self evaluation that was completed in March 2016. Since that time the outcomes assessed within this evaluation have been aligned with the Care Assurance framework and are now reviewed within the Level 3 assessments.

6.3 Monitoring and Reporting

6.3.1 Older People Dumfries & Galloway Steering Group

The remit of this group as detailed in the terms of reference is to provide assurance about the care of older people in Dumfries & Galloway with parties working together to ensure that all associated standards are applied and monitored. The group provides leadership and oversees the delivery of 5 key areas;

- Standards of care for older people in hospital
- Food, Fluid & Nutritional Care Standards
- Care Assurance/Excellence in Care
- Dementia Strategy (non specialist services)
- Action plans resulting from inspection

The group membership is multiagency and multidisciplinary reflecting the critical partnerships that are required. The membership also includes carer and public representatives. It meets quarterly and reports to the Clinical & Care Governance Committee of the IJB and the Health & Social Care Management Team. In addition cyclical updates are also provided to Healthcare Governance Committee. We have also observed discussion of this work at Health Board Committees and Groups but this is not formalised or part of structured agenda items.

We have been provided with minutes from the Steering Group's meetings that demonstrate the level of scrutiny undertaken.

6.3.2 IJB Clinical & Care Governance Committee

The remit of this group is to the provide assurance to the IJB *with regard to Clinical and Care Governance systems and outcomes to the NHS Board via the Healthcare Governance Committee, and the Local Authority for Adult Social Work Services via the Social Work Committee.* In respect of Services to Older People this committee will review reports received highlighting any risks and endorse any action plans for addressing these risks after which the committee will then monitor progress being made.

We can confirm that the work of the Older People Dumfries & Galloway Steering Group has been approved by this committee and updates are expected annually. However this is at odds with the Terms of Reference for the group which states that 4 monthly updates are provided. The ToR should be updated to reflect that annual updates are provided to IJB Clinical Governance Group, or alternatively updates should be provided more frequently. **(Recommendation 2)**

6.3.3 Healthcare Governance Committee

The Healthcare Governance Committee is a standing committee of the Health Board and as such is tasked with providing assurance in relation to a range of subjects one of which is clinical governance. In relation to this process Care of Older People is discussed at Healthcare Governance Committee from updates from the Older People Dumfries & Galloway Steering Group and through the Excellence in Care Lead. Updates are presented at alternate Committee meetings.

6.3.4 Care Assurance Indicator Resource (CAIR)

A national CAIR Dashboard has been developed and is continually being developed to provide a source of external reporting in relation to excellence in care across nursing and midwifery. The CAIR dashboard currently has a number of measures however more are being added regularly. Currently measures range from establishment variance through to pressure ulcer rates and inpatient falls rates.

As part of a national programme we are working towards developing ways to measure against these criteria and testing the potential measures. Currently we are working on Food, Fluid and Nutrition measures as well as Maternity skin to skin measures. This is a relatively new process and is therefore not completely rolled out.

7. Conclusion

Services for Older People are embedded within many of the processes in place across the Board. Policy and direction is taken directly from national guidance and standards and compliance is assessed and enforced through the Care Assurance programme.

This work is captured in focus within the Older People Dumfries and Galloway Steering group and assurance is delivered as part of many other strategies and programmes in place through IJB Clinical and Care Governance Committee as well as the health board's Healthcare Governance Committee.

The information we have reviewed supports that delivery occurs through day-to-day activity and that monitoring via self assessment and independent means provides a perpetual status review that is reportable in a clear and meaningful way.

One potential gap in this oversight is the consistent and appropriate reflection of the risks associated with this process through risk assessments within Datix, particularly at a tactical and operational level to ensure they fully support this strand of control within the Quality of Care corporate risk. This should be reviewed.

Discussions with the Excellence in Care Lead revealed that formal reporting is undertaken externally in relation to Excellence in Care via the national Care Assurance Indicator Resource where the information from this is analysed by Scottish Government. This dashboard is continually being developed with more measures being added regularly.

8. Acknowledgements

We would like to acknowledge with thanks the help and co-operation of all staff during the course of this audit.

9. Glossary of Terms

The following details the abbreviations and associated terms encountered throughout the course of this audit report.

Abbreviation	Term
CAUTI	Catheter Associated Urinary Tract Infection
CAIR	Care Assurance Indicator Resource
COPH	Care of Older People in Hospital
Datix	Risk Management system
DGRI	Dumfries and Galloway Royal Infirmary
FFN	Food, Fluid and Nutrition
GP	General Practitioner
HIS	Health Improvement Scotland
IJB	Integration Joint Board
NHS D&G	NHS Dumfries and Galloway
SPSP	Scottish Patient Safety Programme
ToR	Terms of Reference

10. Management Action Plan

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
1	**Finding Group: Risk Management** **Finding Type: Procedural** Datix has not been consistently populated with risk assessments at a tactical and operational level demonstrating how Services for Older People could fail and the mitigating controls that have been established to minimise adverse events and monitor those that cannot be avoided. This fails to support the Quality of Care Corporate Risk	The identification of a risk(s) at a tactical and/or operational level across all directorates would endeavour to demonstrate how the risk to Services for Older People is being managed. Mitigating controls would include the role of the Care Assurance framework and the oversight of the Older People Dumfries and Galloway Steering Group that provides assurance to both Health and IJB standing committees.	**C**	One of the functions of the newly established Tactical Health, Safety and Risk Group is: To monitor risk registers and ensure mitigation/management of risk. Each Directorate must report to the THS&R group regularly, including risks & Care Assurance results – Care Assurance is closely aligned to the Care of Older People in Hospital HIS standards and both Directorate specific and Partnership wide concerns are raised through Healthcare Governance and Clinical and Care Governance Committees The responsible managers will ensure that services for older people are considered as part of this reporting mechanism to TH,R&S Group **<u>Evidence Required</u>** The process detailed above allows for monitoring of identified risks. We require to see sight of a risk(s) being raised on Datix in relation to Services for Older People. Risk 2755 has since been created and on review of this is well populated and sufficient evidence to close this action.	Nicole Hamlet & Alice Wilson	This is on-going however it is reasonable to have this established by end June 2020

	Audit Findings and Recommendations			Management Response		
No	**Key Risk / Control weakness**	**Recommendation**	**Grade**	**Management Action**	**Manager Responsible**	**Target Date**
2	**Finding Group: Governance** **Finding Type: Monitoring** The Terms of Reference for the Older People Dumfries and Galloway Steering Group state that status updates will be provided to IJB Clinical Governance Committee on a 4 monthly basis. However the committee only requires updates on an annual basis.	The Terms of Reference for the Older People Dumfries and Galloway Steering Group should reflect the correct frequency of updates for the respective standing committees.	A	Terms of Reference for the OPPDG Steering Group are due for review, beginning November 2019 **<u>Evidence Required</u>** Require to see sight of the reviewed terms of reference showing the correct frequency of updates for the respective standing committees.	Alice Wilson	February 2020