To: **Renfrewshire Health and Social Care Integration Joint Board Audit, Risk and Scrutiny Committee**

On: **18 November 2022**

Report by: **Chief Internal Auditor**

Heading: **Summary of Internal Audit Activity in Partner Organisations**

1. Summary

1.1 The Renfrewshire Health and Social Care Integration Joint Board directs both Renfrewshire Council and NHS Greater Glasgow and Clyde to deliver services that enable the Renfrewshire Integration Joint Board to deliver on its strategic plan.

1.2 Both Renfrewshire Council and NHS Greater Glasgow and Clyde have Internal Audit functions that conduct audits across each organisation and report the findings of these to the respective audit committees.

1.3 Members of the Integration Joint Board have an interest in the outcomes of audits at both Renfrewshire Council and NHS Greater Glasgow and Clyde that have an impact upon the Integration Joint Board's ability to deliver the strategic plan or support corporate functions.

1.4 This report provides a summary to the Renfrewshire Integration Joint Board's Audit, Risk and Scrutiny Committee of the Internal Audit activity undertaken within these partner organisations.

2. Recommendations

2.1 That the Integration Joint Board Audit, Risk and Scrutiny Committee are asked to note the contents of the report.

3. Renfrewshire Council Internal Audit Activity

3.1 The following Internal Audit reports have been issued to the Renfrewshire Council, which are relevant to the Integration Joint Board from 1 April 2022 to 30 September 2022.

Audit Engagement	Assurance Level (note 1)	Number and Priority of Recommendations (note 2)			
		Critical	Important	Good Practice	Service Improvement
Self-Directed Support	Substantial	0	0	2	0
Creditors	Reasonable	0	2	1	0

Note 1 – For each audit engagement one of four assurance ratings is expressed:
Substantial Assurance – The control environment is satisfactory
Reasonable Assurance – Weaknesses have been identified, which are not critical to the overall operation of the area reviewed
Limited Assurance – Weaknesses have been identified, which impact on the overall operation of the area reviewed
No Assurance – Significant weaknesses have been identified, which critically impact on the operation of the area reviewed

Note 2 – Each audit recommendation is assigned a priority rating:
Critical Recommendation - Addresses a significant risk, impacting on the area under review
Important Recommendation – Implementation will raise the level of assurance provided by the control system to acceptable levels
Good Practice Recommendation – Implementation will contribute to the general effectiveness of control
Service Improvement – Implementation will improve the efficiency / housekeeping of the area under review

3.1.1 Self-Directed Support

The objectives of the review were to ensure that:

1. Individuals who may be eligible for self-directed support are identified and there are mechanisms in place to engage with those individuals to determine how services are to be provided.
2. Assessments for services provided are undertaken in line with eligibility criteria and approved procedures.
3. Care plans provided meet assessed needs within available budgets and decisions about services provided are appropriately evidenced.
4. Direct payment agreements clearly outline the responsibilities of the council and the client.
5. Services provided are adequately monitored to ensure expected outcomes are met.

The audit identified that satisfactory arrangements are in place to engage with, assess and provide support and care for eligible clients. The only audit findings identified during this review related to good practice associated with review dates for procedures and recording of information. The auditor has therefore made a provision of substantial assurance for the area reviewed.

3.1.2 Creditors

The objectives of the audit were to ensure that: -

1. There were documented procedures for the creation of new creditors;
2. There were adequate controls to ensure that only valid creditors are created;
3. There was adequate segregation of duties in relation to the creation of new creditors.

The audit identified that superuser access alongside operational access for one of the systems has the potential to create a lack of segregation of duties. Management have accepted that this risk is mitigated as far as possible with the superuser not undertaking those operational tasks.

The controls in place over the five procurement systems tested are generally satisfactory. The auditor has made a provision of reasonable assurance for the areas tested.

4 NHS Greater Glasgow and Clyde Internal Audit Activity

4.1 The following Internal Audit reports have been issued to the NHS Greater Glasgow and Clyde Audit and Risk Committee from 1 July 2021 to 30 September 2022, which are relevant to the Integration Joint Board. A summary has been provided for those reports, with recommendations graded from limited risk exposure to very high risk exposure and improvements graded from effective to major improvement required. The internal audit service is provided by Azets.

Audit Review	Audit Rating (note 1)	Risk Exposure and Number of Recommendations (note 2)			
		Very High	High	Moderate	Limited
Assurance Framework – Directorate Risk Register	Minor Improvement Required	0	1	1	0
Bed Management	Minor Improvement Required	0	0	2	0
ICT Service Delivery	Minor Improvement Required	0	0	6	0
Financial Systems Health Check – Procurement and Tendering	Substantial improvement required	0	3	4	0
HEPMA – Project Governance	Minor Improvement Required	0	0	2	0
Remobilisation Planning	Effective	0	0	2	0
Recruitment	Minor Improvement Required	0	0	4	0

Note 1 – For each audit review one of four ratings is used to express the overall opinion on the control frameworks reviewed during each audit:
Immediate major improvement required – Controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met.
Substantial improvement required - Numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and objectives should be met.
Minor improvement required - A few specific control weaknesses were noted; generally however, controls evaluated are adequate, appropriate and effective to provide reasonable assurance that risks are being managed and objectives should be met.
Effective - Controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.

Note 2 – Each audit recommendation is assigned a risk exposure rating:
Very high risk exposure - major concerns requiring immediate senior management attention.
High risk exposure - absence / failure of key controls.
Moderate risk exposure - controls not working effectively and efficiently.
Limited risk exposure - controls are working effectively but could be strengthened.

4.1.1 Assurance Framework – Directorate Risk Register

The objectives of the review were to ensure that:

1. In line with the requirements of the NHSGGC Risk Register Policy, each Directorate has a documented process in place outlining its approach to identifying current and emerging risks.
2. Risks are recorded consistently across each Directorate and there is an appropriate governance structure in place to facilitate ongoing monitoring of risks at this level, and
3. There is clear guidance in place that clearly articulates the circumstances under which risks should be escalated to the Corporate Risk Register and the processes for doing so.

In recognising the need for improvement in this area, NHSGGC has made significant efforts to improve risk management arrangements over the past eighteen months as part of the wider Active Governance Programme. Most notably, a revised Risk Management Policy and Guidance document and overarching Risk Management Strategy were developed and subsequently approved by the Audit and Risk Committee in September 2021.

The 2020/21 audit of risk management recognised this progress, but highlighted that further work was required to improve arrangements for the identification, recording and monitoring of risks at Directorate level. Since then, the newly appointed Chief Risk Officer has worked with nominated Risk Leads to refine and improve local arrangements within each Directorate by reference to a

detailed workplan that extends into 2022/23. This approach is endorsed as a means of prioritising activity and ensuring that NHSGGC maintains pace with current efforts in this area.

Through this review, a number of improvement actions have been identified, intended to support consistent application of risk management arrangements across the Directorate areas. The most significant of these relates to the need to ensure there is clear articulation of local approaches to risk identification and subsequent monitoring.

4.1.2 Bed Management

The objectives of the review were to ensure that:

1. There are clear and consistent arrangements in place across each of the sampled wards to report the overall bed availability position on a regular basis.
2. This bed position is reported with appropriate frequency within Acute Services as a means of matching demand with capacity.
3. There is oversight by management over system wide capacity and demand, using reliable and up to date data to inform management's understanding of the impact on waiting times and support effective decision making.
4. Modelling information is used to inform resource planning for in-patient and day-case services with capacity issues escalated and reported appropriately.

The Covid-19 pandemic has resulted in unprecedented demand across each of the hospitals within the NHS Greater and Glasgow and Clyde (NHSGGC) estate, making effective bed management a key priority. The analysis of datasets from March 2020, April 2021 and February 2022 within this report illustrate the continuing pressures faced by hospitals and the high levels of occupancy that NHSGGC are managing, with several hospitals reaching in excess of 90% bed occupancy.

The priority placed on bed management is illustrated by the regular and detailed scrutiny of the bed position that we found to be taking place at the most senior levels – most notably through weekly meetings of the Strategic Executive Group (SEG) established to lead NHSGGC's response to the pandemic. The SEG consistently reviews past and current data, as well as future forecasts informed by Scottish Government Covid demand modelling data.

Audit visits, were undertaken at 22 locations across Acute wards within NHSGGC hospitals to confirm the effectiveness of local arrangements for the monitoring, reporting and overall management of the bed position. These interviews highlighted two key areas for improvement relating to the consistent application of bed management processes, specifically with regard to the supporting technology systems used to capture bed data.

Implementation of the improvement actions identified within the Management Action Plan will better support the consistent application of these processes, thereby improving the quality and reliability of data considered by senior management. This is also likely to facilitate improved decision making and data modelling in relation to patient flow over the longer term.

4.1.3 ICT Service Delivery

The objectives of the review were to ensure that:

1. There are effective incident management processes in place.
2. There are effective problem management processes in place.
3. There are effective change management processes in place.

The review has identified opportunities to improve approaches to incident, problem and change management activities within the health board.

Management should establish a formal cohesive suite of IT incident policy, procedure and process documentation. At present, there is some documentation, but it is not sufficient in defining an agreed framework and approach to IT incident management activities.

Problem management was found to be less mature in nature. It was identified that there was no policy or procedures for managing problems and known errors. This may have been a factor in problems being incorrectly raised.

The change management policy has not been updated to reflect agreed change to operational practices. This means that there is a lack of clear policy specifically in relation to testing of changes. It is important for a high risk areas such as change management that all parties involved in changes have a clear understanding of testing requirements to minimise risk to the availability and integrity of clinical and business applications.

4.1.4 Financial Systems Health Check – Procurement and Tendering

The objectives of the review were to ensure that:

1. NHSGGC's Procurement Strategy includes reference to the key themes underpinning the Board's Corporate Objectives.
2. The Standing Financial Instructions on Procurement are adequate and up-to-date and being adhered to.
3. Local Guidance on the application of procurement practices for the relevant staff to follow had been developed.

It was found that there was no consistent approach to the development of local guidance across the devolved areas. Other improvement areas identified related to:-

- Ensuring compliance with processes for both competitive and non-competitive tendering activity;
- Improving arrangements for ensuring the completeness and accuracy of the contracts register;
- Refining processes for ensuring that procurement activity is subject to appropriate approval, in line with the NHSGGC Scheme of Delegation.

The new head of procurement was sighted on the main issues identified and is progressing the work to address the issues.

4.1.5 HEPMA – Project Governance

HEPMA (Hospital Electronic Prescribing and Medicines Administration) is a new digital system that is replacing the paper drug chart (kardex) for inpatient areas across NHSGGC on a phased basis. The system represents significant business change within the organisation which is being managed through formal project and programme governance arrangements. The objectives of the review were to assess the adequacy of project governance arrangements over the implementation of HEPMA across NHS GGC

The audit work identified that effective programme management and governance arrangements are in place for the implementation of HEPMA with only two minor improvements identified. These related to the need for establishing benefits realisation processes at the outset of the programme and for an approach to lessons learned activities for the programme to be agreed.

4.1.3 Remobilisation Planning

The objectives of the review were to ensure that:

1. the governance and project management arrangements over both the development of RMP4 and oversight of RMP3 were satisfactory
2. the use of modelling in setting future projections and the extent to which outcomes set out in RMP3 have been successfully implemented.

It was concluded that NHSGGC had developed robust arrangements to oversee both preparation and submission of the fourth iteration of its remobilisation plan (RMP4) to the Scottish Government. There was also an appropriate level of senior management oversight of its content, and a clear process by which management reviews Covid infection and transmission rates within the community as a means of projecting future demand for inpatient services.

4.1.4 Recruitment

The objectives of the review were to ensure that the arrangements for staff recruitment with a particular focus on the selection process and completion of pre-employment checks for successful candidates were adequate.

The review identified that NHSGGC has generally robust and well-designed processes in place to ensure consistent and effective recruitment of staff into vacant posts.

It was recognised that there have been major challenges within the Recruitment service due to Covid-19 and there has been a substantial increase in the normal base level for new permanent, fixed term and temporary staff critical to the delivery of health and social care services with the recruitment programmes. There was also a requirement for bespoke recruitment campaigns over the course of the pandemic – for example recruitment of Test and Protect Contact Tracers and Health Care Support Workers and that the timescales to authorise recruitment programmes via the normal vacancy approval process, schedule interviews and undertake pre-employment checks required to be reduced from pre COVID 19 levels. These alternative measures were risk assessed against the NHS Scotland Recruitment SOPs, emergency Covid-19 legislation and Scottish Government directives on increasing NHS Boards workforce capacity and the action taken by the Recruitment service during this period was considered to be proportionate and appropriate.

The audit identified a number of minor improvement actions designed to support the consistent application of recruitment processes within NHSGGC.

1. **Financial** - none.

2. **HR & Organisational Development** - none.

3. **Community Planning** - none.

4. **Legal** - none.

5. **Property/Assets** - none.

6. **Information Technology** - none.

7. **Equality & Human Rights** - none

8. **Health & Safety** - none.

9. **Procurement** - none.

10. **Risk** - The subject matter of this report is the matters arising from the risk based Audit Plan's for Renfrewshire Council and NHSGGC in which the IJB would have an interest.

11. **Privacy Impact** - none.

List of Background Papers – none.

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