Renfrewshire Council

NHS Greater Glasgow and Clyde

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

On: 21 June 2024

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.

Audit Engagement	Assurance Level (note 1)	Number and Priority of Recommendations (note 2)			
		Critical	Important	Good Practice	Service Improvement
Payroll Overpayment Processes	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 Payroll Overpayment Processes

The objectives of the review were to ascertain the main reasons for overpayments occurring and ensure that;

1. The payroll processes in place to pay employees accurately are adequate and well communicated to services to minimise the amount of overpayments occurring;
2. Overpayments arising, are recorded and employees are notified timeously;
3. Overpayment reports are regularly sent to senior management and regularly reviewed;
4. Reasons for overpayments are ascertained by service management and action is taken to strengthen controls where required;
5. Employees and former employees have been made aware of their responsibilities and action to be taken in relation to overpayments.

Key Audit Assurances

- The value of payroll overpayments has decreased in recent years although the number of overpayments has remained relatively static.
- Payroll overpayments are being identified and acted upon by Business Services employees more quickly than in previous years.
- The Salary Adjustment Policy provides clear guidance as to the responsibilities and actions to be taken in relation to recovery of payroll overpayments for employees and former employees.

Key Audit Risks

- The risk of avoidable overpayment is increased where clear and accessible guidance is not made available to services managers to inform them of the correct procedures and the required payroll deadlines.
- Where employees are not informed timeously about payroll overpayments, it can make them more difficult to recover and there may be reputational damage to the council.

Management Response

To ensure we receive notification of permanent payroll changes as quickly as possible, we are on the process of streamlining our leavers and flexible working request forms onto the Business World system and on completion, the process to be followed will be communicated to Managers. A monitoring process for the recovery of overpayments has now been put in place.

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, which are relevant to the Integration Joint Board. A summary of each has been provided, 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
Infection Prevention and Control	Minor improvement required	0	1	1	1
Consultant Job Planning	Substantial improvement required	0	3	4	0
eHealth Application Access Management	Minor improvement required	0	0	3	0
Public Health Screening	Minor improvement required	0	2	4	0
Managing Staff Attendance	Minor improvement required	0	1	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 Infection Prevention and Control

The objectives of the review were to ensure that:

1. Up-to-date infection control policies, procedures and standards are maintained and are easily accessible to staff.
2. Training is provided to ensure that staff understand all relevant infection control standards and are clear on their roles and responsibilities.
3. Appropriate processes are in place to ensure the timely and consistent identification of any infection control cases.
4. Accurate and consistent data is recorded for infection control cases that is monitored and reported appropriately within the management and governance structures.
5. Data is analysed to identify any systemic issues, patterns or trends that may require specific action to be taken, with actions agreed and followed-up on a timely basis.
6. Progress towards the implementation of recommendations from inspection visits is regularly monitored and reported.

Good practice

- NHSGGC has a well-established Infection Control (IC) Team and their work is embedded throughout the health board. Weekly visits to all wards has enabled them to deliver a ‘Theme of the week / month to provide continuous delivery of education. This was praised by all the wards we visited throughout the audit.

- There is a suite of policies and procedures for all IC related incidents and care plans for each infection that enables the timely implementation of care for all patients and staff.
- NHSGGC has an effective evaluation process in place conducted by the Learning and Education team and subject matter experts (module leads) which keeps Learnpro modules up to date. This ensures that any new legislation or changes to the operational processes are updated within the modules to best reflect the current practices.
- The IC team use ICNet to centrally record and monitor infection throughout the health board. We found the functions of the system to be effective and that ICNet supports well the monitoring of infections.
- The data team regularly report on infection rates, which enables management throughout the health board to identify trends and patterns of infection cases and where appropriate investigation and actions can take place. This information is shared and reported to four levels of management: Point of Care/Ward; Sector and Health & Social Care Partnerships; Division Acute and Health & Social Care Partnerships; NHS Board.
- The IC conduct audits on an ongoing basis to identify issues and recommend actions. These are followed up upon to ensure timely implementation.

Areas for improvement

We have identified three areas for improvement which, if addressed, would strengthen NHS GGC's control framework. These include the need to both improve the completion rates of training, and the associated monitoring of this.

4.1.2 Consultant Job Planning

The objectives of the review were to ensure that:

1. The Job planning guidance in place is being applied consistently across speciality areas, and are aligned with the requirement of the 2004 Consultants Contract.
2. Each consultant has a job plan in place that is reviewed annually and has been developed in line with the Consultant's Contract.
3. Consultants' actual activity levels are consistently monitored to ensure that the required levels are achieved, and to support matching of demand with capacity.
4. Performance against job plans is reported on a regular basis to ensure clear oversight of areas where actual activity is not in line with expectation, and allow corrective action to be taken where necessary.

Good practice

- NHSGGC uses the Electronic Job Plan (EJP) recording system to record details of activity along with the frequency of the activity and calculates the number of programmed activities within the weekly plan. All job plans follow the same format/design which is aligned to requirements noted in the Consultants Contract;

- The NHSGGC Job Planning Policy aligns with requirements set in the Consultants Contract including content of job plans, job plan review, roles and responsibilities of both clinicians and the relevant clinical manager and mediation process;

- All relevant information on the job planning process is accessible via the HR connect web site. This allows all staff involved in job planning to refer to this guidance to ensure they understand expectations; and

- Job planning communications for the current year are sent to Chiefs of Medicine by the Deputy Medical Directors. This is a crucial part of the job planning process as it informs actions required and responsibilities with regards to these actions.

Areas for improvement

We have identified several areas for improvement which, if addressed, would strengthen NHSGGC control framework:

- Ensuring that formal review of individual job plans takes place to ensure all job plans are signed off before the required deadline;

- Ensuring that the contents of job plans are reviewed and fully completed so that they reflect current service requirements;

- Ensuring that actual job plan activity monitoring is clearly defined and implemented by management; and

- Ensuring performance against job plans and responsibility for this is clearly defined and implemented.

4.1.3 **eHealth Application Access Management**

The objectives of the review were to ensure that:

1. There are adequate and up-to-date system administration and user procedures for each application.
2. There is effective user account management which ensures only authorised users have access.
3. There are effective controls over the provisioning, management and monitoring of privileged user accounts, including third party access.
4. User access levels are appropriate and ensure adequate segregation of duties in relation to the administration and operation of the system.
5. There are appropriate audit facilities to allow proactive monitoring of the application.

Good practice

- Processes are in place to control the provisioning and revocation of access to systems. We identified no errors in our sample testing.

Areas for improvement

We have identified areas for improvement which, if addressed, would strengthen NHS Greater Glasgow and Clyde's control framework. These include:

- The update of System Security Policies (SSPs) for each application which are currently overdue review and which do not reflect current practices for user account management.

- We sample tested 32 administrative accounts and found that an annual recertification response had only been logged for 10 of those. We noted that the review procedure does not set out the steps to take when no response from the reviewer is received.

- Auditing facilities are in place, however, these are reactive and require extraction before manual review with no set schedule for the review of the logs or automated alerting in place.

4.1.4 Public Health Screening

The objectives of the review were to ensure that:

1. Policies and procedures are in place for BSP and DES that align to guidance provided by HIS
2. Failsafe mechanisms are in place for BSP and DES that are clearly documented and adhered to
3. BSP and DES each have a steering group that governs and scrutinises programme related matters
4. Reporting is produced on the public health screening KPIs and targets set through the HIS programme guidance

Good practice

- The Bowel Screening Business Process Flowchart clearly sets out the process implemented by NHSGGC once a positive result has been communicated via SCI Gateway. We were able to confirm that the process itself clearly aligns with standards 4-6 established by Health Improvement Scotland (HIS).

- While we have recognised a potential need to articulate the failsafe mechanisms for both screening programmes, our testing revealed that staff are well versed on the controls in place to protect the efficiency and accuracy of both BSP and DES.

- There are two steering groups in place to govern and scrutinise programme related matters for both Bowel Screening and Diabetic Eye Screening. We confirmed appropriate meeting minutes are recorded for each meeting including a relevant action log to maintain a sufficient audit trail of the group's activities.

- The Public Health Screening Programme Annual Report, which is presented to the Population Health and Wellbeing Committee, collates appropriate updates and performance of each of the screening programmes within NHSGGC. We deemed this report to be sufficient in reporting against national targets and key performance indicators, which provides sufficient assurance to the appropriate governance committee.

Areas for improvement
We have identified a number of areas for improvement which, if addressed, would strengthen NHSGGC's control framework. These include:

- The timely review of local policies in respect of both bowel screening and diabetic eye screening.

- The introduction of clearly documented failsafe mechanisms in relation to bowel screening and diabetic eye screening.

- The timely review of the terms of reference for the bowel screening steering group and the diabetic eye screening steering group.

4.1.5 Managing Staff Attendance

The objectives of the review were to ensure that:

1. Managers record and manage absences in line with agreed policy and procedures, which are accessible to staff;
2. There is adequate management information, including trend analysis, provided in relation to staff absence so that any emerging issues are identified and addressed timeously;
3. Management use sickness absence data to develop and implement initiatives to improve absence management and promote attendance; and
4. The success of these initiatives at local level is subject to ongoing review to ensure that initiatives driving increased attendance can be rolled out across the wider organisation.

Good practice

- NHSGGC manages staff absences by reference to the national NHS Scotland Attendance Policy, which sets out national-level requirements to be implemented by all NHS Boards in Scotland.

- The Attendance Policy sets out the responsibilities of both staff and their respective line managers. The policy has been made available across the organisation via HR Connect pages. The policy also sets out the specific circumstances under which managers are required to take action and a number of template documents and letters have been designed to support the consistent enforcement of the policy.

- NHSGGC has effective and robust arrangements in place to collate and report absence data. Data is made available through a variety of reporting and dashboard tools, such that managers at all levels of the organisation are able to obtain information regarding absence rates within their respective areas of responsibility.

- An Attendance Action Plan is currently in place which is intended to support reduction in absence rates to a locally agreed target within NHSGGC of 5%. Actions are agreed in consultation with department/sector senior managers and the corresponding Human Resources Lead to ensure they are tailored to specific issues within each area.

- We obtained the NHSGGC Absence Action Plan and confirmed it featured numerous specific actions assigned to different individuals/departments in a bid to rectify staff attendance issues. The actions were directly aligned to issues raised during regular meetings with

Human Resources Leads and consistently included an action owner and timescale for completion.

Areas for improvement
We have identified a number of areas for improvement which, if addressed, would strengthen NHSGGC's control framework in this area:

- More clearly articulating local responsibilities within NHSGGC for ensuring compliance with the national Attendance Policy. This should include reinforcement of the role of line managers within the process, and monitoring arrangements in place by Human Resources to ensure compliance in this regard;

- Ensuring that line managers receive appropriate training to allow them to manage staff absences consistently and appropriately;

- Reinforcing the need to ensure that absences are recorded accurately within SSTS by line managers, including appropriate use of reason codes;

- Enhancing current management information to allow a more overt assessment of the extent to which the Attendance Management Policy is being correctly applied; and

- Implementing a measuring regime to ensure that the success of local initiatives to reduce absence can be reliably assessed.

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.

Author: Andrea McMahon, Chief Internal Auditor