

Follow-up of CAMHS CSG: Workforce

Final Internal Audit Report

November 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services



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Contents

Executive Summary	3
1. Background.....	4
2. Findings.....	5
Appendix A: Management Action Plan.....	6
Appendix B: Assurance opinion and action plan risk rating	24

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Executive Summary

Purpose

To undertake a follow up review of the workforce recommendations arising from our 2020/21 review that attributed a limited assurance rating.

Overview of findings

Of the three high priority prior year matters arising, two have remained open and both remain at a high priority rating. These relate to:

- Low completion rates of consultant job plans.
- Missing personal files and therefore documentation relating to absence management.

One medium priority and two low priority matters arising remained open and at the same priority rating, as detailed in the table to the right.

A Limited Assurance opinion has been allocated due the limited progress that has been made across the six matters arising.

Follow-up Report Classification¹

		Trend
	Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.	

Assurance summary

Previous matters arising	Previous priority rating	Direction of travel	Current priority rating
1 Consultant Job Plans	High		High
2 Sickness Absence Records	High		High
3 PDR Compliance	High		Closed
4 Mandatory Training	Medium		Medium
5 Flexi Time / TOIL	Low		Low
6 Annual Leave Balances	Low		Low

¹ The scope of this follow-up review provides assurance against the implementation of the agreed action plan from our prior year Internal Audit report. It does not provide assurance against the full scope and objectives of the original audit.

1. Background

- 1.1 The follow-up review of Child and Adolescent Mental Health (CAMHS) Clinical Service Group (CSG) management arrangements was completed in line with the 2021/22 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').
- 1.2 The original CAMHS CSG review was undertaken in the autumn 2020 and the two Internal Audit reports (management arrangements and compliance) were finalised in January 2021. Our management arrangements reports are split into three areas: Governance and Risk Management; Workforce; and Planning and Performance. As such, we give four audit opinions across the two reports.
- 1.3 Our current audit work has focussed on the two limited assurance areas of Workforce and Governance and Risk Management. The updated position on the implementation of the six Workforce recommendations is outlined in this report, with the Governance and Risk Management information outlined in a separate report.
- 1.4 The relevant lead for the assignment was the Interim Chief Operating Officer.
- 1.5 The potential risks considered in this review were as follows:
 - The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.
 - Services are not effectively planned.
 - Risks materialise as they have not been identified and / or addressed.
 - Reduced service provision / additional costs due to inappropriate or unauthorised absence.
 - Staff performance is not effectively assessed and addressed.

2. Findings

- 2.1 The action plan within Appendix A provides a summarised version of the previous recommendations (matters arising), priority ratings and full management responses from the original review, along with details of the current position, as verified by our follow-up work. Revised recommendations and priority ratings are included where necessary.
- 2.2 In summary of the six matters arising made in our original audit report, only one has been fully implemented. Whilst we could see that some action has been taken by management to address the issues raised, we felt that not enough progress has yet been made and as such in five areas revised recommendations have been made.
- 2.3 Part of the response to address a number of the issues raised in our original review involved the development and roll out of a 'Line Management Training Package'. At the time of our follow up review, the training package has been developed, but due to pressures within the CSG, it has not yet been rolled out. Management hope to begin training sessions in the autumn. Our review of the training package found it to be comprehensive, though we have identified a small number of areas where it can be enhanced ahead of roll out. Details of which are contained in Appendix A.
- 2.4 The table below provides an overview of the progress:

Original Priority rating	Recommendations to be implemented	Fully implemented	Partially implemented	Not implemented
High	3	1	0	2
Medium	1	0	1	0
Low	2	0	1	1
Total	6	1	2	3

Appendix A: Management Action Plan

Previous matter arising 1: Consultant job plans	
Original recommendation	Original priority
<ol style="list-style-type: none"> 1. Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off ahead of the job plan start period. 2. Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off. 3. Once all job plans have been brought up to date, the Clinical Service Group should be able to assure itself that the sessions agreed on the job plan are what are actually worked by the consultants. 	<p>High</p>
Management response	
<p>Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis.</p> <p>A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off.</p> <p>System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.</p>	

Current findings		Residual risk
<p>1. We acknowledge that due to the pandemic, there was a pause in the requirement to review and update consultant job plans. Within the CAMHS team, management have been experiencing significant challenges with Allocate (the consultant job planning system) due to the split of CAMHS and CYP and the system not accurately reflecting their current workforce. We have been informed that this has been repeatedly raised with the Allocate team, but the problems are still unresolved.</p> <p>As a result of this problem, updated job plans have not been uploaded onto the system and we have not been able to assess progress or undertake any audit testing. We did identify through the July 2021 CSG Performance Review meeting that only 17% of consultants and no SAS doctors had plans in place.</p> <p>2. While we understand that there is a line management structure in place for completing job plans, which incorporates the resolution of disputes, the lack of completed plans means that we have not been able to test this.</p> <p>3. As only a small percentage of plans are up to date and no testing could be undertaken, we were unable to confirm if the sessions agreed on job plans align to what is being worked by consultants.</p> <p>Conclusion: Due to limited progress made in relation to our recommendations, we consider this action to be not implemented.</p>	<p><i>Disputes may arise between the Health Board and Consultants where signed contracts are not in place. Splits between clinical sessions and personal development sessions are not in line with WG guidance, leaving the Health Board with a deficit in capacity.</i></p>	
Recommendation		Priority
<p>1.1 The outstanding issue in relation to accessing the job plans of CAMHS staff within the Allocate system should be resolved with immediate effect so that the updated Consultant Job plans can be uploaded on to the system.</p>	<p>High</p>	

1.2	Consultant job plans should be reviewed and agreed on an annual basis, with planning discussions commencing in enough time to get the plan signed off and any disputes resolved ahead of the job plan start period.	High	
1.3	Once all job plans have been brought up to date, the Clinical Service Group should be able to assure itself that the sessions agreed on the job plan are what are actually worked by the consultants.	Medium	
Management response		Target Date	Responsible Officer
1.1	<p>Access to Allocate requested for all relevant staff. Appointments made with all Doctors with outstanding job plans to update.</p> <p>The CAMHS folder on Allocate has been reviewed and organised to align with recent organisational changes. Consultant/SAS lists were updated with new appointments added and legacy names removed (Krishna Menon, July 2021)</p> <p>A clear system of delegation has been established whereby Clinical Leads in each service are responsible for creating/ updating job plans for doctors in their areas jointly with the CSG Manager who will be the 1st sign off, with the Clinical Director reviewing the finished job plans for assurance before completing 2nd sign off. Training on Allocate is being organised to support Clinical leads in this regard.</p> <p>Clinical Leads will continue to be job planned jointly by the CSG Manager and CSG Director.</p>	December 2021	Clinical Director (Krishna Menon)

	<p>Clinical Leads have been approached on several occasions (July 2021) in order to undertake job plans in their areas but progress has been slower than anticipated due to clinical pressures and lack of operational support.</p> <p>It is anticipated that this will be resolved at pace with the new CAMHS CSG Manager taking up her post in February 2022 but the Deputy CSG Manager will be requested to progress this in the interim with support from the Director of Operations.</p>		
1.2	<p>Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis.</p> <p>A clear dispute process to be followed: Where issues are raised in relation to the job plans created, prompt discussions should take place between the individual, the Clinical Service Group Manager and Clinical Director in order to resolve any problems in a timely manner and ensure plans get signed off.</p> <p>System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants.</p> <p>The Clinical Director will review and complete 2nd sign off of all job plans to provide assurance that they accurately reflect the consultant/SAS doctor's commitments are aligned to the service needs.</p> <p>A process has been agreed to escalate any disputes to the ILG Group Director.</p>	December 2021	Clinical Director (Krishna Menon)
1.3	<p>The annual job plan review will provide assurance, ensuring sessions agreed reflect the work undertaken.</p>	December 2021	Clinical Director (Krishna Menon)

Previous matter arising 2: Sickness absence records	
Original recommendation	Original priority
<ol style="list-style-type: none"> 1. Staff personal records should be stored in such a way that allows other managers to have access to them should an employee's direct line manager be absent from work for a period of time. 2. In order for absence to be properly managed, comprehensive and accurate documentation in relation to each episode of sickness should be maintained. It should be ensured that self-certification and return to work forms are fully completed in a timely manner following the employee's return. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates. 3. Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file. 4. It should be ensured that all employees are correctly allocated on ESR to the right team within the Clinical Service Group. Incorrect allocations will have an impact on sickness, training and PDR compliance rates for teams and may result in manager not receiving essential ESR prompts. 	High
Management response	
This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report.	

Staff personal records will be stored securely (in line with IG requirements) to allow access should a line manager be absent from work for a period of time. This will be incorporated into line management training package. ESR log in details to be shared as required.

Comprehensive and accurate documentation in relation to each episode of sickness will be maintained.

- Self-certification and return to work forms are fully completed in a timely manner following the employee's return.
- All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates.

The Managing Attendance Policy will be followed where periods of absence result in a prompt being breached. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individual's file.

All employees will be reviewed to ensure they are correctly allocated on ESR to the right team within the Clinical Service Group.

Current findings

Residual risk

We undertook follow up testing of documentation in relation to Swansea Bay and CTM nursing staff, in line with our original testing. We saw that improvements had been made at CTM, but compliance with the Managing Attendance at Work policy at Swansea Bay had not improved. For example:

- 1) For Swansea Bay staff the personal files reviewed were temporary files and not the originals. At the time of the fieldwork a number staff files, including some from our sample, could not be located and appeared to have been missing for a number of months since an office move and change in line management responsibility.
- 2) Due to the minimal information on the temporary files, no self-certification forms were on file for the episodes of sickness and return to work (RTW) forms had not always been completed.

Sickness is not properly recorded resulting in incorrect pay.

Sickness is not properly managed resulting in additional costs as shifts have to be covered by agency or bank staff.

<p>At both sites there were examples of the information contained on self-certification forms, RTW forms and ESR not corresponding, and periods of absences that were not fully covered by self-certification forms or medical certificates.</p> <p>3) We saw identified periods of absence at both locations that resulting in a prompt being breached, but not all had been managed in line with the Managing Attendance Policy.</p> <p>4) We were informed that all employees had been reviewed and correctly allocated on ESR to the right team within the Clinical Service Group. No issues were identified when we undertook testing in this area.</p> <p>Conclusion: While there has been limited progress in relation to our recommendations, a 'line management training package' has been developed and is due to be rolled out to relevant staff in September 2021. At the time of our fieldwork, we consider this action to be not implemented.</p> <p>The training package could be strengthened by referencing the 'Managing Attendance at Work toolkit' that is available on the Health Board's intranet and the All Wales Managing Attendance at Work policy.</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%; text-align: left;">Recommendation</th> <th style="width: 30%; text-align: center;">Priority</th> </tr> </table>		Recommendation	Priority
Recommendation	Priority		
<p>2.1 Staff personal records should be stored electronically and in such a way that allows other relevant managers to have access to them should an employee's direct line manager be absent from work for a period. This will also enable line managers to access files wherever they are based and will reduce the risk of files being mislaid.</p>	<p>High</p>		
<p>2.2 Advice should be sought from the Health Board's information governance officer with regard to the series of missing files to establish the action that needs to be taken.</p>	<p>High</p>		
<p>2.3 We acknowledge that the Line Management Training package is a way of addressing many of the recommendations from our original audit, however we feel that it needs to be reviewed</p>	<p>Medium</p>		

	further by the Senior Management team before it is implemented to ensure it is comprehensive and contains all relevant information such as performance targets and links to Health Board and localised polices.		
2.4	<p>It should be ensured that:</p> <ul style="list-style-type: none"> Comprehensive and accurate documentation in relation to each episode of sickness should be maintained. All information contained on self-certification forms, RTW forms and ESR should correspond, and the period of absence should be fully covered by self-certification forms or medical certificates. Where periods of absence result in a prompt being breached, appropriate action in line with the Managing Attendance Policy should be taken. <p>The roll out of the Line Management Training package should assist in making staff aware of the absence management processes they need to follow.</p>		High
Management response		Target Date	Responsible Officer
2.1	The Health Board agrees with the recommendation that staff electronic records are ideal. This will be explored and progressed with IT with regards to the governance & security of IT records for all CAMHS staff.	November 2021	Deputy Directorate Manager (Bronwyn Baldwin)
2.2	The missing personnel files have subsequently been located. If there are further instances of missing files this will be raised immediately with the Health Board's Information Governance team.	Complete	

2.3	<p>The Line Management training package will be reviewed to ensure that it:</p> <ul style="list-style-type: none"> • Reflects the Health Board’s Managing Sickness Toolkit • Reflects TOIL policy & documentation • Links to Health Board wide and CAMHS specific policies • Refers to performance management & targets • Reference the Welsh Government target of 85% and the expectation that staff are also responsible in managing their own compliance rates. • Reflects annual leave expectations & carry over arrangements 	November 2021	Lead Nurse (Julie Cude)
2.4	<p>The Line Management training will continue to be delivered across CAMHS to all staff with line management responsibilities as a rolling programme.</p> <p>A line management check list will be rolled out & used by all staff during line management supervision to ensure consistency with issues discussed. This checklist (currently in use in a different directorate) will be updated and reviewed to ensure it is comprehensive and meets the requirements for CAMHS.</p> <p>A monthly audit will be undertaken to provide assurance regarding the quality of line management supervision delivered.</p>	November 2021	Senior Nurse (Christina Morgan)
		November 2021	Improvement Manager (Sue Gwyn)
		November 2021	Lead Nurse (Julie Cude)

Previous matter arising 3: PDR compliance	
Original recommendation	Original priority
In line with Health Board targets, all staff should participate in a PDR on an annual basis. Where departments are failing to carry out PDRs due to resource constraints, support should be provided.	High
Management response	
<p>This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report</p> <p>In line with Health Board targets, all staff will participate in a PDR on an annual basis.</p> <p>Support will be provided if a drop in compliance is due to resource constraints.</p>	
Current findings	Residual risk
<p>By June 2021 there had been an increase of 31% in the number of completed PDRs compared to September 2020, taking the overall compliance rate to 73.49%. Our original review focussed on nursing staff whose compliance rates have risen from 44% to 72%.</p> <p>The process that Line Managers need to follow for the completion, recording and monitoring of PDRs has been included in the new 'Line Management Training Package'.</p> <p>Conclusion: Good progress has been made against our recommendations. This progress will need to continue to ensure Health Board targets can be achieved. We consider this action to be implemented.</p>	N/A

Previous matter arising 4: Mandatory training	
Original recommendation	Original priority
<ol style="list-style-type: none"> 1. The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that all staff are provided with the opportunity to undertake their mandatory training. 2. Monitoring at a departmental level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary. 	Medium
Management response	
<p>This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All Line Managers to ensure staff have the opportunity to undertake their mandatory training.</p> <p>LMT will monitor on a monthly basis to identify any problem areas, establish reasons for non-compliance and provide support or escalate to SMT where necessary.</p>	
Current findings	Residual risk
<p>In June 2021 the compliance rate for the CSG against the 10 core subjects was 64.71%, increasing from 60.39% at the time of our last audit. While this is still less than the Welsh Government target (85%), the CSG is actively raising awareness via 'module of the month' whereby they identify modules with the lowest compliance rates and contact staff to ask them to complete the module within one month.</p> <p>We note that both PDR and mandatory training is considered at the CTM LMT meetings. However, we did not see evidence of similar monitoring at the Swansea Bay and Tier 4 LMT meetings.</p>	<p><i>Staff performance is not effectively assessed and addressed.</i></p>

<p>The Line Management training package could be strengthened by referencing the Welsh Government target of 85% and what is expected of individuals in managing their own compliance rates.</p> <p>Conclusion: Progress has been made against the various elements of our recommendations and as such we consider this action to be partially implemented.</p>			
Recommendations		Priority	
4.1	The Clinical Service Group should ensure that staff are reminded that undertaking level one training in the core skills modules is in line with Welsh Government expectations, and that all staff are provided with the opportunity to undertake their mandatory training.	Medium	
4.2	Monitoring at a locality level should take place to identify any problem areas and to establish reasons for non-compliance with a view to providing support where necessary.	Medium	
Management response	Target Date	Responsible Officer	
4.1	The responsibility for monitoring and addressing mandatory training rates will continue to be addressed through the LMT meetings, with any issues with compliance between staff or professional groups addressed via the lead manager (Administrative, Therapies, Nursing or Medical). In the interim period while the CSGM post is vacant the Director of Operations will oversee improvement.	December 2021	Directorate Manager (Lisa Davies commencing Feb 2022)
4.2	LMT meeting agendas will reflect mandatory training & PDR requirements. The minutes from each meeting will be shared with SMT to provide assurance and check consistency between areas. The	December 2021	Directorate Manager (Lisa Davies commencing Feb 2022)

	<p>examples of good practice within CTM CAMHS are noted and will be shared between teams.</p> <p>In the interim period while the CSGM post is vacant the Director of Operations will oversee improvement.</p>		
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Previous matter arising 5: Flexi time / TOIL	
Original recommendation	Original priority
<ol style="list-style-type: none"> 1. Management should ensure that TOIL documentation is fully completed, and the hours are recorded correctly. 2. The Clinical Service Group should have a policy in place that provides guidance on the use of TOIL. 	Low
Management response	
<p>This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. Line Managers will ensure that flexi / TOIL is fully completed and the hours are recorded correctly. TOIL will be used in line with HB policy.</p>	
Current findings	Residual risk
<p>The number of staff who use flexi time or TOIL within the Swansea Bay and CTM nursing teams is minimal meaning that our follow up sample was proportionally small. We found that:</p> <ul style="list-style-type: none"> • Both TOIL records that we reviewed from the Swansea Bay team were incorrect and incomplete. The records did not appear to have been reviewed by the line manager. • Within CTM, due to service needs, one member of staff regularly works additional hours, at times up to 21 hours per month and therefore in excess of the limit of 8 hour per month. <p>It was not clear if line managers are authorising the TOIL sheets prior to the additional hours commencing or when the hours are taken back.</p>	<p><i>Time is inappropriately accrued and taken off causing an impact on the provision of the service or the need to backfill shifts with bank / agency staff.</i></p>

<p>A CAMHS CSG TOIL procedure has not been developed as recommended. However, the forms that are used within CTM, whilst historic, do provide an overview of the system and the principles in place. The forms used by Swansea Bay provide little guidance or expectations and only state the maximum number of hours that can be brought forward, which is a different value to the CTM forms.</p> <p>The Line Management Training package does not refer to the TOIL documentation or how TOIL is managed within the CSG.</p> <p>Conclusion: Due to limited progress made in relation to our recommendations, we consider this action to be not implemented, however we have kept the categorisation as Low due to limited number of staff who utilise TOIL or Flexi.</p>			
Recommendation		Priority	
5.1	Management should ensure that TOIL documentation is fully completed, and records are reviewed for accuracy. Monitoring of TOIL balances should form part of the review and where possible the number of hours brought forward each month should not exceed the maximum limit.	Low	
5.2	Without an overall TOIL policy for the CSG, the existing information contained on TOIL and Flexi forms should be reviewed to ensure it is up to date, relevant and consistent across all localities.	Low	
Management response		Target Date	Responsible Officer
5.1	<p>The Line Management training packaged will be reviewed to ensure that it:</p> <ul style="list-style-type: none"> Reflects the Health Board’s Managing Sickness Toolkit 	November 2021	Senior Nurse (Christina Morgan)

	<ul style="list-style-type: none"> • Reflects TOIL policy & documentation • Links to Health Board wide and CAMHS specific policies • Refers to performance management & targets • Reference the Welsh Government target of 85% and the expectation that staff are also responsible in managing their own compliance rates. • Reflects annual leave expectations & carry over arrangements • That it is understood that TOIL is agreed up front (understanding the need and balancing this with staff wellbeing). 		
5.2	A monthly audit will be undertaken to provide assurance regarding the quality of line management supervision delivered.	November 2021	Lead Nurse (Julie Cude)





Previous matter arising 6: Management of annual leave balances	
Original recommendation	Original priority
<ol style="list-style-type: none"> 1. In line with the Scheme of Delegation, all requests to carry forward unused annual leave should be authorised in line with the scheme of delegation. 2. Consideration should be given to reviewing annual leave balances at intervals throughout the year to try and ensure leave is taken as the year progresses, to prevent the build of outstanding leave and the need to carry forward so much. 	Low
Management response	
<p>This action will be addressed via the Line Management responsibilities training as per finding 3 in the Compliance Audit report. All requests to carry forward unused annual leave will be authorised in line with the scheme of delegation. Line Managers will review annual leave balances quarterly during supervision to ensure leave is taken as the year progresses, to prevent the accumulation of outstanding leave.</p>	
Current findings	Residual risk
<p>The requests to carry forward annual leave into 2021/22 were processed differently this financial year due to the pandemic and the volumes each CSG were predicting. Instead of individual forms being approved by the CSG manager, this was done collectively for all staff.</p> <p>The Line Management Training package that will be in rolled out from September 2021, emphasises the importance of staff booking 75% of their leave prior to the Christmas period. Although this advice is appropriate, it could be enhanced by reminding Line Managers to periodically check that this requirement is being fulfilled. This checking of annual leave balances appears to have recently</p>	<p><i>Services are not effectively planned.</i></p>

<p>started within the CTM locality, but such checks are not in place in either of the other two CAMHS localities.</p> <p>Conclusion: Progress has been made against the various elements of our recommendations and as such we consider this action to be partially implemented.</p>		
Recommendations		Priority
6.1	<p>Consideration should be given to reviewing annual leave balances at intervals throughout the year to try and ensure leave is taken as the year progresses</p>	Low
Management response	Target Date	Responsible Officer
6.1	<p>The Line Management training packaged will be reviewed to ensure that it:</p> <ul style="list-style-type: none"> • Reflects the Health Board’s Managing Sickness Toolkit • Reflects TOIL policy & documentation • Links to Health Board wide and CAMHS specific policies • Refers to performance management & targets • Reference the Welsh Government target of 85% and the expectation that staff are also responsible in managing their own compliance rates. • Reflects annual leave expectations & carry over arrangements <p>A monthly audit will be undertaken to provide assurance regarding the quality of line management supervision delivered.</p>	<p>November 2021</p> <p>Lead Nurse (Julie Cude)</p>

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Follow up: All recommendations implemented and operating as expected
	Reasonable assurance	Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	No assurance	Follow up: No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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