Follow-up of CAMHS CSG: Governance & Risk Management

Final Internal Audit Report

November 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

Executive Summary

Purpose

To undertake a follow up review of the governance & risk management 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, all have remained open with one remaining at a high priority rating. This relates to:

- Identification and update of CAMHS related policies and procedures.
- There remains three medium priority matters arising. These relate to:
- The Terms of Reference for some of the key governance groups remain out of date or incomplete.
- The action logs in relation to some of the key groups are not comprehensive enough to be able to determine attendees or matters discussed.
- The process for risk register monitoring is not clear within the terms of reference of key groups or their action logs.

Whilst not all high priority matters have been implemented, progress has been made across the seven matters arising to allocate a Reasonable Assurance opinion.

Follow-up Report Classification[1]

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Assurance summary

Previous matters arising		Previous priority rating	Direction of travel	Current priority rating
1	Committees and structures	Medium		Low
2	Terms of Reference	High		Medium
3	Frequency of Meetings	Medium		Closed
4	Records of Meetings	High		Medium
5	Policies and Procedures	High		High
6	Risk Reporting	Medium		Medium
7	Declarations of Interest	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 & Risk Management; Workforce; and Planning and Performance. As such, we give four audit opinions across the two reports.

1.3 We issued limited assurance opinions in two areas: Governance & Risk Management; and Workforce. The updated position on the implementation of the seven recommendations relating to Governance & Risk Management are set out in this report, with the recommendations relating to workforce information set out 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 seven matters arising made in our original audit report, only one has been fully implemented. However, management has taken action to address the majority of the remaining issues. In three of the five cases where we have categorised the matter arising as being partially implemented, the revised recommendation has been given a lower priority rating.

2.3 Our main concern, and the area that remains as a high priority rating, is in relation to policies and procedures. Whilst there has been some work to capture, review and update existing policies and procedures, this effort has been hampered due to changes in the staffing structure in the CSG and the wider ILG.

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	0	2	1
Medium	3	1	2	0
Low	1	0	1	0
Total	**7**	**1**	**5**	**1**

Appendix A: Management Action Plan

Previous matter arising 1: Committees and structures	
Original recommendation	Original priority
1. CAMHS should undertake a mapping exercise that identifies all of the groups and committees that currently exist. The remits, attendees and frequency of meetings for all groups should be reviewed, along with the relationship and flow of information between the groups, to identify if there is any overlap or gaps in the current governance arrangements. Consideration should be given to simplifying the current arrangements. 2. Once a mapping exercise has been completed, a structure diagram that shows the inter-relationship between each of the key committees and groups within the Clinical Service Group and how these feed upwards into the ILGs' governance arrangements should be documented. A brief summary of each group's purpose should also be added to the diagram where a formal Terms of Reference (ToR) does not need to exist for a particular group.	**Medium**
Management response	
CAMHS meeting structure & ToRs for Quality and Business meetings to be reviewed and simplified. • Business Meeting (SMT) created, • Quality and Safety meeting ToR to be reviewed and signed off at next meeting. • Meeting structure at LMT level to feed into these two key meetings. • Performance meetings are in place monthly with LMTs. These do not require a ToR & feed directly into the Business Meeting (SMT)	

ToRs will be updated to reflect attendees, quoracy requirements, and frequency of meetings. ToR for Locality meetings will cover all three areas to ensure consistency. All formal meetings will be minuted including who was in attendance, the key agenda items discussed, decisions made and points for future action. Actions from other groups that appear to have remained open for a number of years will be reviewed, addressed and closed.

Current findings	**Residual risk**
1. Work has been carried out by the management team within CAMHS to review the various groups and committees that were previously in existence. We understand that the CSG has set up the following four key meetings in relation to monitoring quality and business: • Senior Management Team Business meetings (SMT). • Quality Safety and Patient Experience meetings (QS&PE). • Locality Governance meetings - which cover all three localities. • Locality Business meetings - one meeting for each of the three service areas: CTM; Swansea Bay; and Tier 4 (LMT). There are also CAMHS CSG performance review meetings with ILG directors as part of the wider ILG governance arrangements. 2. There is no diagram that maps out the various groups and their inter-relationships, although creating one was discussed at the Locality Governance meeting in November 2020. As such, it has not been possible to understand what groups remain in addition to the key meetings. Information on update of ToRs, recording of meetings and historic actions is recorded in 'Previous Matters Arising' 2 to 4 below.	*The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.*

Conclusion: Progress has been made against one element of our recommendation and as such we consider this action to be **partially implemented**.		
Recommendation		**Priority**
1.1	A structure diagram that shows the inter-relationship between each of the key committees and groups and any other groups within the Clinical Service Group, and how these feed into the ILG's governance arrangements should be documented.	**Low**

Management response		**Target Date**	**Responsible Officer**
1.1	Flow chart will be produced to reflect current structure	December 2021	Lead Nurse (Julie Cude)

Previous matter arising 2: Terms of Reference	
Original recommendation	Original priority
1. In conjunction with a mapping exercise, the Terms of Reference (ToRs) for all current groups should be reviewed. Where it is deemed that a group remains relevant, the ToRs should be brought up to date including attendees, quoracy requirements, and frequency of meetings. Where one type of meeting is to be held in each of the three service areas (CTM, Swansea Bay, Tier 4), consideration should be given to having a single ToR that covers all three areas and ensures consistency. 2. When reviewing each group and assessing the need for its existence, the name of the group should be agreed and consistently applied on documents such as their Terms of Reference, the structure diagram, group agendas and minutes.	**High**
Management response	
Quality meetings – plan as per Finding 1 ToR to be completed A new performance meeting structure is in place with the Bridgend ILG	
Current findings	**Residual risk**
While progress has been made, we note that: • A revised ToR is in place for the SMT, QS&PE and LMT, although the ToR for the LMT does not include the 'Functions' (remit) of the group.	*The CSG is not appropriately governed which could result in a service that is not being*

• The ToR for the Locality Governance meeting were dated 2018 and stated they were due for review in 2019. • The ToR for the SMT and LMT made no reference to quoracy requirements. **Conclusion:** Some progress has been made against the various elements of our recommendation and as such we consider this action to be **partially implemented**.	*delivered safely and effectively.*

Recommendation		**Priority**
2.1	The ToRs for the Locality Governance meeting should be reviewed and updated as required and the ToRs for the Locality Management Team meeting should be checked for completeness.	**Medium**
2.2	When ToRs are reviewed, where there are no quoracy requirements for a group, consideration should be given to stating this in the ToRs. This will provide clarity over quoracy expectations.	**Low**

Management response		**Target Date**	**Responsible Officer**
2.1	The relevant ToR will be reviewed & updated to reflect the recommendations.	December 2021	Lead Nurse (JC)
2.2	The ToR will be reviewed & updated to reflect quoracy requirements.	December 2021	Lead Nurse (JC)

Previous matter arising 3: Frequency of meetings	
Original recommendation	Original priority
Future meetings should be held in line with the frequency stated in their ToR and only cancelled as a last resort. Where named attendees cannot be present at a meeting, deputies should attend in their place.	**Medium**
Management response	
Meetings will be held in line with the frequency stated in their ToR and only cancelled as a last resort. Where named attendees cannot be present at a meeting, deputies will attend in their place. Local meetings being held to be mapped re frequency, including hosted services. Frequency of SMT is now monthly with updated ToR.	
Current findings	**Residual risk**
Our testing confirmed that the four key groups (listed in Previous Matter Arising 1, above) are meeting in line with the frequency set out in their ToR. (See 'Previous Matter Arising 4' in relation to attendees) **Conclusion:** Our recommendation has been **fully implemented** and as such this finding has been closed.	*N/A*

Previous matter arising 4: Records of meetings	
Original recommendation	Original priority
1. Comprehensive and meaningful records should be retained of each meeting including who was in attendance, the key agenda items discussed, decisions made and points for future action. 2. It should be ensured that any actions that remained open during the January 2020 Clinical Business Meeting have either been completed or have been transferred to the new Service Group Performance Review meeting or another appropriate group or committee. Furthermore, actions from other groups that appear to have remained open for a number of years should be addressed.	**High**
Management response	
As per finding 1	
Current findings	**Residual risk**
1. We tested the action logs in relation to the four key groups listed above: Attendees: For the SMT, QS&PE and LMT meetings attendance was broadly in line with requirements set out in the ToRs. Although we note that: • SMT - action log could be improved to give greater clarity around the posts and locality of attendees. • Locality Governance meeting - Locality managers do not attend these meetings and only one of the three clinical leads attended. As such, the quoracy requirements were not met.	*The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.*

Key agenda items discussed: While the areas discussed aligned to the requirements of the ToR for three of the groups, the ToR of the LMT does not include its functions so it was not clear if appropriate areas were discussed. We also note that the Locality Governance meeting ToR were out of date, so there could be duplication between the areas covered by this group and the QS&PE meeting. Action logs retained: While action logs were in place for meetings, the quality of them varied. For the LMT meetings, the Tier 4 locality and Swansea Bay action logs gave limited information. By contrast the CTM locality action logs were comprehensive. 2. We note that there were no historical actions remaining on the action logs. We understand that these have been reviewed and closed. **Conclusion:** Progress has been made against elements of our recommendation and as such we consider this action to be **partially implemented**.	

	Recommendation	**Priority**
4.1	Meeting action logs should list attendees, their post and locality in order to easily establish the correct people or deputies are in attendance, allow confirmation of quoracy where required, and allow easier identification of gaps in attendance by staffing group or locality.	**Medium**
4.2	Specifically, in relation to the LMT Tier 4 and Swansea Bay action logs, more comprehensive and meaningful records should be retained of each meeting including who was in attendance, the key agenda items discussed, decisions made and points for future action.	**Medium**

	Management response	Target Date	Responsible Officer
4.1	Administrative support will be provided to meetings to ensure the quality and consistency of action logs & minutes is improved as per the recommendations.	December 2021 Complete	Lead Nurse (JC)
4.2	Administrative support will be provided to meetings to ensure the quality and consistency of action logs & minutes is improved as per the recommendations.	December 2021 Complete	Lead Nurse (JC)

Previous matter arising 5: Policies and procedures	
Original recommendation	Original priority
1. We agree with the planned approach to identify CAMHS related policies in existence and to review them to ensure consistency across the localities. This work should also ensure relevance and alignment to current legislation and expected working practices. 2. Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	**High**
Management response	
CAMHS Policy Group newly established, with ToR being developed. All CAMHS policies to be identified, reviewed and standardised to ensure consistency across localities, and to ensure relevance and alignment to current legislation and expected working practices. Action plan will be devised. Policies will be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	
Current findings	**Residual risk**
A CAMHS Policy Group was established in October 2020 and terms of reference for the group drafted. However, subsequent changes to the staffing structure within both CAMHS and the ILG has meant the loss of a dedicated governance manager in the CSG. As such, the ToR for the group has not been finalised and no meetings have taken place. We understand that the Head of Nursing has started to produce a list of CAMHS policies. At the time of our audit fieldwork this work is ongoing with the need for the Lead Nurses from each of the three CAMHS localities to provide information for their area.	*The CSG is not appropriately governed or managed and poor decisions made where staff do not have policies or procedures to guide them.*

The CAMHS management team have also raised some concerns about the new corporate policy template and the complexity of it, and the time it will take to transfer any current policies to the new format or prepare new policies in this format. **Conclusion:** Due to limited progress made in relation to our recommendations, we consider this action to be **not implemented**.		

Recommendation		**Priority**
5.1	A definitive list of all CAMHS policies should be generated and an action plan developed for reviewing and updating them, to ensure consistency across the localities and relevance and alignment to current legislation and expected working practices.	**High**
5.2	Once updated, the policies should be made accessible to relevant staff and have dates for future review and individuals / post holders named who are responsible for such reviews.	**High**
5.3	Concerns in relation to the new policy format should be formally fed back to the corporate team.	**Low**

Management response		**Target Date**	**Responsible Officer**
5.1	A comprehensive single list of policies will be finalised with the Governance team, ensuring there is clarity between existing policies & SOPs by December 2021. The Corporate Governance team will work with CAMHS to assist with the update of policies.	December 2021	Lead Nurse (JC)
5.2	Updated CAMHS policies will be shared with Corporate Policy Group for ratification & then uploaded to CTM intranet with a review date included, as per standard Health Board process.	April 2022	Lead Nurse (JC)

5.3	Concerns regarding the new policy format highlighted with the Corporate Governance Team.	December 2021	Lead Nurse (JC)

Previous matter arising 6: Risk reporting	
Original recommendation	Original priority
1. The review of CAMHS risk register should take place to ensure all risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process should be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. 2. The CSG should have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This should include clearly defined responsibilities within the terms of reference of the various groups. 3. The CSG should ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change.	**Medium**
Management response	
CAMHS risk register will be reviewed to ensure risks are scored consistently and any risks scoring below eight are, in line with the Risk Management Strategy, removed from the CSG risk register and logged separately by departments. A process will be put in place to review and monitor those risks and where necessary escalate back up to the CSG risk register. The CSG will have appropriate mechanisms in place to review and monitor risks including those scoring below between 6 and 12. This will include clearly defined responsibilities within the terms of reference of the various groups. The CSG will ensure risks are not only individually monitored by risk owners, but that the risk register is collectively monitored at the appropriate level, with escalation and de-escalation between groups and committees if risk scores change. Putting Things Right – themes & trends will be collated and added to bimonthly report for CAMHS (senior nurses).	

Current findings	Residual risk
1. In recent months work has taken place in the CSG to review the risk register, but to some extent, this has been delayed due to the loss of the governance manager position within the CSG. This work included cleansing the register of closed risks and risks with a low score. 2. We reviewed the ToR of the four key groups to confirm that risk is appropriately captured. We note that the only reference to risk is in the Quality Safety and Patient Experience (QS&PE) meetings. The ToR state that the group will review high and extreme clinical related risks included on the organisational risk register. 3. We reviewed the agendas and action logs for the key groups for the period April to July 2021 to confirm risk monitoring. While we saw *ad hoc* references to work to cleanse the risk register, we only saw regular reference to risks on the action log at the CTM LMT meeting, but the level of discussion was not clear. We note that 24 low scoring risks which all relate to Tier 4 had been removed from the CSG risk register. We believe these risks should be monitored at the Tier 4 LMT meeting, but the meeting notes from this group are brief and there are no references to risk monitoring. In addition to the four key groups that we have identified, there is a fortnightly CAMHS Governance meeting, where we saw evidence that the risk register was reviewed. However, we have not seen a ToR for the group so we are unclear of its remit or who should attend. As the groups and committees have not been mapped out, we are unclear as to its relationship with the other governance groups in the CSG, specifically the Locality Governance meeting. The monthly CSG Performance review meetings held with ILG Directors also include a review of the CSGs top three risks. There has been work to build a more robust risk register for the CSG, however the responsibility for the monitoring of risk is not clear as ToR remain either incomplete, out of date, or were not provided. Whilst we have seen regular monitoring of the risk register at the CAMHS Governance	*Risks materialise as they have not been identified and / or addressed.*

meeting, we are unclear who is involved in these meetings and the remit of the group. In contrast the QS&PE meetings do not appear to be reviewing the high and extreme risks which is a requirement of their ToRs. **Conclusion:** Progress has been made against the various elements of our recommendations and as such we consider this action to be **partially implemented**.			
Recommendation			**Priority**
6.1	Clarity should be sought on which group is responsible for monitoring the CSG risk register, including where lower scoring risks will be monitored. The ToRs should clearly reflect this responsibility.		**Medium**
6.2	The action logs or meeting notes from those groups responsible for monitoring risk should evidence the discussion that has taken place in relation to risk monitoring.		**Medium**
Management response		**Target Date**	**Responsible Officer**
6.1	The relevant ToR will be reviewed & updated to reflect the recommendations. Fortnightly meeting with Governance team to review all risks on the CAMHS risk register (focus on over 12s). Minutes & agenda circulated.	November 2021 Complete	Lead Nurse (JC)
6.2	Administrative support will be provided to meetings to ensure the quality and consistency of action logs & minutes is improved as per the recommendations.	November 2021 Complete	Deputy Directorate Manager (Bronwyn Baldwin)

Previous matter arising 7: Declarations of Interest	
Original recommendation	Original priority
1. As the revised Declaration of Interest (DoI) forms are introduced by the Health Board, staff should be reminded of the requirements of the Standards of Behaviour policy and its relevance to different roles and posts within the Health Board. 2. Where individuals fail to make a return, managers should continue to prompt staff to do so.	**Low**
Management response	
All staff (8A & above) will complete the revised Declaration of Interest forms when requested by the Health Board.	
Current findings	**Residual risk**
A revised DoI was introduced by the Health Board in the summer of 2020. The line managers are now aware of the declarations made as they have to authorise the returns, but responsibility for managing the process is a corporate function. In May 2021 Health Board staff, band 8A and above, were required to complete a 2021/22 DoI (or nil return). Within CAMHS 47 staff were contacted, but at the time of our fieldwork only 12 (25%) had responded. The corporate team were due to send a reminder to all non-responders. **Conclusion:** Acknowledging that the corporate team oversee the issuing and chasing of DoI returns, responsibility for completion annual returns rests with individuals. As such we consider this action to be **partially implemented**.	*The CSG is not appropriately governed which could result in a service that is not being delivered safely and effectively.*

Recommendation			Priority
7.1	CSG management should remind staff of the requirements of the Standards of Behaviour Policy and of the need for annual DOIs or nil returns to be submitted.		**Low**
Management response		**Target Date**	**Responsible Officer**
7.1	Staff have been formally reminded of the requirement to complete this form & it was also minuted in the Senior Management Team Business meeting on 21/10/21.	Complete	CSG Manager (Kate Burton)

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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