Follow-up: CAMHS Workforce Recommendations

Final Internal Audit Report

July 2022

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Review reference:	CTM 2022.23-27
Report status:	Final
Fieldwork commencement:	07/06/22
Fieldwork completion:	21/06/22
Draft report issued:	30/06/22
Debrief meeting:	N/A
Management response received:	19/07/22
Final report issued:	25/07/22
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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 and 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

The overall objective of the audit was to provide the Health Board with assurance regarding the implementation of the agreed management responses from the November 2021 CAMHS Workforce follow up audit.

Overview of findings

Action has been taken by management against all of our previous recommendations, resulting in some closed recommendations and others reassessed with a lower priority rating.

The areas where further action is needed are in relation to:

- Completion of the roll out of electronic staff files.
- Improvements to the recording of Locality Management Team meeting notes and ensuring key workforce messages are cascaded through the teams from the Senior Management Team.

Follow-up Report Classification

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

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Consultant job plans	**High**		**Low**
2	Sickness Absence Records	**High**		**Medium**
3	Mandatory Training	**Medium**		**Medium**
4	Flexi time / Toil	**Low**		**Closed**
5	Management of Annual Leave balances	**Low**		**Closed**

1. Introduction

1.1 The follow-up review of the outstanding Child and Adolescent Mental Health (CAMHS) Clinical Service Group (CSG) workforce recommendations was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original CAMHS CSG review was undertaken in the autumn of 2020 and the two Internal Audit reports (management arrangements and compliance) were finalised in January 2021. At that time, within our management arrangements audit report, limited assurance opinions were issued in relation to the areas of Governance & Risk Management and Workforce.

1.3 In November 2021 we followed up on the progress that had been made against the 13 recommendations from the two limited assurance areas. A reasonable assurance opinion was issued in relation to Governance & Risk management. However, while some management action had been taken, significant progress had not been made in relation to the workforce issues. As such, a further limited assurance report was issued containing five recommendations.

1.4 The Health Board has continued to monitor progress against the agreed management actions, updating the Audit and Risk Committee via the audit tracker. The tracker currently indicates that four recommendations have been implemented and work is in progress for the remaining one.

1.5 The relevant lead for the review is the Chief Operating Officer.

1.6 The potential risks considered during our review were:

- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	0	2	0
Medium	1	0	1	0
Low	2	2	0	0
Total	**5**	**2**	**3**	**0**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 For the two recommendations that have been closed management have taken sufficient actions to address the matter arising raised in our previous report. These include:

- Introducing a consistent approach to flexi time recoding, with completed documentation and monitoring.
- Having a process in place to monitor annual leave balances throughout the year and help prevent high levels of 'carry forward' leave.

2.4 Whilst three recommendations remain open, we have seen that actions have been taken to start to address the findings, and in two of the three cases the priority rating of those recommendations has reduced.

Appendix A: Management Action Plan

Previous Matter Arising: Consultant job plans		
November 2021 Follow up Recommendations		Original Priority
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.		**High**
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**
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 Responses	Target Date	Responsible Officer
1. Access to Allocate requested for all relevant staff. Appointments made with all Doctors with outstanding job plans to update. 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) 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. Clinical Leads will continue to be job planned jointly by the CSG Manager and CSG Director.	December 2021	Clinical Director (Krishna Menon)

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. 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.		
2. Clinical Director will ensure that all Consultant job plans are reviewed and agreed on an annual basis. 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. System to provide assurance that the sessions agreed on the job plan are what are being delivered by the Consultants. 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. A process has been agreed to escalate any disputes to the ILG Group Director.	December 2021	Clinical Director (Krishna Menon)
3. The annual job plan review will provide assurance, ensuring sessions agreed reflect the work undertaken.	December 2021	Clinical Director (Krishna Menon)
Current findings		**Residual Risk**
1. We evidenced that the issue around accessing the job plans of CAMHS staff within the Allocate system has been resolved and a clear system of delegation has been agreed and implemented. As such this finding is **closed**. 2. 18/20 job plans were either complete or in the process of being completed, including a number that were waiting sign off by the Consultant. We understand that the CSG manager will use the 'presumed signed off' route, set out in the new Job Planning User Guide, if these are not signed off by the Consultant within the timeframe outlines in the user guide. As such this finding is **partially implemented**.		Disputes may arise between the Health Board and Consultants where signed contracts are not in place.

3. The monitoring of job plan sessions to actual hours worked is undertaken as part of the annual planning review process and more frequently during the year as part of activity monitoring within the service area. As such this finding is **closed**. **Conclusion:** Progress has been made against our previous recommendations and the majority of relevant staff either now have a job plan in place or are in the process of completing one. As such we consider this action to be **partially implemented**.			
New Recommendations			**Priority**
1.1	a) The annual job planning process should commence as soon as possible for the two members of staff who are yet to have a plan in place. b) To maintain compliance rates, arrangements should be made to review the job plans of those staff whose plans are due for review in the next few months. c) The CSG Manager should ensure that Job Planning User Guide is followed and for those Consultants who have not signed off their job plans in the required timeframe, the 'presumed sign off' process should be pursued.		**Low**
Management Response		**Target Date**	**Responsible Officer**
1.1	a) The annual job planning process has commenced for one of the members of staff who does not have a plan in place with an initial discussion with the member of staff on their current job plan. The second member of staff works on a term time contract so is currently on leave, plans are in place to discuss their job plan on their return in September. b) The Clinical Director is making plans with the Clinical Leads to review the job plans of those staff whose plans are due for review in the next few months. The CSG Manager is supporting the Clinical Director with this and ensuring meetings are scheduled with the relevant staff in line with job plan review dates. c) The CSG Manager will circulate the Job Planning User Guide together with information on the Allocate system for all consultants and speciality doctor posts for their review and understanding. For those job plans that are waiting sign off from	a) End of September 2022 for both staff members to discuss and upload their job plan. b) By November 2022 to review those job plans due for review c) End of September 2022	a) CSG Manager b) Clinical Director c) CSG Manager and Clinical Director

	the Consultant, the CSG Manager and Clinical Director will implement the process of 'presumed sign off' as laid out in the guide.		

Previous Matter Arising: Sickness Absence records		
November 2021 Follow up Recommendations		Original Priority
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.		**High**
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.		**High**
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 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.		**Medium**
4. It should be ensured that: • 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. The roll out of the Line Management Training package should assist in making staff aware of the absence management processes they need to follow.		**High**
Management Responses	Target Date	Responsible Officer
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. 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	
3. The Line Management training package will be reviewed to ensure that it: • 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)
4. The Line Management training will continue to be delivered across CAMHS to all staff with line management responsibilities as a rolling programme.	November 2021	Senior Nurse (Christina Morgan)
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.	November 2021	Improvement Manager (Sue Gwyn)
A monthly audit will be undertaken to provide assurance regarding the quality of line management supervision delivered.	November 2021	Lead Nurse (Julie Cude)

Current findings	**Residual Risk**
1. The use of electronic personal records is being trialled within one area of CAMHS and a Standard Operating Procedure (SOP) is being produced to ensure consistent practices when the process is rolled out to other CAMHS teams. The set-up of the electronic files has allowed shared access at the appropriate level. Further work is now needed to finalise the SOP, fully populate existing files and roll out to the rest of the CAMHS CSG. As such this finding is **partially implemented**.	Sickness is not properly recorded resulting in incorrect pay. Sickness is not properly managed resulting in additional

2. The set of files missing at the time of our previous testing were subsequently located and as such there was no need to contact the Information Governance Officer. The move to electronic files should prevent similar issues occurring in the future. As such this finding is **closed**. 3. Since our last follow up audit, the Line Management Training package has been updated and improved. During the course of our work, we have identified some areas of the training package that would benefit from further updates such as including information about mandatory training requirements, annual leave carry over rules and relevant forms and documentation in relation to flexi time and TOIL. As such this finding is **partially implemented**. 4. We saw evidence of the Line Management Training Package having been delivered to a number of key staff within the CAMHS CSG. However, we have been unable to confirm if all key staff have been invited to or attended the training sessions. A line management checklist was created for use during line management supervision. However, following the update of the Line Management Training Package, the checklist needs updating. We saw evidence of file audits relating to the quality of line management supervision being undertaken. However, different approaches were adopted by the Swansea Bay (SB) and CTM teams. The CTM approach was more structured with a checklist of points to cover, and the SB approach incorporates recommendations to allow for future improvements. We tested a small number of absence records within the SB team and identified a small number of minor errors in all files reviewed. These have been discussed with management. As such this finding is **partially implemented**. **Conclusion:** The CSG has undertaken work to improve the administration processes involved in absence management and other areas. The Line Management Training Pack and monthly audits will help to further strengthen processes, as will the full role out of electronic personal files. We consider this recommendation to be **partially implemented.**	costs as shifts have to be covered by agency or bank staff.

New Recommendations		**Priority**
2.1	a) The SOP in relation to the set up and use of electronic staff files should be finalised. b) All current electronic files should be fully populated with documentation scanned from hard copy files. c) The roll out of electronic staff files to all other areas of the CSG should commence.	**Medium**
2.2	Further enhancements could be made to the Line Management Training pack to include:	

	• Annual leave - carry over arrangements including relevant documents and a link to the annual leave policy. • Mandatory training - the responsibility for all staff to complete the required Welsh Government modules, plus further levels and modules depending on role and how to access training via ESR. • Flexi / TOIL – links to relevant forms and documents. The line management checklist should be reviewed and where necessary, updated to reflect the new training pack.	**Low**
2.3	Consideration should be given to reviewing the format of the monthly line management supervision audits to capture the best practice aspects from each locality and developing a standardised approach.	**Low**
2.4	a) All staff that require Line Manager Training should be identified and training provided. b) Feedback to line managers from the supervision audits should continue with the aim of reducing the number of administrative errors that are found within staff personal files, including sickness documentation.	**Medium**

Management Response		**Target Date**	**Responsible Officer**
2.1	a) A SOP is being drafted by the Swansea Bay CAMHS locality Senior Nurses on the set up and use of electronic staff files and will be taken to the Quality, Patient Safety and Experience meeting for review and discussion prior to sign off. b) Swansea Bay CAMHS locality Senior Nurses will ensure all current electronic files will be fully populated with the documentation from the hard copy files c) CTM CAMHS locality will commence the roll out of electronic files following sign off of the SOP to approach and any learning from the Swansea Bay CAMHS team	a) End of October 2022 b) End of September 2022 c) End of November 2022	a) Senior Nurses for Swansea Bay CAMHS locality b) Senior Nurses for Swansea Bay CAMHS locality c) Head of Nursing and Senior Nurses for each locality
2.2	The Senior Nurse who is leading on the line management training pack has updated the pack to include the recommendations highlighted above and review of the line management checklist.	End of August 2022	Senior Nurse for CTM UHB

2.3	Following review of the line management supervision audits, a standardised approach for all localities will be taken using the checklist and ensuring recommendations are made. This will be agreed via the Quality, Patient Safety and Experience Meeting.	End of September 2022	Head of Nursing
2.4	a) New training dates have been circulated to all relevant staff in the localities for attendance for the next 3 months. The CSG has agreed that the Senior Nurses in each area will then take the approach of providing training locally for new managers as part of the induction for these staff. b) The Senior Nurses will ensure that there is ongoing feedback from the supervision audits of the findings and recommendations made in both one to one line management to pick up any specific issues and more generic feedback and recommendations will be shared in the localities governance meetings.	a) End of October 2022 b) End of October 2022	a) Senior Nurses for each locality b) Senior Nurses for each locality

Previous Matter Arising: Mandatory Training		
November 2021 Follow up Recommendations		Original Priority
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**
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 Responses	Target Date	Responsible Officer
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)
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 examples of good practice within CTM CAMHS are noted and will be shared between teams. 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)
Current findings		**Residual Risk**
1. We saw evidence of monitoring mandatory training compliance rates at a CSG level through the Senior Management Team Meetings. During recent meetings, discussions were held around the need to ensure staff had completed their required training as this may have an impact on their pay progression appraisal. As such this finding is **closed.**		Staff performance is not effectively assessed and addressed.

2. We could not evidence consistent approaches to monitoring mandatory training compliance rates within the localities. Our review of the SB Locality Management Team (LMT) meeting minutes identified that whilst 'Governance' (which includes training compliance) was a standard item on the minutes, no information of what was discussed is ever recorded. Cwm Taf LMT minutes confirmed that compliance rates were discussed. A recommendation was made in our original CAMHS audit about the variation in approach and therefore quality of LMT meeting minutes.

   Furthermore, in both localities we could not confirm that key messages being discussed at SMT were being cascaded down, for example the impact on pay progression if mandatory training is not complete. As such this finding remains **open.**

Conclusion: There continues to be different approaches to how LMTs are operating and capturing key discussions from their LMT meetings. As such we have not been able to fully confirm what compliance monitoring is taking place at a local level, where the responsibility lies, or that key messages from the SMT are being cascaded down. We consider this recommendation to be **partially implemented**.

New Recommendations		Priority
3.1	a) Records of LMT meetings should be comprehensive enough to confirm what monitoring of mandatory training compliance rates is taking place, and what actions are being taken to address any problem areas. b) It should be ensured that key messages discussed at SMT are cascaded down to LMT meetings so all staff can be made aware of the messages.	**Medium**

Management Response		Target Date	Responsible Officer
3.1	a) Each locality LMT will ensure that at least one meeting a month there is discussion around the current compliance of mandatory training and the actions taken to address any problem areas. The locality managers will ensure that the meeting notes document this discussion	a) End of August 2022	a) Locality Managers
	b) Each locality LMT will ensure there is an agenda item within their business meeting for feedback from the LMT on any key messages discussed with the SMT for all staff to be made aware of the information	b) End of September 2022	b) Senior Nurses in each locality

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**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **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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