Grant Thornton

NHS Lothian

NHS Lothian
Internal Audit Report 2022/23
Remobilisation and Recovery of Scheduled Care

Assurance Rating: Moderate Assurance

Date: 15 June 2023

Final Report

Contents

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Timetable

- Date closing meeting held: 30 May 2023
- Date draft report issued: 7 June 2023
- Date management comments received: 14 June 2023
- Date Final report issued: 15 June 2023
- Date presented to Audit and Risk Committee: 21 June 2023

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Executive Summary

Introduction

During the Covid-19 pandemic, Boards have produced the Mobilisation/Remobilisation Plan sequence, which has outlined a short-term set of responses to the most acute elements of the pandemic.

Remobilisation Plan 4 (RMP4) covered the period 1st October 2021 to 31st March 2022. This was an update to the previous plan (RMP3) approved by the NHSL Board in June 2021. RMP4 provided an update on key actions specified in RMP3, as well as focussing on the risks and mitigating actions from October 2021 to the end of March 2022.

For the financial year 2022/23, Boards are expected to produce an Annual Delivery Plan (ADP). The Scottish Government signalled early in the year that the expectation for this year was that these plans would be focused on a narrower set of priorities, although clarification on exactly what these priorities were was delayed until 14th July 2022. The plan is concentrated on a limited set of priorities for 2022/23 to enable system recovery, and to support the health and care system to stabilise and improve as NHS Lothian recovers from the COVID-19 pandemic.

Remobilisation of Scheduled Care continues to be overseen by the Scheduled Care Programme Board and supported by the 4 constituent recovery boards - Cancer, Diagnostics, Outpatient, and Inpatient Daycases.

As at October 2022, Acute services remains under significant pressure due to a combination of high occupancy across its sites, high volume of Delayed Discharges, unscheduled care demand and significant workforce gaps with detrimental impact on recovery, especially across Inpatients and Daycases for Scheduled Care

Scope

The objective of the audit was to consider how well the Remobilisation and Recovery plans within acute areas were adhered to, identifying any areas for improvement. Specific focus was placed on Scheduled Care Remobilisation. As such, we evaluated the adequacy of internal controls in place and reviewed the design and operating effectiveness of the controls to mitigate against the following potential risk areas:

- Acute Remobilisation and Recovery of Scheduled Care plans not being adhered to, resulting in the Remobilisation and Recovery of the Organisation being ineffective.
- The Governance Structures in place are not sufficient to oversee the delivery of Remobilisation and Recovery of Scheduled Care plans and as a result the Board is not assured that outcomes have been met.
- NHS Lothian fail to embed innovative and digital approaches to provide quality patient care.
- NHS Lothian fail to understand the needs of people and places which will be most impacted by any new models of care.

Approach

Our audit approach was as follows:

- Obtain understanding of the key areas outlined in scope above, through discussions with key personnel, review of management information and walkthrough test, where appropriate.
- Identify the key risks relevant within Remobilisation and Recovery
- Evaluate the design of the controls in place to address the key risks.
- Test the operating effectiveness of the controls in place.

It is Management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit should not be seen as a substitute for Management's responsibilities for the design and operation of these systems.

A complete list of staff involved in the audit and documents reviewed can be seen at Appendix 2.

Acknowledgments

We would like to thank all staff consulted during this review for their assistance and cooperation

Limitations in Scope

Please note that our conclusion is limited by scope. It is limited to the risks outlined above. Other risks that exist in this process are out with the scope of this review and therefore our conclusion has not considered these risks. Where sample testing has been undertaken, our findings and conclusions are limited to the items selected for testing.

This report does not constitute an assurance engagement as set out under ISAE 3000.

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Executive Summary

Summary of Findings

We have concluded that the controls in place in respect of the Recovery and Remobilisation of Scheduled Care provides a **MODERATE** level of assurance. The table below provides a summary of the findings. The ratings assigned are based on the agreed internal audit rating scale (**Appendix 3**).

Detailed findings, recommendations and agreed management actions are found in Section 2 of this report.

Moderate Assurance			
HIGH	MEDIUM	LOW	ADVISORY
-	2	4	-

Ref	Risk Area ~~Issue~~	H	M	L	A
1	**Acute Remobilisation and Recovery of Scheduled Care plans are not being adhered to, resulting in the Remobilisation and Recovery of the organisation being ineffective**	-	2	1	-
2	**The governance structures in place are not sufficient to oversee the delivery of Remobilisation and Recovery of Scheduled Care plans and as a result the Board is not assured that outcomes have been met**	-	-	3	-
3	**NHS Lothian fail to embed innovative and digital approaches to provide quality patient care.**	-	-	-	-
4	**NHS Lothian fail to understand the needs of people and places which will be most impacted by any new models of care.**	-	-	-	-
TOTAL		**-**	**2**	**4**	**-**

Main Findings

NHS Lothian's Annual Delivery Plan for 2022/23 includes a plan for the Recovery of Planned Care which outlines the key deliverables. Progress against each of the key deliverables for the year is routinely reviewed by the constituent recovery Boards and reported into the Scheduled Care Recovery Board.

The Lothian Strategic Development Framework (LSDF), published in April 2022 lays out what is intended across Lothian's Health and Care system over the next 5 years. The Annual Delivery Plan has underpinned the key priority areas of the LSDF in the recovery of scheduled care.

Appropriate governance arrangements are in place and supported by the Scheduled Care Recovery Board and the four constituent recovery Boards. Meetings of the Boards are frequent and adhere to clear agendas. Additional oversight is provided by:

- NHS Lothian's Planning, Performance & Development Committee,
- the Additional Capacity Board, and
- the Acute Senior Management Team.

The NHS Lothian Workforce Plan 2022-25 includes a section relating to Scheduled Care and the priorities that will provide additional capacity to both increase the elective capacity and provide modern state of the art facilities. Within the Workforce Plan each of the LSDF service groupings have been reviewed by services to highlight the key workforce challenges and opportunities they face, and the key high-level actions to be taken over the next 3 years to best ensure that NHS Lothian sustains, develops and where necessary grows its workforce.

Opportunities for capital investment have been taken forward through the National Treatment Centre for planned surgery on St John's Hospital campus, a new Eye Pavilion in Edinburgh and a new Edinburgh Cancer Centre for the East Region on the Western General Hospital.

The Lothian Capital Investment Group has also approved a series of Standard Business Cases by individual business units setting out their requirements for additional end user devices towards greater digital delivery of services to patients.

Stakeholder events have been held in relation to the Eye Pavilion and National Treatment Centre to understand the needs of staff and service users.

While no formal lessons learned exercise had been scheduled for the annual delivery plan's conclusion at the end of March 2023, it is noted that the governance framework in place supports the ongoing identification and resolution of issues, ensuring that improvement opportunities are being identified, alongside aspects of the Plan's delivery that had not progressed as intended.

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NHS Lothian's Out-patient redesign programme is continuing, with positive progress in remobilising out-patient services to comparable levels of activity to 2019.

However, we have identified improvement opportunities relating to the risk management arrangements, the management of specific actions arising from meetings of the Recovery Boards and the review and update of the Terms of Reference for the Boards.

These findings are discussed in full within our Management Action Plan.

Follow Up

Approximately two weeks following issue of the final Internal Audit report, a member of the Audit Team will issue an 'evidence requirements' document for those reports where management actions have been agreed.

This document forms part of the follow up process and records what information should be provided to close off the management action.

The follow-up process is aligned with the meetings of the Board's Audit & Risk Committee. Audit Sponsors will be contacted on a quarterly basis with a request to provide the necessary evidence for those management actions that are likely to fall due before the next meeting of the Audit and Risk Committee.

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Risk Area 1: Acute Remobilisation and Recovery of Scheduled Care plans are not being adhered to resulting in the Remobilisation and Recovery of the organisation being ineffective	MEDIUM
Finding 2.1 – The management of risks associated with the recovery of scheduled care and key deliverables of the Annual Delivery Plan is not clearly communicated	

Control

Recovery of Scheduled Care is documented within section four of NHS Lothian's Annual Delivery Plan for 2022/23. The Plan was signed off by the NHS Lothian Board on the 5 October 2022. The Annual Delivery Plan has included as an appendix a Delivery Plan, which specifies the 2022/23 key deliverables and milestones associated with the recovery of scheduled care.

The Delivery Plan also has a section alongside the key deliverables to record the key risks to each and the mitigating controls/actions necessary to reduce the likelihood and impact of the risks.

Risk registers have been developed by the Scheduled Care Recovery Board and the Outpatients, Inpatients and Diagnostics Recovery Boards.

Observation

Of the 35 key deliverables related to the recovery of scheduled care recorded in the Delivery Plan, one related to the Endoscopy Recovery Plan does not have any risks, controls and outcomes assigned to it. Also, ten risks (from a total of 26) recorded in the January 2023 Diagnostics Recovery Board risk register had no mitigating actions assigned.

While the Risk Register for the Scheduled Care Recovery Board has included a column to add the 'owner' of each risk, the review of the risk register from October 2022 has noted that this is incomplete. As per Appendix 1 of this report, we identified some inconsistencies in the content and layout in the risk registers for the Diagnostics, Outpatients and Inpatients Recovery Boards. We also concluded that there is no clear link between the risks assigned to each of the key deliverables recorded in the annual delivery plan and the risks recorded in the recovery board risk registers.

While it was noted that the risk registers are routinely reviewed by the Diagnostics, Inpatients and Cancer Recovery Boards, there is no evidence in the minutes associated with the Outpatients Recovery Board that the risk register is being routinely tabled as an agenda item for review.

The minutes for the Scheduled Care Recovery Board have recorded regular updates from each of the four Recovery Boards, which occasionally includes the management of their individual risks. However, there is no evidence in the Board minutes to indicate that the high level / critical risks are being routinely escalated and considered by the Scheduled Care Recovery Board.

The Cancer Recovery Board has no assigned risk register and instead risks are discussed at the Board meetings, although a risk register is in place and owned by the Western General Hospital (WGH) site management team.

Risk

There is a risk that with no clear link between the Recovery Board risk registers and the risks recorded in the Annual Delivery Plan, management cannot be assured that the risks to the Plan's key deliverables are being effectively managed.

There is a further risk that without consistent application of risk management controls around the owners, risk scoring and review/closed dates, mitigating actions will be insufficient in reducing the risk, or management will be unable to effectively assess the Board's risk management activities.

Recommendations

Recommendation 1

Management should ensure that for future Annual Delivery Plans, all key deliverables identified have been assessed to record the risks and mitigating actions.

Recommendation 2

The Recovery Boards should ensure that risk registers record risk owners, review dates and post mitigation scoring of residual risk. Where applicable, risk registers should clearly state the link between the risk and the Annual Delivery Plan's key deliverables.

Recommendation 3

The Recovery Boards should ensure that the review of their risk registers is a standing agenda item at all meetings and evidence of review and scrutiny should be recorded in the meeting minutes. Additionally, the Scheduled Care Recovery Board should implement a process for the escalation and routine review of high level / critical risks recorded in the Recovery Board risk registers.

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Finding 2.1 - Continued

Management Response – Recommendation 1

Scheduled Care Recovery Board recognises the need to ensure all deliverables within the ADP for 2023/24 have risks and mitigating actions clearly identified.

Management Action – Recommendation 1

Each of the four Recovery Boards will develop a comprehensive action plan relative to their area within the ADP which includes risk & mitigating actions.

Once done, they will be reviewed by Constituent Recovery Board Chairs to confirm completeness and presented to the Scheduled Care Recovery Board for further approval.

Responsibility	Target Date
Recovery Board Chairs, overseen by Chief Officer, Acute Services	30 August 2023

Management Response – Recommendation 2

The risk registers within the Diagnostic and Outpatients Recovery Boards record the risk owners, review dates and post mitigation scoring of residual risk. However, there is not always a clearly stated link between specific risks and the ADP key deliverable. There is specific reference to there not being an assigned Risk Register in place for the Cancer Recovery Board (slide 6), although an acknowledgement that there is a Risk Register in place managed by Chair of group/site director. We will now formally incorporate this into CRB for more clear governance oversight. In addition, we will make sure risks are being recorded with clear actions and owners against them, and that these are followed through and completed.

Management Action – Recommendation 2

A consistent risk register format will be introduced across the Scheduled Care programme.

All specific risks relating to individual ADP deliverables will be clearly linked on all four Recovery Board risk registers.

Current Cancer Services risk register will be formally incorporated into Cancer Recovery Board.

Once done, they will be reviewed by Constituent Recovery Board Chairs to confirm completeness and presented to the Scheduled Care Recovery Board for further approval.

Responsibility	Target Date
Recovery Board Chairs, overseen by Chief Officer, Acute Services	30 August 2023

Management Response – Recommendation 3

Risk register review as a standing agenda item has been undertaken for Diagnostic & IPDC Board. Cancer Recovery Board has to date undertaken new risk review only, Outpatients undertaking review of risks intermittently – both will move to regular risk reporting as standard.

Management Action – Recommendation 3

Risk register review, incorporating consistent use of registers, will be a standing item on agenda across Scheduled Care programme and Recovery Boards

Responsibility	Target Date
Recovery Board Chairs, overseen by Chief Officer, Acute Services	30 August 2023

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Risk area as per scope: The governance structures in place are not sufficient to oversee the delivery of Remobilisation and Recovery of Scheduled Care plans and as a result the Board are not assured that outcomes have been met	LOW
Finding 2.2 – The use of action logs to monitor actions and responsibilities arising from Board meetings is inconsistent across the constituent Recovery Boards	

Control

Action Logs are maintained by the Recovery Boards to record actions arising from review meetings and ensure that the progress against each is reported at future meetings. Actions should have owners assigned, alongside the date that the action was first raised and when it was completed / closed off.

Observation

Action Logs are in place for the Scheduled Care Recovery Board and two of the four constituent Recovery Boards (Diagnostics and Inpatients). While it was noted that the action logs for each of the recovery boards have recorded the date the action had been added, action owner and updates / notes for further action, the action logs for the Scheduled Care Recovery Board and Inpatients also record the date the action was completed.

Review of three action logs from the Scheduled Care, Diagnostics and Inpatients Recovery Boards confirmed that there is ongoing dialogue around each of the actions and where an action is incomplete a reason / explanation has been provided.

Risk

Without the appropriate management of actions arising from Recovery Board meetings, there is a risk that progress is not routinely reviewed and agreement to close of completed actions obtained.

Recommendation

Recommendation 4

Management should ensure that the Action Logs used by each of the Recovery Boards are consistent in their layout and that Board members are able to record the agreed completion of actions.

Management Response & Action

Each Recovery Board has used a consistent ADP reporting format in 2022/23 but acknowledges there is variation in individual Recovery Board action log recording and updating.

A consistent action log template will be introduced within each Recovery Board which includes all ADP deliverables and relevant supporting actions for each individual board.

Responsibility	Target Date
Programme Team & Recovery Board Chairs, overseen by Chief Officer, Acute Services	30 August 2023

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Risk area as per scope: The governance structures in place are not sufficient to oversee the delivery of Remobilisation and Recovery of Scheduled Care plans and as a result the Board are not assured that outcomes have been met	LOW
Finding 2.3 – Terms of Reference for the Scheduled Care Recovery Board and constituent Recovery Boards are not routinely reviewed and updated	

Control

Terms of Reference are in place for the Scheduled Care Recovery Board and the four constituent Recovery Boards. These have been produced to ensure that each of the recovery Boards understand their responsibilities in overseeing a comprehensive recovery programme for Acute Scheduled Care in line with the national Centre for Sustainable Delivery (CfSD). The Terms of Reference for each of the Boards follow a similar format in documenting the Board's purpose, remit, membership and reporting arrangements.

Observation

The Terms of Reference for each of the boards were reviewed to confirm that they are in date and clearly state the Boards responsibilities for the implementation and monitoring of the Annual Delivery Plan and the recovery of Scheduled Care.

Only the Scheduled Care Recovery Board and Cancer Recovery Board Terms of Reference have been reviewed internally within the last 12 months (January 2023 and February 2023 respectively).

The Terms of Reference for the other Recovery Boards were last reviewed as follows:

- Diagnostics Recovery Board – August 2020
- Outpatients Recovery Board – July 2020
- Inpatients recovery Board – July 2021.

It has also been noted that personnel changes relating to the departure of the previous Chief Officer, Acute Services have not been noted in the Scheduled Care Recovery Board and Diagnostics Recovery Board.

Whilst the Terms of Reference for the Scheduled Care Recovery Board note that it is the responsibility of the Project Owner to provide assurance to the Executive Leadership Team (ELT) that appropriate project governance and management arrangements are in place, there is no mention of the requirement to report into the Acute Recovery Board, Acute Senior Management Team and the NHS Lothian Planning and Performance Committee.

Risk

Without the routine review of the Terms of Reference of the Recovery Boards there is a risk that the Boards are unable to adapt to ensure the effective management of the recovery of scheduled care as it progresses through the short, medium and longer-term recovery priorities. A lack of clarity around the reporting arrangements also presents the risk that the right people are not being presented with the right information at the right time.

Recommendations

Recommendation 5

Management should complete a formal review of the Diagnostic, Outpatients and Inpatients Recovery Board Terms of Reference. Thereafter a schedule for the annual review of the Terms of Reference should be agreed.

Recommendation 6

Management should review the reporting arrangements recorded in the Terms of Reference for the Scheduled Care Recovery Board and, if necessary, include the reporting into the Acute Recovery Board, Acute Senior Management Team and the NHS Lothian Planning and Performance Committee.

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Finding 2.3 - Continued	
Management Response – Recommendation 5	
Cancer Recovery Board TOR are reviewed annually in February. All other boards are timetabled to revise & review pending SCRB TOR review June 23.	
Management Action – Recommendation 5	
SCRB will approve revised TOR at June board. Thereafter all Recovery Boards will be required to update and approve individual TOR in line with ADP delivery & funding allocation requirement.	
Responsibility Scheduled Care Programme Team & Recovery Board Chairs, overseen by Chief Officer, Acute Services	**Target Date** 30 August 2023
Management Response – Recommendation 6	
TOR review needs to include reporting requirements.	
Management Action – Recommendation 6	
Impending TOR review will include clarification of reporting requirements to Acute SMT, CMT & SPPC	
Responsibility Scheduled Care Programme Team, overseen by Chief Officer, Acute Services	**Target Date** 30 August 2023

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Appendix 1 – Risk Register Content Review

Recovery Board		
Diagnostics	**Outpatient**	**Inpatient**
Risk ID	Risk ID	Risk ID
Service Area	Risk Description	Risk Level
Risk Description	Date Added to Risk Register	Division
Risk Rating Prior to Mitigation	Risk Rating	Management Team
Mitigation	Mitigation	Service Area
Risk Rating Post Mitigation		Risk Owner
Risk Owner		Handler
Next Review Date		Title
		Description
		Mitigation Controls
		Adequacy of Controls
		Risk Level (Current)
		Rating (Current)
		Date Opened
		Date Risk Reviewed
		Review Date
		Closed Date

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Appendix 2 – Staff Involved and Documents Reviewed

Staff Involved

- Chief Officer, Acute Services
- Head of Implementation, Strategic Planning

Documents Reviewed

- Annual Delivery Plan 2022-23
- Terms of Reference for the Scheduled Care Recovery Board and four constituent Recovery Boards
- Scheduled Care Recovery Board minutes – 31/08/2022, 12/10/2022, 01/12/2022
- Inpatient Recovery Board minutes – 19/10/2022, 16/11/2022, 21/12/2022
- Diagnostics Recovery Board minutes – 23/08/2022, 04/10/2022, 15/11/2022
- Cancer Recovery Board minutes – 25/08/2022, 06/10/2022, 17/11/2022
- Outpatient Recovery Board minutes – 04/10/2022, 01/11/2022, 06/12/2022
- Scheduled Care Recovery Board Risk Register
- Constituent Recovery Board Risk Registers
- Additional Capacity Board Minutes – 30/09/2022, 28/10/2022, 25/11/2022
- Acute Senior Management Team minutes – 25/08/2022, 27/10/2022, 24/11/2022
- Planning, Performance and Development Committee minutes – 18/02/2022, 17/09/2022, 16/11/2022
- Constituent Recovery Board Highlight Reports
- Action Logs for meetings of the Scheduled Care Recovery Board, Inpatients Recovery Board and the Diagnostics Recovery Board
- NHS Lothian Workforce Plan 2022-2025
- Planned Care - WT Interventions - Summary and Costs - 2022-23
- NHS Lothian Board Papers and minutes - 05/10/2022
- NHS Lothian Strategic Development Framework
- Lothian Capital Investment Group Digital Device Programme Initial Agreement and Summary of Business Unit Investment Cases.
- National Treatment Centre Lothian Community Engagement Briefing
- National Treatment Centre Lothian Workforce Model – Recruitment Phasing
- Scheduled Care Inpatient and Day-Case Treatment Time Guarantee (TTG) Recovery - Options Appraisal, April 2022 Board Paper
- NHS Lothian - Scheduled Care Performance, Trajectories and Funding – Presentation to Scottish Government 25 April 2023

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Appendix 3 – Our IA Report assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating	Definition	When Internal Audit will award this level
Significant assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all.	There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)
Moderate Assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Limited Assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken.	This may be used when: ▪ There are known material weaknesses in key control areas. ▪ It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk.	The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk(for instance one Critical finding or a number of High findings)

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Appendix 3 - Continued

The table below describes how we grade our audit recommendations based on risks

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	▪ Key activity or control not designed or operating effectively ▪ Potential for fraud identified ▪ Non-compliance with key procedures / standards ▪ Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	▪ Important activity or control not designed or operating effectively ▪ Impact is contained within the department and compensating controls would detect errors ▪ Possibility for fraud exists ▪ Control failures identified but not in key controls ▪ Non-compliance with procedures / standards (but not resulting in key control failure)
Low	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	▪ Minor control design or operational weakness ▪ Minor non-compliance with procedures / standards
Advisory	Items requiring no action but which may be of interest to management or which represent best practice advice	▪ Information for management ▪ Control operating but not necessarily in accordance with best practice

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