Hampshire Partnership NHS Trust

Final Internal Audit Report

Clinical Governance and Risk Committee

July 2008

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Executive Summary

This report details the internal audit of procedures and controls in place at Hampshire Partnership NHS Trust over the Clinical Governance and Risk Committee. The audit has been undertaken in accordance with the 2007/08 Internal Audit plan. The audit approach and summary of the work undertaken is provided in the audit framework in Appendix A.

Background

The Chief Executive has devolved responsibility to the Executive Director of Nursing and Governance, who works with the Head of Clinical Governance to promote and develop clinical governance systems. Together with the Head of Risk Services, they act as the Clinical Governance Support Team, which provides advice, information and guidance in relation to clinical governance issues to managerial and clinical staff.

Summary of Findings

Audit Opinion : **Substantial Assurance**

Evaluation Opinion : While there is a basically sound system there are weaknesses which put some of the control objectives at risk,

Testing opinion : There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.

01 Composition, establishment, quality and duties

A Clinical Governance Strategy 2007-2012 is in place and adequately identifies the Trust's aims, objectives and reporting arrangements. A suitable Clinical Governance structure had been established with accountabilities and reporting lines clearly defined. The duties of the Clinical Governance and Risk Committee (CG&RC) have been formally delegated from the Trust Board. These duties are established and effectively documented within a formal Terms of Reference. Each Directorate has a Clinical Governance Group chaired by a Directorate Clinical Governance Lead who attends the CG&RC. The work plans for each of the Directorate Clinical Governance Groups reflect strategic aims as they relate to the Directorate's activity. The Overall aim of the Directorate Groups is to steer and progress clinical governance activity at Directorate and Locality/Service level, thus ensuring a consistent, co-ordinated approach to clinical governance across the Directorate and to support locality / service clinical governance groups. Discussion with Directorate leads indicated that clinical governance at a local level requires further development, with some areas not having a separate meeting / forum at which they can contribute to the clinical governance agenda. This area was not considered in depth therefore no formal recommendation has been raised but it is proposed that

local clinical governance arrangements be subject to a separate audit in 2008/09.

Clinical governance is included in the formal induction process for all new members of staff. There are a number of related clinical governance training sessions included within the induction programme, and specific general clinical governance training is available on request on an ad-hoc basis from the Clinical Governance Team.

02 Communication and Reporting

The CG&RC, chaired by the Executive Director of Nursing and Governance, meet on a monthly basis and clear records are maintained to support meetings held. Review confirmed that the Committee is generally well attended. It was however noted that the Chair of the Health & Social Care Reference group is not in regular attendance as is required by the Committee's Terms of Reference.

The Directorate Clinical Governance Groups report to the CGRC, which in-turn reports to the Trust Board. It was confirmed that Directorate Clinical Governance Operational Groups have been established for Adult Mental Health, Older Person's Mental Health, Learning Disabilities/Social Care, and Specialised Services Directorates. However, we were unable to confirm that terms of reference were up to date and approved at an appropriate level, a recommendation has been raised to address this issue.

Standard reporting proformas have been produced for the sub committees of the CG&RC. This ensures that the required documentation is obtained to enable assurance to be given to the CG&RC and subsequently the Trust Board against achievements of NHS guidelines and Standards for Better Health.

It was confirmed that the Audit Committee obtain sufficient assurance of the work of the CG&RC via the submission of a summary report on a quarterly basis in accordance with the Audit Committees' meeting schedule. Furthermore, it was confirmed that the minutes of the CG&RC had been presented to the Trust Board on a quarterly basis, with the Board noting receipt from the Chair and identifying any issues or further action to be undertaken.

03 Compliance with regulations

The Trust has developed an approach to Implementing NICE guidelines. In addition to having a policy document describing HPT's processes to implement NICE guidance and monitor the progress of NICE consultations, the Trust has a NICE Committee, which is a permanent sub committee of the CG&RC. The NICE Committee's purpose is to coordinate, plan and monitor the implementation of NICE clinical guidelines, technology appraisals, public health guidance and other issued national guidance. Furthermore, a NICE Lead, has been

established to; disseminate guidance, liaise with Clinical Champions, ensure effective processes for monitoring and feedback and provide regular reports to the NICE Committee.

A cyclical agenda is in place which details the leads/groups responsible for each standard and when they are due to report on their progress. Each core standard has been assigned a member of staff as a lead who is responsible for reporting on progress against the standard as per the cyclical agenda. For each core standard a bespoke report has been produced which incorporates the requirements for the relevant standard. Each lead must report as to whether they meet the criteria taken from the inspection guide. These are reviewed by the CG&RC. Testing confirmed that reports are presented in accordance with the cyclical agenda with an audit trail to support non submissions and deferrals.

04 Risk Management

The Trust has a bespoke integrated risk register and assurance framework database administered by the Head of Risk Services. The database stores the identified risks in "chapters" including a Board Chapter and one for each Directorate, clinical and non-clinical. The chapters are reported to the CG&RC on a cyclical basis. The Risk, Health and Safety Committee reports to the CG&RC and is chaired by the Executive Director of Nursing & Governance. It is the core committee within the Trust tasked with ensuring that robust systems are in place to manage the health and safety of staff.

Each operational directorate within the Trust has an annual clinical audit programme. The directorate clinical audit programmes consist of priorities identified by the Trust as well as local priorities. This programme is monitored by the directorate's Clinical Governance Groups and reported to the CG&RC.

05 Procedures and Administration

A Clinical Governance Facilitator has been established and their roles and responsibilities appropriately documented. Clinical policies and procedures are available on the Trust's website and are subject to regular review by the responsible officer. All policies and procedures are subject to on-going review, with a schedule maintained by the Litigation Information Governance Manager. However, it was found that there were some out of date polices in place and therefore a recommendation has been raised to address this.

Acknowledgement

We would like to take this opportunity to thank the management and staff for their assistance during the audit.

Recommendations

In this report we have raised one Priority 2 recommendation and one Priority 3 recommendation.

Section 1 – Observations and Recommendations

In order to assist management in using our reports:

a) We categorise our **opinions** according to our assessment of the controls in place and the level of compliance with these controls. For each audit, we arrive at a conclusion that assesses the audit assurance in one of four categories. These arise from:

Our evaluation opinion: we assess the system of controls, which are in place to achieve the system of objectives.

Our testing opinion: we check whether the controls said to be in place are being consistently applied.

Full Assurance	**Evaluation opinion** - There is a sound system of control designed to achieve the system objectives, and **Testing opinion** – The controls are being consistently applied.
Substantial Assurance	**Evaluation opinion** – While there is a basically sound system there are weaknesses which put some of the control objectives at risk, and/or **Testing opinion** – There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
Limited Assurance	**Evaluation opinion** – Weaknesses in the system of controls are such as to put the system objectives at risk, and/or **Testing opinion** – The level of non-compliance puts the system objectives at risk.
No Assurance	**Evaluation opinion** – Control is Financially weak leaving the system open to significant error or abuse, and/or **Testing opinion** – Significant non-compliance with basic controls leaves the system open to error or abuse.

b) We categorise our **recommendations** according to their level of priority.

Priority 1	Major issues for the attention of senior management.
Priority 2	Other recommendations for local management action.
Priority 3	Minor matters.

1. Directorate Clinical Governance Groups TOR (Priority 3)

Recommendation	Rationale	Responsibility
A formal terms of reference should be in place for each of the directorate Clinical Governance Groups which are subject to approval by the CG&RC, and reviewed for accuracy on an annual basis.	To enable Directorate Clinical Governance Groups to work efficiently and effectively providing sufficient and accurate reporting to the CG&RC, a terms of reference should be in place for each of the sub groups that details it's role, responsibilities, membership and frequency of meetings as a minimum. It was noted that each Directorate Clinical Governance Operational Group have established terms of reference. However, they did not contain appropriate control information therefore audit was unable to confirm that the ToRs were up-to-date and had been approved by the CG&RC. Where roles and responsibilities of the Directorate Clinical Governance Groups have not been formally established and suitably documented and approved there is a risk that operational groups do not work effectively and efficiently.	ADONs
Management response		**Deadline**
The Trust accepts this recommendation, and all Directorate TORs will be reviewed and approved by the CG&RC		End September 2008

2. Policies and Procedures (Priority 2)

Recommendation	Rationale	Responsibility
The Clinical Governance and Risk Management related policies should have specified review dates and be reviewed at an appropriate level to ensure that they are kept up to date and remain relevant.	The Trust's policies and procedures should be kept up to date and remain relevant. Examination of the Clinical Policies and Non-Clinical Policies Indexes identified that the following policies were out of date/due for review: - Action to be taken following recall of mentally disordered patients subject to Home Office restrictions on discharge, Nov 2007; - Operational Policy for the provision of Place Safety and Assessment under sections 135 and 136 of MHA 1983 - Nov 2007; - MHA 1983 sections 45A and 45B Hospital Limitation Direction - Nov 2007; - Sex Offenders Act 1997 - Nov 2007; - Interagency Policy on Confidentiality & the Management of Service User Information - Jun 2007; - Confidentiality and Information Sharing - Jun 2007; - Consent on Examination of Treatment Policy - Oct 2007; - Integrated Care Programme Approach Overarching Policy - Feb 2007; - Policy and Procedure for Missing/Absent without leave Patients - Oct 2007; - Children Visiting Hampshire Partnership NHS Trust Premises - Nov 2007; - Children Admitted to Adult Wards - Nov 2007; - Medicine Control, Administration and Prescribing Policy	Author's of Policies

	(MCAPP) - Apr 2007; - Substance Misuse Policy - Nov 2007; - Management of Inoculation or Contamination Incidents Policy (IPC 3.1) - Nov 2006; - Inoculation or Contamination Incidents Poster (IPC 3.2) - Nov 2006 - Noted Under Review; - Waste Management Policy - Apr 2006 - Noted Under Review; - Guidelines for the Management of Mental Health & Learning Disability Service Inpatient - Jul 2006 - Noted Under Review; - Medication Administration by authorised Occupational Therapists and their Support Workers- Jul 2007; - Section 117 Policy - Nov 2007; - Protocol for admission & transfer of People between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMH) - Nov 2007; and - Protocol for Admission & Transfer of People between AMH and Old Peoples Mental Health (OPMH) Services - November 2007. If policies are not kept up to date or subject to regular review for their relevance, there is a risk that staff are abiding by outdated guidance which does not reflect current practice. This could lead to organisational objectives not being achieved and possible litigation against the Trust.	
Management Response		**Deadline**
The Trust accepts this recommendation. These audit findings will be escalated to the Trust's Policies & Procedures Committee to address.		End December 2008

Statement of Responsibility & Contact Persons

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which came to our attention during the course of our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of internal audit work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Auditors, in conducting their work, are required to have regards to the possibility of fraud or irregularities. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our audit work and to ensure the authenticity of these documents. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

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July 2008

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Appendix A - Audit Framework

Audit Objectives

The audit was designed to ensure that management have implemented adequate and effective controls over the Clinical Governance & Risk Committee.

Audit Approach and Methodology

The audit approach was developed with reference to the agreed Method Statement and by an assessment of risks and management controls operating within each area of the scope.

The following procedures were adopted:

- identification of the role and objectives of each area;
- identification of risks within the systems, and controls in existence to allow the control objectives to be achieved; and
- evaluation and testing of controls within the systems.

From these procedures we have identified weaknesses in the systems of control, produced specific proposals to improve the control environment and have drawn an overall conclusion on the design and operation of the system.

Areas Covered

Audit work was undertaken to cover the following areas and control objectives:

- Composition, establishment ,quality & duties;
- Communication and Reporting to Trust Board and the Audit Committee;
- Communication and reporting links to Trust directorates to include whether the Directorate Governance structures are fit for purpose;
- Compliance with regulations governing the NHS;
- Understanding the clinical governance environment including risk management;
- Performance assessment and reporting processes including internal controls;
- Oversight of clinical audit and risk management functions; and
- Administrative arrangements, processes and procedures.

Appendix B – Staff Interviewed

• Pat Shirley	-	Director of Nursing and Governance
• Ruth Lord	-	Head of Clinical Governance
• Steve King	-	Head of Risk Services
• Fiona Penfold	-	Associate Director of Nursing – AMH
• Debbie Sloane	-	Clinical Governance Facilitator
• Kevin Page	-	Associate Director of Nursing – OPMH
• Huw Stone	-	Associate Director of Nursing - SS
• Nicola Trenowden	-	Associate Director of Nursing – LD
• Carol Bode	-	Non Executive Director
• Helen Matthews	-	Medical Director