Prince Philip Hospital Directorate Governance Review

Final Internal Audit Report

October 2021

Hywel Dda University Health Board

NWSSP Audit and Assurance

Contents

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Executive Summary

Purpose

The purpose of the review is to establish whether the Directorate governance structures follow the principles set out in the Health Board's system of assurance and support the management of key risks.

Overview

The Directorate has faced challenges and difficulties due to the Covid-19 pandemic over the past 18 months that has resulted in the refocus of operational duties through this period. During this period the Directorate has maintained adequate governance structures and arrangements.

We identified no high priority issues for reporting in our review, although a few medium priority findings were highlighted to further enhance the current arrangements, including governance reporting, updating of risk actions and identification financial saving schemes.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A No previous audit

Assurance summary[1]

Assurance objectives		Assurance
1	Governance Structures	Reasonable
2	Risk Management	Reasonable
3	Declarations of Interest, Gifts, Hospitality and Sponsorship	Reasonable
4	Financial Management	Reasonable
5	Incidents and Concerns	Reasonable

Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Terms of Reference	1	Operation	Medium
2	Risk Register	2	Operation	Medium
3	Declaration of Gifts, Hospitality, and Sponsorship	3	Operation	Low
4	Savings Plan	4	Operation	Medium
5	Complaints Group	5	Operation	Low

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The governance review of the Prince Philip Hospital (PPH) Directorate was completed in line with the 2021/22 Internal Audit Plan. The relevant Executive Director lead for the assignment was the Director of Operations.

1.2 The following inherent risks were considered during this review:

- the directorate is not appropriately governed;
- risks are not identified or addressed;
- the financial position is not met; and
- lessons learned are not captured and addressed.

2. Detailed Audit Findings

Objective 1: The Directorate has appropriate governance structures, with key meetings having approved terms of reference, agendas, and work plans to provide assurance on key objectives and risk areas

2.1 The PPH Directorate has an established Governance Meeting, which is supported by several sub-groups. A review of agendas and papers for the period April to August 2021 confirmed that bi-monthly meetings were being undertaken with key members in attendance that met quorate

2.2 A Terms of Reference (ToR) for the Governance Meeting was in place that describes its purpose, objectives, membership, attendees and operating arrangements. However, a review of the ToR highlighted the following:

- The ToR was dated June 2017 and was in 'Draft'.
- Details within the ToR require updating, for example, frequency of meetings was stated as monthly; and
- Not all items for discussion within the group are listed under the 'Key Responsibilities', for example, workforce. **[Matters Arising 1]**

2.3 Whilst we noted that there was no annual work plan for the Governance meeting, we did note that the key standing items had been identified around governance, patient experience, quality, health and safety, external reporting, research and development, risks and safeguarding. A review of the papers for the period April to August 2021 confirmed that sufficient discussion, scrutiny and reporting against key standing items was evident on key areas, such as, finance, workforce, and performance.

2.4 A review was undertaken of the following Directorate sub-groups ToR and minutes and the following noted:

SUB GROUP/ FORUM	VALID TOR	SET PURPOSE/ OBJECTIVE	FREQUENCY OF MEETINGS
MIU Governance	No	-	Monthly
Infection Prevention & Control	No	-	Bi-Monthly
Nursing Scrutiny/Assurance	No (Review date Aug 21)	Yes	Monthly
Complaints Group	No	-	Not met since Aug 2020

2.5 The review of the PPH sub-groups/forums identified three instances where a ToR was unable to be located – MIU Governance, Infection Prevention & Control and the Complaints Group; whilst the ToR for the Nursing Scrutiny/Assurance meetings was due for review in August 2021. **[Matter Arising 1]**

2.6 We noted that the Complaints Group had not met since August 2020. Management recognise this and are in the process of reestablishing the group. However, this has not had any consequences on the management of complaints within the Directorate as they are still being managed via the Governance Meetings. The reintroduction of the Complaints meetings will ultimately reduce the workload of the Governance meetings.

Conclusion:

2.7 The above have resulted in a Reasonable assurance rating.

Objective 2: A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, and escalated.

2.8 We can confirm that the Directorate risk registers are a standing agenda item at the bi-monthly Directorate Governance meetings. A review of the minutes and action notes between April and August 2021 confirmed that the risk register had been presented for discussion together with updates on actions taken to mitigate risks.

2.9 A review of the latest directorate risk register was undertaken to establish whether progress actions had been updated or closed. Every progress action is allocated a date for completion set by the Directorate. Of the nine risks recorded on the Directorate's risk register, as at August 2021, five risks had progress actions that had expired their set completion date and no update had been provided. **[Matter Arising 2]**

Conclusion:

2.10 The above findings have resulted in a Reasonable rating.

Objective 3: The requirements of the declaration of interests, gifts, hospitality, and sponsorship has been implemented within the Directorate.

2.11 We undertook a review of the 2020/21 Health Board's registers of Staff Interests and Register of Gifts, Hospitality and Sponsorship to identify whether the Directorate had actively contributed to them.

2.12 The Health Board's *Standards of Behaviour Policy* requires specified groups of staff, senior members of staff are required to submit a declaration of interest form. We

took a sample of five senior Directorate staff members and checked the Register of Staffs Interests for submission of their form. All five had submitted a Declaration of Interest form. A review of the Register of Gifts Hospitality and Sponsorship showed no entries of gifts, sponsorships or hospitality had been recorded for staff within the Directorate. **[Matter Arising 3]**

Conclusion:

2.13 The above findings have resulted in a Reasonable rating.

Objective 4: Appropriate financial management arrangements are in place within the Directorate, including compliance with an up-to-date scheme of delegation.

2.14 We can confirm that the structure of the Directorate is based on the scheme of delegation set out in the Health Board Standing Orders and Standing Financial Instructions and budget holders' roles and responsibilities are defines within the Health Board Standing Financial Instructions.

2.15 We can confirm that the financial position of the Directorate was discussed by the Service Delivery Managers together with the Senior Finance Business Partner on a weekly basis, with ad-hoc meetings also taking place at service level with the Senior Finance Business Partner. These are informal meetings with no formal minutes recorded.

2.16 We noted that sufficient scrutiny of the directorate's financial position, covering overall and service level status is undertaken and minuted at the PPH Directorate Governance meetings.

2.17 The Directorate receives a monthly report that details the Directorate's financial position including actual and forecasted spend, key overspend and other variances to the budget. The Directorate's financial position as at Month 4 highlighted just over a £500k overspent, with a forecasted overspend for the year of £3.96million, against an annual budget of £28.42m. Whilst actions were listed to address the current in-year overspend, specific savings schemes had not been identified to address the overall Directorate deficit, reflecting the service pressures during the Covid-19 pandemic. However, a review of potential savings schemes is currently being identified by the Directorate. **[Matter Arising 4]**

Conclusion:

2.18 The finding above has resulted in a Reasonable assurance rating.

Objective 5: Directorate has appropriate processes in place to ensure actions are taken as a result of incidents and concerns.

2.19 We can confirm that incidents and concerns are a standing agenda item on the Directorate Governance meetings. Review of the Governance Meetings action plans for the period April to August 2021 confirmed that incidents and complaints were discussed, monitored, and closed off when necessary.

2.20 As highlighted in 2.7 above, a complaints group was in existence but had not met since August 2020. The General Manager confirmed that it is intended to recommence these meetings in the near future, which will reduce the workload of the directorate Governance meetings. **[Matter Arising 5]**

Conclusion:

2.21 The findings above have resulted in a Reasonable assurance rating.

Appendix A: Management Action Plan

Matter Arising 1: Terms of Reference (Operation)		**Impact**
Review of the PPH Directorate Governance Meeting ToR highlighted the lack of an approval and review date. In addition, we noted key areas discussed at the Governance meetings, for example workforce, were not referenced within the ToR. We also identified three instances where a ToR was unable to be located for MIU, Infection, Prevention & Control and Complaints Group; whilst the ToR for the Nursing Scrutiny/Assurance meetings was due for review in August 2021.		Potential risk of: • the Directorate is not appropriately governed.
Recommendations		**Priority**
Management should ensure complete and accurate terms of reference for the Governance Meeting and supporting sub-groups are maintained and approved.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Accepted – Management will ensure the terms of reference for the Governance Meeting and supporting sub-groups are updated and approved.	31st December 2021	Brett Denning (General Manager)

Matter Arising 2: Risk Register (Operation)		**Impact**
Of the 9 risks recorded on the Directorate's risk register, as at August 2021, five risks had progress actions that had expired their set completion date and no update had been provided		Potential risk of: • risks are not identified or addressed.
Recommendation		**Priority**
Management must ensure the progress of actions recorded on the Directorate's risk register are updated and reviewed on a regular basis.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Accepted – Management will update the progress of actions recorded on the Directorate's risk register and ensure they are updated and reviewed on a regular basis.	31st December 2021	Melanie Long (Support Service Manager)

Matter Arising 3: Register of Gifts, Sponsorships and Hospitality (Operation)		**Impact**
A review of the Register of Gifts Hospitality and Sponsorship showed no entries of gifts, sponsorships or hospitality had been recorded by staff within the Directorate.		Potential risk of: • the directorate is not appropriately governed
Recommendation		**Priority**
Management must ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
Accepted – We will continue to ensure all employees comply with the Standards of Behaviour Policy by ensuring all gifts, sponsorships and hospitality received by the Directorate are submitted for registration on the relevant corporate register.	31st December 2021	Brett Denning (General Manager)

Matter Arising 4: Savings Plan (Operation)		**Impact**
Whilst actions were listed to address the current in-year overspend, specific savings schemes had not been identified to address the overall Directorate deficit. A review of potential savings schemes is due to be undertaken by the Directorate by September 2021.		Potential risk of: • the financial position is not met.
Recommendations		**Priority**
Management should ensure a review and identification of potential saving schemes is completed to contribute to addressing the Directorate's financial deficit.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Accepted – A review of savings schemes has now been completed.	10th September 2021	Brett Denning (General Manager)

Matter Arising 5: Complaints Group (Operation)		**Impact**
The complaints group had not met since August 2020. Whilst we evidenced that complaints are satisfactorily scrutinised at the Directorate Governance meetings, management have recognised that the recommencement of the group will inevitably reduce the workload of the governance meetings.		Potential risk of: • the directorate is not appropriately governed.
Recommendations		**Priority**
Steps should be taken to reintroduce the complaints group to facilitate the reporting within the directorate.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
Accepted – Discussions to take place with PPH team as to the benefit of re-starting the complaints specific governance meeting.	31st October 2021	Brett Denning (General Manager)

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.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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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