

## E- Meeting of the Audit Committee

## minutes

### Minutes of the Audit Committee Meeting held on Tuesday 10<sup>th</sup> January 2023

**Committee  
Members:**

Julian Farmer  
Nick Brooks  
Margaret Carney  
Bob Burgoyne  
Louise Robson

Non-Executive Director (Chair)  
Non-Executive Director  
Non-Executive Director  
Non-Executive Director  
Non-Executive Director

**Committee  
Attendees:**

Karen Edge  
Karan Wheatcroft  
Kate Warriner  
James Bradley  
Jennifer Crooks  
Nigel Woodcock  
Georgia Jones  
Chris Whittingham  
Gary Baines  
Jennifer Ohlsson

Chief Finance Officer  
Director of Risk and Improvement  
Chief Digital and Information Officer  
Deputy Chief Finance Officer  
Deputy Research & Innovation Officer  
Senior Audit Manager, MIAA  
Engagement Lead, Grant Thornton  
PSA Senior Manager, Grant Thornton  
Regional Assurance Director, MIAA  
Senior Executive Assistant (Minutes)

**Apologies:**

## **1. Apologies for Absence**

Apologies noted as above.

## **Action**

## **2. Declarations of Interest**

The Committee were asked for declarations of interest with respect to agenda items. All participants confirmed they had no interests.

## **3. Minutes of the previous meeting held on 11<sup>th</sup> October 2022**

The minutes of the e-meetings held on 11<sup>th</sup> October 2022 were accepted and recorded as a true record.

## **4. Action Log**

**Item 1:** Update required on the annual report of organisational learning.

**Item 2:** An update was provided and it was noted that a lot of work is being done around risk and a paper will be brought back. Action to remain open.

**Item 3:** It was noted that the review of losses and special payments paper is only due to come to twice annually but CFO confirmed that the charity reports are now synchronised. Action closed.

**Item 4:** Update required on further actions to strengthen the validity of the waiting lists.

## **5. Governance and Risk**

### **5.1 Risk Management KPIs**

Audit Committee colleagues were asked to note the Trust wide risk and KPI report. The Director of Risk and Improvement provided an overview of the current position.

Compliance with risk reporting requirements as set out in the risk management policy for risks. This is inclusive of MIAA reported risks, CQC risks and QIA risks on the risk registers. There is 100% completeness of information with the following exceptions; 92% assurances against a target of 95% and 98% review against a target of 95%

The Trust has 517 active risks and regular review of risks is in line with policy.

67% of incidents have been closed within 28 days, decreased from 69%. This KPI is currently under review to determine if there is a more supportive way to monitor this KPI.

The current number of incidents open over 28 days is 59 reduced from the previous reported figure, which was 60. The Divisions receive a monthly update on incidents that are open over 21 days in order for them to take action on open incidents.

Comments and questions were welcomed and a query was raised on the 28 day risk and whether there is confidence these are dealt with. It was

confirmed that the Risk Manager gets an alert and there is confidence that these are escalated and looked into.

Clarity was sought on what constitutes as closing a risk off. It was confirmed that there are a number of stages to the process, including approval and quality checks by the Risk Team.

The incident reports were noted and it was highlighted that these are monolithic. It was added that looking back over of the last 5 years, the number of incidents are quite constant and a query raised whether incidents continue to occur and what is the response to the learning. It was confirmed that there will be a wider review and it was noted that there needs to be a balance between high level incident reporting and incidents occurring.

An observation was highlighted on the reporting and felt there should there be an overall commentary. It was confirmed that this will be included in a wider piece of work.

Support was noted for looking at the process before a digital solution is created.

## **5.2 Review Clinical Audit Plan and 6-monthly progress reports**

Jennifer Crooks, Deputy Director of Research & Innovation attended Audit Committee to present an overview of the Clinical Audit plan and the 6 monthly progress report and colleagues were asked to note the report circulated prior to the meeting.

Processes continue to be followed as per updated policies and understanding is stressed, of the importance of reviewing and completing projects, acting upon recommendations and delivering actions to ensure learning and improvement.

There are new workstreams to be supported as the Trust enroll and submit data to new national audits and there is the need to facilitate the changes to existing NICOR National audits in collaboration with clinicians, and i-Digital, moving from the old data warehouse to the new MARTS data warehouse.

The team will continue to plan the use of resources and ways of working within the Clinical Quality team to achieve the Research & Innovation Strategic team objectives and support the Trusts Quality and Safety agenda.

Comments and questions were welcomed and it was raised that there is a huge amount of detail within the report but it is difficult to get a sense of how well the Trust are performing and where the pinch points and challenges to performance lie. It was noted that it is difficult to get overall picture as a lot of audits are managed differently. It was noted that that the new risk and incidents software could also help to manage this as it includes an audit tracking module. It was stated that things are going well but there is a large pressure across the team and there is a need for resource.

Concern was raised with the data quality issue and how seriously this is impacting upon the Trust and a query raised on whether this need to be reviewed more regularly.

It was confirmed that the iDigital team are working on dashboards and the validation process has been implemented as an SOP. Assurance was given that work is currently underway.

A query was raised on whether there any risk around patient records. It was confirmed that there is no risk and this is related to mandatory fields.

It was agreed that there needs to be more understanding on the impact on the Trust and it was agreed that a report will be brought back to provide assurance on the points raised above.

A query was raised on what quality control is in place for the local audit plans and ad hoc audits. It was noted that these are reviewed each week and these go to R&I Committee for review.

A query was raised on the level of risk that clinicians are unable to devote time to data cleansing and whether there any other ways of ensuring this work is done. It was confirmed that each project has to have a Project Lead and Supervisor and there is a clear process for this. It was added that the Trust data analysis is responsible for ensuring that the data is synchronised. It has been recognised that having one Data Analyst is a risk and work will be done with iDigital to expand.

Audit Committee colleagues were also informed that maternity cover for the Deputy Director and Research and Innovation has been found and they are due to start in post on Wednesday 1<sup>st</sup> March 2023.

### **5.3 Committee Effectiveness Approach 22/23**

An overview was provided of the proposed committee effectiveness approach for 2022/2023. The proposed approach is as follows:

Survey ('microsoft forms') to be sent to Committee members and regular attendees (to be confirmed with Chair and Exec Lead for each committee) to include a range of questions around operation of the committee (January 2023)

Desk top review against Terms of Reference (Director of Risk and Improvement to support Exec Lead, January 2023)

Facilitated (1 hour) workshop with Committee members and regular attendees to review the survey feedback, desktop review and wider committee review findings in February 2023.

Committee annual report to be drafted (Director of Risk and Improvement to support Exec Lead, by 14th March 2023) for reporting to the Audit Committee 21st March

It was suggested that this approach is used on a wider basis for all of the Trust Committees.

### **5.4 Compliance with Licence: Review of quarterly checklist**

Director of Risk and Improvement provided an overview of the compliance with Licence paper and noted that the Trust has been able to achieve

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compliance with the 6 week diagnostic target, and continues to manage the risks associated, mainly relating to availability of workforce.

Due to reduced operating during the Covid pandemic the Trust accumulated a backlog of patients that are waiting longer than 18 and 52 weeks for treatment, predominantly on the admitted pathway. In line with national standards the Trust approached recovery prioritising the most clinically urgent patients first and then by waiting time on the waiting list. This inevitably means that patients will continue to breach the RTT standards until the backlogs are fully recovered. The Trust's position and forecast demonstrates strong performance and recovery in 2022/23 when benchmarked across the country

These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board.

Planned industrial action during the end of Q3 and into Q4 may have significant impact on the Trust's recovery against performance targets. This will continue to be assessed based on the regional and national picture and reported back to Board.

Also to note is that from 1st September 2022, NHSE establishing agency expenditure limits at system level, with NHS trusts and foundation trusts mapped to ICBs in line with financial planning and reintroducing agency staffing performance and monitoring within the NHS Oversight Framework. The Trust has continued with the agency controls and processes in place pre-Covid 19.

NHSEI are consulting on a revised Provider Licence for introduction in 2023/24 and an update on this will be provided in due course.

Comments and questions were welcomed and a query was raised on whether it is possible to predict or estimate how the agency expenditure limits will affect the Trust. CFO confirmed that in the draft operational plan and guidance, it was outlined what the focus would be on the agency cap and this will be applied at a system level. It will be for each ICB to manage agency spend and this is capped at 3.7% of the pay bill. CFO added that for context LHCH spends 1.7% of the pay bill on agency, so the Trust is fairly low user compared to other Trusts. CFO also added that there is focus on reducing and managing agency spend and agenda is only utilised when there is a clinical risk.

### **5.5 Review of Register of External Visits**

Audit Committee colleagues were asked to note the external visits log circulated prior to the meeting.

### **5.6 Regulatory Action Plan**

Audit Committee colleagues were informed that there were no regulatory action plans to update on.

### **5.7 Cyber Security Update**

Chief Digital Officer provided an overview of the Cyber Security paper.

and noted that within LHCH, there continues to be progress compliance with the national revised Data Security and Protection Toolkit ahead of our audit next calendar year as well as management and ongoing development of IT infrastructure estate.

The threat landscape is continuing to evolve, however as detailed in the paper the Trust control environment is being developed to meet these and future challenges. There have been a number of changes to national standards and requirements which have a structured programme of activities to meet underway.

Colleagues were also informed that an Associate Director and an apprentice are now in post

Chair noted that it was good to see work being done and paints an overall picture and thanked the team for the hard work being done.

It was noted that this is a good Assurance report and also noted that KPI compliance will need to be monitored closely and a query raised on what the consequences of not achieving the KPIs are. CIO confirmed that the Trust would be out of kilter nationally from compliance point of view if these were not achieved and operationally having unsupported software could cause other problems. CIO added that it is key to keep on top of the basics and pre-empt any issues.

A query was raised on the new standards and whether the new standards go far enough in terms of mitigating risk, noting that the national standard for High Severity Care Certs is 14 days for reporting mitigation. CIO noted that the team is keen on responding as quick as possible and the Trust average is 7 days. Each high severity care cert is assessed and prioritised as it comes in.

### **5.8 Data Quality Assurance Report**

Chief Information Officer provided an overview of the data quality assurance report and noted that The trust has due process in place including Data Quality Strategy recently approved by Patient Pathway and Assurance Group along with an in-date data quality policy. Appropriate governance is in place and is led by the DQ Steering Group which meets bi-monthly.

The Trust is viewed favourably when reviewing metrics from external submissions CDS and SUS. Outpatient CDS has flagged up a minor area for concern to investigate Attendance Indicator completion. This is being addressed via the Data Quality Steering Group.

MIAA are due to complete a data quality audit in the final quarter of 2022/23 which will provide a deep dive into assurance processes around our corporate reporting.

There are plans in place to utilise an in-house developed DQ App and create a Metric Maturity Model to give senior leaders an ability to quantify data quality at a glance.

Comments and questions were welcomed and it was noted that it was good to see effective arrangements in place and that there is a clear focus on improving and strengthening them.

The encouraging improvements in clinical coding were noted and further assurance sought, on the plans to undertake a review of waiting list accuracy. CIO confirmed that this will be picked up as part of the developments over the next quarter.

### **5.9 Partnership Working**

It was agreed that Partnership working will be deferred to the March 2023 meeting and chair has assurance that there are no issues at present.

### **5.10 FPPT Checklist Compliance**

Audit Committee Colleagues were asked to note the MIAA FPPT checklist compliance report circulated prior to the meeting.

MIAA have produced a checklist to support Trusts and ICBs in ensuring that they have sufficient and effective processes and governance arrangements in place for Fit and Proper persons regulations (FPPR).

Completion of the checklist has confirmed compliance with all but two of the FPPR best practice elements. The exceptions are;

- Whilst the Chair signs off the annual self-declarations, we will also ensure this is also done on appointment.
- Whilst we do complete annual self-declarations we do not routinely undertake any further regular checks such as searching of registers (Insolvency and Bankruptcy register, Disqualified directors and Charities Commission disqualified register). This will be explored with HR.

### **5.11 HFMA Audit Committee Handbook Supplement**

The HfMA Audit Committee handbook has been a long standing guide for NHS Audit Committees, setting out the requirements and best practice.

HfMA have produced the supplement as an interim update to the 2018 handbook, with a full revision expected in 2023.

The Audit Committee is asked to note the update and the intention to reflect on the requirements as part of the Committee effectiveness review.

Comments and questions were welcomed and it was noted that this was a useful summary of key changes.

### **5.12 LHCH Q3 tender and quotation waivers.**

CFO informed colleagues that Health Procurement Liverpool have recommended that the tender waiver update is presented at every Audit Committee and presented an overview of the LHCH Q3 tender.

There was a total of three tender waivers signed off in Q3 22/23, one relating to the Innovation agency, where the value of the contract exceeded £50k (inc. VAT).

The department processing the most tender waivers in Q3 22/23 was the Projects team.

There was a total of twelve quotation waivers signed off in Q3 22/23 where the value of the contract exceeded £10k (inc. VAT) but was less than £50k (Inc. VAT).

The department(s) processing the most quotation waivers in Q3 22/23 was The Projects team and Theatres.

The main reason for Tender and Quotation waiver requests in Q3 22/23 from the SFI's was for "The supply of goods and services with special character."

There were no further comments or questions.

## **6. Internal Audit**

### **6.1 Progress report on delivery of plan**

Nigel Woodcock provided an overview of the progress report.

Reviews that have been finalised include; HFMA Finance Checklist, Risk Management and Health & Safety.

Reviews in progress include; Cost Improvement Programme, Roster, Outpatient Planning and Appointment Process, Cancelled Operations and Key Financial Controls.

The TORs have been agreed and published for; Consultant Job Planning, Performance Monitoring/Management, Audit Committee Progress Report

The TORs issued in draft include; Assurance Framework Review, Procurement Collaborative and DSPT.

There were no further comments or questions and assurance was sought on whether the Trust is on track to deliver the plan by the end of the financial year. It was confirmed that MIAA have experienced some resource issues, however no issues are anticipated.

The Health and Safety Audit was also noted and it was confirmed that the follow up process has started on this report. It was added that these actions are linked to the annual Health and Safety report due in June 2023.

### **6.2 Follow-up report**

Nigel Woodcock provided an overview of the follow-up report and asks Audit Committee colleagues to note the report circulated prior to the meeting.

Comments and questions were welcomed and CFO noted that a lot of progress has been made over the past few years and a good culture has been created.



### **6.3 HFMA NHS financial sustainability report**

An overview of the HFMA financial sustainability report was presented and colleagues informed that in April 2022 the Healthcare Financial Management Association (HFMA) produced a briefing Improving NHS financial sustainability: are you getting the basics right? The briefing included a detailed checklist for organisations to use as a self-assessment tool.

NHS England (NHSE) issued guidance that required organisations to commission from their internal auditors a review of the completed self-assessment. The NHSE guidance described the process to be undertaken locally and set out the scope of the internal audit review.

MIAA performed the review to provide an objective and unbiased assessment.

Clarity was sought on what the impact of this was. CFO confirmed that these results are reported to the region and Trusts scoring below 4/5 would be subject to an improvement. Anything scoring below 4/5 would have an improvement action applied to it.

The valuable session at the BoD strategy day was noted and it was agreed that this will be added to the planning/effectiveness agenda.

### **6.4 Anti-Fraud update report**

Michelle Moss attended Audit Committee to provide an overview of the Anti-Fraud update report circulated prior to the meeting. The MIAA Anti-Fraud Progress Report sets out the work undertaken during the period 2<sup>nd</sup> July 2022 to 16<sup>th</sup> December 2022 and details the activities carried out and outcomes achieved in accordance with the agreed anti-fraud, bribery and corruption work plan, compliant with counter fraud standard requirements, and in response to any referrals (incidents) / investigations reported.

Comments and questions were welcomed and the low number of referrals were noted and the importance of the robustness and the ease of referral was highlighted. It was confirmed that this is caveated with a lot of the preventative work that is done. It was also noted that a smaller Specialist Trust would receive less referrals than larger Trust and this is not a concern.

## **7. External Audit**

### **7.1 External audit update reports**

Christopher Whittingham, Grant Thornton's PSA Senior Manager provided the committee with an update on the progress in delivering the responsibilities of the external auditors.

It was noted that there is some useful information on the developments and challenges.

## **8. Review of Audit Committee Work Plan – 2022/2023**

Audit Committee colleague were asked to note the Audit Committee Work Plan and this was approved by the committee.

**9. AGS Issues**

The Audit Committee had nothing further to note for the Annual Governance statement.

**10. Evaluation of Meeting**

The Audit Committee was content with the mechanism in place for the e-meeting.

All committee members confirmed that the meeting had been conducted effectively and useful documentation had been received and discussions had taken place.

**11. Date and Time of Next Meeting:**

Tuesday 21<sup>st</sup> March 2023, 08.30am – 10.30am, MS Teams