

## minutes

### E- Meeting of the Audit Committee

#### Minutes of the Audit Committee Meeting held on Tuesday 11<sup>th</sup> January 2022

<b>Committee Members:</b>	Julian Farmer Nick Brooks Bob Burgoyne Karen O'Hagan Margaret Carney	Non-Executive Director-Chair Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director
<b>Committee Attendees:</b>	Karen Edge Michelle Moss Karan Wheatcroft Nigel Woodcock Georgia Jones Gary Baines Kate Warriner Janet Deane  Megan Underwood	Chief Finance Officer Anti-Fraud Specialist-MIAA Chief Governance Officer Senior Internal Audit Manager-MIAA Key Audit Partner-Grant Thornton Regional Assurance Director-MIAA Chief Digital Information Officer (Item 3.5 only) Clinical Audit Effectiveness Manager (Item 3.2 only) Senior Executive Assistant (Minutes)
<b>Apologies:</b>	Lucy Lavan	Director of Corporate Affairs
<p>In accordance with the Trust's response to COVID-19, the meeting was conducted remotely via video conferencing to maintain social distancing.</p> <p><b>1. Apologies for Absence</b></p> <p>As noted above.</p> <p><b>2. Declarations of Interest</b></p> <p>Karan Wheatcroft declared herself as a senior member of MIAA, the Trust's internal auditors, and confirmed that she would not take part in any discussion relating to any compromised agenda items. All other participants declared that they had no interests.</p> <p><b>3. Governance and Risk</b></p> <p><b>3.1 Risk Management KPIs</b></p> <p>A significant amount of work has been completed on the risk KPIs and looking at the Divisional level drilling into any gaps on the risk register.</p>		<b>Action</b>

There has been a lot of cleansing, several the KPIs have improved, the Risk Management Committee oversee this and the actions and developments. Incident reporting was included within the report – work was to be done on this with the Director of Nursing, Quality and Safety, Risk and Safety Lead and Chief Governance Officer to look at how the incidents could be broken down, a number of the incidents over 28 days have external involvement with responses awaiting, nearly 60% of incidents over 28 days were awaiting a response from external bodies.

The number of incidents over 28 days was discussed and the committee were reassured this was being looked into. Incidents were discussed on a weekly basis within the Executive team, the incidents were split across the organisation with no known themes. Divisions receive a 21-day notice on incidents with a forewarning of one week for the KPI to be met. The Chief Governance Officer was to look into collating the data into a monthly trend.

KWh

An additional risk of 16 had been added to the report, this would be discussed at length during the Board of Directors, however, this was in relation to theatre sessions – staffing absences and recruitment gaps. Divisional Head of Operations have been brought into the Risk Management Committee, the reporting has been improved with a focus on the actions – the response to this has been good. Reports have been automated; however, this remained a work in progress. Next piece of work was to look at the Risk Register to see what could be archived to ensure main risks were focused on.

The Chief Governance officer provided reassurance that risk was visible across the organisation with the risks on the register being actively managed with the organisation being aware on how to escalate risks.

There had been 1,500 reported incidents year to date.

### **3.2 Review Clinical Audit Plan & 6 Monthly Progress Report including NICE Guidance Review**

Currently on track with progress against objectives that had been set. Clinical Audit Effectiveness group has continued to meet throughout the last 12 months with participation in national confidential enquiries and reviewing NICE guidance, requesting clinicians' feedback and gap analysis remaining a priority.

The department have achieved development of an automated process for registering of projects and education has commenced across the organisation to ensure clear registration of clinical audits, service evaluation and surveys.

Close links have been developed with the Research and Innovation Committee (R&I) to ensure projects were being reviewed and discussed at R&I Committee for improvements in governance. Research and Innovation Audit Governance Guidelines have been introduced to make it clearer around accessing patient information around studies.

New National Clinical Audits were currently being worked on in which the Trust would like to participate, the Stroke service were keen to

participate in the sentinel stroke national audit, work has been ongoing with the Physiotherapists looking at current documentation within EPR and copies of the dataset to build the documentation to collect the relevant dataset, the next steps would be to work with the Data Warehouse team and i-Digital team to get these into the data warehouse to commence work on national audits with uploads. This applies to stroke audit and the national vascular registry – the Trust have not participated in this previously but do now due to new vascular service and the relationship with the vascular surgeons at Liverpool University Hospitals. Thoracic data was being built into EPR. A significant amount of work has been completed with clinicians.

Over the next 12 months a significant amount of work will be completed due to the development of the new data warehouse with engagement ongoing with i-Digital and the data warehouse team.

For future reports the assurance box was to be inserted at the top of the report. The Clinical Audit and Effectiveness Manager would seek advice from the Chief Governance Officer.

The committee were satisfied with the progress that had been made to date, however, there was a risk around the volume of work and resources required over the next 12 months to be able to move across to working with a new data warehouse environment and ensuring the repointing of scripts, a lot of the work required reliance on clinicians input to ensure the correct data and documentation was being used. Review was ongoing and scoping out the demands to decipher what could be achieved.

From a clinical perspective, this was noted as an extraordinary and comprehensive program with all relevant essential audit boxes being ticked. Assurance can be taken from this.

### **3.3 Compliance with Licence: Review of Quarterly Checklist**

This was a quarterly update, however points in here will remain within the report which is cumulative for the year. Requirements were the same as pre-Covid with those impacted throughout the pandemic to remain sighted on.

Diagnostic performance – this was a cumulative report; therefore, the diagnostic performance was a concern in quarter 1, however, this was no longer flagging as an issue. Integrated Performance Committee will continue monitoring the diagnostic and performance targets and receiving assurance through this committee. Diagnostics was not a concern currently and the team had worked incredibly hard to bring the waiting list down. There were risks in relation to staff shortages, this was related to the current issue of staffing availability and Covid, this was not seen to be a permanent concern as the Trust continue to move away from the pandemic situation. Each year in annual planning a capacity and demand model exercise will be completed in which the availability of scanning time and people resources will be looked at and compared against demand, this work is currently underway and should the work suggest that the Trust need to invest in additional capacity this would be looked at with a case of need being brought forward. The second CT

and MR scanner were replaced several years ago and this has provided the BAU capacity required.

### **3.4 Regulatory Action Plans: None to Report**

There were none to report this quarter.

### **3.5 Digital Systems Partnerships Working: Alder Hey & LHCH**

New service was set up in June 2021 – the i-Digital Service, this was an integrated digital service across LHCH and Alder Hey, this has been subject to a fast-moving pace of change, the aim was to provide a strengthened digital service across both Trusts. Strategically, looking at the shape and professional model of the service.

There was an emphasis on staff engagement and staff development during last year, including a number of external accreditations in which the workforce have been reviewed, particularly the North West Informatics Skills and Development Network and the Excellence in Informatics Accreditation, both Trusts achieved level one with a view to go jointly for level 3. Support was received from MIAA with the Audit Committee being interested in cyber security service – this was the first service in which joint appointments were made – good feedback was received from the work internal auditors had completed.

200 staff have been involved within the new arrangements, both Trusts were thoughtful around the branding of the service with extensive engagement exercises. A joint staff forum has been set up, this was led by the staff and sat across the whole service. A significant piece has been done on equality diversity and inclusion and ensuring staff opportunities are equitable. There has been a significant amount on communications and engagement, the Chief Digital and Information Officer leads a twice week all staff briefing. Additionally, the teams have been working on activities to involve both charities. Staff engagement piece was the top priority.

Key areas were around staffing and staff engagement, the Trust were keen to understand any risks associated with this and as a service manage them effectively. The second was around the current and future models and ensuring both Trusts have the support in the investments they are making and as the service matures thinking about a relationship and an account type model and strengthening this.

Both Trusts have ambitious delivery programmes, at LHCH there is the Digital Excellence Strategy and Digital Aspirant programme, in terms of support needed to ensure that the pace is supported by both Boards.

The Trusts have been on a long journey in terms of the new service. There was a question raised in relation to resilience, the Chief Digital Information Officer confirmed a report will be presented to the Board of Directors. For information, year one, was around going back to basics and building the foundations with the Board backing the investments, a brand new infrastructure was in place across the partnership, priority one incidents have reduced significantly, this was due to the additional investment and the digital aspirant programme. Additionally, some of the

issues were around the basic devices in clinical areas, new computers and equipment have been put out across the clinical areas and building the cyber security resilience which has been the main priority during the last year.

### **3.6 External Visits Register January-June 2021**

This continued to be included on the agenda following work from CQC and as a committee ensuring any actions points were not missed as a result of an external visit by a regulator. This was to allow the committee to focus on any areas that may require a follow up.

There have been a small number of visits which have increased from the previous period, nothing exceptional to note.

## **4. Internal Audit**

### **4.1 Progress Report on Delivery of Plan**

Four reports had been issued for the Committee:

- ESR/HR payroll – this was a core piece of work with Substantial assurance achieved.
- Secure health messaging – this was a management requested piece of work resulting in Moderate. Value has been added with a request for the action plan be taken forward with a view for this to be considered at the Quality Committee. This was an important safety issue; this has been discussed at Quality Committee for several years with some serious incidents coming from this. Verbal assurance has been received; however, the audit and implementation report would provide complete assurance.
- Hosted services – this was also a management piece of work requested resulting in Substantial assurance - this was in relation to cyber security arrangements which was a partnership model with Alder Hey. The other aspect of the audit was around financial governance on the three organisations in which the Trust host: Liverpool Health Partners, Innovation Agency and Liverpool Network Alliance.
- Key financial systems – this was a core piece of work which as resulted in a High assurance rating.

It was noted the difficult circumstances presently for internal auditors to work with the Trust to deliver the work programme, however good progress has been made with Trust and on track to deliver the plan, only work left is the mandated work in quarter 4 – this gives assurance that an opinion will be available for the full financial year.

The Audit Committee agreed that the Secure Health Messaging internal audit report be discussed at Quality Committee.

### **4.2 Audit Committee Effectiveness Report 2020/21 and Preparations for 2021/22**

A suggested process for evaluating the Committees Effectiveness had been developed for consideration with the proposal for this to be delivered through Microsoft Teams workshop for members. It would also provide a good opportunity to discuss any issues that have arisen previously.

The Audit Committee approved the paper to review the Committees effectiveness. Workshop was to be set up in line with the timeframes highlighted within the report.

**MU**

#### **4.3 Follow Up Report**

This is reported to the Audit Committee formally twice a year. During the last number of years individual recommendations have been picked up. Since the last report, 11 recommendations implemented with a further 13 in progress, two high risk recommendations have had some progress on them, residual risk has been reduced. No concerns to raise to the committee.

In relation to Research Finances which had a number of overdue actions, it was noted this was a Trust management instigated report with a high number of recommendations which required a significant amount of work in terms of changing how the Trust monitor research finances governance and processes. Significant changes have been made to financial management arrangement and processes. Confident that a lot of progress has been made with those outstanding being in relation to assurances as to how systems were used. All trial balances have been reconciled with this being monitored individually and a feedback mechanism to the Research Finance Committee.

Internal Audit were thanked for the work that has been completed.

#### **4.4 Anti-Fraud Update Report**

The report was for the work that has been undertaken from July-December 2021. There was a significant amount of work being undertaken on strategic governance around fraud risks with a fraud risk register embedded in the organisation, this is due to be reviewed in quarter 4 with work commencing imminently.

Work has been ongoing, awareness sessions, newsletters, alerts, mandate checks with finance, bespoke training being done with short animation videos to be distributed across the organisation. The National fraud initiative was a significant piece of work this year focused on purchase orders; within the report, one duplicate payment was noted of £2,208 which was successfully recovered after a review of the finance team. In addition, within the report it was noted there was one payroll to payroll match that was being reviewed, this has since been closed.

The current work included an overtime proactive review with several meetings to finalise the data for the review in place with the report to come back to the March Committee.

**MM**

In terms of referrals, there had been two investigations which have concluded to no case to answer. There was one query linked to the same type of referral, the outcome of this was no case to answer.

Key performance indicators for counter fraud governance standard were included in the report and it was noted the anti-fraud bribery corruption strategy has been moved to a green rating. Component three which was amber will be reviewed in quarter 4, once this has been updated it will be changed to green and the return submitted in May 2022 with a draft to come to March Audit Committee.

The bribery and compliance review has been concluded in June 2021, there were six actions to complete and six no actions taken, five of these were in relation to procurement and updating policies and procedures, assurance received that the policy has been updated and will be ratified at the end of February 2022. All six no actions were partial and should be concluded by the end of March.

## **5. External Audit**

### **5.1 External Audit Update Report**

The regular progress update report was presented in a slightly different format. Page three sets out responsibilities with key information commencing on page five. From the last committee, the Auditors Annual Report was discussed, this will be the second year of the new value for money arrangements, plan for delivery to be issued for the next committee in March – risks had been identified and how they will be addressed which will be discussed in more detail on confirmation of the timelines.

On page six, more information was highlighted on statutory responsibilities and additional value provided to the Trust by the external auditors.

Page seven sets out the deliverables with the plan to come to March committee, interim work will be included within the plan or in a progress report. Since writing the report, the deadline for the opinion on financial statements will be 22<sup>nd</sup> June.

Grant Thornton are inspected by Financial Reporting Council on an annual basis, results were highlighted within the report – improvements have been made during the last number of years in terms of the quality grading received.

Remainder of the report is usual sector update with reports and information articles.

## **6. Review of Audit Committee Work Plan**

The work plan was noted, there were no further comments from the Audit Committee.

## **7. Minutes of e-Meeting held on Tuesday 19<sup>th</sup> October 2021**

The minutes of the previous e-meeting were recorded as a true and accurate record.

#### **8. Action Log**

All items within the action log have been dealt with through the course of the meeting.

#### **9. AGS Issues**

No issues or concerns have been raised; the Audit Committee had nothing further to note.

#### **10. Evaluation of Meeting**

Colleagues were pleased with the format of the meeting, no further comments to note.

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

Tuesday 22<sup>nd</sup> March 2022, 8.30am-10.30am