

Item 5.2.1a*

minutes

Audit Committee

Minutes of the Audit Committee Meeting held on Tuesday 14th January 2020

Present:	Julian Farmer Bob Burgoyne Mark Jones Karen O'Hagan	Non-Executive Director (Committee Chair) Non-Executive Director Non-Executive Director Non-Executive Director
In Attendance:	Ruth Barker Sue Hodgkinson Gregg Holland Laura Hunter-Cross Georgia Jones Lucy Lavan Frankie Morris Michelle Moss Jennifer O'Brien Mina Patel Marga Perez-Casal Nigel Woodcock	Anti-Fraud Specialist-MIAA Interim Director of People & Culture (Item 4.4 only) Chief Information Officer (Item 3.6 only) Head of Financial Accounts Senior Audit Manager-Grant Thornton Director of Corporate Affairs Acting Chief Finance Officer Anti-Fraud Specialist-MIAA Senior Executive Assistant Interim Deputy Chief Finance Officer Director of Research & Innovation (Items 3.1 & 3.2 only) Senior Internal Audit Manager-MIAA
Apologies for Absence:	Nick Brooks	Non-Executive Director

	Action
1. Apologies for Absence As above.	
2. Declarations of Interest Relating to Agenda Items None declared.	
3. Governance and Risk 3.1 Risk Management KPI's The Director of Research & Innovation presented the usual report seen at the Audit Committee which reviewed the KPIs that were set for the Risk Management and Corporate Governance Committee (RMCGC) in order to review the effectiveness of the risk management function.	

The majority of targets were being met with the exception of risk register management in the corporate division and the closure of incidents within 28 days.

The decrease in meeting the target with regards to review of registers in the corporate division was largely due to managers in the division not undertaking a review of the risk registers in a timely manner. Part of the process included the Risk and Safety Lead contacting the respective managers in order to prompt a review of the registers and would provide further support if necessary.

In relation to closure of incidents within 28 working days, the Divisional Head of Operations received a weekly report advising which managers had incidents open over 28 days. Each Divisional Governance Committee received a monthly report which named those managers that had incidents open over 28 days. The Executive team received a weekly harm report which detailed which incidents were open over 28 days and the status of the incident. Managers would be reminded about the importance of closing incidents in a timely manner in order to ensure the learning was applied and the incident was prevented from reoccurrence. The executive team would monitor this more closely going forward.

MPC

The Risk Management performance dashboard together with a graph detailing the LHCH reported patient incidents by month was provided in the attachment to the paper. Whilst the graph showed that the Trust had improved in the area of reporting incidents, it was agreed that a smaller time frame, other than the 2012-2019 shown would be more advantageous and allow the committee to assess the reporting in more granular detail.

MPC

It was confirmed that the operational lead for Risk met with ward managers and heads of departments to ensure any reported incidents were addressed, whilst the Director of Research & Innovation met with the Chief Operating Officer (COO) and other corporate colleagues.

Audit Committee members agreed that it would be helpful to see which incidents were still open over 28 days due to external partners. It was agreed that this could be shown in the next report seen at the Audit Committee in July 2020.

MPC

The Audit Committee noted the contents of the report.

3.2 Review Clinical Audit Plan & 6 Monthly Progress Report Including NICE Guidance

The paper was presented in order to provide assurance on delivering the Clinical Quality Audit Plan including NICE guidance.

Pages two and three of the paper detailed how this was being achieved and what plans were in place in order to ensure that the Clinical Quality Audit Plan was achieved going forwards.

CQUINS for Q2 were submitted at the end of October 2019 to both Liverpool CCG and the Specialist commissioners. Quality Schedule submissions by exception and monthly had also been submitted on time. The Q3 submission was due 31st January 2020.

The CQUIN dashboard was updated following confirmation of achievement from the CCGs and the Deputy Director of Nursing & Quality presented updates to the Quality & Patient Family Experience Committee (QPFEC) each quarter.

The Clinical Audit Effectiveness Group (CAEG) had met on 5 occasions and reviewed 81 NICE publications of which 26 had been deemed relevant to the Trust, Appendix 1 of the report contained those recommendations.

The Board of Directors received the Learning from Deaths report and dashboard on a quarterly basis and the divisions received regular reports with the action log from the mortality review group. Mortality statistics were also provided to the business information team for the quality performance dashboard. Audit Committee members were informed that the Trust had only two death reviews pending as three had been reviewed since the publication of this paper.

NICOR data within the EPR system had been reviewed, updated and new documentation had been added to enable the collection of the required dataset for ACHD National Clinical Audit. However, due to the complexity of Congenital Heart Disease there was still a need to manually review data from various correspondences.

On 2nd July 2019, an external validation visit was performed by NICOR reviewing the data quality of LHCH submissions to NICOR. The NICOR Validation Report was received in December 2019. The report stated the submitted NCHDA data was accurate, well documented, of good quality and was appropriately recorded in the Theatre and Congenital Cath lab log books that were seen.

Following the Data Quality Indicator Assessment the overall Trust DQI result was 93.5%, Cardiology DQI was 94% and Surgery DQI was 92.75%. The recommendations within the report were currently being reviewed by the congenital team.

The transfer of data from TOMCAT to EPR was ongoing and colleagues were working with the data warehouse and informatics teams to ensure the timely transfer of data in order to monitor/report from April 2020.

Audit Committee members expressed concern regarding the clinical quality department's database being out of date. The Director of Research & Innovation assured colleagues that whilst the database itself was historical, the information contained within is accurate and the team were still working with it. Audit Committee members were informed that a new system had been approved at the Digital

Healthcare Committee and was expected to be installed over the coming months.

The Director of Research & Innovation confirmed that whilst NICE guidance suggested that Rivaroxaban could prevent atherothrombotic events in people with coronary or peripheral artery disease, the Trust could not use it without the approval of the Pan Mersey review process which applied to every Trust in the Mersey area.

A question was raised regarding the attendance at the CAEG, as this had been an issue in the past. The Director of Research & Innovation confirmed that the Terms of Reference had been amended to state that members must attend 60% of the meetings or send a Deputy and there had been an improvement in attendance.

The Audit Committee noted the contents of the report and the appendices stating that significant assurance was given that clinical audit processes were in place and the areas for improvement were recognised.

The Director of Research & Innovation left the meeting.

3.3 Compliance with License: Review of Quarterly Checklist

The quarterly checklist had been updated at Q3 2019/20. The primary risks related to;

- The Trust was continuing to face pressures in diagnostic performance; compliance and diagnostic targets would not be achieved until Q1 2020/21. A revised trajectory had been submitted to NHSI. The new scanners were operational but there had been significant downtime of the old MR scanner which had impacted upon waiting times. Patients continued to be prioritised in accordance with clinical need.
- Underperformance of surgical activity; a recovery plan was in place with a weekly tracking process led by the Chief Operating Officer.
- Failure to meet the RTT standard in both November and December 2019, due to the reasons above and also short term capacity constraints, including the impact of the pensions taxation issue which had resulted in lower uptake of additional work required to manage the backlog.

The Director of Corporate Affairs highlighted that the breached RTT target was the first time the Trust had breached in some time. Audit Committee members were informed that the Director of Corporate Affairs and the COO were meeting regularly with colleagues from NHSE / I to monitor the position and to enable NHSE/I to have a fuller understanding of the sub-specialty operational pressures and the reasons for increased size of the overall waiting list.

Audit Committee noted that both a surgery and medicine recovery plan would be seen at the January 2020 Integrated Performance Committee (IPC) where the COO would be asked to clarify the

capability of the new scanner in relation to its suitability for different patient cohorts. Discussions would also take place at the Board of Directors' meeting in January 2020.

The national pensions issue remained a great concern; as of 1st April 2020 onwards there was currently no national plan in place. However it was noted that consultations had commenced involving NHS Providers and the Local Negotiating Committee (LNC). The LNC had agreed to the policy drafted by LHCH which could be rolled out to LHCH staff on the understanding that it would be superseded as soon as a national solution was identified.

The Board of Directors would discuss the impact of the three primary risks on the BAF and review the risk scores assigned to the related principal risks at the next Board meeting on 28th January 2020.

The Audit Committee reviewed the checklist and confirmed its satisfaction that there were effective systems and processes in place to identify and manage risks in relation to compliance with the licence.

3.4 Review of Register of External Visits

The Audit Committee reviewed the Register of External Visits and confirmed their satisfaction with the governance arrangements to deal with the findings and recommendations following external visits and inspections.

The Audit Committee would continue to review the register on a twice yearly basis, with the next review scheduled for the 14th July 2020.

3.5 Regulatory Action Plans

Following recent meetings with NHSE/I and the CQC, it was noted that the NHSE/I main concern related to the activity and waiting list pressures as discussed above under agenda item 3.3 and regular monitoring would continue in relation to those risks.

The CQC expressed no concerns. The Trust's Well Led review was due to commence Q3 / Q4 of 2020/21, and preparatory work would commence shortly.

3.6 Informatics Review: Data Quality Assurance

Greg Holland, Chief Information Officer (CIO) joined the meeting. He reported that there were no concerns nationally.

A key change was noted in relation to Commissioner data quality issues which had decreased markedly with the additional focus by the data management team and no issues had been raised in the last two reviews.

Work was still ongoing to address day to day data quality issues. The data quality group was currently focusing on the reasons why users made errors before investigating system solutions to these issues. An

increased level of local ownership in addressing issues, in line with the data quality strategy of 'correct at source' had been seen.

An emerging issue was the increasing questioning of the quality of referrals data, submitted through both national and local routes. This would be reviewed as a matter of urgency. One idea to be discussed with commissioners was to propose a retrospective 'corrective' submission on the referrals data that clearly indicated the number of cohort 3 referrals to be removed from the data volumes.

Ward ownership was much improved and the involvement of the hospital co-ordinators had been key.

Audit Committee members were informed that data quality now formed part of the data warehouse and the team had a new starter in February 2020 who would focus on this.

The CIO highlighted that in relation to recording of referrals, Commissioners only deemed a referral as an actual outpatient appointment. Therefore the team would now work on determining how many of the outpatient appointments related to what the data suggested was an outpatient referral.

The Audit Committee accepted the report as an informed update, taking assurance that accuracy of the data was much improved with work continuing.

The CIO left the meeting.

3.7 Due Diligence Process Outcome: Hosting Contracts

The Acting Chief Finance Officer informed colleagues that the Trust had been working with both Liverpool Health Partners (LHP) and The Innovation Agency to take over hosting arrangements.

There were VAT advantages to bringing LHP under the NHS and the finance team were currently working through the accounts. Hosting of the Innovations Agency would transfer from Lancashire Care FT to LHCH.

The transfer of services for LHP was expected to be the 1st February 2020 and the Innovation Agency the 1st April 2020.

Taking on those hosting arrangements was broadly low risk and discussions were taking place surrounding the governance and the business transfer arrangements.

Audit Committee members noted that LHP and The Innovation Agency would maintain their autonomy as organisations with LHCH undertaking the transactional work relating to payroll and accounting. Terms of Reference and a clear scheme of delegation would be set out to support this arrangement.

The Audit Committee would be kept updated as the arrangements progressed.

3.8 IFRS 16 Update

The Acting Chief Finance Officer provided details on the new financial reporting standards relating to the International Financial Reporting Standard 16 Leases (IFRS 16) which was published by the International Accounting Standards Board (IASB) in January 2016 and had been operating within the private sector for over a year. It would be adopted within the NHS from 1st April 2020.

This update in regulation would change how lessees accounted for leases as it removed the distinction between operating and finance leases. For lessors, the distinction would remain and IFRS 16 was not expected to change their accounting.

The finance and procurement teams were reviewing all operating leases and embedded leases, and assessing them against the IFRS 16 criteria. Current leases under review included:

- Lease of blocks A, B and C from Liverpool University Hospitals NHS Foundation Trust
- Rental charges from NHS Property Services and others
- Equipment leases

The Acting CFO stated that the capital change was quite complicated and providers had been given up to November 2020 to gather information, which would be audited in October 2020. An additional audit would be required as result and for which there would be an additional charge.

Disclosures regarding IFRS 16 would be made in the year end accounts but there would be no changes to figures required.

It was noted that Operating plans for 2020/21 would be prepared on an IFRS 16 basis and these updates would result in a cost pressure in the coming years, however finance colleagues were currently working through the detail.

4. Internal Audit

4.1 Progress Report on Delivery of Plan

The report provided an update in respect of the assurances, key issues and progress against the Internal Audit Plan for 2019/20. Since the October 2019 Audit Committee, the following reports had been issued as final:

- Water and Air Ventilation Safety-Substantial
- Staff Integrity Vetting-Limited
- General Ledge-High
- Budgetary Control-High

- Accounts Payable-Substantial
- Accounts Receivable-High
- Treasury Management-High

In addition, the Audit Committee Effectiveness Review had been completed and the draft report was included below as agenda item 4.3.

Due to the limited assurance given to the Staff Integrity Vetting report this would be discussed in detail below under agenda item 4.4.

The work in progress was detailed on page six of the report where it was highlighted that significant delays had been experienced with the PAS Operation in Practice, and the Senior Internal Audit Manager had now escalated this to the Trust's Executive Lead for digital. It had been confirmed that the Head of IG & Administrative Services had become involved and had agreed to provide a timetable to the internal auditors on when the information required would be provided.

A request for audit plan changes was made with a proposal to move Data Quality from Q4 2019/20 into Q1 2020/21 due to other Data Quality related audit work performed. There would be no financial loss to the Trust regarding the audit fee if this change was made.

The Senior Internal Audit Manager confirmed that they were still on track to get all work completed by the end of the financial year.

Audit Committee noted the contents of the report and approved the requested change to the audit plan.

4.2 Follow Up Report

The report provided an update on the progress towards the implementation of recommendations made in audit reports where related actions were agreed.

Of the 36 recommendations followed up, 12 had been implemented with a further 12 in progress. Two were recorded as not implemented and one recommendation had been superseded. The status of seven IT audit report related recommendations were still to be confirmed by the Trust. Four recommendations from the Cyber Security audit were to be followed up in Q1 2020/21 as part of the next Cyber Security audit. Five recommendations had revised target dates which were not yet due. For those recommendations not yet fully implemented, revised target dates had been noted or were in the process of being agreed with the Trust.

Since distribution of the report, the CIO had confirmed that four of the seven IT related recommendations were dealt with and those would be closed off appropriately.

Audit Committee members raised concern that the recommendations were not being implemented quickly enough to which the Senior Internal Auditor did confirm that progress was being made and it was

hoped that responses would be quicker once the new automatic email prompts were in place which was expected to be from the 1st April 2020 onwards. It was agreed that the Executive Team would rigorously review the management recommendations to ensure timely completion.

FM

4.3 Audit Committee Effectiveness Review

A review of Audit Committee Effectiveness which focused on the following areas was conducted during 2018/19:

- The new areas relevant to the Trust in the last iteration of the NHS Audit Committee Handbook (partnership working at scale; cyber security; working with the regulators)
- Data quality (as new to the formal TOR of the LHCH Audit Committee in 2018/19)
- Assurance from third parties such as SBS (due to the supplier bank account amendments example arising from the recent financial audit)
- Two other areas from the standard NHS Audit Committee Handbook checklist (working with other Committees)

All five Non-Executive Director Committee members and two regular Executive attendees at the Committee were asked to complete a summary checklist in relation to the above.

Three potential areas for development were identified during the 2018/19 review. Following on from this, a review had been conducted in 2019/20 to update the Chair and Members of the Audit Committee of progress against the action points made as a result of the 2018/19 review.

The review found all actions to be on track or partially implemented. The table provided on page two of the report detailed the current position, implementation status, and further recommendations made against each action point.

The Audit Committee noted the report and acknowledged it as a fair assessment.

The internal auditors would issue a questionnaire for 2019/20 to Audit Committee members and all regular attendees.

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4.4 Staff Integrity Vetting-Limited Assurance

The Interim Director of People & Culture joined the meeting and informed Audit Committee members that this audit related to assurance that certain employment checks were in place and being adhered to. It was noted that it was originally given moderate assurance by the internal auditors, however, The Interim Director of People & Culture stated that she was not comfortable with one of the indicators in relation to agency staffing and following discussions with

the Trust's internal auditors the outcome was changed to a limited assurance report.

The Interim Director of People & Culture explained that problems had been encountered in previous organisations relating to agency workers and this was considered an area of concern throughout Cheshire & Merseyside.

Moving forward the HR department would be working within the procurement framework and within the guidelines of Health Trust Europe (HTE) to ensure robust procedures were undertaken.

It was noted that the IT based recommendations did have a much longer lead-in time, however a standing agenda item for the People Committee were any audit reports, those would also be presented at any internal review meetings.

The detailed recommendations were provided on pages eight to thirteen of the report with the Interim Director of People & Culture informing colleagues that many of the actions had since been completed.

A disclosure relating to this report would need to be included in the 2019/20 Annual Governance Statement.

LL

The Interim Director of People & Culture left the meeting.

4.5 MIAA Insight Report*

This report was provided for information only, with the contents of the report noted by the Audit Committee.

4.6 Anti-Fraud Update Report

The report provided the second progress report for 2019/20, setting out the work undertaken during 1st July to 31st December 2019. Pages two to four provided the key messages of work undertaken.

Six awareness sessions had been given as part of the Trusts corporate induction and three private sessions had taken place.

Information had been passed onto the NHS CFA regarding the phishing email payroll fraud that the Trust had been a victim of.

Fraud prevention notes had been issued and an NHS Procurement exercise had been administered, with no concerns reported thus far.

Audit Committee members noted that the delivery of the plan was on target to be delivered by the end of the year.

Following an initial assessment on an enquiry received from Trust management Anti-Fraud colleagues did not believe there was a fraud to investigate.

It was confirmed that the Amber 'hold to account' rating would remain as no investigation had taken place on the payroll fraud.

5. External Audit

5.1 External Audit Plan and Fees

The report provided an overview of the planned scope and timing of the statutory audit at the Trust for 2019/20.

Page three of the report provided the key headlines and detailed the significant risks as;

- Revenue recognition
- Management override of controls
- Valuation of land and buildings

Details of Materiality and Value for Money arrangements were also included.

The interim audit would take place throughout January and February 2020 with the year end audit scheduled to take place during April and May 2020.

The Audit fees showed a slight increase for 2019/20 due to the increased expectations on the auditors by the regulator, further details of which could be found on page 13 of the report.

The Audit Committee noted the contents of the report and accepted the fee for the 2019/20 audit.

6. Review of Audit Committee Work Plan

Committee members were satisfied that work was being carried out per the business cycle schedule.

7. Minutes of the Meeting held on Tuesday 8th October 2019

The minutes of the previous meeting were noted and approved.

8. Action Log

Item 1-The retrospective review into the EPR project would be presented to the Audit Committee in March 2020.

Item 2-The Director of Research & Innovation confirmed that a review into the Risk Management Corporate Governance Committee had taken place and a paper would be brought to the March 2020 Audit Committee.

Item 3- The outcome of the due diligence process into the two hosting contracts was discussed above under agenda 3.7. This item would be marked as complete and removed from the action log.

9. AGS Issues

The limited assurance report on staff integrity vetting would be included in the AGS, as would the operational risks discussed under agenda item 3.3 compliance with licence.

LL

10. Evaluation of Meeting

All committee members confirmed that the meeting had been conducted effectively.

11. Date and Time of Next Meeting:

Tuesday 24th March 2020, 8.30-10.30am, Research Meeting Room.