

Item 6.2.1a

Audit Committee

minutes

Minutes of the Audit Committee Meeting held on Tuesday 15th January 2019

Present:	Julian Farmer Nick Brooks Mark Jones Ken Morris Marion Savill	Non-Executive Director (Committee Chair) Non-Executive Director Non-Executive Director Non-Executive Director (Interim) Non-Executive Director
In Attendance:	Robin Baker Alex Brady Laura Hunter-Cross Mark Jackson Georgia Jones Lucy Lavan Frankie Morris Jennifer O'Brien Claire Smallman Nigel Woodcock	Director-Grant Thornton Auditor-MIAA Head of Financial Accounts Director of Research & Innovation (Items 3.1 & 3.2) Audit Manager-Grant Thornton Director of Corporate Affairs Deputy Chief Finance Officer Secretary Anti-Fraud Manager-MIAA Senior Internal Audit Manager-MIAA
Apologies for Absence:	Claire Wilson	Chief Finance Officer

	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 paper was provided to give assurance to the Audit Committee around the effective implementation of the Risk Management Policy. In addition, the report provided an update on the actions taken since the risk management review undertaken by the internal auditors in	

June 2018.

In October 2017 a dynamic risk register audit was implemented, which provided up to the minute compliance with the presence of controls, assurances, owners, risk locations, and timeliness of most recent review, replacing the manual based audits previously seen. This approach had been instrumental in improving performance against the KPI's.

The Committee noted that there were no red indicators at present.

The assurance KPI had improved from 88% to 91% although remained below the target of 95%. There had been an improvement in the timely review KPI which had now achieved green status.

Divisions had been receiving feedback on the performance against incidents open over 28 days as a matter of routine. Implementation of Datix had offered a much improved process by which to track open incidents and better facilitate timely closure through the Divisional Governance process. However, senior staff continued to receive direct mailing of individuals with open incidents rather than relying on the new self-service functionality now present in Datix.

At the last Audit Committee meeting in October 2018, approval was given to remove those corporate incidents where there was dependency upon an external organisation for timely closure of the incident. Additionally, from July 2018 a named presentation of all open incidents over 28 days now accompanied the corporate risk register report to the Operational Board. Whilst open incidents were reducing, with recent improvement from 68% to 75%, there was still some work to be completed in order to achieve target, as staff often allowed the incident to breach before acting. In order to focus attention, a new presentation of open incident information was being proposed as seen at appendix two of the paper. This cumulative summation chart tracked current compliance with time to incident closure from initial report, so senior staff acted before a breach rather than after.

In order to improve risk registers further, the risk management department was mid-way through conducting a qualitative audit of the risk registers with the risk manager having spoken to risk owners in some depth to ensure that the essence of the risk and any controls in place were all documented on the risk register. The results of this audit would be available by March 2019.

The table provided on page three of the report showed that five of the six recommendations made by the internal auditors had been implemented, with the sixth due for completion in March 2019.

The Audit Committee noted that the report showed a positive and improving position whilst showing that the Trust was continuing to push for an even better position.

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

The paper showed the progress made with the Clinical Quality Forward Plan 2018/19 together with an update on new technology and NICE guidance relevant to the Trust.

The clinical audit plan was implemented in collaboration with the divisions and continued to be dominated by the national audits, with national concern raised regarding the robustness of organisational responses to patient safety alerts. LHCH had responded by improving the accountability, scrutiny and audit of all future patient safety alerts. The responsible lead for reviewing and actioning patient safety alerts would need to identify and include audits of compliance where necessary within their action plan. Such audits were to be reported to the Quality, Patient & Family Experience Committee (QPPEC).

The report also included national learning which was currently dominated by the cardiac sector.

As NICOR heart disease audits embed into EPR, work continued to develop mechanisms for feeding back to clinician's data quality issues.

Between April and Nov 2018 all NICE publications had been reviewed at the Clinical Audit Effectiveness Group (CAEG). Those relevant to the services provided by the Trust had been sent to clinical colleagues to review and complete gap analyses. Progress with this had been reported to each division monthly. A clinical effectiveness review template was designed to support divisions in monitoring and reporting both internally and externally to the Commissioners.

MiraQ was currently showing as red, however, a funding decision had been approved at Ops Board recently, it should therefore be implemented and become green by March 2019.

The Trust would be involved periodically in NCEPOD national audits, with the most recent one being the NCEPOD study Pulmonary Embolism in which LHCH submitted 2 cases as per the study criteria. The organisational questionnaire was due to be submitted by 11/01/2019.

Between April to November 2018, six new technology proposals had been processed and approved at the CAEG, the details of which were shown on page eight of the report. Training for these new technologies was in place, together with a consent programme in place for patients, and also an audit programme to ensure benefits promoted by the technology were seen.

Concern was raised over the inaccuracies to be reported in relation to the National Mesothelioma Audit report 2018 (for the audit period 2014–16)(June 2018). The Director of Research & Innovation explained the issue regarding the old system being unable to sector

secondary and tertiary patients. Audit Committee members were informed that this was a national issue and all organisations would submit inaccuracies.

Going forwards into Q4 2018/19 support would be needed to establish a smarter way to submit data for the National Audit of Cardiac Rehabilitation using both EPR and EMIS as several senior members of the digital healthcare team were leaving LHCH, it would be decided whether this would need to be added as a risk to the risk register.

Other work planned for Q4 2018/19 included;

- National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) Pulmonary Rehab audit would commence in March 2019.
- Consent and VTE audits.
- Preparation of Quality Accounts and forward planning for CQUINs and audit requirements in 2019/20 would be undertaken.

Audit Committee members noted the report as a very thorough analysis of the Trust's progress.

The Director of Research & Innovation left the meeting.

3.3 Annual Audit Committee Evaluation

The Audit Committee undertakes a self-assessment exercise on an annual basis and it was agreed that this year's assessment would be focused on the following areas:

- 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 Audit Committee)
- 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 completed a summary checklist in relation to the above.

The responses received indicated that Committee members and attendees felt that the Audit Committee was obtaining relevant assurances in the areas reviewed. There were three areas noted which the Committee would consider further;

- Assurances from third parties.
- Partnership working at scale.

- Data Quality, this would now be included within the Audit Committee ToR per agenda item 3.9 below.

It was agreed that clarity over where the Trust received assurance from on third parties would be dealt with in the final accounts audit.

The above three areas would be added to the Audit Committee work plan with timings of review still to be agreed.

JO'B

3.4 Compliance with Licence: Review of Quarterly Checklist

The quarterly checklist had been updated at Q3 2018/19. The primary risks related to;

- An unresolved funding issue relating to recognition of HRG4+ for Welsh activity – this issue had been escalated through a joint letter from CFOs to NHS Wales and a national meeting was to take place on 15.01.19. There was a risk to LHCH delivering the control total if this issue was not resolved.
- Continuation of breach of the 6 week diagnostics waiting time due to on-going capacity constraints. The imaging business case was being implemented but had been subject to delay in implementation. There were risks associated with the interim mitigation plans which would be monitored via Operational Board. The impact of acquisition of the scanners would not be realised until Q2 of 2019/20, which was later than originally planned. Regulators had been fully briefed on this.

The Board of Directors would discuss the impact on the BAF and review the risk scores assigned to the related principal risks at the next Board meeting on 5th March 2019.

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.

3.5 Review of Register of External Visits

There was nothing significant to report on this quarter's register. The Director of Corporate Affairs highlighted the Trust's involvement in the TV series 'Hospital' and the delegation from the Asia Heart Hospital.

The Audit Committee noted the contents of the 2018/19 register and acknowledged how it provided a good overview of external visits and reviews.

3.6 BAF Policy Review

At the Audit Committee in July 2018 members considered some proposed amendments to the BAF Policy and supported these on a pilot basis for 6 months. Audit Committee members were now asked to evaluate the value of the changes made and determine whether or not it wished to recommend to the Board of Directors (BoD) that these continued.

It was concluded that the new processes had added value in enhancing visibility of the changing risk profile and relationship with the Board's appetite for risk; and in provoking richer debate on the principal risks to delivery of the Trust's strategy.

The Audit Committee would recommend to the BoD that these changes were formally adopted and embedded into practice.

3.7 External Assurance Update

Following recent media coverage of failings in the external audit market and concerns regarding audit quality, the Council of Governors questioned whether there were any risks in relation to the external audit arrangements at LHCH. In response, the Director of Internal Audit attended the Council of Governors meeting held on the 11th December 2018 to explain the implications of the press coverage and discuss how governors could be assured that the external audit arrangements at the Trust were safe and of a high quality.

The recommended assurance processes were set out in section two of the paper with section three detailing the LHCH position, which included the areas noted for consideration for further strengthening.

Members agreed that a review on the external auditors had not been consistent in the past and agreed that this should be completed on an annual basis in May/June time following the final accounts.

Audit Committee members also agreed with the recommendation to consult the Council of Governors on the Audit Committee ToR.

3.8 Regulatory Action Plans

The Trust's Quarterly Review Meetings for Quarters 2 & 3 with NHS Improvement took place on the 12th September and the 12th December 2018 respectively and the letters provided to the Audit Committee as item 3.8a & b summarised the discussions.

NHSI confirmed that LHCH continued to be categorised in Segment 1 (lowest category of risk from regulatory perspective) and there were no significant concerns. The key areas of discussion and associated actions were documented within the letters.

Audit Committee members were informed that the Trust was imminently awaiting a CQC inspection, with the results expected in April/May 2019.

3.9 Audit Committee ToR Update

The following addition had been made to the duties and responsibilities of the Audit committee:

[In particular, the Committee shall review the adequacy and effectiveness of:]

- *the policies and procedures in place to support high quality*

CW

JF/LL

The Audit Committee would recommend that the Board of Directors approved the revised Terms of Reference as set out in Appendix 1, item 3.9a.

3.10 Losses & Special Payments

For the period 26th September to 28th December 2018 there had been no fruitless payments, nor payments in respect of other losses in excess of £10,000. Details of amounts less than £10,000 were detailed in appendix 1 of the report.

The movements on the bad debt provision were set out in Appendix 2 of the report, which included monthly additions to the bad debt provision, reflecting the risk associated with private patient work carried out during that period. The Audit Committee noted that the bad debt over 90 days had not declined since the previous quarter. One success had been the payment of a debt which dated back over 18 years.

Following a review of debts owed to the Trust, due to salary overpayments, it had been identified that there were debts owing to the Trust that were over six years old, but had not yet been invoiced. Under the statute of limitations Act 1980, these invoices could not be chased and therefore the Deputy CFO requested authority to write-off values over £1,000. The full list of salary overpayments was set out in appendix 3 of the report, with a total value of £20k. It was noted that arrangements relating to salary overpayments had now been tightened to avoid this happening again.

The Audit Committee was informed of a review of debtors associated with Research & Development which had identified a number of balances that required credit notes; these would be transacted over the coming months.

The Trust was aware that accepting private patients brought with it certain risks. Trust documentation had now been updated to alert patients that where they were in critical care longer than five days they would be liable for the additional payments.

The Audit Committee noted the contents of the report.

4. Internal Audit

4.1 Progress Report on Delivery of Plan

Six reports had been finalised since the Audit Committee in October 2018;

- Financial Reporting & Integrity
- General Ledger
- Accounts Payable

- Budgetary Control (including CIP)
- Treasury Management
- Accounts Receivable

Both general ledger and accounts payable had received substantial assurance, whilst the remaining four had been given high assurance. The key areas of the above work and subsequent actions were detailed within pages two to four of the report.

It was stated that the Trust should implement a more robust evidence process in regards to reconciling as well as the Trust ensuring that the Balance Sheet Review and SBS Reconciliation pack reviews were embedded as monthly controls.

The work in progress was detailed on page four of the report with the Senior Internal Audit Manager advising his colleague, the IT Audit Manager to the March 2019 Audit Committee meeting in order to give further details on the IT specific pieces of work.

Overall the report gave Audit Committee members good levels of assurance and members noted the high levels seen for the first time.

There was slight concern raised over the work in progress, however, the Senior Internal Audit Manager confirmed that he was confident that all reviews would get completed.

4.2 Follow Up Report

Of the 56 recommendations followed up, 26 had been implemented with a further 22 in progress (partially implemented). Eight recommendations were recorded as not yet implemented and no recommendations had been superseded. For recommendations not yet fully implemented, revised targets had been noted or were in the process of being agreed with the Trust.

The internal auditors reported the Trust in a good position, although stated that Trust management may wish to consider implementing and reporting on their own tracking mechanism which internal audit could then validate.

Audit Committee members would like to see an improvement in the partially implemented actions and stated that it would be useful to see when the original recommendation were due for completion rather than it reading 'dated passed'. With members also requesting that the wording in the table was changed to 'ungraded' rather than NA.

NW

The Audit Committee requested that the management escalation process for the partially implemented actions be instigated.

CW

4.3 Anti-Fraud Update Report

The internal audit Anti-Fraud Manager provided the second progress report of the year with the key messages provided on page two of the report.

Three intelligence bulletins had been received from NHS Counter Fraud Authority (NHSCFA) relating to a national investigation into a mandate fraud which occurred at an NHS organisation. The Trust's finance department had undertaken various checks for bank accounts known to NHSCFA to ensure that the Trust had not been a victim.

The internal auditors anti-fraud colleagues had spent time in supplies & procurement with no issues to report.

No new referrals had been received throughout this reporting period.

Appendix A gave details of the KPI's with Appendix B showing the detailed plan delivery which was on track to be delivered with no issues currently identified.

4.4 MIAA Insight Report

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

The Senior Internal Audit Manager referred colleagues to the updates detailed on page two of the report and informed committee members that the Audit committee members survey would come through shortly.

5. External Audit

5.1 External Audit Plan and Fees

The external audit plan for 2018/19 was provided which set out the key information, the risks that had been identified and the actions to be taken to mitigate those risks. The three significant risks identified were;

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

The external auditors stated the above risks were expected for an NHS Foundation Trust.

Planning materiality had been determined to be £2.623m for the Trust, which equated to 2% of the Trust's gross operating costs for 2017/18.

One Value for Money significant risk was noted in relation to financial sustainability, detailed on page three of the report.

The interim visit was scheduled for February and March 2019 with the Audit planned for April & May 2019, with the Charitable Funds accounts audited at the same time.

The Audit Committee noted that there was no change to the external

auditor's fees from last year.

5.2 External Audit Update Report

The reported provided assurance to committee members that the external auditors were on track with the work proposed, with page four of the report giving the progress as at January 2019.

The deliverables were set out on page five which showed the following time line;

- Accounts Audit Plan-January 2019, complete.
- Interim Audit findings-due March 2019.
- Audit Findings Report-due May 2019.
- Auditors Report-due May 2019.
- Annual Audit Letter-due July 2019.

6. Review of Audit Committee Workplan

The additions as agreed above under agenda item 3.3 would be added to the work plan.

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

7. Minutes of Meeting held on Tuesday 9th October 2018

The minutes of the previous meeting were noted and approved.

8. Action Log

Item 1- This item was discussed above under agenda item 3.6. This item would be marked as complete and removed from the action log.

Item 2- This item was for review at the March 2019 Audit Committee meeting.

9. AGS Issues

No AGS issues were raised.

10. Evaluation of Meeting

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

11. Date and Time of Next Meeting:

Tuesday 26th March 2019, 1.30-3.30pm, Research Meeting Room.