

Item 6.1.1a*

Audit Committee

minutes

Minutes of the Audit Committee Meeting held on Tuesday 16th July 2019

Present:	Julian Farmer Nick Brooks Bob Burgoyne Mark Jones Karen O'Hagan	Non-Executive Director (Committee Chair) Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director
In Attendance:	Robin Baker Alex Brady Gregg Holland Laura Hunter-Cross Georgia Jones Lucy Lavan Mary Liley Frankie Morris Michelle Moss Jennifer O'Brien Marga Perez-Casal Claire Wilson Nigel Woodcock	Director-Grant Thornton Auditor-MIAA Chief Information Officer (item 3.9 only) Head of Financial Accounts Audit Manager-Grant Thornton Director of Corporate Affairs Head of Fundraising (item 4.4 only) Deputy Chief Finance Officer Anti-Fraud Specialist-MIAA Secretary Interim Director of Research & Innovation (Items 3.2 and 3.3 only) Chief Finance Officer Senior Internal Audit Manager-MIAA
Apologies for Absence:		

1. Apologies for Absence

As above.

2. Declarations of Interest Relating to Agenda Items

None declared.

3. Governance and Risk

3.1 Annual Review of Corporate Governance Manual

The annual review of the corporate governance manual supported by the Trust's internal auditors was presented. The Senior Internal Audit

Action

Manager and Deputy Chief Finance Officer were thanked for their support in updating the manual.

The Director of Corporate Affairs presented the high level summary of changes which were included as Appendix 2. Colleagues were asked to note that all of the content had been presented with tracked changes for review and consideration by the Audit Committee, following which a recommendation would be made to the Board of Directors.

It was noted that minor changes had been made to the Scheme of Reservation and Delegation (SORD) in order to make the approval process stronger. Audit Committee members were also asked to note that further changes were expected to the Fit and Proper Persons policy following the Kark review, due to be published in September 2019.

The Audit Committee supported all proposed changes and recommended the updated Corporate Governance Manual to the Board of Directors for approval and adoption.

3.2 Risk Management KPI's

The Interim Director of Research & Innovation presented the Risk Management KPI's which provided the Audit Committee with assurances around the effective implementation of the Risk Management Policy.

There were no red indicators at present, however three amber results were reported which in summary referred to;

- Timely review KPI with a score of 88% at the end of May 2019 against a target of 95%. This was principally due to the review of risks in the Corporate Governance Division. The issues had been highlighted to the managers concerned and escalated to the Risk Management and Corporate Governance Committee.
- The assurance KPI remained static at 91% against a target of 95%. The recently conducted educational sessions stressed the understanding and importance of assurance; this knowledge was reinforced with the Managers responsible for completing the risk register.
- Incidents Open > 28 days by Division. Divisions had been receiving feedback on performance against this indicator as a matter of routine. The implementation of Datix had provided a more efficient way of tracking open incidents and thus facilitate a more timely closure through the Divisional Governance process. Senior staff continued to receive direct mailing of individuals with open incidents. It was questioned whether enough was being done to ensure closure of these incidents, with the Interim Director of Research & Innovation confirming that there was no real concern of progress in this area.

At the October 2018 Audit Committee approval was given to remove those corporate incidents where there was a dependency upon an

external organisation for timely closure of the incident from this calculation; and whilst open incidents were reducing, there was some way to go to achieve target. In order to focus attention, a new presentation format of open incident information was being proposed to the Committee which was provided at Appendix 2 of the paper. This cumulative summation chart tracked current compliance with time to incident closure from initial report, allowing senior staff to act before a breach rather than after.

A recent qualitative audit of the risk registers was completed by the Trust's Risk & Safety Lead, the results of which demonstrated an overall good performance in the management of the risk registers. Suggestions for improvement had been acted upon and added to the format of the register. The full report into this audit was provided at Appendix 3 of the paper.

Audit Committee members were also informed that the internal auditors had recently carried out a Risk Management Review and had concluded a good system of internal control. Substantial assurance was awarded and six recommendations made; five of which had already been applied. The final recommendation regarding the inclusion of target risk in the corporate risk register report was now being reviewed following the Interim Director of Research & Innovation's discussions with the Senior Internal Audit Manager.

The Audit Committee noted the contents of the report and approved the new format for reporting open incidents over 28 days.

It was noted that following a recent review into Trust committees by the Trust's internal auditors and subsequent recommendations, the performance of the Risk Management & Corporate Governance Committee would be assessed by the senior management risk team.

MPC

3.3 Review Clinical Audit Plan & 6 Monthly Progress Report and NICE Guidance Review

The paper was presented in order to provide assurance on delivering the Clinical Audit Plan, including NICE. To support this aim the CAEG annual report 2018/19, Clinical Quality Forward Plan 2019/20 and audit of monitoring compliance with the protocol for the review and implementation of nationally agreed best practice, including national confidential enquires had been included as Appendix 1, 2 and 3 of the paper.

The achievements for 2018/19 were provided on pages two and three of the report with the committee asked to note that all submissions in relation to CQUINS had been made to Liverpool CCG and the specialist commissioners as per the schedules.

KPI monitoring was a standing agenda item at the Clinical Audit and Effectiveness Group (CAEG). All new technology was processed following the Trust policy and the audit of the consent process for new technology had been followed where appropriate.

In 2018/19 every mortality had the appropriate review document

completed, the Divisions received monthly reports from the mortality review group and the BoD received the Learning from Deaths dashboard.

The Clinical Quality team would continue to work closely with the Clinical leads and data warehouse team to develop mechanisms for feeding back to clinicians on data quality issues. The team would also continue to develop strong communication channels with the divisions to ensure they were aware of the support required by their clinical teams to deliver audits both nationally and locally.

Audit Committee members expressed assurance that there was a strong process in place. A concern was raised regarding attendance at the CAEG; the Interim Director of Research & Innovation confirmed work was taking place with the clinical leads in order to identify the most appropriate membership list. The main issue surrounded critical care attendees; however their attendance was directly linked to the activity on the unit at the time of the meeting.

3.4 Review Losses and Special Payments

For the period 1st March to 30th June 2019 there had been no fruitless payments and one payment in respect of other losses in excess of £10,000. Details of amounts less than £10,000 were reported at Appendix 1 of the report. There had been no special payments in excess of £10,000 during the same time frame, with details of payments less than £10k also shown in Appendix 1.

There was one write off requested per Appendix 3 for a salary overpayment of just over £1,000 where the individual had refused to settle the invoice despite regular debtor management and escalation.

The movements on the bad debt provision were set out in Appendix 2. This was recalculated at year-end to comply with IFRS 9, which required a more prudent approach to be taken. It also included monthly additions to the bad debt provision, reflecting the risk associated with private patient work carried out during that period.

The question was raised over the progress made with private patient debt; the Chief Finance Officer (CFO) confirmed that resources had been utilised in order to work on reducing the older debt and the situation had now stabilised. Less private patient debt should be seen going forward due to the new processes in place. It was noted that the level of private patient debt was monitored by the Integrated Performance Committee (IPC).

The CFO gave an explanation for the large size of debt owed to the Trust by the RLBUHT; informing colleagues that the RLBUHT was experiencing significant cash flow pressure and was prioritising invoice payments accordingly. The CFO did not consider there to be a risk of non-payment as there was no dispute in relation to the debt.

The Audit Committee noted the contents of the report and approved the write-off of the salary overpayment set out in Appendix 3.

3.5 Review Single Supplier Tender Waivers

There had been 12 tender waivers raised between 26th February and 13th June 2019 for a total value of £331k, none of which were for over £100k.

Full details of all tender waivers raised for the financial year to date were provided in Appendix 1 of the paper.

The Audit Committee noted the contents of the report and accompanying appendix.

3.6 Compliance with Licence: Review of Quarterly Checklist

The quarterly checklist had been updated at Q1 2019/20. The primary risk related to;

- Pressures in diagnostic performance; compliance with the diagnostic targets would not be achieved until the new scanners were operational. As part of the CT/MRI Business Case improved performance was expected in Q3 2019/20 with a return to compliance in Q4 2019/20.

The Board of Directors would discuss the impact on BAF and review the risk scores assigned to the related principal risks at the next Board meeting on 30th July 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

The CFO confirmed that the BoD was sighted on the agreement in principal with NHS Wales. The activity contract had been agreed by both parties, and NHS Wales had acknowledged the new tariff, however the agreement couldn't be signed until the funding had been confirmed by the Welsh government. The risk would remain on the risk register at a lower level until the contract had been signed.

3.7 Review Register of External Visits

The Audit Committee noted the contents of the register which detailed the information of visits to the Trust from January 2019 to date.

There were no key assurance issues to highlight and the register would be reviewed again at the 14th January 2020 Audit Committee.

3.8 Regulatory Action Plans

The Director of Corporate Affairs informed Audit Committee members that the CQC rating of 'outstanding' awarded to LHCH had now been confirmed. The Director of Nursing & Operations was scheduled to present a paper to the BoD on 30th July 2019 detailing the actions taken by the Trust following the inspection, with mandatory training

noted as the key area for improvement.

Audit committee members were informed that NHS England and NHS Improvement were currently restructuring and as a result the Q1 QRM had been postponed. The Trust had a new temporary relationship manager in place that had quarterly conference calls with the Director of Corporate Affairs and the regulators were looking to move towards system-wide regulatory oversight. The Trust's CFO also had regular meetings with NHSE/NHSI finance colleagues whose key focus was capital as it continued to be a challenge nationally, with the BoD sighted on this.

3.9 Informatics & PAS Development Programme including Data Quality Assurance

The Chief Information Officer delivered a progress update presentation regarding PAS and Informatics Development with the following summary noted;

PAS

- Patching of the PAS was no more than two releases from the latest issued by Silverlink.
- The Trust was a much more active participant in the development of the system (reference site consideration)

Informatics

- Informatics Capability Plan developed for 2019/20 focusing on:
 - Data Warehouse
 - External recommendations
 - Informatics Restructure
 - Reporting Development and Enhancement

EPR Upgrade

- Joined up plan across Systems, Data and Reporting to ensure business safe release.

Progress to date had been positive, with clear evidence that the Informatics function was beginning to mature into the service that the organisation required. Outputs from the function were increasingly professional and business focused, being professionally led by Informatics with user co-design. Work was still on-going, however the structured plan in place would steer the effort and ensure the benefits were felt throughout the year

It was noted that gaps were highlighted recently in a lack of understanding from the digital team in the role they played in other departments BCPs when it came to disaster recovery. Discussions were underway regarding teams working together in the future, with a further work to be done and a considerable amount of learning to be determined following the recent network incident. Audit Committee colleagues were informed that the internal auditors had been commissioned to undertake a full review into the incident. An internal investigation into the network incident would be presented to the BoD

on 30th July 2019.

Audit Committee members commented on the positive picture compared to the previous position. It was also noted that the Coding Team had been nominated at a recent awards ceremony for their work.

The Chief Information Officer and Interim Director of Research & Innovation left the meeting.

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 March 2019 Audit Committee, the following reports had been finalised;

- 2018-19: Consultant Annual Appraisal-moderate assurance given.
- 2018-19: Data Security and Protection Toolkit-substantial assurance given.
- 2018-19: Cyber Security Extended Controls-substantial assurance given.
- 2018-19: PAS High Level Review-assurance level NA.
- 2019-20: Charitable Funds Income and Expenditure-limited assurance given.
- 2019-20: Corporate Governance Statement-assurance level NA.

Key areas from the work and actions to be delivered by Trust management were detailed on pages one to seven of the report. Appendix A provided the categorisation of assurance levels and risk ratings, Appendix B confirmed performance against plan and the details of high level actions agreed with the Trust were provided in Appendix C.

The Senior Internal Audit Manager confirmed that good progress was being made.

4.2 Follow Up Report

Of the 49 recommendations, 23 had been implemented, 19 partially implemented, four had been superseded and three were yet to be implemented. For partially implemented recommendations, revised target dates had been noted or were in the process of being agreed with the Trust.

There was concern over the support given to the internal auditors in

implementing the recommendations; the CFO responded that the Trust planned on introducing a tracking process which the internal auditors were developing and LHCH had agreed to pilot, however the Senior Internal Audit Manager informed colleagues that this would not be available until April 2020.

It was agreed that the CFO would present a management response update to the next Audit Committee meeting.

CW

4.3 Anti-Fraud Update Report

The report set out the work undertaken during the period from 1st April to 30th June 2019, highlighting activities and outcomes which were brought to the attention of the Audit Committee for consideration.

Page two of the report detailed the key messages of the report, whilst page three showed the plan delivery dashboard with the full details of plan delivery provided in Appendix B. In line with the new requirements of standard 1.4 of the Standards for Providers 2019 the internal auditors had developed a fraud risk matrix and process for consideration of which fraud risks should be considered for inclusion on organisations' risk registers. This was scheduled to be rolled out in LHCH in Q2.

The annual self-assessment (SRT) against the NHS Counter Fraud Authority's (NHSCFA) Standards for Providers 2019 was formally submitted on the 30th April 2019 and an overall rating of green was achieved.

There were currently no on-going investigations to report.

The internal auditors Anti-Fraud Specialist (AFS) confirmed that 'Hold to Account' was rated as amber as there were currently no investigations underway and therefore nothing to measure against. A note would be put in the report going forward explaining this reasoning in order to ensure clarity for readers.

MM

4.4 Charitable Funds Income & Expenditure Report 2019/20

A review of the Charitable Funds systems and processes at the Trust were undertaken in line with the 2019/20 audit plan approved by the Audit Committee.

Limited Assurance was given with the report stating there was a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls put the achievement of the system objectives at risk.

The summary conclusion was provided on pages two and three of the report, with the detailed findings provided within pages three to seven. Eleven recommendations were made; one high, nine medium and one low. The high recommendation related to gifts in kind with the specific risk relating to there being no clear audit trail to show the gifts being received by individuals.

The Head of Fundraising presented the management response to the recommendations and subsequent action plan. It was noted that the Donorflex had already been adapted to record the sub-categories of gifts received in relation to the high rated risk of gifts in kind.

Audit committee members were informed that whilst the internal auditors had recommended a follow up time of one to two months for home collecting boxes, the Head of Fundraising had amended this time to six months following a complaint from a donor that they were being contacted too soon. The Director of Corporate Affairs advised that arrangements would be agreed on a case by case basis depending on the circumstances of individual fundraising plans but that it was important to have a documented agreement with each external fundraiser setting out expectations and ensuring robust governance in each case.

A till had now been ordered which would allow the Charity Office to record all donations/merchandise payments in order to further enhance the reconciliation process. As the merchandise activity was increasing year on year with a significant scope for growth, ensuring strong processes were in place was key.

The Audit Committee noted the full contents of the report and subsequent management response and action plan and welcomed the internal auditors follow up in 6-12 months' time.

A discussion followed in relation to the scope of external audit work and it was noted that the size of the charity required only independent review at the present time. It was agreed that there was no requirement to expand the scope of external audit assurance at this stage.

The Head of Fundraising 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.

5. External Audit

5.1 External Audit Update Report

The external auditors confirmed that the 2018/19 audit work had now been completed and an unqualified opinion had been given on all areas with all key items delivered. Finance colleagues were thanked for their assistance in ensuring the audit was completed within the timeframe.

Colleagues were informed that the external auditors were going to propose a one off fee adjustment for 2018/19 to reflect the additional work required on the valuation of land and buildings and the quality report. The CFO stated that advance notification on the fee adjustment would have been preferred. The Director of the external auditors did confirm that requesting additional fees for additional work

was consistent with how all NHS bodies were charged which mitigated the risk of the auditor proving their independence. It was confirmed that this would be discussed at the planned de-brief meeting to take place before the end of July.

The external auditors would now begin to look to the 2019/20 financial year and begin the planning process for the audit, with page five setting out the deliverables for 2019/20.

The external auditors recognised the outstanding CQC achievement recently awarded to the Trust.

The issue was raised with the Director of the external auditors regarding recent negative media reports on their performance. Audit Committee members were informed that these reports related to the commercial audit activity part of the business and a new Head of Audit had recently been appointed with a sole objective to address the issues raised. There were also other plans in place to ensure positive changes were made. In order to provide assurance to Audit Committee members and Trust Governors, the Director of the external auditors would provide a detailed formal response to the query.

RB

5.2 Annual Review of Performance of External Auditor

It had been agreed that an annual review, linking the Governors into the process, would be completed on the external auditors. The response as agreed above would prove helpful to this review and would be informed also by the de-brief meeting.

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 28th May 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 completed in the next financial year and presented to the Audit Committee in March 2020.

Item 2- The annual review on the External Auditors would be completed following the final accounts in May/June time and seen at the Audit Committee in October 2019.

Item 3- The progress against the PAS action plan was presented by the Chief Information Officer and detailed above under agenda item 3.10. This item would be marked as complete and removed from the action log.

9. AGS Issues

The Audit Committee noted the limited assurance report the internal auditors conducted into the Charitable Funds function.

10. Evaluation of Meeting

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

11. Date and Time of Next Meeting:

Tuesday 8th October 2019, 8.30-10.30am, Research Meeting Room.

12. NEDs to Meet in Private with Internal & External Auditors

The Non-Executive Directors met with internal and external auditors and no issues were raised.