

Audit Committee

Item 6.1.1.2

minutes

Minutes of the Audit Committee Meeting held on Tuesday 17th July 2018

Present:	Julian Farmer Nick Brooks Mark Jones Ken Morris	Non-Executive Director (Committee Chair) Non-Executive Director Non-Executive Director Non-Executive Director (Interim)
In Attendance:	Mark Jackson Lucy Lavan Frankie Morris Michelle Moss Jennifer O'Brien Mike Thomas Claire Wilson Nigel Woodcock	Director of Research & Innovation (Item 3.1 & 3.2 only) Director of Corporate Affairs Deputy Chief Finance Officer Anti-Fraud Specialist-MIAA Secretary Director, Grant Thornton Chief Finance Officer Senior Internal Audit Manager-MIAA
Apologies for Absence:	Georgia Jones Marion Savill	Audit Manager-Grant Thornton 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 (agenda item 3.2 refers)	
The Director of Research & Innovation presented the key issues from the report stating that there were two sections to note; KPI's in the Risk Management Policy and also the MIAA audit that was referred to throughout.	
The KPI's displayed in Appendix 1 of the report showed no red	

indicators, with only a few areas of amber where performance was just below the target set, with the assurance column showing 88% against a 95% target. Audit Committee colleagues were informed that this report was now in a dynamic audit format which was available to all staff at all times and continually monitored by the Risk Manager.

The progress in relation to incidents over 28 days was detailed in appendix 2 of the report. Constant tracking was required, however an improved percentage of open incidents over 28 days was reported, the Trust were still over target but work was progressing in reducing this percentage.

Included in the report was a supplementary assurance report from the risk management review undertaken by the Trust's internal auditors. The review reported substantial assurance and made six recommendations; five low risk and one medium, these recommendations had been reported to the Risk Management & Corporate Governance Committee (RMCGC).

The Director of Research & Innovation confirmed that he was satisfied with the progress being made on the recommendations and informed Committee members that there was more risk management training planned towards the end of the year which would help with achieving the medium risk recommendation.

Committee members questioned the level of open incidents, the Director of Research & Innovation informed colleagues that open incidents were sent out to the designated managers every month, the Risk Manager & Head of the Department were in constant communication and they were also a standing agenda item at the RMCGC at every bi-monthly meeting. The level of open incidents was reviewed at the Executive meeting recently and a summary of the RMCGC minutes are seen at Operational Board which also included this information. Open incidents over 28 days would be escalated to the Executive team for action with progress reported back at the October 2018 Audit Committee meeting.

MJ

The Audit Committee noted the report.

3.2 Review Clinical Audit Plan & 6 Monthly Progress Report (agenda item 3.3 refers)

The Director of Research & Innovation presented the paper which included the 2017/18 CAEG annual report, Clinical Quality Forward Plan 2018/19 and showed the processes being established to strengthen assurance.

Clinical audits that must be undertaken to meet external monitoring requirements and meeting contractual obligations were the main focus and use of the Clinical Audit & Effectiveness team's resources. National and specialist commissioning CQUINs had been supported with the collation and submission of information by the Clinical Quality Department.

Committee members were asked to note that Clinical Audit was changing, moving from stand-alone database systems into EPR and the additional work initially that this posed was resulting in periods of instability during the transition of reporting from existing processes into new.

The Department had been concerned about the ability to meet all of the national audit deadlines for Q4 2017/18, however, the Audit Committee noted that these had now all been met. With one WTE staff member leaving the team in January 2018, there were additional pressures however the Trust still delivered on external deadlines, with all submissions made.

The clinical quality forward plan was included as item 3.3b, with the Director of Research & Innovation informing Audit Committee colleagues that assessments would follow after six months.

Better engagement through the Divisions was reported due to the organisational learning meetings, presentation of work at Operational Board & Team Brief. The Clinical Audit & Effectiveness Manager also worked closely with the Heads of Nursing.

Going forwards, the Clinical Quality team would:

- a) Continue to work closely with the Clinical leads, EPR team and BI analysts to implement the NICOR datasets built from EPR to allow a smooth transition for future submissions, aligned with national developments.
- b) 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 noted good assurance that there was a plan in place.

3.3 Annual Review of Corporate Governance Manual (agenda item 3.1 refers)

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

The proposed amendments to the BAF Policy included the assignment of a target risk score based on the Board's appetite for

risk (as set out in the Risk Management Policy) for each strategic objective and quarterly tracking of the risk scores assigned to each principal risk to enable the Board to readily see how the risk profile had changed over the course of the year.

Discussions took place as to whether these changes added value, or whether they over complicated the policy. The primary purpose of the BAF was to prioritise the Board's time in accordance with the level of risk associated with the delivery of the Board's strategic objectives and ensuring regulatory compliance. Whilst it was important to understand the changing risk profile, the Committee noted that LHCH had an established risk management process and was a small Trust in which the Board and managers had a good understanding of the risks facing the Trust.

The Audit Committee agreed to accept the suggested changes to the BAF policy on a pilot basis. The changes would be implemented for the next two quarters the Committee would recommend that the Board evaluate the impact in January 2019 and determine whether or not to continue with the risk tracking.

LL

The Deputy Chief Finance Officer took the Audit Committee through the proposed amendments to the SORD, Standing Financial Instructions and other financial policy documents.

Audit Committee members noted that in relation to D2 Policy for Raising Concerns there was now an amended route for Governors to seek independent advice as the Independent Panel originally set up by Monitor had been dis-banded, that section had been updated to reflect this.

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

LL

3.4 Review Losses & Special Payments

The paper updated the Committee on losses and special payments recorded for the period 1st April to 30th June 2018 and the governance arrangements associated with those payments.

There had been 3 small new losses and special payments agreed during the period, totalling £366.51. This related to:

- 1 payment relating to property lost whilst an inpatient totalling £120.
- 1 payment for providing transport to a patient's relative as a result of an ambulance cancellation totalling £284.
- A partial reversal of a loss recorded in the 2017/18 accounts in respect of the write off of obsolete stock, totalling -£37.49.

There had been one payment in the period relating to a historical permanent injury benefit totalling £1,750.26.

There were no individual expenditure items which exceeded the £50,000 threshold requiring Board approval. Appendix 1 provided a breakdown of all expenditure on losses and special payments for the period 1st April 2018 to 30th June 2018.

The movements on the bad debt provision were set out in Appendix 2 of the paper. The bad debt provision was reviewed at year-end and increased from £691,843 to £1,054,964. This included a provision for a single invoice of just over £200k which was currently under dispute with BUPA.

In the first quarter of 2018/9 the provision had been increased by £30k, reflecting the risk associated with private patient work carried out in that period and had been decreased by £143,539 for credit notes (88 invoices), £6,691 write off for 47 invoices under £1,000 and £21,748 write off for 3 invoices over £1,000, for which permission from the Audit Committee was requested. Full details were set out in Appendix 3.

The reasons for credit notes and write-offs remained similar to those previously described to the committee; incorrect invoices values were raised, charges for wrong procedures and a few duplicated invoices. The remaining balance on the bad debt provision was £912,986.

Committee members were able to view the profile of outstanding debt (debt over 90 days old) over the past 12 months in a graph format contained within the report, and in addition debt levels excluding Welsh Specialist Commissioners were also shown.

The Deputy Chief Finance Officer confirmed that although figures indicated that the aged debt had been growing, the non-NHS debt position included the on-going dispute on HRG4+ with Welsh Commissioners. The Trust received £2.2m of non-recurrent income to support this loss in 2017/18 from NHS Improvement, but as this balance remained outstanding with Wales it was still recoded as a debtor in the account. This value was fully provided against in the Trust accounts. Regular updates on this issue continued to be reported to the Board of Directors.

Work had focused on analysing aged debt, identifying common themes and developing strategies for resolving them. Regular meetings had been initiated with SBS to allocate responsibilities and create accountability for completing agreed actions. In this way the Trust were able to reduce NHS aged debt by 2/3rds by the end of October 2017. There had also been a reduction in the level of aged debts with Insurance companies.

Work to reduce debt levels continued and there may be further invoices which needed to be written off. Given the timing of the next Audit Committee, members were asked to consider a delegation of its authority to approve the write off invoices to a total value not exceeding £30,000, to the Chief Finance Officer for the period of July to September 2018. The write off of such invoices would be reported retrospectively to the Audit Committee in October 2018. This was supported.

CW

During March 2018, Jenkinsons Office Supplies advised the Trust of a stock write off for printed stationery totalling £7,155.32. In June 2018 the invoice was received from the supplier for a total of £7,117.83, the difference of £37.49 would be credited to the income and expenditure account in 2018/19. Approval to write off the stock was received from Jane Tomkinson on 26th March 2018.

The Deputy Chief Finance Officer informed Committee members that the Trust was keeping a member of agency staff on until the end of August 2018 to continue working on private patient debt. Having a Private Patient Manager in post had also had a positive impact enabling disputes with BUPA to be identified and addressed at an earlier stage.

The Committee stated their assurance that good progress had been made and approved delegated authority to the Chief Finance Officer to write off invoices up to a maximum total value of £30,000 for the period of July to September 2018. Permission was also given for the write off for the 3 invoices totalling £21,478.

3.5 Review Single Supplier Tender Waivers

The Committee was updated on instances of single supplier tender waivers recorded for the period 22nd March to 30th June 2018, and the governance arrangements associated with these payments.

There had been 16 tender waivers raised for a total value of £669k.

Full details of all tender waivers raised for the financial year to date were provided in Appendix 1 of the report with a summary of individual tender waivers raised provided below;

- Consumables, Quality control material and maintenance contracts for 5 blood gas analysers based in POCCU and ITU £126k-maintenance and supplies were only available from this supplier, Radiometer Ltd.
- Mail server infrastructure funded by the NHSE Cyber scheme £79k-NHSE Cyber Scheme deadlines did not allow for a full competitive tender process, CDW Ltd.
- 34 laptops/tablets £51k-3 quote process had already been completed to ensure value for money, Dell Corporation Ltd
- Diagnostic Sleep Devices £30k-to increase the capacity for sleep diagnostic studies, equipment needed to be consistent with existing devices, Resmed UK Ltd.
- Video Bronchoscope £22k-equipment was compatible with the current stacker system already in use in the theatre, Pentax UK Ltd.
- Supply of parts & service to Draeger equipment already owned by LHCH £60k- parts and service could only be sourced from the original supplier, Draeger Medical Ltd.
- Synergy Spine Coil for Phillips Intera 1.5T £16k- The parts were unique to the system and thus it was the sole supplier, Mount International United Services Ltd.

- Maintenance Management Fee £50k-Year 2 of the maintenance management service fee contract, Aintree University Hospital NHS Foundation Trust.
- Ramblegard patient falls monitoring device £13k-procured in line with the devices on other wards in the Trust, Volair Ltd.
- Replacement UPS £13k-approved and current service contractor on site, Bender UK Ltd.
- LAMP refurbishment works £34k-collaborative procurement arrangement with RLBUTH, IED Installations Ltd.
- ACHD equipment £119k-procured from the existing supplier for equipment already owned by LHCHC, therefore ensuring compatibility with new equipment, Love Medical Ltd.
- Qlikview licences £12k-fixed price from all suppliers, chosen supplier provides improved service and support, Clikhealth Solutions

Audit Committee noted the contents of the report.

3.6 Compliance with Licence: Review of Quarterly Checklist

The quarterly checklist had been updated at Q1 2018/19. The primary risks related to;

- Breach of RTT in April 2018 and continued breach of diagnostic targets pending implementation of imaging business case which aimed to see a return to compliance by the end of the financial year 2018/19.
- The findings of the informatics review which highlighted gaps in controls and assurance relating to data quality.
- Delivery of the Control Total as a result of financial risks relating to recurrent funding for HRG4+ (Wales) and impact of transition to national procurement of devices.

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 4th September 2018.

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.

3.7 Review of Register of External Visits

The Audit Committee noted the 6 monthly report which gave an oversight of the external visits since 1st April 2017, shaded entries on the report were those which were report to the November 2017 Audit Committee with action 26 onwards the additions following the last Audit Committee.

The next review of the register would take place at the 15th January 2019 Audit Committee.

3.8 Review of Freedom to Speak Up Arrangements

The Trust's Freedom to Speak Up Policy had recently been reviewed and updated to reflect changes in roles and responsibilities and the Audit Committee had been asked to consider the recommended revisions to the policy as part of its annual review of the Corporate Governance Manual as detailed above under agenda item 3.3.

The latest annual report of the LHCH Freedom to Speak Up Guardian was presented to People Committee and the Board of Directors in March 2018, with the next half yearly report scheduled for September 2018.

In May 2018, NHS Improvement and the National Freedom to Speak Up Guardian jointly published guidance which set out the expectations of Boards in relation to Freedom to Speak Up and provided a self-review tool designed to help Boards to identify areas for development and improvement. Boards were expected to commit to using the guide and self-review tool. As well as this being a key part of demonstrating that the Trust was well led, it was a requirement of the NHS Standard contract that the Trust followed guidance from the National Guardian's Office.

The Board's focus on Well Led was important from the perspectives of both patient safety and staff experience, in light of recent reviews including Kirkup, Gosport and also case studies undertaken by the National Guardian's Office.

Board Directors would be asked to contribute to the self-evaluation of FTSU arrangements using the published self-review tool, however, an initial assessment undertaken by the Director of Corporate Affairs (Executive Lead for FTSU) and the FTSUG had enabled some improvement work to be identified and actions were being progressed in the following areas;

- Develop
- Promote
- Learn
- Monitor

The Audit Committee noted the new national guidance and supported the Trust's initial response, including the engagement of Board Directors in the self-review tool and increased (quarterly) reporting on FTSU activity direct to the Board of Directors.

The recommendation that FTSU reports would be brought directly to the Board of Directors in future was supported and therefore current reporting schedules to Audit Committee and People Committee would cease and business cycles updated accordingly.

JO'B

3.9 Regulatory Action Plans

The Director of Corporate Affairs provided the Audit Committee with a summary of discussions letter following the Trust's latest Quarterly Review Meeting with NHS Improvement which took place on 20th

June 2018.

Audit Committee members were informed that all actions were completed or in progress.

4. Internal Audit

4.1 Progress Report on Delivery of Plan

The Senior Internal Audit Manager stated that three reports had been finalised since the Audit Committee in April 2018;

- EPR Payments Reviews, Phase 2
- Corporate Governance Statement Review
- Risk Management Review

The EPR Payment review highlighted that reporting and monitoring of project benefits realisation had been poor and this had been detailed within the report. From the documents provided, it had not been possible to conclude whether a comprehensive post project evaluation had been completed at the Trust although it was acknowledged that the EPR System as a whole was functioning and a revised contract with the supplier had been signed.

It was recommended that the Trust undertook a retrospective review of the EPR project to determine whether all of the anticipated services and benefits as outlined in the original business case had been realised. The Chief Finance Officer would provide future updates on this, although Audit Committee with the next update scheduled for March 2019.

An overall assurance opinion was not applicable to the first two reports, with substantial assurance noted for the Risk Management review, as previously noted above under agenda item 3.1.

Audit Committee approved the request for the following amendments to the original plan which had been agreed with Executive colleagues;

- Audit Committee self-assessment from Q3 to Q4
- Consultant Appraisal from Q1 to Q2
- Consent from Q1 to Q2
- Cyber Security from Q2 to Q3

Following discussions at previous Audit Committee meetings members were pleased to see the new levels of assurance as referred to in Appendix A.

4.2 Follow Up Report

Of the 25 recommendations followed up, six had been implemented, 13 were in progress, five had been superseded and one recommendation was awaiting implementation. The summary of recommendations follow up was provided on pages 3-12 of the report.

CW

The one outstanding critical/high level recommendation relating to community admin services and the risks associated with having incomplete patients should be assessed, logged on Datix and continually monitored for implementation.

The post audit follow up concluded that gaps on the audit tracker had been completed. A new process had been established for secretaries to verify whether entries were correct and tests ordered on a daily basis. Comprehensive checks were conducted on a weekly basis. A Community Services Sub Group which reported to the Medicines Group was established in September 2017 and met on a monthly basis. A report to provide assurance (showing KPIs, breaches and outstanding) would be presented to the group. As at 17th November 2017 there were 33 incomplete patients. Risks associated with having incomplete patients were logged on Datix and included in the report to the sub group. EMIS system was now in place.

Trust Management had advised that this recommendation was now fully implemented but audit evidence was awaited.

The internal auditors would now carry out a full cleanse relating to this issue as it was a considerable risk if this recommendation was not implanted or tracked.

It was agreed that the Trust would look at improving arrangements for departmental follow up of internal audit recommendations.

CW

4.3 MIAA Insight Report

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

4.4 Anti-Fraud Progress Report

The Trust's Anti-Fraud Specialist presented the first progress report for 2018/19, which set out the work undertaken within April to June 2018, Committee members were asked to note that those highlighted in red were for attention not concern.

There were two items highlighted for Audit Committee attention in relation to the Anti-Fraud, Bribery & Corruption Policy and Pro-active Detection Exercise-Working Whilst off Sick on which the Anti-Fraud Specialist gave further details.

Pages three and four of the report provided items of interest highlighted for Audit Committee's information.

Audit Committee noted that there was currently no on-going investigations. It was also noted that the current Anti-Fraud Specialist would be on planned sick leave for three months from October 2018,

however a plan was in place for cover and there would be no negative impact on the Trust.

5. External Audit

5.1 Annual Audit Letter

The Director of the external auditors informed Committee members that there was nothing new contained within the letter and topics were positive, including the Value for Money Conclusion.

This annual audit letter would now be taken to the Council of Governors AMM meeting on 18th September 2018 and be published on the Trust's website.

LL

6. Review of Audit Committee Workplan

The Anti-Fraud Specialist requested that the anti-fraud update report be seen again at the January Audit Committee meeting rather than the March. The Director of the external auditors requested that the external audit plan and fees be seen at the January Audit Committee meeting rather than the March. The workplan would be updated to reflect these changes.

JO'B

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

7. Minutes of Meeting held on Tuesday 29th May 2018

The minutes of the previous meeting were noted and approved.

8. Action Log

Item 1- A more detailed process in relation to data quality framework should be available once the new CIO is in post. A further update would be provided at the October 2018 Audit Committee meeting.

Item 2- This item was for review at the October 2018 Audit Committee.

Item 3- It was confirmed that the Audit Committee Chair had recommended to the Board of Directors on 29th May 2018 that they formally approve the 2017/18 annual report, accounts and financial statements prior to submission to NHS Improvement. This item would be marked as complete and removed from the action log.

9. AGS Issues

Monitor incident report closures and timeliness of them together with those actions detailed in the letter from NHSI. No other 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 9th October 2018, 1.30-3.30pm, Boardroom.

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

It was noted that a private meeting was held with the Non-Executive Directors and both the Internal and External Auditors.