

E- Meeting of the Audit Committee

minutes

**Minutes of the Audit Committee Meeting held on
Tuesday 9th January 2024**

**Committee
Members:**

**Julian Farmer
Margaret Carney
Louise Robson
Bob Burgoyne
Nick Brooks**

**Committee
Attendees:**

**Karen Edge
Karan Wheatcroft
James Bradley
Nigel Woodcock
Gary Baines
Jing Ma
Ying Li
Kate Warriner
Jennifer Ohlsson**

Apologies:

**Non-Executive Director (Chair)
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director**

**Chief Finance Officer
Director of Risk and Improvement
Deputy Chief Finance Officer
Senior Audit Manager, MIAA
Regional Assurance Director, MIAA
Head of Financial Services
PSA Senior Manager, Grant Thornton
Chief Digital and Information Officer
Senior Executive Assistant (Minutes)**

1. Apologies for Absence

Apologies noted as above.

2. Declarations of Interest

The Committee were asked for declarations of interest with respect to agenda items. All participants confirmed they had no interests.

3. Minutes of the previous meeting held on 10th October 2023

The minutes of the e-meeting held on 10th October were accepted and recorded as a true record.

4. Action Log

The action log was reviewed and updated as follows:

Action 1: Strategic piece due in March 2024

Action 2: It was noted that the consultant job plans are covered in the MIAA follow up report and it is a positive position at present. It was agreed to remove from the action log.

Action 3: Annual requirements for annual effectiveness update required.

Action 4: Updates to be provided on in-phase until the reports are complete.

Action 5: Update was provided, and it was noted that the BUPA payments relate to a historic data and it is likely there will be a resolution by the next Audit Committee.

5. Governance and Risk

5.1 Risk Management KPIs – InPhase Update

An overview was provided of the risk report and KPIs paper circulated prior to the meeting. Key messages for the Committee include; Compliance with risk reporting requirements as set out in the risk management policy for risks. 100% completeness of information with the following exceptions. 50% assurances against a target of 95%. 70% review against a target of 95%

The Head of Risk Management is working closely with the In-Phase development team to enhance the reporting and visibility of gaps in information to support Divisions to improve completeness of information in the right fields within In-Phase.

The Trust has 494 active risks and regular review of some of these risks (particularly those with a residual score below 12) is outside of policy expectations. The Head of Risk Management is continuing to work with the In-Phase development team to progress automated alerts for risks due for review and reiterating the importance of the timely review of risks with managers.

75% of incidents have been closed within 28 days (previously 68%). The Trust ensures 100% compliance with the closure of Serious Incidents within 60 days. The implementation of the new Patient Safety Incident Response Framework (PSIRF) includes weekly review of all incidents rated moderate or above, and the new tools are being used to ensure rapid review and learning. The current number of incidents open over 28 days is 130. A dashboard has been developed on In-Phase that shows each of the Divisions the numbers and locations of incidents open. This will continue to be monitored through the weekly executive quality and safety report and monthly Divisional Board meetings.

Comments and questions were welcomed, and a query was raised on why there was a big drop against targets, 50% against 95% and 70% against 95%. It was confirmed that this is a temporary dip as a result of the newly implemented system. Assurance was provided that controls are in place.

Further detail was sought on when the Audit Committee expects to see these targets being met. It was noted that the focus has been on basic information and there is no specific deadline, however improvements are being seen. It was agreed that a more regular update is provided to the committee.

Further assurance was sought on the trajectory and that this is being monitored on a regular basis and what report could Audit Committee see to provide the assurance that there are improvements. It was agreed that the Risk Management team can run a report on the KPIs section and feedback to NED colleagues.

KWh

A query was raised on where the responsibility lies at divisional level. It was noted that there isn't a governance and risk lead in each division, however there is a lot of traction through the Divisional Directors.

It was added that the fact that KPIs are actually being seen at committee is a real positive and it would be good to see progress over the next few months.

5.2 Review Clinical Audit Plan and 6-monthly progress report

Jenny Crooks, Deputy Director of Research & Innovation attended the Audit Committee to provide an overview of the clinical audit plan and the 6-monthly progress report and colleagues were asked to note the report circulated prior to the meeting.

The Clinical Audit department has worked towards fulfilling statutory reporting responsibilities; National Audits, NCEPOD, CQUINS, National Inpatient Survey; concurrent with fulfilling ad hoc requests for support with service evaluations and local clinical audits.

In response to concerns raised in the previous progress report, the Clinical Audit team are maintaining regular learning session with staff; pursuing methods for reporting national audit data back to clinical staff; and improving the robustness of data collection, and the quality of data supplied to national audit stakeholders.

Comments and questions were welcomed and it was noted that the report looks positive and a query raised on whether there are any concerns with delivery. It was noted that there will be a transitional period, however there is good support from across the organisation.

A query was raised on e-Consent and the target for improvement. It was noted that the E-Consent project started on the back of a serious incident and consent is on the quality committee agenda.

5.3 Annual Audit Committee evaluation/effectiveness workshop

An update was provided, and it was noted that this is on the workplan, however it was added that there was a very thorough exercise undertaken last year. It was noted that the intention is to draft the annual report using the same process as the other committees and the approach will be reviewed next year.

5.4 Register of external visits

Audit Committee colleagues were asked to note the external visits register and further detail was sought on items 4, 7 and 9.

It was confirmed that outcomes for items 4 and 7 need to come back to the Audit Committee and item 9 can be closed off.

5.5 Compliance with Licence: Review of quarterly check-list

Audit Committee were asked to note the compliance with licence update circulated prior to the meeting.

The Trust continues to manage the recovery of waiting lists, alongside the challenges of continued industrial action, staffing constraints and operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board.

A query was raised on what the status of the questions in green is. It was confirmed that the questions in green are just a note of the questions that Executive colleagues should be asking.

5.6 Regulatory Action Plans

There was no update on the regulatory action plans.

5.7 Cyber Security report

An overview of the cyber security report was provided to Audit Committee colleagues and it was noted that the threat landscape is continuing to evolve, however as detailed above the Trust control environment is being developed to meet these challenges.

Over the last year we have been tracking our Cyber Security performance against the previously published NHS England national priorities and have been providing formal assurance against these monthly to the Digital Excellence Committee (DEC). Which reports by exception to the LHCH Operational Board and Executive Team for visibility.

In summary, performance against local and national targets remains positive and continual monitoring and improvement works remain in place.

An emerging risk with the data manager was raised, who is leaving the Trust.

It was noted that this is a really good report, and it was appreciated that it must be challenging to stay on top of the issues. It was added that the Trust should never underestimate the importance of cyber security.

Clinical coding was raised and further clarity sought on what the issues around clinical coding are. It was noted that there were some challenges with coding last year. It was added that accuracy is good and it was timescales that had issues, however this is resolved and there are no further concerns or issues.

5.8 Data quality report

An overview was provided on the data quality report. The paper provides an update to Audit Committee on the current processes around Data Quality at Liverpool Heart and Chest Hospital. The Trust has due process in place including Data Quality Strategy recently approved by Patient Pathway and Assurance Group along with an in-date data quality policy. Appropriate governance is in place and is led by the DQ Steering Group which meets bi-monthly.

The Trust is viewed favourably when reviewing metrics from external submissions CDS and SUS. Admitted Patient Care CDS previously flagged up two issues around Discharge Ready Date which is now resolved and Patient Pathway which is currently compliant against national standards but shows room for improvement which will be taken through the DQ Steering Group.

MIAA completed a data quality audit around the accuracy of Corporate Reporting in July 2023 and all recommendations had been put in place to provide assurance by November 2023.

A Data Quality Programme of work currently includes projects on Secure Health Messaging, NICOR, Private Patients and Outpatient Procedures. Recruitment has commenced with the successful appointment of a Data Quality Lead. Next steps are progressing to recruit a Data Quality Officer. This will allow the DQ team to take ownership of reporting/updates and progress with the roll out of the Data Quality App.

Further detail was requested on the admitted patient care table within the report. It was confirmed that the table covers the key data items that are submitted and assessed against.

5.9 Update to SORD

Deputy CFO provided an overview of the update to SORD and noted that the internal audit review of the Trust's key finance systems identified that the staff associated with procurement and IT are no longer employed directly by the Trust, but continue to play a role in financial transactions. The SORD

had not been adequately amended to incorporate the controls in place around delegation of procurement limits for partner organisations. The SORD has been amended to explicitly include reference to procurement and IT staff to ensure such staff can carry out their duties within the framework of the SORD and governance arrangements in place.

It was agreed by Audit Committee to approve the update to the SORD.

6. Internal Audit

6.1 Progress report on delivery of plan

A overview was provided on the progress report on the delivery of plan. Since the last meeting, there has been focus on recruitment. Reviews currently in progress include; Asset Management, Key Financial Processing Controls, Standard Operating Framework Reporting, Waiting List Management, Assurance Framework Review, Risk Management and Quality Spot Checks.

The following reviews are being planned in advance of issuing the TOR to the Trust: Duty of Candour and WHO Checklist.

Comments and questions were welcomed and a query raised on the waiting list management audit delay, the issues and whether this is an important risk area for the Trust. It was noted that there has been movement on this audit this month and operational pressures will have an impact.

6.2 Follow-up report

NW provided an overview of the follow-up report and colleagues were asked to note the report circulated prior to the meeting.

It was noted that secure health messaging remains a concern and a query raised on the impact of the text messaging issue in outpatient planning audit. It was confirmed that this is now in place.

It was noted that the secure health messaging is no longer 'high risk' but when will it be fully implemented. It was confirmed that the operational team do not want to declare as fully implemented.

6.3 Anti-Fraud update report

Karen McArdle attended Audit Committee to present an overview of the anti-fraud update and it was confirmed that this fraud report is on track to delivery.

It was noted that there is a relatively small number of fraud cases in the Trust and it would be good to see historical data.

7. External Audit

7.1 External audit update reports

An overview was provided on the external audit update report and colleagues were asked to note the paper circulated prior to the meeting.

Ying Li, Audit Manager was introduced to Audit Committee colleagues.

It was noted that it was a helpful update and good to see continuity within Audit.

8. Review of Audit Committee Work Plan – 2023/24

Audit Committee colleagues were asked to note the 2023/24 work plan, circulated prior to the meeting. There were no further comments or questions.

9. AGS Issues

A queried was raised on whether the inphase issues will need to be referenced. It was noted that the risk management is important to the AGS and this will be flagged as something to monitor.

10. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting.

All committee members confirmed that the meeting had been conducted effectively and useful documentation had been received and discussions had taken place.

12. Date and Time of Next Meeting:

Tuesday 12th March 2024, 08.30am – 10.30am, MS teams