Trust Board paper I

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 1 March 2012

COMMITTEE: **Audit Committee**

CHAIRMAN: **Ms K Jenkins, Non-Executive Director**

DATE OF COMMITTEE MEETING: 14 February 2012

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

None.

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

None.

DATE OF NEXT COMMITTEE MEETING: 18 April 2012

Ms K Jenkins, Non-Executive Director and Audit Committee Chair
24 February 2012

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

DRAFT MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON TUESDAY 14 FEBRUARY 2012 AT 10:30AM IN CONFERENCE ROOMS 1A & 1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL SITE

Present:
Mrs K Jenkins – Non-Executive Director (Chairman)
Mr R Kilner – Non-Executive Director

In Attendance:
Mrs F Coles – Assistant Director of Finance
Mr P Cleaver – Risk and Assurance Manager (for Minutes 5/12/3 and 5/12/4)
Miss M Durbridge – Director of Safety and Risk (for Minutes 5/12/3 and 5/12/4)
Mrs S Hinchliffe – Chief Operating Officer/Chief Nurse (for Minute 5/12/1)
Mrs H Majeed – Trust Administrator
Mr A Seddon – Director of Finance and Procurement
Mr R Smith – Information Governance Manager (for Minute 5/12/2)
Mr S Ward – Director of Corporate and Legal Affairs

Mr D Sharif – KPMG (the Trust's External Auditor)
Ms J Clarke – Local Counter Fraud Specialist (East Midlands Internal Audit Services) (part)
Ms A Breadon – Head of Internal Audit, PWC (the Trust's Internal Auditor)
Ms K Bennett – Internal Audit Manager, PWC (the Trust's Internal Auditor)

RECOMMENDED ITEMS

1/12 CAPS: 2010-11 Restatement of Annual Accounts and 2011-12 Accounts Preparation

Paper I outlined the three main areas of adjustment for the restated 2010-11 accounts and explained the reduction in the bottom line surplus by £295,000. The removal of the donated asset and government granted asset reserves required the Trust to amend the accounting policies in order to reflect the new requirements. The revised accounting policy would be appended to these Minutes for Trust Board approval in March 2012. Members noted the timetable for the 2011-12 final accounts. **ADF**

Recommended – that (A) the contents of paper I be received and noted, and

(B) the revised accounting policy on donated and government granted assets (paper I) be appended to these Minutes and presented for Trust Board approval on 2 March 2012. **ADF/TA**

RESOLVED ITEMS **ACTION**

2/12 PRIVATE DISCUSSIONS WITH BOTH SETS OF AUDITORS

As at previous meetings, and in line with the guidance detailed within paper A, private discussions took place between the Chairman and members of the Audit Committee and External and Internal Audit ahead of the start of the formal meeting.

Resolved – that the position be noted.

3/12 APOLOGIES

Apologies for absence were received from Mr M Lowe-Lauri, Chief Executive, Mr I Reid, Non-Executive Director, Mr J Shuter, Deputy Director of Finance and

Procurement and Mr D Tracy, Non-Executive Director.

4/12 MINUTES

Resolved – that the Minutes of the meeting held on 15 November 2011 (papers B and B1 refer) be confirmed as a correct record.

5/12 MATTERS ARISING REPORT

The Chairman confirmed that the Matters Arising report (paper C) highlighted the matters arising from the meeting held on 15 November 2011. In respect of Minute 83/11/1, Internal Auditors were requested to circulate future draft review reports to the Management representatives and Non-Executive Directors in parallel. **IA**

Resolved – that the matters arising report (paper C) and subsequent discussion on progress of a specific item be received and noted. **IA**

5/12/1 External Auditor's Review of Governance Arrangements

Further to Minute 73/11/1 of 15 November 2011, the Chief Operating Officer/Chief Nurse attended the meeting to provide a further update on progress against KPMG's review of governance arrangements, highlighting the following:-

- CBU confirm and challenge sessions had been held in January 2012 and were planned for end of February 2012;
- Divisional and clinical engagement had been established for CCG links;
- a 'governance pack' for use by Divisions/CBUs had been circulated at the end of November 2011;
- individual letters to CBU, Service and Operational Managers regarding delivery of objectives had been sent;
- a 'deep-dive' into capabilities of middle tier managers had been undertaken with a number of changes proposed at clinical and managerial level;
- opportunities for succession planning were currently limited at UHL;
- specific controls at Divisional and CBU level would reflect the requirement for relevant assurances on the SRR/BAF from April 2012. Cross Divisional learning of the assurances on controls would be addressed through the Quality and Performance Management Group (QPMG);
- the role of the QPMG was being reviewed and cross cutting issues would be discussed through this forum;
- the Executive Team (ET) had reviewed ET meetings and its supporting meetings structure. Further changes would emerge from the review of the NHS East and Midlands Provider Management Regime;
- changes to the Q&P report (refreshing Divisional heat maps, refining stretch targets) and ensuring its compatibility with the SHA's annual plan requirements would be proposed at the Trust Board in March 2012 and commenced from April 2012, and
- the Assurance Framework for Aspirant Foundation Trusts required UHL to review its Board Development Programme.

In discussion, the Audit Committee:-

(a) advised that one of the Divisional Board meetings did not currently comply with the sample agenda/front cover/action sheet format circulated as part of the governance pack, however note was made that the next such meeting was scheduled to be held on 24 February 2012 – the Chief Operating Officer/Chief Nurse agreed to communicate this to the Divisional teams; **COO/CN**

(b) queried whether managers were required to validate compliance with expectations in respect of the letter that had been sent to them (bullet point

4 above refers) – in response, it was noted that the objectives had been agreed with their respective line managers and the letter mainly focused around financial performance, CIP delivery, sickness absence management and corporate responsibility to improve patient experience;

(c) queried how best to address wider cultural and performance management issues – it was noted that a review of the middle managers performance had been completed and the Chief Operating Officer/Chief Nurse was liaising with the Director of Human Resources in respect of expediting the issues identified;

(d) noted that the results of the Staff Survey had been considered at the Executive Team Away Day on 7 February 2012;

(e) welcomed the progress in respect of the Trust's SRR/BAF but noted the need for the CBU-level Assurance Frameworks to be robust;

(f) noted that Divisional confirm and challenge meetings would be continued on a monthly basis and CBU confirm and challenge (c&c) sessions would be held at least twice annually. Issues arising from these meetings would be escalated as necessary to the Finance and Performance and Governance and Risk Management Committees;

(g) suggested that consideration be given to the proposals that:- **COO/CN /DFP**

- Divisions held a confirm and challenge (c&c) session with their respective CBUs prior to the CBU c&c session with the Director of Finance and Procurement and the Chief Operating Officer/Chief Nurse, and
- Divisional Directors be actively involved in confirming and challenging CBU positions at the March 2012 round of such meetings. **EA**

(h) advised that as part of their follow-up review of governance arrangements, it would be helpful if External Auditors contacted CBU staff to ascertain the level of support that they received from Divisional Management teams. Members noted that External Audit colleagues had been made aware of the CBUs that required support.

<u>Resolved</u> – that (A) the presentation on progress against KPMG's review of governance arrangements (tabled paper D) be received and noted;

(B) the Chief Operating Officer/Chief Nurse be requested to undertake the action outlined under point (a) above; **COO/CN**

(C) the Chief Operating Officer/Chief Nurse and the Director of Finance and Procurement be requested to undertake the action outlined under point (g) above, and **COO/CN /DFP**

(D) External Auditors be requested to undertake the action outlined under point (h) above. **EA**

5/12/2 <u>Information Governance</u>

5/12/2 a <u>Information Governance (IG) Toolkit Submission</u>

Mr R Smith, Information Governance Manager attended the meeting to present paper E, an update on current progress to deliver improved IG Toolkit performance for the deadline of 31 March 2012. The IG Toolkit compliance requirement set a minimum standard of 86% compliance across 45 standards. The IG training strategy was the method by which skills were improved to support the achievement of all the requirements in the IG Toolkit.

Lecture theatre sessions and IG self assessment workbooks would assist staff to undertake IG refresher training. Communication relating to the lecture theatre

sessions would commence on 20 February 2012. Members noted that 65% of UHL staff had viewed the 'Danny's Day' DVD in 2010-11.

Responding to a query, it was noted that the following were the priority areas in order to achieve compliance with the IG Toolkit:-

(a) IG Training;
(b) IG Policy, and
(c) IG Audit.

A number of IG toolkit leads had been appointed, who in liaison with the IG Project Support Officer would be required to complete specific areas of review including information security and records governance. A clear project plan had been developed and IG Leads would be required to submit evidence by 1 March 2012 which would then be reviewed and uploaded by 14 March 2012. A gap analysis had been undertaken and the main gaps were related to IG training and policy updates, however, work was in progress to close down these issues. The Information Governance Steering Group would be reviewing the Trust's formal return for 2011-12 against the IG toolkit which would be signed-off on 16 March 2012. A data awareness day had been scheduled for 21 March 2012.

The Committee Chairman queried whether the Trust could aspire to achieve more than 86% compliance – in response, it was noted that consideration could be given to achieving 90%. The Information Governance Manager was requested to provide an update on progress in achieving the IG toolkit compliance requirement at the Audit Committee in April 2012. **IGM**

<u>Resolved</u> – that (A) the contents of paper E be received and noted, and

(B) an update on progress in achieving the compliance requirement across the 45 standards in the IG toolkit be provided to the April 2012 Audit Committee. IGM/TA

5/12/2 b <u>Report from the Information Governance Manager</u>

<u>Resolved</u> – that this Minute be classed as confidential and taken in private accordingly.

5/12/3 <u>Board Assurance Framework</u>

The Director of Safety and Risk and the Risk and Assurance Manager attended the meeting to provide an update on the development of the UHL SRR/BAF (paper G refers).

In respect of the actions listed within section 2.3 of the report, the Committee Chairman noted the need for inclusion of the impact of the risk for instances where action deadlines had been missed. The Risk and Assurance Manager confirmed that this would be discussed and addressed through the ET meetings and reported to the Trust Board via the monthly SRR/BAF report. It was noted that Internal Audit's review of the BAF had been completed and it was suggested that the recommendations on improving the BAF be implemented promptly.

<u>Resolved</u> – that the contents of paper G be received and noted.

5/12/4 <u>NHSLA Accreditation Process for 2011-12</u>

The Director of Safety and Risk introduced paper H advising that the review of progress against NHSLA level 2 compliance was for information as the paper would

be discussed by the Executive Team on the afternoon of 14 February 2012.

Members were advised that the following would need to be considered in order to prepare and progress to achieve NHSLA level 2 accreditation:-

a. feedback from assessors following the achievement of level 1 compliance;
b. many policies and procedural documents would require more detail when describing the minimum requirements for levels 2 and 3;
c. compliance with criterion 3.4 (risk management training) and 3.5 (training needs analysis), and
d. compliance with four criteria (5.4, 5.5, 5.6, 5.7) within standard 5.

It was highlighted in particular that until a timescale was agreed for the resolution of issues identified (i.e. revision/development of policies and implementation of new processes) in points 'c' and 'd' above, it would be challenging to commit to a definitive date for a level 2 assessment as the requirement was to provide 12 months worth of fully compliant evidence. It was noted that the Executive Director leads for the training criteria would be discussed/agreed at the ET meeting on 14 February 2012. **ET**

Section 3 of the report detailed the revised NHSLA standards that were released on 16 January 2012 which contained a number of significant changes from the previous version.

A draft project plan had been developed and it was expected that UHL would be ready for a level 2 assessment between April/May 2013 but this was dependent upon the resolution of the issues outlined above. The Director of Safety and Risk advised that assessment at levels 2&3 could not be performed during March of any year.

The Audit Committee expressed disappointment on the delay in preparation for NHSLA level 2 given that the Trust's Divisional re-structure had happened in April 2010. Mr R Kilner, Non-Executive Director expressed concern that policies and procedures had not been followed and noted the additional costs to the Trust of losing accreditation at level 2.

The Director of Corporate and Legal Affairs also noted the need for a rigorous project plan to prepare for the level 2 assessment of Maternity CNST standards, in parallel.

Responding to a query, it was noted that in order to gain compliance at level 2, the Trust was required to pass at least 40 out of the 50 criteria, with a minimum of 7 criteria out of 10 being passed in each individual standard. The Committee Chairman highlighted the need for urgency in determining month '0' for each criterion given that the requirement was to provide 12 months worth of fully compliant evidence. The Director of Safety and Risk advised that it was proposed that lead Directors would be required to provide a monthly report outlining areas of non-compliance and the actions being taken to resolve those issues.

In response to a query, it was noted that the Trust was required to be level 1 compliant as a minimum in order to be an FT. However, it was noted that it would not be over-looked that previously UHL had been stepped down from level 2 to level 1 compliance. The Director of Corporate and Legal Affairs advised that the prospect of not achieving level 2 would not favour the Trust. The reputational risks to the Trust were also mentioned. The Department of Health and Monitor would scrutinise the Trust's plans to achieve level 2 compliance.

The Committee Chairman and Mr R Kilner, Non-Executive Director noted their wish

for UHL to achieve NHSLA level 2 accreditation in the first quarter of 2013-14. The Executive Directors advised that this matter would be further discussed at the ET meeting and a likely timescale for achieving level two compliance and the status in respect of the standards would be provided to the Audit Committee in April 2012. **DSR/ RAM**

Resolved – that (A) the contents of paper H be received and noted;

(B) the Executive Team to consider and resolve issues in relation to criteria 3.4-3.5 and criteria 5.4-5.7, and **ET/TA**

(C) the Director of Safety and Risk and the Risk and Assurance Manager be requested to provide the likely timescale for achieving level two compliance and the status in respect of the standards at the Audit Committee meeting in April 2012. **DSR/ RAM/TA**

5/12/5 Board Evaluation, Development and Learning

Resolved – that this item be deferred to the next Audit Committee meeting in April 2012 (due to time constraints). **DCLA/ TA**

6/12 FINANCE STATUS AND STRATEGIC ISSUES

6/12/1 Financial Recovery Plan Status

The Director of Finance and Procurement advised verbally that the risks around delivery of the 2011-12 control total of £1.3m surplus had been increasing. The Trust was pursuing a range of remedial actions but there needed to be a balance of those to be delivered with no further deterioration in the underlying position. The Commissioners were aware of the risks in the outturn and had been supportive. In addition to managing the 2011-12 outturn, increased focus was now on the 2012-13 planning as the Trust would be operating within a tighter financial regime.

Resolved – that the verbal update be received and noted.

6/12/2 CIP Forecasting Processes

The Director of Finance and Procurement advised that the Transformation Board meetings had been held and performance by CBU in relation to CIP 2011-12 actuals and 2012-13 plans had been discussed. Discussions on the 2012-13 counting and changes were underway with Commissioners. A presentation on capacity planning was scheduled to be presented to the Executive Team on 14 February 2012.

Resolved – that the verbal update be received and noted.

6/12/3 Commissioner Contracts

Members were advised that the shift to Clinical Commissioning and the subsequent and on-going development of the new Clinical Commissioning Groups (CCGs) required a one-year transitional contractual agreement for 2012-13. There was a requirement to have a signed Heads of Agreement in place by the end of February 2012 and a signed contract by the end of March 2012. Responding to a query, it was noted that the targets for CIPs for all CBUs would be set finally after reflecting the anticipated outcome of the 2012-13 counting and coding challenges and the re-admissions regime.

Resolved – that the verbal update be received and noted.

07/12 **OPERATIONAL FINANCE ISSUES**

07/12/1 Update on UHL's progress against the External Audit ISA 260 Recommendations

Paper J updated the Audit Committee on progress against the recommendations raised in External Audit's 2010-11 ISA 260 report. Five out of the eight recommendations had been closed and three were due for closure in 2012.

Resolved – that the contents of paper J be received and noted.

07/12/2 Discretionary Procurement Actions

Paper K provided a summary of six requests for single tender action between November 2011 and January 2012, in accordance with paragraph 9.8.4 of the Trust's Standing Orders. In the interests of time, Mr R Kilner, Non-Executive Director agreed to raise queries in respect of this paper outside the meeting and provide feedback to the Audit Committee, if required. **RK, NED**

Resolved – that (A) the discretionary procurement actions detailed in paper K be noted, and

(B) Mr R Kilner, Non-Executive Director be requested to raise queries in respect of paper K, outside the meeting and provide feedback to the Audit Committee, if required. **RK,NED**

07/12/3 Personal Injury Claims

Paper L outlined the reasons for the personal injury payments and the insurance arrangements in place.

Resolved – that the contents of paper L be received and noted.

07/12/4 Report from the Assistant Director of Finance

Resolved – that this Minute be classed as confidential and taken in private accordingly.

07/12/5 CEDAR (Finance and Procurement System) Version 4

The Assistant Director of Finance provided a verbal update advising that the Trust had upgraded to version 4 of the Cedar system between 10 -13 February 2012. The Director of Finance and Procurement commented that the upgrade had been successful and noted his thanks to the team.

Resolved – that the verbal update be noted.

08/12 **ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST**

08/12/1 Local Counter Fraud Specialist (LCFS) Progress Report

Paper N summarised progress made towards completion of the Trust's 2011-12 counter fraud work plan. The Local Counter Fraud Specialist particularly highlighted that a fraud warning had been issued due to continuing problems with regard to the fraudulent amendment of creditor bank details by third parties. Recommended practice had been issued to the Trust by the LCFS, in order to ensure controls were in place to counter this.

Resolved – that the contents of paper N be received and noted.

08/12/2 Report from the Local Counter Fraud Specialist

Resolved – that this Minute be classed as confidential and taken in private accordingly.

09/12 ITEMS FROM INTERNAL AUDIT

09/12/1 Internal Audit Progress Report

Ms A Breadon, Chief Internal Auditor presented paper O, an update on progress with the Internal Audit plan and implementation of audit recommendations.

In respect to the outstanding recommendation from the Information Governance review, it was noted that evidence had not been received regarding the smartcard training.

Internal Auditors were preparing actions plans and would meet with the Director of Finance and Procurement to discuss the most effective and efficient ways of tracking IA recommendations. The Committee Chairman noted the need for robust monitoring processes to be in place in order to ensure actions identified from reviews were being completed. **IA**

In discussion on the current scoping work on Emergency Department processes, Internal Auditors agreed to contact Mr R Kilner, Non-Executive Director outside the meeting, to take this forward. **IA**

Resolved – that (A) the contents of paper O be received and noted;

(B) Internal Auditors be requested to discuss the most effective and efficient ways of tracking IA recommendations with the Director of Finance and Procurement, and **IA**

(C) Internal Auditors be requested to agree the scope for the review of ED processes with Mr R Kilner, Non-Executive Director, outside the meeting. **IA**

09/12/2 Internal Audit Reviews

Review of Patient Experience (paper P refers):- Members made the following observations:-

(a) the review focused mostly on inpatients and it was suggested that in future a proportion of outpatients' feedback also be considered;
(b) in addition to the patient experience survey, other forms of patient feedback be taken into account;
(c) the Trust's patient experience dashboard might provide helpful information, and
(d) the agreed action in respect of the finding relating to 'monthly and cumulative target for survey returns not being met' was not robust.

Ms K Bennett, Internal Audit Manager acknowledged the above points and agreed to ensure that robust actions were in place in future.

Bank and Agency Staff Review (paper Q refers):- Members queried the reason for the delayed implementation deadline (31 May 2012) for the new staff bank system given that the risk was rated as 'medium' – in response, it was noted that a series of processes needed to be put in place but the full system would be rolled out and be functional by 31 May 2012.

Review of IT General Controls (paper R refers):- Internal Auditors advised that this review mainly focused on the leavers' process and the removal of leavers' access to IT systems. This review focused on the IT general controls over the designated financial systems only.

Review of IT Risk Management Controls and Benchmarking Exercise (paper S refers):- The Committee Chairman requested that agreed actions in response to the recommendations in this report be made explicit. **IA**

Review of Financial Systems (paper T refers):- Members noted the 'high' risk rating in relation to invoices not being supported by a purchase order. In further discussion on this matter and on whether controls could be put in place, the Assistant Director of Finance agreed to check the invoices that were not required to be supported by a purchase order and confirm the details to the Internal Auditors. The Committee Chairman noted the need for this issue to be resolved prior to the end of the financial year and the preparation of the Statement on Internal Control. **ADF**

Overpayments Review (paper U refers):- The report had been split by 'preventative controls' and 'detective controls'.

Resolved – that (A) the contents of papers P-U be received and noted;

(B) the Internal Auditors be requested to ensure that the agreed actions were explicit in respect of the 'Review of IT Risk Management Controls and Benchmarking Exercise', and **IA**

(C) the Assistant Director of Finance be requested to check the invoices that were not required to be supported by a purchase order and confirm the details to the Internal Auditors. **ADF**

10/12 ITEMS FROM EXTERNAL AUDIT

10/12/1 External Audit Progress Report

External Audit presented paper V, which detailed progress made in terms of work undertaken since the November 2011 meeting of the Audit Committee, work planned for the next quarter, and an update on the Audit Commission tendering exercise. The terms of reference for the 2011-12 follow up review of governance arrangements was appended to the report.

Resolved – that the contents of paper V be received and noted.

10/12/2 External Audit Plan 2011-12

Mr D Sharif, KPMG (The Trust's External Auditor) introduced paper W which summarised the process and timetable for delivery of the financial statements audit and use of resources plans, based on the indicative plan presented to the Audit Committee in May 2011 (Minute 46/11/1 refers).

Resolved – that the contents of paper W be received and noted.

10/12/3 PbR Data Assurance Follow-up Report

Members received and noted the contents of paper X which provided a summary of key findings from the follow-up review of all previous local work delivered by the PbR assurance framework. The scope of the review was to follow up the implementation of recommendations arising from the following reviews:-

- 2009-10 reference cost submission to the DoH;
- 2009-10 clinical coding audit of admitted patient care activity, and
- 2009-10 data quality review of outpatient data.

Out of the 19 recommendations from the above 3 reviews, 7 recommendations were on-going and 3 new (low priority) recommendations were raised. External Audit confirmed that actions were on-going, progress was satisfactory and it was anticipated that all actions would be completed within the timescales.

Resolved – that the contents of paper X be received and noted.

11/12 MINUTES FOR INFORMATION AND DISCUSSION

11/12/1 Governance and Risk Management Committee

Resolved – that the Minutes of the Governance and Risk Management Committee meetings held on 27 October 2011, 25 November 2011 and 4 January 2012 (papers Y-Y2 refer) be received and noted.

11/12/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meeting held on 27 October 2011, 24 November 2011 and 4 January 2012 (papers Z-Z2 refers) be received and noted.

12/12 ANY OTHER BUSINESS

Resolved – that there were no items of any other business.

13/12 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that there were no items to be brought to the attention of the Trust Board.

14/12 DATE OF NEXT MEETING

Resolved – that (A) the next meeting of the Audit Committee be held on Tuesday, 18 April 2012 from 10:30am in Conference Rooms 1A and 1B, Gwendolen House, Leicester General Hospital, and

(B) it be noted that this meeting would be preceded by a private meeting between the Audit Committee Chairman and the Non-Executive Director members at 10:00am, with representatives from Internal and External Audit to attend from 10:15am in the Members' Room, Gwendolen House, Leicester General Hospital.

The meeting closed at 1:00pm

Hina Majeed, **Trust Administrator**