University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 5 February 2015

COMMITTEE: Audit Committee

CHAIRMAN: Mike Williams, Interim Non-Executive Director

DATE OF COMMITTEE MEETING: 8 January 2015

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:

- Assurance around the risk management process in the Clinical Services and Imaging CMG (Minute 05/15 refers), and
- Review of Governance Arrangements for Empath (Minute 07/15/1b refers).

DATE OF NEXT COMMITTEE MEETING: 5 March 2015

Mike Williams
30 January 2015

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS Trust

MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON THURSDAY 8 JANUARY 2015 AT 2:00PM IN THE CJ BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Present:
Mr M Williams – Non-Executive Director (Interim Chair)
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr P Panchal – Non-Executive Director

In Attendance:
Mr N Callow – Director of Finance, Empath Pathology Services (for Minute 7/15/1b)
Mr P Cleaver – Risk and Assurance Manager (for Minutes 4/15-5/15 inclusive)
Miss M Durbridge – Director of Safety and Risk (for Minutes 4/15-5/15 inclusive)
Ms J Halborg – Clinical Services and Imaging CMG (for Minute 5/15)
Mrs H Majeed – Trust Administrator
Mr A McGregor – Consultant Pathologist, Empath Pathology Services (for Minute 7/15/1b)
Mr A Rickett – Deputy Clinical Director, Clinical Services and Imaging CMG (for Minute 5/15)
Mr C Shatford – Acting General Manager, Clinical Services and Imaging CMG (for Minute 5/15)
Mr P Shaw – Managing Director, Empath Pathology Services (for Minute 7/15/1b)
Mr N Sone – Financial Controller
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr S Ward – Director of Corporate and Legal Affairs
Ms J Wilson – Non-Executive Director

Mr M Curtis – Local Counter Fraud Specialist (East Midlands Internal Audit Services) (until and including Minute 6/15/3)

Mr D Hayward – KPMG (the Trust's External Auditor)
Ms S Rai – KPMG (the Trust's External Auditor)

Ms A Breadon – Director, PwC (the Trust's Internal Auditor)

RESOLVED ITEMS **ACTION**

1/15 APOLOGIES

Apologies for absence were received from Ms R Overfield, Chief Nurse.

2/15 MINUTES

Resolved – that the Minutes of the meeting held on 6 November 2014 (papers A and A1 refer) be confirmed as correct records.

3/15 MATTERS ARISING FROM THE MINUTES

In response to a query from the Interim Audit Committee Chair, the Financial Controller advised that the thresholds for the authorisation limits for spend and invoices were different to discretionary procurement waiving limits (as detailed under reference 79/14/1 in paper B).

Resolved – that the matters arising report (paper B) be received and noted.

4/15 UHL RISK MANAGEMENT REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) FOR THE PERIOD ENDING 30 NOVEMBER

The Director of Safety and Risk and the Risk and Assurance Manager attended the meeting to present paper C, providing an overview of the development of the UHL 2014-15 BAF and assurance in relation to the effectiveness of risk management processes within UHL.

The following points were highlighted in particular:-

(a) the intention to hold a thinking day in February 2015 in respect of the 2015-16 BAF;
(b) during the reporting period there had been no instances of elapsed risk review dates or action due dates;
(c) four high risks had been on the UHL risk register for greater than five years – a brief update on these was provided. Two of these risks were in the Clinical Services and Imaging (CSI) CMG. Members noted that the CSI CMG could be challenged regarding these risks when they would be attending the Audit Committee shortly (Minute 5/15 below refers), and
(d) the current risk score assigned to principal risk 2 (failure to implement LLR emergency care improvement plan) had been increased to 20 (i.e. likelihood score increased from 4 to 5) due to a number of recent internal major incidents within the Trust which reflected extreme pressures within the Trust's Emergency Department. Responding to a query from Mr P Panchal, Non-Executive Director, it was noted that all processes were systematically followed in respect of the internal major incidents and this was meticulously reviewed by the Chief Operating Officer.

In response to a query from Ms J Wilson, Non-Executive Director, the Director of Safety and Risk undertook to arrange for the risk score and actions to address the gaps in relation to Principal Risk 5 (Failure to deliver RTT improvement plan) to be reviewed. Responding to a query from the Interim Audit Committee Chair, the Director of Safety and Risk agreed to also arrange for Principal Risk 24 (Failure to implement the IM&T strategy and key projects effectively) to be reviewed. **DSR** **DSR**

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

(B) the Director of Safety and Risk be requested to arrange for the risk score and actions to address the gaps in relation to Principal Risk 5 (Failure to deliver RTT improvement plan) and Principal Risk 24 (Failure to implement the IM&T strategy and key projects effectively) to be reviewed. **DSR**

5/15 CLINICAL SERVICES AND IMAGING (CSI) CMG PRESENTATION – UPDATE ON RISK MANAGEMENT PROCESS IN THE CMG

Mr A Rickett, Deputy Clinical Director, Mr C Shatford, Acting General Manager and Ms J Halborg, Head of Nursing from the CSI CMG attended the meeting to present paper D, an update on risk identification, management and maintenance of the risk register within the CSI CMG.

The Deputy Clinical Director briefed members on the multifaceted spectrum of services provided by the CMG, highlighting the variety and complexity of different specialties which included Pathology, Pharmacy, Imaging etc.

In response to a query on the risk management process followed within the CMG, it was noted that the leads of each service in the CMG were required to provide an update on any risks at the CMG's monthly Quality and Safety Group, CMG Board and Assurance and Performance meetings.

Members challenged the CMG colleagues in respect of the two high risks which

had been on the CMG risk register for greater than five years (Minute 4/15 above refers) – the Head of Nursing explained the background to these risks which were in relation to (a) the Asceptic Unit, and (b) failure to implement electronic tracking for blood and blood products to provide full traceability from donor to recipient. She provided a brief overview of the issues and the actions that had been put in place to mitigate the risks.

The Acting General Manager advised that in terms of financial risk management, the CMG had robust governance of Cost Improvement Programme management.

There were a number of risks around levels of staffing which were due to the need to recruit Specialists (i.e. Pharmacists, Physiotherapists, and Paediatric Radiologists etc.) in some areas within and outside the CMG. Responding to a query from the Interim Chair of the Audit Committee, the CMG Head of Nursing advised that 'mixed sex accommodation' was an area of concern within the CMG highlighting that the CMG recognised all of the pertinent issues and was working to resolving them. It was also highlighted that acting on results and interaction with GPs were also areas where the CMG was working towards improving the current position.

Audit Committee members were assured that the CMG had a robust risk management process despite the challenges that were highlighted at the meeting.

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

6/15 ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST

6/15/1 Local Counter Fraud Specialist (LCFS) Progress Report

Paper E provided assurance regarding the actions taken to mitigate the risk of fraud, bribery or corruption within the Trust. Mr M Curtis, Local Counter Fraud Specialist advised that he had commenced a review of the Trust's efforts to prevent and detect pre-contract procurement fraud and invoice fraud, to ensure actions were taken in line with NHS Protect's Provider Standards. The Counter Fraud eLearning module had been issued to the Trust's Core Training Lead and was being prepared for distribution to staff.

In respect of contract performance, 59% of the annual plan was complete and work was in-train for the remainder of 2014-15. The Committee's view was that, given the size of UHL, the current number of fraud cases seemed 'low' – the Local Counter Fraud Specialist acknowledged this highlighting that the distribution of cases varied significantly between geographical regions.

In discussion on whether the National Fraud Initiative matching processes would be able to highlight issues in relation to staff working in other Trusts whilst sick, it was noted that these issues might not be raised through the matching process. Members noted the importance of ensuring staff were made aware that the Trust undertook these checks in order to help deter the risk of fraud.

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

6/15/2 Update on National Fraud Trends

Paper F, a report issued by NHS Protect to Local Counter Fraud Specialists dated November 2014 aimed to provide a strategic understanding of the economic crime risks facing NHS providers and the efforts being undertaken locally within the NHS to tackle these. Payroll fraud was the most prevalent type of non-patient fraud reported to NHS Protect in the calendar year 2014. NHS Protect took the view that

procurement fraud and corruption in the NHS was likely to be significantly under-reported and under-detected due to the complex and diverse nature of this type of fraud.

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

6/15/3 On-going Cases

The Local Counter Fraud Specialist tabled a report with the list of open fraud investigations highlighting that in future, this report would be incorporated into the Local Counter Fraud Specialist Progress report.

Resolved – that the contents of the tabled report be received and noted.

7/15 ITEMS FROM INTERNAL AUDIT

7/15/1 Internal Audit Reviews

a. Delayed Transfers of Care (DTOC) Review

The Director, PwC advised that, further to recommendations arising from the DTOC review, Trust staff had advised that a process/software would be piloted to resolve the issues raised. The Audit Committee requested that a written update be provided to the Audit Committee in May 2015 further to the embedding of this software. The Director, PwC undertook to feedback the Audit Committee's request to the Chief Operating Officer and the Head of Operations. **IA**

Resolved – that (A) the verbal update be received and noted, and

(B) the Internal Auditors be requested to feedback to the Chief Operating Officer and the Head of Operations regarding the Audit Committee's request for a written update to the May 2015 Committee meeting on the Delayed Transfers of Care (DTOC) position further to the processes/software being put in place to resolve the DTOCs issues. **IA**

b. Review of Governance Arrangements for Empath

Paper G1 included details of Internal Audit's review of the governance arrangements of Empath. The final report had been classified as high risk with 3 findings reported as follows:-

- 2 high rated operating effectiveness findings, and
- 1 medium rated operating effectiveness finding.

The Joint Venture Agreement (JVA) set out a number of compliance requirements for Empath and the Parent Trusts. The Internal Audit review had identified a number of areas of non-compliance with the JVA and had raised a recommendation in the report to set out how this should be dealt with. This included the preparation of an annual business plan, within which the JVA required a number of financial reports, including a cash flow statement, monthly projected profit and loss account, operating budget, management report and financial report. The review of the 2014-15 plan had found that there was a lack of adequate financial information, including only proposed budget and projected business development income.

Mr P Shaw, Managing Director, Mr N Callow, Director of Finance and Mr A McGregor, Consultant Pathologist, Empath Pathology Services attended the meeting to provide a management response to the findings from the review. They advised that Empath had become operational in 2012 and was led by a Managing Director, hosted by both parent Trusts (UHL and Nottingham University Hospital

NHS Trusts). Empath did not operate as a separate legal entity. They advised that the Empath Board had acknowledged that the current model of governance and reporting arrangements needed to be reviewed.

Empath colleagues briefed members on a transitional plan to resolve the issues identified. The financial management framework was still being developed. The shortfalls identified in financial management reflected the constraints of operating across two different Trust finance systems, policies and procedures. The lack of segmental reporting in relation to Empath within parent Trust accounts had restricted the ability to produce a balance sheet and cashflow statement as required within the Joint Venture Agreement.

There were currently 3 risk registers relating to Empath including inconsistencies in the recording and monitoring of risks across the joint venture. Significant risks to the joint venture or pathology services could potentially be overlooked due to the challenge of managing three risk registers. The Managing Director advised that a business case for a new IT system would hopefully soon be approved by the NHS Trust Development Authority, allowing each Trust and Empath to then monitor risks using the same system.

In discussion on these issues and taking into account the history of the development of Empath, the following actions were agreed. Empath colleagues were requested to:- **Empath colleagues**

(a) work up a transitional plan pending options being explored on the best possible way to give effect to the provisions set out in the Joint Venture Agreement,
(b) explore the opportunities available to accelerate the timescale for completion of actions which were being put in place in respect of the 'Ongoing financial management and monitoring' and 'Risk Management' findings, and
(c) ensure that a plan was put in place to resolve all of the issues raised by the Internal Auditors in their review and provide a further update to the Audit Committee before December 2015.

<u>Resolved</u> – that (A) the contents of paper G1 be received noted, and

(B) Empath colleagues be requested to undertake actions (a) to (c) above. **Empath colleagues**

c. <u>Implementation of NICE Guidance</u>

Paper G2 detailed Internal Audit's review of the Implementation of NICE Guidance and the report had been classified as low risk with 4 findings reported as follows:-

- 1 low rated control design finding, and
- 3 low rated operating effectiveness findings.

The Director, PwC highlighted that the Trust had a documented process and approved policy for the implementation of the National Institute for Health and Care Excellence (NICE) guidance which included procedures for providing assurance that the Trust was compliant with the guidance. The policy relied on staff confirming that they had complied with the guidance, however there were no further checks to confirm whether, infact, the staff had complied with the guidance. It was noted that adhoc follow-ups were undertaken. The Interim Audit Committee Chair queried whether non-compliance with NICE guidance was presented to the Quality Assurance Committee (QAC) – in response, the QAC Chair advised that this matter did not feature on the QAC agenda specifically and she undertook to liaise with the Director of Clinical Quality and Head of Outcomes and Effectiveness outwith the meeting regarding the process for the QAC to be notified of any non-compliance with NICE Guidance. **QAC Chair**

Resolved – that (A) the contents of paper G2 be received and noted, and

(B) the QAC Chair be requested to liaise with the Director of Clinical Quality and Head of Outcomes and Effectiveness outwith the meeting regarding the process for the QAC to be notified of any non-compliance with NICE Guidance. **QAC Chair**

d. Review of Charitable Funds

Paper G3 included details of the report classification and findings of the 2014-15 Internal Audit review of Charitable Funds which had been classified as medium risk with 5 findings reported as follows:-

- 1 medium rated control design finding, and
- 4 low rated operating effectiveness findings.

Resolved – that the contents of paper G3 be received and noted.

e. Corporate Planning

Paper G4 included details of the report classification and findings of the 2014-15 Internal Audit review of the Corporate Planning process. The final report had been classified as low risk with 1 low rated control design finding and 1 low rated operating effectiveness finding.

Resolved – that the contents of paper G4 be received and noted.

f. IT General Controls

Paper G5 included details of the report classification and findings of the 2014-15 Internal Audit review of the IT General Controls. The final report had been classified as low risk with 2 low rated control design findings.

Resolved – that the contents of paper G5 be received and noted.

7/15/2 Internal Audit Progress Report

The Director, PwC presented paper H, an update on progress made against the 2014-15 Internal Audit Risk Assessment and Plan. Following a request from the Director of Estates and Facilities, Internal Auditors had agreed with the Director of Finance to use the time available in the plan to undertake a review of car parking income collection. The Mortality and Morbidity Review had now been deferred to 2015-16. Fieldwork for the review had been completed in December 2014. The Director of Finance also highlighted the possibility that a review regarding the use of R&D funds might also be included within the 2014-15 plan.

The Interim Audit Committee Chair requested that an update on the total number of days allocated and utilised in respect of the Internal Audit work be included in the progress report for the Audit Committee in March 2015. **IA**

In discussion on the list of overdue and outstanding Internal Audit actions, the Director of Corporate and Legal Affairs was requested to coordinate and ensure that a consolidated list of outstanding and in-progress actions following Internal Audit, External Audit and LCFS recommendations was submitted to the March 2015 Audit Committee meeting and to each subsequent Committee meeting. **DCLA**

Resolved – that (A) the contents of paper H, Internal Audit progress report for 2014-15 be received and noted;

(B) an update on the total number of days allocated and utlised in respect of the Internal Audit work be included in the progress report for the Audit Committee in March 2015, and **IA**

(C) the Director of Corporate and Legal Affairs be requested to coordinate and ensure that a consolidated list of outstanding and in-progress actions following Internal Audit, External Audit and LCFS recommendations was submitted to the March 2015 Audit Committee meeting and to each subsequent Committee meeting. **DCLA**

8/15 ITEMS FROM EXTERNAL AUDIT

8/15/1 External Audit Progress Report

Paper I detailed the External Audit progress report updating the Committee on work undertaken in the last quarter, planned for the next quarter and provided technical updates, for information. Ms S Rai, KPMG highlighted the following:-

- the External Audit opinion and ISA260 report for Leicester Hospitals Charity for 2013-14 had been issued in December 2014;
- meetings continued with key officers at the Trust, including the Financial Controller, to discuss emerging technical topics and identify significant issues that would contribute to the audit approach, and
- the External Audit plan would be presented to the Audit Committee in March 2015.

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

9/15 FINANCE

9/15/1 Discretionary Procurement Actions

Paper J outlined the discretionary procurement actions for the period November to December 2014 in line with the Trust's Standing Orders. The Director of Finance advised that the number of cases remained low. The submitted cases of need were largely for specialist support for specific areas of work and had also been approved by the Chief Executive.

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

09/15/2 Month by Month Private Patient Income to the Trust

Paper K informed the Audit Committee of the level of monthly private patient Trust income between April 2012 and November 2014, the areas within the Trust which had attracted 70% of the private patient income and the customers which comprised 70% of the Trust's private patient income. The Financial Controller advised that the Head of Partnerships would be submitting a report on the development of the private patient strategy to the Executive Strategy Board in February 2015.

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

09/15/3 Update on UHL's Progress Against EA ISA 260 Recommendations

Paper L outlined the progress against the recommendations raised in External Audit's 2013-14 ISA 260 report, as at the end of December 2014. The detail of the recommendations and progress against them was included in Appendix 1 of paper

L. Due to the nature of the 4 recommendations raised, these were on-going and full implementation would be evidenced at year-end.

In discussion on the full revaluation of the Trust's land and buildings which had been undertaken in September 2014, the Interim Audit Committee Chair requested the Financial Controller to confirm to him the expenditure outwith the meeting. **FC**

Resolved – (A) that the contents of paper L be received and noted, and

(B) the Financial Controller be requested to confirm to the Interim Audit Committee Chair, the expenditure on the revaluation of the Trust's land and buildings. **FC**

9/15/4 Timetable for 2014-15 Accounts

Paper M provided an update on the 2014-15 year-end accounting processes and timetable. Responding to queries, the Financial Controller advised that appropriate plans were in place for the ledger closedown, accounts and annual report production, and audit sign off.

Resolved – that the contents of paper M and verbal update be received and noted.

10/15 REVIEW OF AUDIT COMMITTEE ANNUAL WORK PROGRAMME

Further to Minute 82/14/1 of 6 November 2014 and in discussion on paper N, the Audit Committee annual work programme, the Director of Finance suggested that the reports from the Local Counter Fraud Specialist be excluded for the Audit Committee meetings in May. The Director of Corporate and Legal Affairs undertook to update the work programme accordingly. **DCLA**

Resolved – that (A) that the contents of paper N be received and noted, and

(B) the Director of Corporate and Legal Affairs be requested to update the Audit Committee work programme by excluding the need for reports from the Local Counter Fraud Specialist for the Audit Committee meeting in May 2015. **DCLA**

11/15 ITEMS FOR INFORMATION

11/15/1 Confirmation of Auditor Appointment from 2015-16

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

11/15/2 Clinical Coding Update on Backlog Reduction

Resolved – that (A) the contents of paper P be received and noted, and

(B) the Director of Finance be requested to ensure that the clinical coding backlog position was discussed with CMGs at the weekly Monday afternoon performance management sessions. **DF**

12/15 ASSURANCE GAINED FROM THE FINANCE AND PERFORMANCE COMMITTEE (FPC), QUALITY ASSURANCE COMMITTEE (QAC) AND CHARITABLE FUNDS COMMITTEE (CFC)

12/15/1 Quality Assurance Committee

Resolved – that the Minutes of the Quality Assurance Committee meetings

held on 29 October 2014 (paper Q refers), 26 November 2014 (paper Q1 refers) and 15 December 2014 (paper Q2 refers) be received and noted.

12/15/2 Finance and Performance Committee

Resolved – that the Minutes of the Finance and Performance Committee meetings held on 26 November 2014 (paper R refers) and 18 December 2014 (paper R1 refers) be received and noted.

12/15/3 Charitable Funds Committee

Resolved – that the Minutes of the Charitable Funds Committee meeting held on 17 November 2014 (paper S) be received and noted.

13/15 ANY OTHER BUSINESS

13/15/1 Delegated Authority Limits

The Director of Finance undertook to review the delegated authority limits for signing-off discretionary procurement actions and provide an update to the Audit Committee meeting in March 2015. **DF**

Resolved – that the Director of Finance to review the delegated authority limits for signing-off discretionary procurement actions and provide an update to the Audit Committee meeting in March 2015. **DF**

14/15 IDENTIFICATION OF KEY ISSUES THAT THE COMMITTEE WISHES TO DRAW TO THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be brought to the attention of the Trust Board:-

- **Assurance around the risk management process in the Clinical Services and Imaging CMG (Minute 05/15 refers), and** **Interim AC Chair**
- **Review of Governance Arrangements for Empath (Minute 07/15/1b refers).**

15/15 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Thursday, 5 March 2015, 2:00pm-4:00pm in the CJ Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 16:09pm.

Hina Majeed,
Trust Administrator

Cumulative Record of Members' Attendance (2014-15 to date):

Name	Possible	Actual	% attendance
K Jenkins (Chair)	2	2	100%
M Williams (Interim Chair)	2	2	100%
I Crowe	5	4	80%
S Dauncey	3	2	66%
P Panchal	5	5	100%

Attendees

DRAFT

Name	Possible	Actual	% attendance
P Hollinshead	2	2	100%
S Ward	5	5	100%
R Overfield	5	1	20%
S Sheppard	1	1	100%
P Traynor	2	2	100%