Trust Board paper N

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: 4 February 2016

COMMITTEE: Audit Committee

CHAIRMAN: Richard Moore, Non-Executive Director

DATE OF COMMITTEE MEETING: 7 January 2016

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:

- Minute 4/16 – Clinical Quality Assurance Process;
- Minute 7/16 – Local Security Management Specialist report and the need to increase Executive Team awareness of the relevant issues;
- Minute 12/16/2 – relating to the proposals for self-assessment of the Audit Committee's effectiveness, and
- Minute 12/16/3 – relating to outstanding Internal Audit, External Audit and Counter Fraud recommendations.

DATE OF NEXT COMMITTEE MEETING: 3 March 2016

Richard Moore
Non-Executive Director

25 January 2016

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON THURSDAY 7 JANUARY 2016 AT 2.30PM IN SEMINAR ROOMS A & B, EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Moore – Non-Executive Director (Chair)
Dr S Dauncey – Non-Executive Director

In Attendance:
Mr C Benham – Director of Operational Finance (up to and including Minute 7/16)
Mr J Clarke – Chief Information Officer (for Minute 5/16 only)
Mr P Cleaver – Risk and Assurance Manager (for Minutes 6/16 and 7/16 only)
Miss M Durbridge – Director of Safety and Risk (for Minutes 6/16 and 7/16 only)
Mr A Furlong – Acting Medical Director (for Minute 4/16 only)
Mr A Johnson – Non-Executive Director
Ms K Rayns – Trust Administrator
Ms J Smith – Chief Nurse (for Minute 4/16 only)
Mr N Sone – Financial Controller
Mr M Traynor – Non-Executive Director (up to and including Minute 9/16)
Mr P Traynor – Director of Finance
Mr S Ward – Director of Corporate and Legal Affairs

Mr M Curtis – Local Counter Fraud Specialist (EM Internal Audit Services) (for Minute 8/16 only)

Mr D Hayward – Manager, KPMG (the Trust's External Auditor)

Ms A Breadon – Director, PwC (the Trust's Internal Auditor)
Ms C Wood – Senior Manager, PwC (the Trust's Internal Auditor)

ACTION

RESOLVED ITEMS

1/16 APOLOGIES AND WELCOME

Apologies for absence were received from Mr J Brown, Director, KPMG (the Trust's External Auditors), and Colonel (Retired) I Crowe, Non-Executive Director.

2/16 MINUTES

Resolved – that the Minutes of the meeting held on 5 November 2015 (papers A1 to A3) be confirmed as correct records.

3/16 MATTERS ARISING FROM THE MINUTES

Paper B1 advised members of progress on actions from previous Audit Committee meetings, noting in particular:-

(a) **Minute 75/15 of 5 November 2015** – the scope of the Internal Audit review on elective waiting lists was currently being drafted and the Chief Financial Officer confirmed that this would be shared with External Audit colleagues (when available); **CFO**
(b) **Minute 77/15(b) of 5 November 2015** – the Payroll Senior Project Manager had expressed a differing view regarding the documented action to explore whether the next ESR module would support a self-service approach for line managers. An update on this matter would be provided to the Audit Committee in March 2016; **DCLA**
(c) **Minute 84/15/2.2 of 5 November 2015** – the Chief Financial Officer advised that a follow-up review of the governance around the Elective Alliance Contract would be scheduled once an appointment had been made to the post of Alliance Director. In **CFO**

this instance the delay was unavoidable, as no appointment had arisen from the interviews held in December 2015;

(d) Minute 53/15(b) of 17 September 2015 – Internal Audit advised that the standard for withdrawal of access to IT systems when employees left the Trust was usually 3 days. However, there was a facility to withdraw IT access more swiftly (eg in the event of disciplinary action). The latter facility was not yet reflected in the relevant HR policy nor had this been tested as part of the fieldwork. A sample would be tested during 2016-17 to provide greater assurance in this area, and **IA**

(e) Minute 50/15(b) and (c) of 17 September 2015 – a draft user guide had been developed for staff in relation to the Trust's corporate governance policies. This would be shared with the relevant leads for approval prior to publication by the end of January 2016 alongside the appropriate communications messaging to cover performance management elements. **CFO**

Resolved – that the matters arising report and any associated actions be noted and taken forward by the appropriate lead.

4/16 CLINICAL QUALITY ASSSURANCE PROCESS

The Chief Nurse and the Acting Medical Director attended the meeting to introduce paper C, briefing the Committee on issues arising from the 30 November 2015 unannounced CQC inspection of the Emergency Department at the LRI and the subsequent decision to impose conditions upon UHL's registration as a service provider under section 31 of the Health and Social Care Act 2008. The report provided an update on the actions underway to address the key areas of non-compliance and the resources required to strengthen UHL's preparations for the next comprehensive CQC inspection.

The Committee Chair confirmed that the Quality Assurance Committee (QAC) and the Executive Quality Board (EQB) would continue to seek assurance in relation to the detailed workstreams to support CQC compliance. The role of the Audit Committee would be to reflect upon the underlying root causes and any wider implications of potential lapses in processes or controls. He sought assurance in respect of the following key areas:-

- whether all of the root causes had now been identified, and (if so) whether these were fully understood within the organisation;
- whether there were any other issues of a similar magnitude which might require urgent attention, and
- what lessons (if any) had been learned from these recent developments.

In response, the Acting Medical Director reported on the already-known issues arising from over-crowding in ED and the associated loss of operational efficiency, the stressful working environment for doctors and nurses, lack of strong leadership and cultural issues, all of which combined had led to a lack of focus on the "bigger picture". He highlighted ongoing concerns relating to the quality of the care environment, insulin safety procedures and care of the deteriorating patient.

Particular discussion took place regarding the effectiveness of the Trust's risk management arrangements, eg whether the right risks were being highlighted and whether the right conversations were being held. The Chief Nurse queried whether Board members would be able to consistently articulate the Trust's top 3 clinical risks (if requested to do so). In further discussion on CQC compliance and the Trust's risk management arrangements, members raised the following comments and queries:-

(a) commented that excellent work was taking place to address CQC non-compliance and this was being effectively monitored by QAC and EQB;
(b) suggested that a renewed focus was required on the Trust's risk management process, to assess whether it was fit for purpose and whether it supported a sufficiently granular approach towards escalation of risks from ward level to Board

level;
(c) queried whether there was a sufficient and consistent approach to risk identification and whether each risk had a robust mitigation or risk reduction action plan;
(d) noted opportunities to sharpen the focus of Trust Board discussions on the Board Assurance Framework (BAF). The Director of Corporate and Legal Affairs suggested that discussions be held at a Trust Board thinking day in order to clarify the governance roles of each Committee in respect of risk management; **DCLA**
(e) highlighted the relatively short time available to the Board each month to consider the BAF and link back the discussions on key issues to the risk register to ensure that the Board was comfortable with the level of risk being accepted or tolerated;
(f) queried the scope for creating dedicated time for risk management discussions at either QAC or IFPIC meetings;
(g) suggested an amendment to the executive summary sheets accompanying all Board and Committee papers to indicate the relevant risks and their current score; **DCLA**
(h) noted that Mr M Traynor, Non-Executive Director and IFPIC Chair had invited an external company to demonstrate a computerised risk management system to himself and the Director of Safety and Risk on 29 January 2016. The Audit Committee Chair expressed an interest in attending this demonstration, and **MT, NED**
(i) commented that although monthly reports on the ED and emergency care performance were received and discussed at the public Trust Board meetings, there had still been a lack of awareness of the key issues highlighted during the CQC inspection.

The Audit Committee Chair commented on the valuable nature of this discussion and he requested the Director of Corporate and Legal Affairs to liaise with the Trust Chairman to ensure that an in-depth discussion was scheduled on the Trust Board thinking day agenda in the near future. **DCLA** A further update on the clinical assurance process would be provided to the March 2016 Audit Committee and further reports would be scheduled until the Committee was assured that the right processes were in place to improve visibility. **CN/AMD**

<u>Resolved</u> – that (A) the Director of Corporate and Legal Affairs be requested to liaise with the Trust Chairman to schedule an in-depth discussion on risk management and the governance roles of each Committee at a future Trust Board thinking day; **DCLA**

(B) consideration be given to amending the executive summary sheet for all Board and Committee papers to include the relevant risk register entry and its current risk score; **DCLA**

(C) the Audit Committee Chair be invited to attend a risk management demonstration on 29 January 2016, and **MT, NED**

(D) a further report on clinical assurance processes be presented to the Audit Committee in March 2016 and subsequent meetings until the Committee was sufficiently assured in this respect. **CN/AMD**

5/16 REPORT BY THE CHIEF INFORMATION OFFICER

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

6/16 INTEGRATED RISK MANAGEMENT UPDATE

Further to Minute 81/15 of 5 November 2015, the Director of Safety and Risk and the Risk and Assurance Manager attended the meeting to present paper E, providing the first iteration of the integrated risk management report incorporating the Board Assurance Framework (BAF) and the organisational risk register as at 24 December 2015. Members noted that the Trust Board would now receive copies of the BAF and risk register dashboards within the Chief Executive's briefing report and that the detail

of any high and extreme risks would be made available as an information pack (similar to the arrangements for the Quality and Performance reports). At the request of the Audit Committee, the colour coding of the risks with the BAF had been amended.

The Director of Safety and Risk provided assurance that the dashboards and the risk assurance process were proving to be effective, but she was seeking an improvement in the level of challenge and scrutiny undertaken by the Executive Team, eg whether the Executive Team was prepared to accept or tolerate any key risks where appropriate action was not being taken to mitigate or reduce the risk. CMG-level risks were being scrutinised regularly via the performance management review meetings and the quality, safety and risk templates had recently been refreshed to support this approach. Front line staff were encouraged to identify their top risks and a thematic analysis had shown that 29 risks (scoring 15 and above) were all related to workforce capacity and capability.

Responding to a query raised by Mr A Johnson, Non-Executive Director, the Risk and Assurance Manager detailed the existing arrangements for risk management at UHL including the identification, scoring mechanism, level of challenge, frequency of review periods, action plans and mitigation methods. He also expressed concern regarding the limited availability of time for discussion at the weekly Tuesday afternoon Executive meetings.

The QAC Chair highlighted the different types of assurance being sought from the QAC and Audit Committee, with the latter seeking assurance that the risk management process was effective and fit for purpose. In response, the Director of Safety and Risk noted that the Trust had moved away from the use of a dedicated Risk Management Committee in favour of a more integrated approach. However, she voiced concern that some key risks were remaining “high” for too long and were becoming culturally acceptable as they fell into the “too difficult” category. To this end, she was hoping to attend the relevant Executive meetings during 2016 in order to improve the level of challenge undertaken.

In summary, the Committee Chair noted the positive direction of travel in development of the risk management approach at UHL. He particularly noted the helpful nature of the dashboards, the risk management summary, and the thematic analysis but he queried whether the hyperlink to the full BAF (contained within the Trust Board report) was consistently being used to good effect.

Resolved – that (A) the integrated risk management report incorporating the BAF and organisational risk register be received and noted, and

(B) the lack of available assurance in respect of the amount of time dedicated to Executive Team discussion on risk management issues be escalated to the Chief Executive for his attention. **DCLA/ DSR**

7/16 LOCAL SECURITY MANAGEMENT SPECIALIST (LSMS) UPDATE REPORT

Paper F provided an update on progress against the LSMS action plan arising from the annual self-assessment process. The Director of Safety and Risk highlighted the 3 most significant risks arising as a consequence to delayed progress with the identified actions:- (1) a lack of assurance that adequate numbers of Interserve security staff would be available to respond to security incidents (especially out of hours); (2) appropriate investment in security management (including CCTV), and (3) delays in delivery of conflict resolution training.

In respect of item (3) above, suitable training facilities had now been identified and this training had commenced. A meeting had been held with the Director of Estates and Facilities and a line-by-line review of the key issues being escalated in relation to the Facilities Management contract had been undertaken.

Particular discussion took place regarding the importance of clear CCTV images and the reliance upon high quality video surveillance to secure a conviction in the event of a crime being committed on UHL premises. Assurance was provided that a detailed survey had been undertaken and a schedule of the equipment required to replace the aging CCTV infrastructure was readily available. Members noted that the implications of non-compliance with NHS Protect standards were currently risk-rated as "high" and the risks to staff and patients were rated at the high end of "moderate". The Chief Financial Officer commented upon the need to triangulate the above risks with the CQC action plan and the organisational risk register. Benchmarking data with other Trusts had determined that UHL was not a particular outlier in relation to hospital CCTV equipment.

The Committee Chair queried whether the Executive Team was accepting the existing risks, or whether further mitigating action would be taken. In response, the Director of Corporate and Legal Affairs observed that whilst the LSMS progress report was a regular Audit Committee agenda item, this report and the LCFS report should ideally receive prior consideration by the Executive Team in order to increase Executive ownership and document concerns at the lack of progress.

Resolved – that (A) the Local Security Management Specialist progress report and the associated discussion be noted, and

(B) future iterations of the LSMS and the LCFS reports be scheduled for Executive Team discussion prior to the Audit Committee. **DSR/ CFO**

8/16 LOCAL COUNTER-FRAUD SPECIALIST PROGRESS REPORT

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

9/16 ITEMS FROM INTERNAL AUDIT

9/16/1 Internal Audit Progress Report

Paper H provided an update on progress made against the 2015-16 Internal Audit risk assessment and plan, since the previous Audit Committee in November 2015. The report was taken as read.

Resolved – that the Internal Audit Progress Report be received and noted as paper H.

9/16/2 Internal Audit Review Reports

9/16/2.1 Review of the Implementation of Electronic Patient Records Gateway Actions

Paper I1 detailed Internal Audits review of EPR gateway actions, noting that the EPR project was currently on hold pending NTDA approval. No major issues had been noted and 9 of the 11 actions had been implemented. The remaining 2 actions were reliant upon the Trust receiving NTDA approval. A number of governance observations had been raised in relation to the terms of reference, membership and reporting route for the EPR Programme Board and these were all being implemented. A follow-up review would be arranged once the project was underway. In response to a query from the Committee Chair, it was confirmed that the governance observations would be included in the consolidated list of outstanding and in-progress IA, EA and LCFS actions.

Resolved – that the Internal Audit review of the EPR Gateway Actions (paper I1) and the reasons for this not being allocated a risk rating be noted.

9/16/2.2 Review of Cancelled Operations

Paper I2 detailed Internal Audit's 2015-16 review of cancelled operations. The report had been rated overall as low risk, with 1 medium and 3 low rated findings. In discussion on this item, Audit Committee members noted that the review had been broadly positive in terms of the processes in place and implementation of the policy. Due to the real-time nature of the processes used, it had been difficult to review relevant documentary evidence and a recommendation had been made in this respect. Also, it had become apparent that there was no policy covering cancellations before the day of surgery and the Deputy Director of Operations had agreed to rectify this.

Resolved – that the Internal Audit review of cancelled operations (paper I2) and the arrangements for preparing a policy to cover cancelled operations prior to the day of surgery be noted.

9/16/2.3 Financial Systems Review

Paper I3 detailed Internal Audit's 2015-16 review of financial systems which had focused on the following areas:-

(a) purchase to pay process – rated overall as low risk, with 2 medium rated findings. In discussion on the report, members agreed that the overall rating felt more like a medium risk, but assurance was provided that the medium rated findings all had short timescales for resolution and would be achieved by the end of January 2016. The Financial Controller briefed the Committee on improvements to the automated payments process for matching invoices to the appropriate purchase order and goods receipt notes. An effectiveness review had been completed in respect of the finance function and recruitment to key posts would now continue, alongside an enhanced focus on staff training, culture and behaviours. In response to a query raised by External Audit, it was confirmed that the review period for transactions had been April 2014 to October 2015. A progress report on the implementation of the review findings was requested for the March 2016 Audit Committee; **CFO**

(b) agency staffing invoice process – rated overall as medium risk, with 2 medium rated findings, 1 low rated finding, and 1 advisory finding. The areas identified for improvement were considered to be "teething issues" linked to evidencing the new controls process for processing agency invoices, and

(c) overseas patient income – rated overall as low risk, with 1 medium rated finding and 2 low risk findings. The review had replicated the 2014-15 review and found that the new database for overseas visitors had improved the recording of patient data. Confirmation was provided that a candidate had been offered the post of OSV Assistant Manager.

Resolved – that (A) the Internal Audit review of financial systems be received and noted, and

(B) a progress report on the implementation of the purchase to pay review findings be provided to the Audit Committee in March 2016. **CFO**

9/16/2.4 Review of IT General Controls

Paper I4 detailed Internal Audit's 2015-16 review of IT general controls. The review was carried out annually and little had changed since the previous year. The report had been rated overall as low risk, with no medium and 2 low rated findings. In discussion, Audit Committee members noted that the issue with password complexity would not be addressed until the next upgrade of the Cedar e-financial system. However, the Chief Financial Officer queried whether the Trust would still be using Cedar at that point in time pending a review of the available alternatives.

Resolved – that the Internal Audit review of IT general controls be received and

noted as paper I4.

10/16 ITEMS FROM EXTERNAL AUDIT

10/16/1 External Audit Progress Report

Paper J provided an update on progress made against the 2015-16 External Audit risk assessment and plan, since the previous Audit Committee in November 2015. Members noted that the audit opinion for Leicester Hospitals Charity would be presented to the March 2016 Audit Committee meeting. **EA**

Resolved – that (A) the external audit progress report be received and noted as paper J, and

(B) the Audit Opinion for Leicester Hospitals Charity be presented to the 3 March 2016 Audit Committee. **EA**

10/16/2 Final External Audit Plan for 2015-16

Paper K set out the 2015-16 External Audit plan and audit fee for 2015-16. According to the Audit Commission's Code of Audit Practice, External Auditors were required to review and report on:-

- financial statements (including the Annual Governance Statement): providing an opinion on the Trust's accounts, and
- use of resources: concluding on the arrangements in place for securing economy, efficiency and effectiveness in the Trust's use of resources (the value for money (VFM) conclusion).

Key risks would include the revaluation of property, plant and equipment and revenue recognition. Additional work would also be required to restate the 2014-15 accounts in accordance with FRS 102. The timeframes for UHL's production of the Annual Report and the Quality Account would be key. Members were reminded of the arrangements for Auditor independence and the appropriate disclosure of payments for non-audit services. In further discussion on the report, Audit Committee members noted that:-

(a) the risks relating to revenue recognition were high level and were generally acknowledged nationally within the healthcare sector;
(b) the impact of any contractual arrangements with Interserve Facilities Management would be another key consideration at the year end, although this would be supported by robust documentation;
(c) the final VFM opinion would be restrained by the formal wording requirements of the audit framework and (given the on-going deficit position) was likely to again be unfavourable, however, there was scope in the supporting paragraphs and in the ISA 260 report to provide a more balanced view of the Trust's progress in this area, and
(d) arrangements would be made for Ms S Cordon, Senior Manager, KPMG to provide a presentation on the Trust's Quality Account to a future Audit Committee (or a suitable alternative forum, probably QAC). **EA**

Resolved – that (A) the External Audit Plan 2015-16 be received and noted, and

(B) an External Audit presentation on the Trust's Quality Account be provided to a future Audit Committee meeting (or alternative forum, probably QAC). **EA**

11/16 FINANCE – STRATEGIC AND OPERATIONAL ISSUES

11/16/1 Discretionary Procurement Actions (November to December 2015)

Paper L listed the discretionary procurement actions for the period November to

December 2015 in accordance with the Trust's Standing Orders. In discussion on the report, Audit Committee members:-

(a) noted the smaller than usual number of entries (4) and queried whether the report had captured all of the exceptions for the above period;
(b) queried whether there might be any conflict of interest between the roles of procurement lead and approver, noting that the same person had carried out both roles in 3 of the 4 cases, and
(c) requested that more explicit reasons for discretionary actions be provided within the "explanation for approval" column in future iterations of the report. **CFO**

In response, the Chief Financial Officer undertook to seek additional assurance from the Head of Procurement and supplies and arrange for some sampling to be undertaken to ensure that all discretionary procurement actions were being captured and reported. He confirmed that the joint roles of procurement lead and approver were compliant with Standing Orders, but he agreed to review this to ensure that no conflicts of interest had arisen. **CFO** **CFO**

<u>Resolved</u> – that (A) the discretionary procurement actions report (November to December 2015) be received and noted, and

(B) the Chief Financial Officer be requested to provide a further report to the March 2016 Audit Committee to include:-

- **additional assurance that all discretionary procurement actions were being captured** **CFO**
- **clarity surrounding the roles of procurement lead and approver, and** **CFO**
- **more explicit explanations of the reasons for approval.** **CFO**

11/16/2 <u>Review of Risks and Controls Around Financial Management</u>

The Chief Financial Officer introduced paper M providing a briefing note on the current risks, controls and governance arrangements to support the Audit Committee in its role in ensuring that there was appropriate control over the Trust's financial position (as per the Committee's Terms of Reference).

The Committee Chair invited members to comment on the report and suggest any additional elements which might be required. The Director of Corporate and Legal Affairs queried whether future reports could be structured to reflect upon partnerships and informed decision making and he highlighted opportunities to revise the presentational format. Members agreed that a formal report would be provided to the Audit Committee on an annual basis, during the summer period (once the annual plan and patient care contract had been finalised). In addition, a discussion would be held at each Audit Committee meeting to ensure that progress was on track.

<u>Resolved</u> – that (A) the Review of Risks and Controls around Financial Management be received and noted, and

(B) further reports be scheduled on the Audit Committee agenda for 7 July 2016 and annually thereafter. **CFO**

11/16/3 <u>Review of Any Proposed Changes to Prime Financial Policies and Accounting Policies</u>

The Financial Controller introduced paper N, briefing the Committee on the Trust's compliance with the Department of Health Group Manual for Accounts (MFA) and advising that no material changes to the accounting policies for 2015-16 were expected. Audit Committee members commented upon future changes that might be required to reflect the Pharmacy in-sourced subsidiary and the revised configuration of UHL's estate. Mr A Johnson, Non-Executive Director sought and received assurance that all of UHL's policies were compliant with NHS and FRS requirements.

Resolved – that the review of proposed changes to prime financial and accounting policies be received and noted.

12/16 GOVERNANCE

12/16/1 Review of Whistleblowing Arrangements

Paper O from the Director of Corporate and Legal Affairs advised the Audit Committee of the current arrangements and impending changes in the light of the planned promulgation of a new National Whistleblowing Policy by Monitor, the NTDA and NHS England. Audit Committee members noted that regular reports on this subject were provided to the Executive Quality Board, Quality Assurance Committee and Commissioners (via the Clinical Quality Review Group).

In discussion on the proposals, members noted the proposal to appoint a local whistleblowing guardian and commented upon the scale of the remit and the importance of robust detailed guidance to support this role. The Director of Corporate and Legal Affairs drew members' attention to the preparations for UHL's next formal CQC inspection and the fact that the Board would be requested to sign-off a self-assessment which would include evidence of robust whistleblowing arrangements.

In response to a query from Mr A Johnson, Non-Executive Director, regarding the level of incidence of whistleblowing at UHL, it was noted that this level of detail was considered by the Quality Assurance Committee and that the next such report was scheduled for the end of January 2016.

Resolved – that the briefing note on Whistleblowing arrangements be received and noted.

12/16/2 Self-Assessment of the Audit Committee's Effectiveness and Annual Review of Terms of Reference

Paper P from the Director of Corporate and Legal Affairs set out the proposed arrangements for undertaking the above self-assessment and invited the Committee's views on taking forward this initiative. The Committee Chair advised that initial discussions had been held with Internal Audit on the proposals and it had been agreed that it would be useful to use the NHS Audit Committee guidance checklists as a starting point for this exercise. The outputs would then be collated by Internal Audit and a self-assessment session (facilitated by Internal Audit) would be held prior to the 3 March 2016 meeting of the Audit Committee. The arrangements for this self-assessment session would be finalised by the Director of Corporate and Legal Affairs and the Committee Chair outside the meeting.

Resolved – that (A) the proposed arrangements for undertaking a self-assessment of the Audit Committee's effectiveness be received and noted, and

(B) arrangements for a facilitated session on the Audit Committee's self-assessment process be finalised by the Director of Corporate and Legal Affairs and the Committee Chair (outside the meeting).

12/16/3 Consolidated List of Outstanding Actions from Internal Audit, External Audit and Local Counter-Fraud Audit Reports

Paper Q from the Director of Corporate and Legal Affairs advised the Audit Committee of progress against outstanding actions from Internal Audit, External Audit, and Local Counter-Fraud Specialist reports. UHL's Executive Performance Board (EPB) had received an earlier iteration of this report on 15 December 2015, but since then a significant number of recommendations had become overdue on 31 December 2015. The Director of Corporate and Legal Affairs recorded his appreciation to the Senior Trust Administrator for producing this updated report and assurance was provided that

the Senior Trust Administrator would be liaising with the relevant lead officers prior to compiling the report for the 26 January 2016 EPB meeting.

On 15 December 2015, EPB members had requested that a warning system be implemented to advise the risk owners of the impending due dates and the Senior Trust Administrator had been requested to explore this option with Internal Audit. However, Internal Audit representatives advised that automated email reminders were already sent to the relevant lead officers 30 days before the due date.

Particular discussion took place regarding the challenges relating to submission of sufficient evidence to close the outstanding actions and the need to finalise the response to actions arising from the review of Empath governance arrangements (some of which had become obsolete). A suggestion was made that (in future years) consideration could be given to providing an earlier date for December deadlines (eg 21 December instead of 31 December), recognising the impact of the Christmas holiday periods.

Resolved – that (A) the report of outstanding actions from Internal Audit, External Audit and Local Counter-Fraud reports be noted;

(B) the Senior Trust Administrator be requested to liaise with the relevant lead officers prior to compiling the report for the 26 January 2016 EPB meeting; **STA**

(C) Internal Audit explore the scope to strengthen the automated process for alerting the relevant lead officers to the expiry date for outstanding recommendations, and **IA**

(D) Internal Audit be requested to consider using an earlier date for December deadlines in future years. **IA**

13/16 ITEMS FOR INFORMATION

13/16/1 Pharmacy In-Sourced Subsidiary – Appointment of External Advisors

Paper R informed Audit Committee members of the arrangements to appoint KPMG as the financial and tax advisors for the Pharmacy Subsidiary following a competitive procurement process.

Resolved – that the appointment of KPMG as the financial and tax advisors for the Pharmacy Subsidiary be noted.

13/16/2 Reconfiguration Governance Structure

Further to Minute 78/15 of 5 November 2015, paper S provided a copy of the updated Reconfiguration governance.

Resolved – that the revised Reconfiguration Governance Structure be received and noted for information.

14/16 ASSURANCE GAINED FROM THE BELOW COMMITTEES ON KEY RISKS/ISSUES OF THE TRUST

14/16/1 Quality Assurance Committee

Resolved – that the Quality Assurance Committee Minutes from 29 October, 26 November and 17 December 2015 (papers T1, T2 and T3) be received and noted.

14/16/2 Integrated Finance, Performance and Investment Committee

Resolved – that the Integrated Finance, Performance and Investment Committee

Minutes from 29 October, 26 November and 17 December 2015 (papers U1 – U3) be received and noted.

14/16/3 Charitable Funds Committee

Resolved – that the next Charitable Funds Committee meeting be held on 4 February 2016.

15/16 ANY OTHER BUSINESS

Resolved – that no items of additional business were noted.

16/16 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:- **AC CHAIR**

- **Minute 4/16 – Clinical Quality Assurance Process;**
- **Minute 7/16 – Local Security Management Specialist report and the need to increase Executive Team awareness of the relevant issues;**
- **Minute 12/16/2 – relating to the proposals for self-assessment of the Audit Committee's effectiveness, and**
- **Minute 12/16/3 – relating to outstanding Internal Audit, External Audit and Counter Fraud recommendations.**

17/16 DATE OF NEXT MEETING

Resolved – that the next meeting be held on Thursday 3 March 2016 (following the Trust Board meeting on that date) in the C J Bond room, in the Clinical Education Centre at the Leicester Royal Infirmary.

The meeting closed at 5:20pm

Kate Rayns
Trust Administrator

Cumulative Record of Members' Attendance (2015-16 to date):

Name	Possible	Actual	% attendance
Mr R Moore (Chair)	4	4	100%
I Crowe	4	3	75%
S Dauncey	4	4	100%

Attendees

Name	Possible	Actual	% attendance
J Adler	4	2	50%
A Johnson	2	2	100%
N Sone	4	4	100%
S Ward	4	4	100%
M Traynor	4	4	100%
P Traynor	4	4	100%
J Wilson	3	2	67%