University Hospitals of Leicester NHS
NHS Trust

Trust Board paper R

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 6 April 2017

COMMITTEE: **Audit Committee**

CHAIR: **Mr R Moore, Non-Executive Director**

DATE OF COMMITTEE MEETING: **2 March 2017**

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

- **None**

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

- **Minute 20/17/1 – review of the Emergency Floor project risk assessment;**
- **Minute 22/17/2 – the 3 completed Internal Audit reviews (all medium risk);**
- **Minute 23/17/2 – External Audit review of elective waiting list management, and**
- **Minute 25/17/7 – new NHS England Guidance on Managing Conflicts of Interest.**

DATE OF NEXT COMMITTEE MEETING: 24 May 2017

Mr R Moore
Non-Executive Director and Committee Chair

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE AUDIT COMMITTEE HELD ON THURSDAY 2 MARCH 2017 AT 2PM IN SEMINAR ROOMS A & B, EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Present:
Mr R Moore – Non-Executive Director (Chair)
Dr S Crawshaw – Non-Executive Director (up to and including Minute 23/17/2)
Colonel (Retired) I Crowe – Non-Executive Director
Mr A Johnson – Non-Executive Director
Mr B Patel – Non-Executive Director

In Attendance:
Mr C Benham – Director of Operational Finance
Mr C Carr – Head of Performance and Improvement (for Minute 23/17/2)
Mr J Clarke – Chief Information Officer (for Minute 20/17/2)
Ms J Edyvean – Emergency Floor Project Manager (for Minute 20/17/1)
Ms S Hotson – Director of Clinical Quality (for Minute 20/17/3)
Mr D Kerr – Director of Estates and Facilities (for Minutes 22/17/2.2, 22/17/2.3 and 25/17/3)
Mr R Manton – Risk and Assurance Manager (for Minutes 25/17/1 and 25/17/2)
Mr R Mitchell – Chief Operating Officer (for Minute 20/17/1)
Mrs K Rayns – Trust Administrator
Mr E Robson – Head of Privacy
Mr N Sone – Financial Controller
Mr P Traynor – Chief Financial Officer
Mr C Walker – Clinical Audit Manager
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Webster – Head of Estates Transformation and Property (for Minutes 22/17/2.2, 22/17/2.3 and 25/17/3)

Ms G Lekh – Local Counter Fraud Specialist, PwC (for Minutes 21/17/1 and 21/17/2)

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

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

ACTION

RECOMMENDED ITEM

16/17 **Recommended – that this Minute be classed as confidential and taken in private accordingly.**

RESOLVED ITEMS

17/17 APOLOGIES

Resolved – that apologies for absence be noted from Ms A Breadon, Head of Internal Audit and Mr M Traynor, Non-Executive Director.

18/17 MINUTES

Resolved – that the Minutes of the meeting held on 5 January 2017 (papers A1 and A2) be confirmed as correct records.

19/17 MATTERS ARISING PROGRESS REPORT

The Audit Committee received and noted paper B, advising on progress of the actions and matters arising from previous Audit Committee meetings. Particular discussion took place regarding progress of the following entries:-

(a) Items 15 and 27 – Minutes 8/17/3(d) of 5 January 2017 and 85/16/2(c) of 3 November 2016

The Director of Operational Finance briefed the Committee on the Trust's validation work undertaken in respect of 2 graphs provided by External Audit following their review of Payroll Diagnostics. These graphs illustrated the total amount paid to employees per month where the payment date was after their leaving date. Following discussion with UHL's Payroll Manager, it had transpired that the data had been based upon employee assignment numbers leaving the ESR system (instead of individual post reference numbers). In some cases, a single employee might hold multiple posts within the Trust. In addition, the data did not take account of junior doctor rotations outside of the Trust, where it was usual practice to retain their assignment numbers in preparation for their next rotation within UHL. The Committee Chair accepted this explanation (in part), but suggested that it did not fully account for the level of growth indicated by the 2 graphs. He requested that a concise summary of the factors affecting the data trends be submitted to the May 2017 Audit Committee, and **CFO**

(b) Item 17 – Minute 9/17/4(b) of 5 January 2017

The Director of Corporate and Legal Affairs and the Chief Financial Officer confirmed that they had discussed the extent to which the Trust might be required to share information about overseas visitors with other agencies, advising that the Trust might be required to share information relating to the prevention of crime, if it was deemed to be in the public interest to do so. The Trust would not be sharing any detailed clinical or personal information with other parties, although some high level data matching would be undertaken by the Department of Health as part of the pilot.

<u>Resolved</u> – that the matters arising report and the associated actions be received and noted. **CFO**

20/17 KEY ISSUES

20/17/1 <u>Review of the Emergency Floor Project Risk Assessment</u>

The Chief Operating Officer and the Emergency Floor Project Manager attended the meeting to introduce paper C, providing an overview of progress with the Emergency Floor Project and detailing the current risks, issues and steps being taken to learn from Phase I of the project in order to inform the second phase of this scheme and other UHL reconfiguration projects. A revised scheme of delegation for the Reconfiguration Board was provided at appendix A. As discussed at the Trust Board meeting earlier that morning, there were now 55 days left before the new facility opened on 26 April 2017. Assurance was provided that appropriate governance arrangements were in place and that the project risks relating to operational commissioning were reducing. The main residual risks related to:-

(a) the volume of inflow – emergency attendances were predicted to increase from day 1, but the Trust now had a fair contract in place which would ensure that appropriate income was received for the emergency care activity delivered;
(b) functionality of the new department and maintaining staff mindset and morale – good stewardship and governance arrangements were in place to monitor progress over the next 55 days, and
(c) maintaining patient outflow to enable the department to work effectively and provide high quality patient care – in the short term, there would be some reduced bed capacity when the EDU was relocated onto Ward 7, but there were plans in place to reduce elective activity to maintain the patient flows.

Discussion took place regarding the post project evaluation and whether this would be commissioned externally and the Chief Financial Officer voiced his view that an

internally generated lessons learned review would also be helpful. One of the lessons learned related to the overly-optimistic timeframe between handover and opening of the ED. Colonel (Retired) I Crowe, Non-Executive Director advised that his involvement as a nominated Non-Executive Director representative on the Project Board had been viewed favourably within the Gateway Review, and he raised the following comments relating to the project:-

(i) a suggestion that a benefits realisation review be undertaken against the original business case. In response, the Chief Operating Officer noted some significant changes in scope since the business case had been developed, particularly in respect of demand management measures;
(ii) one of the biggest operational challenges would be to apply the new Standard Operating Procedures (SOPs) and to flexibly adapt them if they were found not to be effective in practice, and
(iii) there were some significant challenges associated with busy staff trying to deliver the project whilst carrying out their day-to-day duties. A temporary hold on annual leave might be required to roll out the staff training and familiarisation processes ahead of the opening date.

Mr B Patel, Non-Executive Director raised concerns regarding the traffic flows to the new ED entrance and whether arrangements were in hand to factor in human behaviours relating to the change in environment for vehicular and pedestrian access. The Chief Financial Officer confirmed that if any changes were required to the project in terms of clinical space, technology or traffic flows, then a process was in place to apply for additional capital via the Capital Monitoring and Investment Committee and/or the Integrated Finance, Performance and Investment Committee. The Project Manager also highlighted that the new ED entrance was closer to the new patient and visitor multi-storey car park and she provided assurance that UHL's Patient Partners were engaged in reviewing the access arrangements, way finding and equality impact assessment. In addition, the Trust was exploring the provision of some short-stay car parking for use as a drop-off facility. Assurance was provided that the ambulance service was fully engaged in the plans and that arrangements would be made for a 'soft' divert during the actual handover phase.

The Audit Committee Chair sought and received additional information in respect of the available evidence to support the governance controls, achievement of value for money in the delivery of the built asset, information about the author of the external desktop review (provided at appendix B) and progress of the IM&T solution in the absence of an approved Electronic Patient Record scheme. In response, members noted the robust controls in place via the Project Board and the Reconfiguration Board which reviewed the project highlight reports and change control reports on a regular basis. Assurance was provided that value-engineering was being delivered under the scheme, whilst recognising that the value for money aspects were harder to evidence. It was noted that the external party who had produced the desktop review had been recommended to the Trust and their profile had been reviewed by the Project Board, prior to the review being commissioned.

Finally, a discussion took place regarding the risks relating to patient inflow and outflow, whether the Trust was mitigating these risks as far as possible, and what further actions could be taken. In response, the Chief Operating Officer commented upon the work required to balance demand and capacity within the wider LLR health economy, advising that further reports were scheduled for consideration at the 9 March 2017 Trust Board thinking day, and 14 March 2017 Executive Strategy Board meeting. **COO**

<u>Resolved</u> – that (A) the update on the Emergency Floor Project (paper C) and the subsequent discussion on this item be received and noted, and

(B) discussion on the requirement to balance demand and capacity within the **COO**

wider LLR health economy be scheduled on the agenda for the March 2017 Trust Board thinking day and Executive Strategy Board meeting.

20/17/2 Confidential Report by the Chief Information Officer

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

20/17/3 Clinical Audit – Annual Review of Systems and Processes

Further to Minute 76/15 of 5 November 2015, the Director of Clinical Quality and the Clinical Audit Manager attended the meeting to introduce paper E, detailing the annual review of UHL's clinical audit systems and processes and the strategy going forward to support UHL's Caring at its Best 5-year plan. The Audit Committee had also considered the findings of the Internal Audit Review of the Clinical Audit Programme on 3 November 2016 (Minute 84.16/2.2 refers) and paper E also addressed the key outputs of that discussion. During consideration of this item, the Audit Committee:-

(a) commended the success of the UHL Clinical Audit Improvement Awards (as detailed in appendices 2a and 2b) in raising the profile of clinical audit, noting the support provided by Colonel (Retired) I Crowe, Non-Executive Director in judging these awards, and commenting upon the scope to raise the profile of these awards on a regional or a national level;
(b) queried the amount of time spent discussing clinical audit related issues at CMG Board meetings. In discussion on this point, the Clinical Audit Manager agreed to review this issue and he requested sight of the Internal Audit Review of Governance and Risk Management which had focused upon the effective operation of the CMG Board meetings and Quality and Safety meetings; **CAM** **IA**
(c) sought and received assurance that a systematic approach was used in planning the Clinical Audit Programme and that a robust prioritisation process was in place;
(d) commented upon the need for Consultants to include evidence of participation in clinical audits within their integrated portfolios to inform the revalidation process, and
(e) received assurance that all outstanding audit action plans were monitored and that completed audit findings were reviewed to ensure that any changes to practice were implemented.

Resolved – that (A) the annual review of Clinical Audit systems and processes be received and noted as paper E;

(B) Internal Audit be requested to forward a copy of the report arising from the Internal Audit Review of Governance and Risk Management to the Clinical Audit Manager, and **IA**

(C) the Clinical Audit Manager be requested to review the arrangements for consideration of Clinical Audit related issues at CMG Board meetings and Quality and Safety meetings. **CAM**

21/17 ITEMS FROM THE LOCAL COUNTER FRAUD SPECIALIST (LCFS)

21/17/1 Local Counter Fraud Progress Report

Ms G Lekh, Local Counter Fraud Specialist, PwC attended the meeting to present paper G providing a summary of progress against the 2016-17 Local Counter Fraud Plan, a brief summary of referrals received and details of the alerts and publications shared with the Trust. The staff fraud and corruption awareness survey was currently live and was due to close in the middle of March 2017. The results would then be

presented to the May 2017 Audit Committee. Noting that there was no UHL prior-year data to measure performance against, members requested that some comparison data be included to measure current performance against other peer group Trusts. **LCFS**

The target to deliver 4 fraud awareness workshops had not yet been achieved, as the target staff groups were expected to be identified once the draft Fraud Risk Assessment had been finalised. A summary of the ongoing 'Prevent and Deter' workstreams was provided on page 5 of paper G, and a decision was awaited from UHL on the selection of 3 policies and/or codes of conduct which were to be reviewed to ensure that they were aligned with the strategic guidance provided by NHS Protect. A schedule of regular staff communications was currently being agreed with Mr P Millington, Communications Officer, but assurance was provided that the Communications Team had completed all urgent and routine staff messages appropriately to date. The NHS Anti-Fraud Standards Self Review Tool (SRT) had been reviewed internally and was on schedule for submission by the 31 March 2017 deadline.

In discussion on the report, the Audit Committee Chair queried the reasons for the delay in finalising UHL's Fraud Risk Assessment, noting in response that additional input was currently awaited in respect of the risk scores. The Chief Financial Officer commented upon the need to maintain momentum with the Fraud Risk Group and it was agreed that the draft Fraud Risk Assessment would be circulated to enable the risk ratings to be finalised prior to the May 2017 Audit Committee. **LCFS**

<u>Resolved</u> – that (A) the Local Counter Fraud Specialist progress report be received and noted as paper G;

(B) feedback from the staff fraud and corruption awareness survey be presented to the May 2017 Audit Committee, alongside national benchmarking data, and **LCFS**

(C) the Local Counter Fraud Specialist be requested to circulate the draft Fraud Risk Assessment and establish the risk ratings ahead of the May 2017 Audit Committee meeting. **LCFS**

21/17/2 <u>Local Counter Fraud Annual Workplan 2017-18</u>

Paper H provided the draft Local Counter Fraud Workplan for 2017-18 which was consistent with the NHS Anti-Fraud Standards and the outputs of the UHL Fraud Risk Group. Appendix B provided some suggested examples of proactive exercises which could be undertaken in addition to the main workplan. However, these suggestions might change once the Fraud Risk Assessment was finalised and it was agreed that any revised proposals for proactive exercises would be considered and agreed at the May 2017 Audit Committee meeting. **CFO/ LCFS**

The Chief Financial Officer commented upon the level of organisational support and engagement required in order to make best use of Local Counter Fraud resources. He suggested that the following key interfaces be clarified and confirmed at the May 2017 Audit Committee:- **CFO/ LCFS**

(a) the required meeting frequency for the Fraud Risk Group;
(b) arrangements for regular and ad-hoc staff communications relating to fraud awareness information;
(c) interface with the Human Resources Directorate and opportunities for accessing induction training sessions, and
(d) appropriate discussion time at the Tuesday afternoon Executive Board meetings (with the CMG Clinical Directors present).

Resolved – that (A) the draft Local Counter Fraud Annual Workplan for 2017-18 be approved, subject to the suggested proactive developments (as detailed in appendix B) being refreshed in line with the finalised UHL Fraud Risk Assessment, and **CFO/ LCFS**

(B) the interfaces between the Local Counter Fraud Specialist and the Fraud Risk Group, Communications Team, HR Directorate and Executive Board meetings be clarified and reported to the May 2017 Audit Committee. **CFO/ LCFS**

21/17/3 Confidential Report by the Chief Financial Officer

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

22/17 ITEMS FROM INTERNAL AUDIT

22/17/1 Internal Audit Progress Report

Paper I provided an update on the work of Internal Audit since the January 2017 Audit Committee, advising that 3 final reports had been issued (as detailed below under Minute 21/17/2). The report also advised that fieldwork had been carried out in respect of the reviews of the Quality Commitment, Data Quality and Debtors. The latter review reflected an amendment to the 2016-17 Internal Audit Plan, following discussion at the January 2017 Audit Committee meeting. This review would also encompass salary overpayments and would utilise 15 days of the contingency resources. Terms of reference had now been agreed for the review of Internal Audit review of Recruitment.

Resolved – that (A) the Internal Audit Progress Report (paper I) be received and noted, and

(B) the amendment to the 2016-17 Internal Audit Plan to allocate 15 days of contingency Internal Audit resource to a review of Debtors be approved. **IA**

22/17/2 Internal Audit Reviews

Internal Audit introduced paper J1 providing an overview of the final reports issued for the reviews of Information Governance Toolkit Phase 2 (medium risk rating), Statutory Compliance of the Estate (medium risk rating) and the Facilities Management Transition from Interserve (medium risk rating). Discussion on these reviews took place under Minutes 21/17/2.1 to 21/17/2.3 below (respectively).

Resolved – that the Executive overview of the 3 completed Internal Audit reviews be received and noted as paper J1.

22/17/2.1 Information Governance Toolkit – Phase 2 (Medium Risk)

Paper J2 detailed the findings of the Internal Audit review of 10 selected requirements from the Information Governance Toolkit (out of the 45 requirements listed). Mr E Robson, Head of Privacy attended the meeting for this item. The Audit Committee noted that Internal Audit had supported the Trust's self-assessment for 8 of the 10 requirements, but there had been insufficient evidence uploaded onto the toolkit to support the self-assessment for the following 2 requirements, at the time of the fieldwork being conducted:-

- requirement 205 – appropriate procedures for recognising and responding to individuals' requests for access to their personal data, and
- requirement 314 – policy and procedures to ensure that mobile computing and teleworking are secure.

The Head of Privacy provided the Committee with assurance that additional evidence had since been uploaded onto the system and that the Trust had recently appointed a new Privacy Officer. He reported verbally on the key risks surrounding the following requirements:-

(a) requirement 112 – the Trust was required to evidence that 95% of staff had completed their mandatory Information Governance (IG) training to achieve level 2 compliance. Current performance had increased to 81% (from 77%) and further work was taking place to support staff from the Estates and Facilities Directorate, where large numbers of staff had transferred to UHL from Interserve and had not yet completed this training package;
(b) requirement 205 – the Trust's policies, procedures and guidance surrounding access to health records were scheduled to be updated in line with forthcoming changes in legislation and the Trust was expected to reach level 2 compliance before the final submission date of 31 March 2017, and
(c) requirement 308 – a project was underway to address the actions required to improve compliance with dataflow mapping. Appropriate processes and procedures were in place, but the relevant Policy was still being developed with IBM and the Trust was unlikely to achieve level 2 compliance by 31 March 2017.

Internal Audit briefed the Committee on expected changes to the Information Governance Toolkit which were likely to take effect in May 2018 and the Head of Privacy suggested that UHL would be more able to comply with the new requirements which would take the form of a single document rather than a requirement to submit approximately 300 separate pieces of supporting evidence.

The Director of Corporate and Legal Affairs welcomed this Internal Audit review and the level of rigour and visibility that it represented. He advised that the Executive IM&T Board had reviewed IG training compliance on 28 February 2017 and that a further report was scheduled for consideration at the Executive Quality Board meeting on 7 March 2017. The final version of the Information Governance self-assessment would be presented to the Information Governance Steering Group for approval, prior to submission by the end of 31 March 2017. It was agreed that the outcome would also be reported to the Audit Committee on 24 May 2017.

<u>Resolved</u> – that (A) the Internal Audit review of the Information Governance Toolkit Phase 2 be received and noted as paper J2, and

(B) a report on the final Information Governance Toolkit self-assessment submission be presented to the Audit Committee on 24 May 2017. **DCLA/ HP**

22/17/2.2 <u>Statutory Compliance of the Estate (Medium Risk)</u>

Paper J3 detailed the findings of the Internal Audit review of UHL's Management of Statutory Compliance of the Estate across the 8 key areas (water safety, fire, control of contractors, electrical safety, asbestos, health and safety, lifts and gas). The review had focused upon the arrangements for monitoring, reporting and resolution of non-compliant areas. The Director of Estates and Facilities and the Head of Estates Transformation and Property attended the meeting for this item.

Internal Audit confirmed that the Compliance and Assurance Team was sufficiently experienced and that the new job roles were being clarified within the updated team structure. The key findings and areas identified for improvement arising from the review were outlined as follows:-

(a) strengthening the reporting arrangements on statutory compliance to increase the organisational transparency (via the Executive Quality Board and the Quality Assurance Board);

(b) clarifying the roles of the groups and Committees which considered the key issues relating to statutory compliance (eg the Water Safety Group and the Fire Committee);
(c) opportunities to use the Compliance Assessment and Analysis System (CAAS) tool more effectively and link it with the action plans;
(d) recommencement of the verification audits to ensure that compliance was independently checked across all areas, and
(e) development of formalised procedures for dealing with any areas of non-compliance.

The Director of Estates and Facilities advised that the action plan which had been prepared in response to the Internal Audit Review was provided in an appendix to a separate report on the backlog maintenance and statutory compliance elements of Principal Risk 2 which featured later in the agenda (paper T and Minute 25/17/3 below refer).

Resolved – that the Internal Audit review of Statutory Compliance of the Estate be received and noted as paper J3.

22/17/2.3 Facilities Management Transition from Interserve (Medium Risk)

Paper J4 detailed the findings of the Internal Audit review of UHL's cash management processes and controls following the transition of Facilities Management services from Interserve to UHL on 30 April 2016. The Director of Estates and Facilities and the Head of Estates Transformation and Property attended the meeting for this item.

A mapping exercise had been undertaken of all income sources that had come back under the Trust's control following the Interserve transition and a specific focus had been agreed in relation to cash management across the car parks and retail premises at the 3 hospital sites. In addition, the Director of Estates and Facilities had requested a high level review of the monitoring and governance arrangements surrounding a number of corporate credit cards.

Assurance was provided that there were clear and well-defined processes in place from the physical cash collection, through to recording of cash receipts in the financial ledger, records were comprehensive and easily auditable and adequate checks were in place over the accuracy of the cash collected through the matching of receipts. However, there was currently an over-reliance upon the experience and knowledge of key staff and formal policies and procedures needed to be put in place to address this. Investigations of any discrepancies over the threshold of £2.50 between till receipts and cash collected also needed to be clearly documented. An action plan had been developed to respond to the findings of the review, and the Audit Committee noted that:-

(a) the Procurement team was now arranging for the inclusion of specialist dietary product suppliers within the procurement framework, to reduce the reliance upon corporate credit cards in this area;
(b) a member of the Security Team would accompany all retail outlet cash collections (as per the current procedure for car parking machine collections) with immediate effect, and
(c) the Finance Team was making arrangements to increase the monitoring and oversight of vending machine revenue.

Resolved – that the Internal Audit review of cash management processes and controls (following the transition of Facilities Management services from Interserve to UHL) be received and noted as paper J4.

22/17/3 Draft Internal Audit Plan for 2017-18

Internal Audit representatives introduced paper K, setting out the proposed content of the 2017-18 Internal Audit programme of work for discussion purposes. Appendix 1 provided a summary of the Trust's key risks identified on the Board Assurance Framework and highlighted the areas where no Internal Audit work was currently planned for 2017-18. Appendix 2 detailed the Internal Audit risk assessment and highlighted areas which would require a review (in line with the methodology used), but had not been reviewed or included in the draft plan for 2017-18.

The Audit Committee noted that the draft plan had been reviewed by the Executive Team on 28 February 2017 and consideration was being given to including a review of Corporate Planning to include the links between the Better Care Together (BCT) Programme and the Sustainability and Transformation Plan (STP). In addition, the Chief Executive had queried how the Internal Audit Programme would reflect the Trust's refreshed Strategic Objectives and Annual Priorities (as agreed at that morning's Trust Board meeting).

The Chief Financial Officer commented that the Internal Audit resources were limited and it might be necessary to use alternative sources of assurance to address the system wide issues relating to BCT and STP. He recommended that the Audit Committee approved the draft Internal Audit Plan for 2017-18 on the basis that the plan could be adjusted in May 2017 to take account of any minor amendments arising from the revised Strategic Objectives, Annual Priorities and refreshed Board Assurance Framework.

The Audit Committee Chair voiced his concerns regarding the STP governance process and delays in the implementation, noting in response the advice provided by the Director of Corporate and Legal Affairs that significant changes were expected to be made to the LLR STP in relation to the 5 year forward view delivery plan. The Chief Financial Officer commented on the scope to allocate 15 days of Internal Audit resources to this workstream (if required), although he noted that the development of a joint dashboard for the LLR STP was currently being monitored as one of the outstanding Trust Board actions. Following further discussion, it was agreed to consider the following potential reviews for inclusion in the 2017-18 Internal Audit plan:-

- STP governance and the development of a single joint dashboard; **IA**
- alternative solution to the Electronic Patient Record project – this proposal had been supported by the Chief Information Officer, and
- patient discharge – Internal Audit advised that the Chief Operating Officer had not raised any concerns about discharge during their scoping meeting, but they agreed to re-check his views (outside the meeting). **IA**

The Audit Committee supported the draft Internal Audit Programme for 2017-18, subject to any amendments which would be submitted to the 24 May 2017 Audit Committee. In terms of the quarter 1 reviews, it was agreed that the fieldwork would commence in respect of Consultant Job Planning and Emergency Department Dynamic Priority Scores. In respect of the latter review, the Committee sought and received assurance that the timescale of this review would not impact upon the opening of the new Emergency Floor, noting in response that the review would not be particularly obtrusive as it was mainly a paper-based review.

<u>Resolved</u> – that (A) the draft Internal Audit plan for 2017-18 be approved for implementation, subject to a finalised version being presented to the 24 May 2017 Audit Committee; **IA**

(B) Internal Audit to contact the Chief Operating Officer to clarify whether there were any areas of concern surrounding patient discharge which could be built into the Internal Audit plan for 2017-18, and **IA**

(C) consideration be given to including Internal Audit reviews of STP governance, the alternative solution for EPR and patient discharge within the finalised Internal Audit plan for 2017-18. **IA**

23/17 ITEMS FROM EXTERNAL AUDIT

23/17/1 External Audit Progress Report

External Audit presented paper L, advising of the work undertaken since the January 2017 Audit Committee, including preparations for the audit of the Trust's 2016-17 financial statements and meeting with the Director of Clinical Quality to agree the 2 indicators selected for testing within the Quality Account. Such indicators were selected on a cyclical basis and for 2016-17 these would be (a) the rate of clostridium difficile infections and (b) the percentage of patient safety incidents resulting in serious harm or death.

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

23/17/2 Progress Report on the External Audit Review of Elective Waiting List Management

Further to Minute 8/17/4 of 5 January 2017, paper M provided a progress report on the above External Audit review. Mr C Carr, Head of Performance and Improvement attended the meeting for this item. Audit Committee members noted that a series of 8 facilitated workshops had now been held, and that the Trust had identified a total of 129 potential points of failure within the patient pathway from referral through to treatment and discharge. Each of these potential points of failure had been categorised according to whether they related to (H) human error, (I) human error or system deficiency with an interim solution, or (S) issues which could only be mitigated by an intuitive Electronic Patient Record (EPR) solution.

The table on page 4 of paper M set out the number and category of potential failure points within each of the 16 logical patient pathway sub-processes. Each of the 129 points of failure had been risk-assessed and there were found to be no extreme risks, 14 high risks, 81 moderate risks and 34 low risks. A list of the high risk issues was provided on page 5 and appendix A provided a sample page from the 16-page risk register. During the discussion on this item, Audit Committee members:-

(a) expressed concern about lack of controls within the patient pathways, noting that all systems should 'fail to safe' and raise a flag at each stage if something fails to happen within the patient journey;
(b) commented upon the need to update the action plan to include references to the alternative EPR solution, now that the Department of Health had advised that no funding would be made available for the original EPR business case;
(c) requested that the Executive Lead for each workstream be made explicit within the action plan;
(d) requested the Head of Performance and Improvement to liaise with the Risk and Assurance Manager to ensure that the relevant entries on the Trust's risk register were updated in line with the findings of this review, and **HPI**
(e) noted that the draft action plan was scheduled for consideration by the Executive Performance Board on 28 March 2017 and that the finalised version would be presented to the Audit Committee on 24 May 2017.

In summary, External Audit re-iterated that the pro-active nature of the review process had been valuable, and had identified a range of issues which had often been seen at other NHS Trusts. The next steps would be for External Audit to test the mitigation and control measures and the level of assurance provided by the finalised action plan.

Resolved – that (A) the update on progress of the External Audit review of Waiting List Management be received and noted as paper M;

(B) the Head of Performance and Improvement be requested to liaise with the Risk and Assurance Manager to ensure that the relevant entries on the Trust's risk register were updated to reflect the findings of the review, and **HPI**

(C) the action plan relating to the External Audit review of UHL Elective Waiting List Management be presented to the 24 May 2017 Audit Committee. **HPI**

24/17 FINANCE – STRATEGIC AND OPERATIONAL ISSUES

24/17/1 Annual Accounts 2015-16 – Correction to Chief Executive's Remuneration Data

Further to Minute 32/16/1.2 of 25 May 2016, paper N advised of a correction to the 2015-16 Annual Report and Accounts, arising from a recent press report on the salary and pension of UHL's Chief Executive. Key entries in relation to the Chief Executive's taxable expenses had been omitted from the disclosure, which had led to an incorrect disclosure of his 'All Pension Related Benefits' figure.

Audit Committee members noted that the NHS Business Services Authority's Pensions Team had formally apologised for providing the incorrect data to UHL. However, this mistake could have been detected and rectified if the timescale for preparation of the accounts had allowed for thorough 'reasonableness' checking process by Directors and Senior Managers. For the 2016-17 accounts and thereafter, an additional process had been incorporated for each Director and Senior Manager to review and confirm their own pay and pension disclosures (including expenses information) prior to finalisation of the remuneration report. The Remuneration Committee had also considered a report on this issue at the meeting held earlier on 2 March 2017.

Resolved – that the correction to the Chief Executive's remuneration data be received and noted as paper N.

24/17/2 Confidential Report by the Chief Financial Officer

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

24/17/3 Discretionary Procurement Actions

Paper P provided a summary of the 9 occasions when it had been necessary to waive the Trust's regular procurement processes during the period January 2017 to February 2017. Appendix 1 set out the details of each case of need and provided additional explanations for the respective approvals. The Director of Operational Finance highlighted the final entry (17/A/1054) which related to provision of specialised transport for an ECMO patient. In response to a query, he also advised that entry 17/A/1050 related to QS services for the LGH haemodialysis water treatment plant and that the same specialist contractor had undertaken a similar project at the Lincoln haemodialysis unit.

Resolved – that the summary of discretionary procurement actions be received and noted as paper P.

24/17/4 Confidential Report by the Chief Financial Officer

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

25/17 GOVERNANCE

25/17/1 Integrated Risk Management Report (including Board Assurance Framework (BAF) and UHL Risk Register)

Mr R Manton, Risk and Assurance Manager attended the meeting to introduce paper R providing the Board Assurance Framework dashboard for January 2017 (appendix 1 refers) and detailing the significant updates to principal risks 3, 4, 13, 16, and 18. Section 3 of paper R advised that 44 risks scoring 15 and above were recorded on the Trust's risk register and a summary of these were provided in appendix 2. The report also detailed the actions underway to address the findings of the Internal Audit review of Governance and Risk Management Arrangements, the development of a risk and safety summit programme for CMGs, training needs analysis, development of a risk assessment toolkit, and a supplementary in-house training model to support Chairs of the CMG Quality and Safety meetings going forwards.

In discussion on the report, Audit Committee members commented that the full Board Assurance Framework report had been considered at that morning's Trust Board meeting. In respect of principal risk 18 (delay to the approvals for the EPR programme), the Director of Corporate and Legal Affairs advised that the Executive IM&T Board had rejected a proposal to reduce the risk score from 25 to 20. The Committee considered the need for the principal risk 18 entry to be completely refreshed and queried whether the wording of the risk could be changed mid-year. Noting that there was only 1 month left until the first draft of the new Board Assurance Framework, it was agreed that discussion on this point would be held at the 9 March 2017 Trust Board thinking day. **DCLA**

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

(B) further discussion on principal risk 18 be held at the Trust Board thinking day on 9 March 2017. **DCLA**

25/17/2 Audit of UHL's Management of Patient Safety Alert Broadcasts

Paper S provided an overview of the effectiveness of UHL's process to manage Department of Health Central Alerting System (CAS) broadcasts within the Clinical Management Groups. CAS alert performance data was also included within the Trust's Quality and Performance report. An audit of the process had been undertaken in response to scrutiny by the UHL Data Quality Forum in November 2016. Section 7 of paper S detailed a number of recommendations to improve resilience plans and strengthen the record keeping. The CAS policy was being updated and a further review would take place in quarter 3 of 2017-18 to monitor improved consistency with CAS compliance.

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

25/17/3 Principal Risk 2 – Update on Statutory Compliance and Backlog Maintenance Issues

Further to Minute 10/17/2 of 5 January 2017, the Director of Estates and Facilities and the Head of Estates Transformation and Property introduced paper T, providing a comprehensive summary of the arrangements in place for capturing the risks and priorities relating to progression of UHL's backlog maintenance programme and detailing the arrangements in place for managing statutory compliance following the repatriation of Facilities Management Services into the Trust in May 2016. Paper T also included the following 10 detailed appendices:-

(i) examples of backlog risk prioritisation and categories;
(ii) backlog position aligned to the previous Development Control Plans and

modelling of site investment upon the backlog reduction;
(iii) the top 10 Health and Safety Executive enforcement areas;
(iv) examples of NHS Premises Assurance Model (PAM) metrics;
(v) examples of Compliance Assessment and Analysis System (CAAS) fields;
(vi) risk and assurance mapping for water safety;
(vii) findings of the deep dive review of water management arrangements undertaken in January 2017;
(viii) arrangements for water sample testing;
(ix) an extract of the estates and facilities risk register, and
(x) the action plan to respond to the findings of the Internal Audit review of Statutory Compliance of the Estate (Minute 22/17/2.2 above refers).

Table 1 on page 2 of the report set out the costs associated with eradicating the high, significant, moderate and low risk backlog issues for each of the Trust's hospital sites. The combined totals of the high and significant risk items for all 3 sites (£7.039m) had been benchmarked and fell within the lower quartile of the 2015-16 ERIC returns. The report also outlined the further analysis work being undertaken in respect of the potential impact of progress with the Trust's Reconfiguration Programme and restricted availability of national NHS capital. In discussion on the report, the Audit Committee:-

(a) commented on the helpful nature of this comprehensive report;
(b) noted the intention to re-fresh the data based on the 2017 Development Control Plans;
(c) received additional information about the rate at which the currently low levels of backlog risk might translate into critical risks in the future;
(d) sought and received additional information in relation to the prioritisation of the higher value items scoring a risk of 5 (eg low voltage switchgear, drainage systems, fire doors, etc);
(e) supported the 5 x 4 matrix approach to ensure that a consistent approach was applied within the risk scoring mechanism;
(f) agreed that a summary of the backlog maintenance and statutory compliance programme for 2017-18 would be presented to the Executive Quality Board and the Integrated Finance, Performance and Investment Committee once the capital allocations were known for the new financial year; **DEF**
(g) noted that Premises Assurance Model (PAM) dashboard would be submitted to the Trust Board for sign-off and then embedded into UHL's Quality and Performance governance process going forwards; **DEF**
(h) received assurance that the Water Safety Group and the Fire Committee reported through to the UHL Health and Safety Committee and that all other groups reported to the Quality Assurance Committee (via the Executive Quality Board).

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

(B) a summary of the backlog maintenance and statutory compliance programme for 2017-18 be presented to the EQB and IFPIC meetings (once the capital allocations were confirmed), and **DEF**

(C) the Premises Assurance Model (PAM) dashboard be submitted to the Trust Board for sign-off and then embedded into the Quality and Performance report going forwards. **DEF**

25/17/4 <u>Draft Annual Governance Statement 2016-17</u>

The Director of Corporate and Legal Affairs introduced paper U, setting out the proposed process for preparation of the Annual Governance Statement and suggesting a range of internal control issues or gaps in control for inclusion in the 2016-17 statement (as listed in section 4 of paper U). No comments were raised on the matters identified and there were no additional suggestions for inclusion in the

final Annual Governance Statement, which would be presented to the Audit Committee on 24 May 2017 for approval, alongside the Annual Report and Accounts for 2016-17.

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

(B) the final Annual Governance Statement 2016-17 be presented to the 24 May 2017 Audit Committee for approval. **DCLA**

25/17/5 Audit Committee – Self Assessment

The Director of Corporate and Legal Affairs introduced paper V, providing relevant guidance from the NHS Audit Committee Handbook on the completion of a self-assessment process, and inviting the Audit Committee to consider and agree the approach to undertaking such a self-assessment, in line with best practice. Members noted that the 2016 self-assessment process had been supported by Internal Audit and this had worked well. Internal Audit representatives advised that they would be happy to help with this work again in 2017 and the Director of Corporate and Legal Affairs was requested to progress this workstream accordingly. **DCLA**

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

(B) the Director of Corporate and Legal Affairs be requested to arrange for Internal Audit to support the UHL Audit Committee's self-assessment process for 2017. **DCLA**

25/17/6 Sustainability and Transformation Plan (STP) Governance Arrangements

The Director of Corporate and Legal Affairs briefed the Audit Committee on forthcoming significant changes to the LLR Sustainability and Transformation Plan and he highlighted the opportunity discussed earlier under Minute 22/17/3 to consider inclusion of an Internal Audit review of the STP governance arrangements within the 2017-18 Internal Audit programme.

Resolved – that the verbal information be received and noted.

25/17/7 Managing Conflicts of Interest – NHS England Guidance

Paper W provided an overview of the new rules relating to managing conflicts of interest in the NHS, as published by NHS England on 9 February 2017 and due to come into force on 1 June 2017. The detailed NHS England advice was appended to paper W for information. Particular discussion took place regarding the provisions for increasing transparency surrounding private clinical practice, relationships with drugs companies, sponsored research and hospitality. Confirmation was provided that the UHL Code of Conduct would be updated to reflect the new guidance. Colonel (Retired) I Crowe, Non-Executive Director noted that there would be significant implications arising from the guidance for the Leicester Hospitals Charity. He also highlighted an opportunity to strengthen the Trust's policy on Intellectual Property. **DCLA**

Resolved – that (A) a report on the implementation of the new rules for Managing Conflicts of Interest be presented to the Audit Committee on 24 May 2017, and **DCLA**

(B) consideration be given to the implications for the Leicester Hospitals Charity and the Trust's policy on Intellectual Property. **DCLA**

25/17/8 Consolidated List of Outstanding and In-Progress Audit Recommendations

Paper X from the Director of Corporate and Legal Affairs advised the Audit

Committee of progress against 4 outstanding actions from Internal Audit, External Audit and Local Counter-Fraud Specialist reports. The Committee Chair commended the continued good progress in reducing the overall number of outstanding audit recommendations and the Director of Corporate and Legal Affairs noted the importance of continued vigilance to maintain progress in this respect.

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

26/17 ITEMS FOR NOTING

26/17/1 2016-17 Costing Assurance Audit

Paper Y provided a summary of the key findings arising from the NHS Improvement Costing Assurance Audit undertaken at UHL in October 2016 to provide assurance on the implementation of costing standards. The report provided an in-year assurance rating of 'moderate' and indicated that the assurance rating would rise to 'significant' upon completion of the identified recommendations. The draft report was appended to paper Y.

Resolved – that the information be received and noted.

26/17/2 Care Quality Commission (CQC) Action Plan

The Audit Committee noted that progress against the CQC action plan was being monitored by the Executive Strategy Board and the Quality Assurance Committee and that substantive reports had featured on the agendas for the February 2017 meetings.

Resolved – that the information be received and noted.

27/17 ASSURANCE GAINED FROM THE FOLLOWING COMMITTEES ON KEY RISKS/ ISSUES OF THE TRUST

27/17/1 Quality Assurance Committee

Resolved – that the Quality Assurance Committee Minutes from the meetings held on 22 December 2016 (paper Z1) and 26 January 2017 (paper Z2) be received and noted.

27/17/2 Integrated Finance, Performance and Investment Committee

Resolved – that the Integrated Finance, Performance and Investment Committee Minutes from the meetings held on 22 December 2016 (paper AA1) and 26 January 2017 (paper AA2) be received and noted.

27/17/3 Charitable Funds Committee

Resolved – that the Charitable Funds Committee Minutes from the meeting held on 2 February 2017 (paper BB) be received and noted.

28/17 ANY OTHER BUSINESS

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

29/17 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 16/17 – confidential report by the Chief Financial Officer ;**
- **Minute 20/17/1 – review of the Emergency Floor project risk assessment;**
- **Minute 20/17/2 – confidential report by the Chief Information Officer;**
- **Minute 22/17/2 – the 3 completed Internal Audit reviews (all medium risk);**
- **Minute 23/17/2 – External Audit review of elective waiting list management, and**
- **Minute 25/17/7 – new NHS England Guidance on Managing Conflicts of Interest.**

30/17 DATE OF NEXT MEETING

Resolved – that the next meeting be held at 2pm on Wednesday, 24 May 2017 in the C J Bond Room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 5:39pm

Kate Rayns, **Trust Administrator**

Cumulative Record of Members' Attendance (2016-17 to date):

Name	Possible	Actual	% attendance
R Moore (Chair)	6	6	100%
S Crawshaw	2	2	100%
I Crowe	6	5	84%
S Dauncey	2	0	0%
A Johnson	6	6	100%
B Patel	4	4	100%
M Traynor	6	4	67%

Attendees

Name	Possible	Actual	% attendance
N Sone	6	6	100%
S Ward	6	6	100%
P Traynor	6	6	100%