**Audit Committee**

**Minutes of the meeting held on**

**09 December 2021 at 09:30
virtual meeting via Microsoft Teams**

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| **Present[[1]](#footnote-1):** |  |
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| Lucy Weston | Non-Executive Director (the **Chair/LW**) |
| Chris Hurst | Non-Executive Director (**CMH**)**RR/App 13/2022**(Agenda item: 22(a)) |
| Mohinder Sawhney | Non-Executive Director (**MS**) |
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| **In attendance:** |
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| *Counter Fraud – TIAA Ltd:* |
| Tony Hall  | Counter Fraud - Senior Fraud Manager, TIAA (**TH**) – *part meeting* |
| *External Audit – Grant Thornton LLP:*  |
| Iain Murray | External Audit – Engagement Lead, Grant Thornton (**IM**) – *part meeting* |
| Laurelin Griffiths | External Audit – Manager, Grant Thornton (**LG**) – *part meeting* |
| *Internal Audit – PwC LLP:* |
| Sasha Lewis | Internal Audit – Director and Engagement Lead, PwC (**SL**) – *part meeting* |
| Reena Bajaj | Internal Audit – Manager, PwC (**RB**) – *part meeting* |
| Karen Finlayson | Internal Audit - Risk Assurance Partner and Regional Lead for Government, PwC (**KF**) – *part meeting* |
| David Schirn | Internal Audit – Assurance Lead, PwC – *part meeting* |
| Andrew Thorpe | Internal Audit – Engagement Director, PwC – *part meeting* |
| *Oxford Health NHS FT:* |
| Tehmeena Ajmal | Interim Executive Managing Director for Mental Health & Learning Disabilities (the **Interim EMD/TA**) – *part meeting* |
| Sigrid Barnes | Head of HR Systems & Reporting – *part meeting* |
| Nick Broughton | Chief Executive (the **CEO/NB**) – *part meeting* |
| Marie Crofts | Chief Nurse (**MC**) – *part meeting* |
| Charmaine De Souza | Chief People Officer (**CDS**) – *part meeting* |
| Karl Marlowe | Chief Medical Officer (**KM**) – *part meeting* |
| Peter Milliken | Deputy Director of Finance (the **Deputy DoF/PM**) |
| Mark Underwood | Head of Information Governance (**MU**) – *part meeting* |
| Robyn Venables  | Education & Quality Assurance Lead (**RV**) – *part meeting*  |
| Martyn Ward | Executive Director – Digital & Transformation (the **ED for D&T/MW**) – *part meeting* |
| Hannah Smith | Assistant Trust Secretary (Minutes) |
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| **Observing:**  |  |
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| Geraldine Cumberbatch | Non-Executive Director (designate) – *part meeting* |
| Charlotte Forder | Governor – Staff (Corporate Services) – *part meeting* |
| Benjamin Glass | Governor – Patients/Service Users (Buckinghamshire & other counties) – *part meeting* |
| Davina Logan | Governor – Age UK Oxfordshire – *part meeting* |
| Chris Roberts | Governor – Patients/Service Users & Carers (Deputy Lead Governor) – *part meeting* |
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The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members, External and Internal Auditors and Counter Fraud.

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| *Private session* |
| **1.**a | **Welcome and Apologies for Absence**There were no apologies for absence from Committee members. Apologies for absence from non-Committee members were received from: Mike McEnaney, Director of Finance; Helen Green, Director of Education & Development (**HG**); and Kerry Rogers, Director of Corporate Affairs & Company Secretary. |  |
| **2.**abcdefghijk | **Child & Adolescent Mental Health Service (CAMHS) Psychiatric Intensive Care Unit (PICU) project** Andrew Thorpe presented the report at paper AC 55/2021 on the execution of the CAMHS PICU project. The Trust had recognised the shortcomings and with the appointment of Martyn Ward to the new role of Executive Director – Digital & Transformation (the **ED for D&T**), there was a renewed focus and robust management action. *The Chief Nurse joined the meeting*. The Chair noted that once issues had been identified, the construction work had stopped and the Chief Executive had commissioned an external review. There were two strands of learning to now consider: how to get the project back on track; and how to address any control weaknesses or breaches, not only for this capital project but for project management more widely (which may be a relevant consideration for Internal Audit planning). The ED for D&T confirmed that action had already been taken in response to the recommendations identified in the report and a checklist had been created to demonstrate the various signatories in place for the project. He reported that each finding from the report had been: identified; assessed as to whether it was specific to the PICU project or of more general applicability; and been allocated an action owner, current status and completion date. The aim was to get the project formally back underway as soon as reasonably possible. In relation to those actions which were specific to the PICU project, all but one were anticipated to be substantially complete by the end of 2021. The findings which were of more general applicability and related more to ways of working and alignment between teams may need a longer timeframe to ensure that staff understood the templates available and were adopting more consistent ways of working; these actions were being overseen by the Service Change & Delivery team. *Geraldine Cumberbatch joined the meeting*. The Chair asked about the proposed course of action before the full construction contract was signed. The ED for D&T replied that a letter of intent had been issued, work would re-start on site in a limited way (£250K maximum value) and within a specific scope so as to complete the foundations work in 2021; the remaining PICU-specific actions needed to be completed before proceeding to sign the full contract. Chris Hurst commented that he had been reflecting upon the way in which the Finance & Investment Committee (**FIC**)operated and its role in scrutinising investment decisions and also continuing to monitor after work had started. He noted that there could be improvements to make at the time of consideration of business cases and in relation to how the FIC was furnished with updates on the progress of capital projects. Mohinder Sawhney commented upon the tight timeframe to get the PICU project back on track and the longer timeframe to reflect upon how the situation had arisen and the more generally applicable findings especially around project management. She cautioned that attention could get subsumed by the immediate project actions and noted that it could also be useful to consider more widely: (i) the relative strength of the governance around this and other capital projects, and the reporting on capital projects through committees up to the Board; and (ii) how system pressure could lead to this kind of result with a project. Mohinder Sawhney noted that she was unclear on: the remit of the Capital Programme Sub-committee and the FIC in relation to a capital project of this size; what was being delegated; and the thresholds that should trigger escalations. This should not be overlooked in the course of any rush to get the project back on track; there needed to be clarity on how the governance would support the project. To date the Capital Programme Sub-Committee and the FIC may have focused on the financial side of capital projects but there should be consideration given as to how to provide updates on progress and any issues (not just financial spend). The Chair noted that although system pressure had impacted in this case, if the control environment had been sufficiently robust then this chain of events should not have been allowed happen. There may therefore be issues with: (i) deficiencies in the control environment or the control environment not being sufficiently robust; and (ii) breaches in actual controls. She emphasised the differences between these two potential issues as the response to a breach in controls should be different to the response to a gap in controls. She noted that, further to discussion with the ED for D&T, she was assured that he had identified two different courses of action for each of these two types of issues and that the FIC should have a revised role in the governance structure supporting the project. Before the construction contract re-started, she proposed holding an extraordinary meeting of the Audit Committee to ensure that the PICU-specific actions from the report had been resolved; later in February 2021, at its regular meeting, the Audit Committee could consider any wider control weaknesses around project management. The way in which project management was embedded across the Trust may also be a relevant consideration for the Internal Audit Plan in the future. Mohinder Sawhney noted that although she had found the report helpful in providing an expert view on what should have happened and what had not happened, she was still unclear on why. If the organisation had been more confident than it should have been, based on its past projects and previous experiences, then what had led to that overconfidence or prevented it from being checked and challenged. She referred to the Director of Finance’s view that the organisation may not have been qualified to implement the clinical brief which had been prepared. It may therefore be helpful to understand what coalition of forces had led to that clinical decision. The Chair replied that she had discussed in more detail with Andrew Thorpe; root cause analysis had been difficult as insufficient evidence was available to be clear about what had happened, especially when some key personnel were no longer with the Trust. Andrew Thorpe and David Schirn thanked the Trust for the assistance which had been provided in a short timeframe and for having been candid about shortcomings. **The Committee noted the report and that before the construction contract re-started, there would be an extraordinary meeting of the Audit Committee to ensure that the PICU-specific actions from the report had been resolved. Later in February 2021, at its regular meeting, the Audit Committee could consider any wider control weaknesses around project management.***Andrew Thorpe and David Schirn left the meeting.*  | **HS** |
| *Main meeting started at 10:00* |
| **3.**ab | **Welcome and confirmation of items for Any Other Business**The Chair welcomed observers to the meeting including Governors, Geraldine Cumberbatch, the Chief People Officer and Karen Finlayson who would be taking over from Sasha Lewis as Internal Audit Engagement Lead. No additional items were requested for Any Other Business. |  |
| **4.**abcd | **Minutes of the Meeting held on 15 September 2021 and Matters Arising**The Minutes of the meeting at paper AC 54/2021 were approved as a true and accurate record. ***Matters Arising*****Item 6(b)-(c) from May 2021 and December 2020 – thematic review of fraud risks during COVID-19**Tony Hall requested that the actions stay on the Summary of Actions document for the time being and he would discuss further with the team at TIAA. The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda for this meeting: * 4(b) FY21 External Audit process review;
* 5(d) Health & Safety reporting;
* 5(g) revised proposals for the Internal Audit Plan;
* 5(k) findings from common themes from Internal Audit directorate reviews
* 8(g) matters for potential escalation or checking against risk registers. The Chief Executive noted that the major capital projects risk should feature on risk registers. The Director of Finance had previously suggested that this risk may be more appropriate at an operational rather than strategic level;
* 8(g) provision of copy of the Risk Management Strategy & Policy;
* 13(a) procurement timeline for review of contracts for External Audit, Internal Audit and Counter Fraud;
* 11(h) updates to the Internal Audit tracker;
* 15(d) Cyber Security and checking accreditations of partners; and
* 8(b)-(c) Clinical Audit assurance on effectiveness of processes – on the agenda for discussion at this meeting.

The remaining actions in the Summary of Actions document were to be progressed:* 3(b) written audit trail of the ideas which had been considered but not ultimately taken forward for inclusion in the Internal Audit Plan; and
* 11(a) risk appetite. The Chair noted that this may be discussed further in a separate risk workshop/session for the Audit Committee.
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| **5.**abcdefghi | **Internal Audit progress report and review reports*****Progress report***Sasha Lewis presented the progress report at paper AC 56(i)-(ii)/2021. She explained that NHS Digital had issued its Data Security & Protection Toolkit (**DSPT**) auditguidance and the Trust had been notified that it had been selected by NHSX to be part of their DSPT audit programme this year. Therefore, a separate Internal Audit of the DSPT was not required and Internal Audit was proposing that the budget which it had been holding in readiness for this review should be reallocated to a review of the new Data Centre. The Chair noted that this would be the second review of the Data Centre in a fairly short space of time and that there may be other areas to be preferred for review, which she could discuss separately with Internal Audit out-of-session. Sasha Lewis added that the budget which had been held for the DSPT review was a small fee which, on its own, may not be sufficient to do a completely different review. Sasha Lewis reported good progress on completing actions since the last meeting. She confirmed that Internal Audit had seen evidence to verify completion of the actions before closing them. Remaining overdue actions were set out in the report. The Chief Nurse referred to the first overdue action, in relation to controls regarding staffing levels and skill mix for ‘other’ clinical staff (arising from the directorate review into Community Services). She noted that she was the relevant Executive lead for Allied Health Professionals but that she had not been made aware of this action; when directorate reviews identified wider corporate or overarching issues then relevant Executive Directors should also be notified and the issues clarified and confirmed with them. She commented that this action potentially related to the Safe Care system but the terminology in the action may not be accurate. The Chair replied that these were also recommendations which had been followed up repeatedly over time and had not received responses; there had been opportunities for the responsible managers to suggest amendments to the wording or to suggest the inclusion of other roles as being more appropriate to own the recommendations. However, it may be possible to discuss these themes arising from directorate reviews in more detail later in the meeting at item 6 below. The Chief Executive noted that he would prefer more discipline in identifying a single person to be responsible for an action; having several different people listed as response could lead to confusion. Chris Hurst referred to the report and the various revised implementation dates against certain overdue actions, noting that if realistic revised dates were not being set then this could be a cause for potential concern. The Chair agreed but noted that this could be for discussion separately with Internal Audit out-of-session. *Sigrid Barnes, Ben Glass and Robyn Venables joined the meeting.* ***Draft Payroll review report***Sasha Lewis presented the draft Payroll review report at paper AC 56(iii)-(iv)/2021 and explained that this was still in draft form whilst the management actions were being agreed and subject to final review by the new Chief People Officer. She highlighted findings in relation to:* amendments to employees’ standing data should be on a change form signed by both manager and employee and processed in a timely way to reduce the risk of incorrect/overpayments being made; and
* leavers’ forms should be used and when used should be submitted in a timely way.

The Chair commended the draft review report and noted that its findings and themes significantly corresponded with those of a previous Internal Audit report on IT/Employee data records. She invited the Chief People Officer to comment, whilst acknowledging that the Chief People Officer had not been in post when the review had been conducted. The Chief People Officer replied that the findings highlighted were not unusual in any organisation which had delegated controls and change forms; she agreed that the implications for payments, especially the risk of overpayments, were significant and could create problems for staff especially as they would be required, in accordance with Trust policy, to pay back any overpayment. Sigrid Barnes, Head of HR Systems & Reporting, added that the review report had reflected what the team was already aware of. Delays in forms being processed were, in the majority of cases, due to lack of clarity on the forms submitted which then required the Payroll provider to revert to the individual submitting it for further information before the form could be processed. The employee systems development programme which she was working on with the ED for D&T, as a result of the findings in the previous Internal Audit on IT/Employee data records, would address most of the issues identified in this review and ensure that there was a robust system to collect information in and to integrate systems. Mohinder Sawhney noted that system improvements would help to address underlying issues but asked whether there could still be overreliance upon manual triggers. Sigrid Barnes replied that cross-checking was being built into the new system so as to reduce errors; however, there needed to be some balance between getting authorisation or validation from various different people and getting changes put through in a timely manner as sometimes the authorisation process could slow things down which led to missing the pay deadline. The Chief Executive noted that a repeat of the Internal Audit review on Payroll should be included on the Internal Audit forward plan, cautioning that it could be easy to forget what had been done historically. The Chief People Officer agreed and noted that in previous organisations she had seen Payroll be a standing item for regular Internal Audit review because of its implications. **The Committee noted the Internal Audit progress report, draft Payroll review report and that Payroll should be included on the Internal Audit forward plan.***Sigrid Barnes left the meeting*.  | **PwC** |
| **6.**abcdefghi | **Themes and recommendations from previous Internal Audit directorate reviews: (i) Safer Staffing; and (ii) Statutory & Mandatory Training** The Chair introduced the item and explained that the two themes of Safer Staffing and Statutory & Mandatory Training had been raised in each of the three directorate reviews which Internal Audit had conducted over the past three years. The reviews had indicated that these themes had not been fully resolved therefore she had asked the action owners to attend to discuss the issues with the Committee and consider how these could be concluded. ***Statutory & Mandatory Training***Robyn Venables, Education & Quality Assurance Lead, presented the report at paper AC 57/2021 on Mandatory Training and Training Matrices. The Chair explained that she had asked for amendments to an earlier version of this report and for additional information to be provided; the revised version was provided as a blackline showing changes but the Chair noted that the report still did not include an estimated date for achieving mandatory training compliance. Robyn Venables replied that the report provided background on why that date was currently difficult to pinpoint; a new Online Training Record (**OTR**)had needed to be put in place further to a cyber security issue but it had been difficult to transfer the compliance data from the old to the new system accurately. Work was still ongoing to check the accuracy of the compliance data and that the correct training matrices had been assigned to staff on the new OTR; this was a significant task and it had not been possible to bring in temporary staff on a short term basis to do this therefore the existing support team was working on it. The Chief Nurse add that assigning the correct training matrices to staff was key, especially if there were issues with training having been suggested which was not required for certain roles. Due to the cyber security issues, the new OTR had had to be brought online very quickly and this situation had been reviewed at the Weekly Review Meeting (Clinical Standards) and the Operations Senior Management Team meeting. There had also been issues with some directorates reporting that staff had been saying that there were no training courses to book onto, but this had not been the case. Trajectories were being set to achieve compliance targets and clinical training was also now being reported through to the Quality & Clinical Governance Sub-Committee. Non-compliance with resuscitation training targets had been identified and this had been escalated to the Executive and to the Quality Committee and mitigations had been put in place; in practice therefore, at every shift handover the nurse in charge would ensure that there were enough staff who had up-to-date resuscitation and PEACE (Positive Engagement And Caring Environments) training available on shift. The Chair noted that the detailed work on monitoring mandatory training compliance and seeking assurance that interim mitigations were sufficient should be conducted through the People, Leadership & Culture Committee (**PLC**), which was also better placed through its remit to review this. An update from Learning & Development was also requested to set out the information which was currently missing from the report in relation to when compliance with mandatory training requirements was expected to be achieved and the issues here resolved. ***Safer Staffing***The Chief Nurse apologised for not having provided a paper in advance of the meeting but provided an oral update instead, noting that she could circulate a paper setting out the detail to the Committee separately after the meeting. She explained that ‘Safer Care’ as alluded to in the Internal Audit reports was different from ‘Safer Staffing’ but that the Internal Audit report had used these terms interchangeably. She confirmed that reporting on staffing levels and fill rates at Board level had continued since she had joined the Trust although this had now been delegated to the Quality Committee through its receipt of the Quality and Safety dashboard. To aid rota management, the Trust had implemented an e-rostering system and invested in the Safe Care acuity tool as part of the software being installed; the Safe Care tool reviewed acuity levels and could help with planning whether additional staff would be needed on shift in order to deal with any increased acuity. It was not an essential or crucial tool to maintain safe staffing; therefore, low usage of the tool did not equate to increased patient safety risk. The professional judgement of the nurse in charge of the shift was key in determining whether an adequate number of registered nurses were on shift. Staffing levels for all inpatient wards were also reviewed weekly at the Weekly Review Meeting (Clinical Standards). Although some wards preferred not to use the Safe Care tool, the Chief Nurse considered that it could still be a useful support tool to measure acuity; she had therefore commissioned a review of the use of the Safe Care tool to determine if it could be rolled out in a more consistent and helpful way for ward nurses. She requested that the Internal Audit action be closed based on the assurance she had set out above. The Chair replied that she may need a call out-of-session with Internal Audit, the Chief Nurse and possibly also the Service Director and the Clinical Director for Community Services to confirm that all parties were clear on what the risk had been and whether the action had been sufficiently addressed; she noted that the action had been ongoing for some time and the Audit Committee had requested management to take a central role in resolving it. The Director of Finance added that the Deputy Director of Finance would be taking a role going forwards in supporting Internal Audit in resolution of their actions. Mohinder Sawhney noted that it was difficult to receive orally that amount of information and be sufficiently assured so as to be able to confirm closure of the action. However, she confirmed that the PLC would follow-up on mandatory training compliance. She asked why this particular action had not been escalated up to the Chief Nurse in a more timely manner, noting that there may be an issue with escalation process which had led to actions such as this being outstanding for a while. The Chief Nurse replied that she would be discussing the escalation process with all Service and Clinical Directors, ensuring clear understanding of when an action should be checked with an Executive lead and emphasising the importance of differentiating between Safer Staffing and Safe Care. In the case of directorate reviews in particular, whilst a management response from the directorate might be sought, there may have been an issue with recognising when a more central Executive response should also have been sought. The Chief Nurse noted that she may then have been able to explain and conclude the action more quickly. The Chair noted that was a fair challenge. **The Committee noted the report and the oral update and that the People, Leadership & Culture Committee would follow-up on mandatory training compliance.***Robyn Venables left the meeting*.  | **RV/HG****HS/MC****MS****MS** |
| **7.** ab | **Internal Audit FY23 planning discussion paper** The Chair referred to the report at paper AC 58/2021, took it as read and noted that whilst she fully supported the process outlined therein, she wanted to move some of the proposed dates forward. **The Committee noted the report.**  |  |
| **8.**abcd | **FY21 External Audit process review** The Deputy Director of Finance provided an oral update and explained that there was no updated version of the paper provided to the previous meeting at AC 53/2021 on the FY21 Annual Accounts Post Review. The findings in that paper had since been discussed with External Audit and plans agreed to take forward into the FY22 audit. This oral update item was therefore to confirm in a more public forum the outcome of the previous discussion of paper AC 53/2021 which had taken place in private. The Chair asked Iain Murray for his perspective on the learning from the FY21 External Audit process. Iain Murray replied that the audit process was not fundamentally flawed and had worked well with the Trust, especially as the Trust was not challenged in terms of capacity to support the audit, but there were some aspects which could be fine-tuned for next time and the External Audit process was becoming ever more time consuming as more aspects were added to it. Conducting assurance work remotely/over a virtual meeting platform during COVID-19 restrictions was also a below par arrangement for all, not only in terms of the interface between External Audit provider and the Trust but also in terms of the within the External Audit team. The Chair noted that the review of the FY21 process had not come about from fundamental failings in the process but was more the result of a Quality Improvement approach being adopted to improve the process. The FY21 audit had run well although there had been challenges around remote working. **The Committee noted the oral update.** *Mark Underwood, Head of Information Governance, joined the meeting*.  |  |
| **9.** abcde | **Information Commissioner’s Office (ICO) draft audit report** The Chair introduced the report and explained that she had asked that it be presented to this Committee although final management responses were still being drafted and it was agreed that the Finance & Investment Committee (**FIC**), through its oversight of the Information Management Group, would have responsibility for delivery of the action plan. She invited Mark Underwood, Head of Information Governance, to present main themes from the draft report at paper AC 60/2021. The Head of Information Governance explained that the Data Protection audit from the ICO was a one-off audit and the ICO intended to eventually audit all healthcare organisations; this had been the Trust’s turn and it had achieved ‘Reasonable’ levels of assurance across the two audited areas of Governance & Accountability and Data Sharing. The ICO report was still in draft but the Trust had submitted its comments on the draft and received an updated version from the ICO earlier today which it would review. Once finalised, the ICO would publish an executive summary of the audit on its website. The Trust had received some recommendations and acknowledgement of examples of good practice; he commented that whilst the ICO had been complimentary about the Trust’s GDPR (General Data Protection Regulation) Group, this had not featured in much detail in the report. He took the meeting through the recommendations, noting themes around: the Trust’s Records of Processing Activity and the need for more detailed directorate or departmental evidence; guidance covering document control requirements; the role of the Data Protection Officer; Information Sharing Agreement logs and a dedicated Information Sharing policy or procedure; and specialised training for staff with data sharing roles. He concluded that ‘Reasonable’ was a reasonably strong level of assurance and he thanked the significant number of people across the Trust who had been involved in, and supported, the audit as much documentary evidence had been provided. The Chair asked whether all recommendations would be closed within the next 2-3 months. The Head of Information Governance replied that recommendations would be actioned over the next 9 months as some of the lower level recommendations were set for next year. The Chair asked Chris Hurst to confirm that the FIC, through its oversight of the Information Management Group, would have responsibility for delivery of the action plan and would feedback to the Audit Committee at an appropriate point. Chris Hurst confirmed this and noted to the Head of Information Governance that it would be useful to have updates against the programme of actions slotted into the 9-month timeframeso that the priorities to be addressed were clear. The Head of Information Governance agreed. **The Committee noted the draft ICO audit report and that the FIC, through its oversight of the Information Management Group, would have responsibility for delivery of the action plan.** *The Head of Information Governance left the meeting*.  | **CMH****CMH** |
| **10.**ab | **Fire Safety Assurance Report** The Chair noted that the Director of Estates & Facilities was off sick on this day and that the report at paper AC 61/2021 would be held for the next meeting. **The Committee noted the deferral.** *Tehmeena Ajmal, the Interim EMD, joined the meeting*.  |  |
| **11.**abcdef | **Service escalation framework** The Chair introduced the report on managing service pressures on a medium to longer term basis. Tehmeena Ajmal, the Interim EMD, presented the report at paper AC 62/2021 on the frameworks being used by Trust services in response to, and to articulate, the pressures that they were under e.g. the Trust’s Business Continuity policy and the national Operational Pressures Escalation Levels (**OPEL**) Framework. The existing frameworks being used were not designed for medium to longer term challenges therefore a more nuanced and appropriate mechanism for describing service pressures may need to be developed in order to trigger escalations and strengthen oversight. The Interim EMD highlighted ways in which the current frameworks were more focused on supporting immediate or short-term responses than managing medium to longer term challenges and escalations. She explained that Business Continuity processes were designed to respond to more short-term disruption to service delivery but services were increasingly experiencing more chronic and longer term challenges. The OPEL Framework had been generated to assess acute and emergency care pressures and flow, and again was focused on more immediate concerns and encouraging systems to work in partnership to resolve specific pressures. The proposal was to review or adapt some different frameworks and consider what the specific criteria for escalation processes might be. This should take account of previously agreed triggers for escalation and further to discussion internally with clinical and corporate services, as well as externally with partners from whom the Trust may be seeking support in such instances. She reported that she had asked Service Directors to start considering this and she hoped to have a new escalation framework which could be piloted and trialled with services, especially District Nursing and Community Mental Health teams. The Chief Executive welcomed the proposals and emphasised the importance of developing a consistent escalation framework which could be recognised across the system. Mohinder Sawhney referred to the action in the report to define criteria the process needs to meet with services and Executives. She recommended precision and being explicit in articulating the purpose of this. She added that the patient perspective and stakeholder requirements should also be included. The Chair asked whether the escalation route should be through the Quality Committee or the Audit Committee. The Interim EMD replied that this had not yet been determined but it was effectively an operational escalation framework which also linked with risk management and mitigation. The Chief Nurse added that there would also be a link with quality of patient care and safety which, together with its operational overtones, would bring it more within the remit of the Quality Committee. **The Committee noted the report.** *The Interim EMD and the Chief Executive left the meeting. The Chief Medical Officer joined the meeting.*  |  |
| **12.**abcd | **Whistleblowing arrangements report** The Chair noted that the report at paper AC 63/2021 should be taken as read and asked the Chief People Officer to extract the key themes. The Chief People Officer gave her assurance that she had personally familiarised herself with the Management of Concerns policy and was assured that there was relevant expertise and experience in the HR Advisory team to deal with whistleblowing matters when they came through; she had also spent time with both Freedom to Speak Up Guardians to understand the support required to deal with these cases. She would also be working closely with the Director of Finance who was the Executive lead for this area. Mohinder Sawhney asked whether: (i) the governance arrangements around Whistleblowing should be reported into the PLC; and (ii) Chris Hurst’s role as Non-Executive Director with an interest in Whistleblowing was a formal one and how it related to the PLC or the Audit Committee. The Chair explained that the route into the Audit Committee related to the control environment around Whistleblowing and ensuring that appropriate practice and procedures were in place to allow this to operate; she would expect that more detailed reporting on specific issues arising from cases would go to the PLC. Chris Hurst explained that although he was currently the Board champion for Whistleblowing, this responsibility could transfer elsewhere, subject to discussion with the Trust Chair, although there may need to be separation from the role of Chair of the PLC. The Chair referred to the report and noted that the absence of unfair treatment allegations as part of any grievance or employment tribunal claim was a crude measure to use to indicate that there had not been instances of staff feeling unfairly treated as a result of raising their concerns. The Chief People Officer agreed but noted that when Whistleblowing cases were brought anonymously then it was not possible to follow-up with the people raising them later in order to check. However, she had been asking the Freedom to Speak Up Guardians to consider triangulation of data alongside HR casework data and they would be joining her team next week to discuss this further; the evolution of this may be more appropriately shared with the PLC. The Chair added that triangulation could also encompass other communication channels, such as complaints, equality networks and cultural ambassadors. **The Committee noted the report.**  |  |
| **13.**abcde | **Clinical Audit – effectiveness of Clinical Audit processes** The Chair introduced the item and noted that although the Audit Committee had been provided with the report (at paper AC 64/2021) which had recently been submitted to the Quality Committee, the Audit Committee had a different role to that of the Quality Committee in reviewing the Clinical Audit function. She commented that for some years the reporting had not quite managed to meet this distinction between the Quality Committee’s oversight of delivery of Clinical Audit and the Audit Committee’s role in reviewing the effectiveness of Clinical Audit. She asked the Chief Medical Officer for his views. The Chief Medical Officer noted that the report provided assurance that Clinical Audit activity was taking place at various levels within the Trust, from responding to national requirements for Trust-wide audits to more local clinical audits being conducted in clinical directorates and divisions. The more local audits being conducted at directorate level were informed by requests from the senior management teams and/or from identifying hotspots in performance dashboards. However, he noted that quality innovation would not result from Clinical Audit practices as these were essentially backwards looking. In order to move forwards to deliver quality innovation, an organisation needed to review metrics in real-time, utilising a performance dashboard and applying a Quality Improvement mindset. Clinical Audit (including national audit requirements and local audits) should be triangulated with review of Serious Incidents and a performance dashboard in order to move the organisation forwards. The Clinical Audit Group was the forum which reviewed Clinical Audit activity across the organisation and the achievement of CQUINs (Commissioning for Quality & Innovation schemes which had been suspended for 2021/22 due to the impact of COVID-19). However, the Clinical Audit Group had only met twice in the last year, as set out in the report. The Clinical Audit Group had however met recently on 15 November 2021 and he noted that the minutes of that meeting were available upon request; he commented that he had requested a flow chart on how Clinical Audit worked and where commissioners and CQUINs could be provided with performance information and that he had changed the agenda for the meeting so that it would provide more assurance going forwards and not just review reports provided to the meeting. He would also be working with the Clinical Audit leads to review the Terms of Reference of the Clinical Audit Group and bring within its remit oversight of NICE (National Institute for Health & Care Excellence) guidance. Ultimately this would lead to the creation of a new Clinical Effectiveness committee or group which would have responsibility for Clinical Audit and NICE guidance and would bring together the three components of: Quality Improvement methodologies; national and commissioning audits; and performance metrics/performance dashboard. In this way, Clinical Audit could become part of how quality could be transformed in the organisation. The Chair noted that this oral update provided a flavour of the kind of information which the Audit Committee had wanted included in the reporting it received on Clinical Audit. In the past there had been somewhat narrow reliance upon a set of nationally mandated clinical audits. However, the Audit Committee was interested in: how risk was identified and managed and how it informed the scoping of the Clinical Audit programme; the rigour of the processes in place for conducting clinical audits; the reporting of clinical audits; and monitoring and escalation of matters arising from clinical audits. This was consistent with the previous action in relation to Clinical Audit (referred to at item 8(b)-(c) from the meeting on December 2020 and as included in the Summary of Actions document to this meeting and the Minutes from that past meeting). The Chief Medical Officer replied that he needed something more tangible than a reference from past Minutes in order to move forwards. The Chair explained that the Audit Committee’s role was to test assurance in relation to the effectiveness of Clinical Audit processes and ensure that the Trust as a whole had effective governance, including assurance and auditing systems such as Clinical Audit. The Chair requested further reporting on Clinical Audit from the Chief Medical Officer to the next Audit Committee meeting in February 2022, providing more detail on the points he had outlined above. Mohinder Sawhney agreed and added that it would be helpful to see the new framework he had outlined for Clinical Effectiveness in a formal report, together with thought given to any external validation which would be included or triggered. The Chief Medical Officer added that in February 2022 forward planning would be decided for the Trust’s wider audit processes and clinical components would be agreed with the External Auditors. He noted that External Audit would normally include a section on Clinical Audit and he invited the auditors present at this meeting to comment. Iain Murray from Grant Thornton, which provided External Audit services to the Trust, replied that this matter may be more appropriate for Internal Audit as represented by PwC. Iain Murray explained that whilst External Audit would be mindful of the Trust’s wider audit arrangements, it would not necessarily review Clinical Audit in detail although Internal Audit might. The Chief Medical Officer replied that Clinical Audit plans should be included for review, as they had been in his previous organisation. The Chair agreed with Iain Murray that this may however be a matter more appropriate for Internal Audit review especially if the focus was upon how Clinical Audit plans/processes worked. Karen Finlayson, from PwC providing Internal Audit services, agreed and explained that Internal Audit’s role would normally be to consider the Clinical Audit approach, methodology and how outcomes fed into clinical quality arrangements and lessons learned (without making clinical judgements). The Chair concluded that she would be happy to support including review of Clinical Audit in the list of priorities for the Internal Audit Plan. **The Committee noted the report and the oral update from the Chief Medical Officer and that a review of Clinical Audit should be included in the list of priorities for the Internal Audit Plan.**  | **KM****PwC** |
| **14.**ab | **Charity Committee annual report (prior to receipt of Charity annual report and accounts by the Board on 15 December 2021)** The Chair presented the Charity Committee’s annual report at paper AC 66/2021 and reminded the meeting that she was also the Chair of the Charity Committee and therefore had an interest to declare in it. She took the report as read. She noted that in the future the report would include encapsulation of the risk management process undertaken by the Charity. **The Committee noted the Charity Committee annual report.** *The Chief Nurse left the meeting*.  |  |
| **15.**abcde | **Counter Fraud (Anti-Crime Service) progress report** Tony Hall took the report at paper AC 65/2021 as read and explained that the benchmarking from the NHS Counter Fraud Authority had been a fair but also more stringent assessment, which was provided for information. He reported that significant work had taken place in the last reporting period to raise fraud awareness, including with a fraud awareness week and the Counter Fraud and Bribery update training which had been provided to the Board at its Board Seminar on 20 October 2021. He highlighted the ‘Prevent & Deter’ activity set out in the report, including the completion of the Bribery Act compliance proactive review and the National Fraud Initiative review. Still in progress were the reviews on staff expenses and pre-employment checks. He highlighted the investigations under ‘Hold to Account’ activity, which both related to allegations of working whilst sick: in one case it had been agreed with HR not to proceed with a criminal investigation but to follow-up and report on HR’s internal investigation and actions; and investigation was still ongoing in the other case. He concluded by referring the meeting to the action plan, in Appendix A of the report, which set out to improve on the amber ratings in the FY21 Annual Counter Fraud Assessment. In relation to potential COVID-19 passport fraud, the Chair informed observers at the meeting that this would be discussed in more detail in a private part of this meeting but would be reported or included in Counter Fraud/Anti-Crime reporting more publicly at the next Audit Committee meeting in February 2022. The Chief People Officer referred to the report and asked who made the decision on whether or not to pursue criminal action in a case. Tony Hall replied that the likelihood of successful prosecution, proportional cost and issue of public interest would be considered; HR would be part of the discussion on whether or not to pursue but the decision would be taken by the Director of Finance. The Chief People Officer noted that she should be part of that decision-making process; the Chair agreed as the decision should be in the remit of HR as it had wider implications than financing. Tony Hall noted that whilst the decision was that of the Director of Finance, the Chief People Officer would still be kept updated. The Chief People Officer asked whether HR processes and disciplinary investigations also ran parallel alongside Counter Fraud investigations. Tony Hall confirmed that they did and parallel sanctions would be taken into account, along with HR input on every Counter Fraud investigation. **The Committee noted the report.**  |  |
| **16.**abcde | **Any Other Business** The Chair invited questions or comments from observers. Davina Logan commented that it had been reassuring to hear the debate and discussion; the detail had also been useful. In relation to Counter Fraud, she commented that she agreed that there were more than financial considerations to the decision on whether or not to pursue criminal action in a case. Chris Roberts commented that when papers were taken as read it obscured some of the information from observers, especially if they did not have access to all the papers, but he was also reassured by the rigour of the discussion. The Chief Medical Officer replied that there could be confidential information to be discussed which could not always be shared for wider distribution. The Chair felt that she would be happy for the governors to have more full access. The Chair requested that observers leave the meeting so that the Committee could continue discussion in private. *Observers, External Audit, remaining Executive Directors, Reena Bajaj, Karen Finlayson left the meeting. Remaining in the meeting were: the members of the Audit Committee, the Deputy Director of Finance, the Assistant Trust Secretary, Tony Hall and Sasha Lewis.*  |  |
| *Private session*  |
| **17.**abcdefg | **Counter Fraud (Anti-Crime Service) progress report (paper AC 65/2021) and any emerging issues**Further to the update provided to the main meeting, Tony Hall provided an oral update on a suspected case of fraud at one of the mass vaccination centres operated by the Trust. The Trust was receiving regular reports and checking the data every few days. Counter Fraud were now following the case which related not just to fraud but also to bribery. The Chief Medical Officer confirmed that the Trust had investigated the incident the same day that it had been reported. He noted that operational delivery of the mass vaccination centres did not sit with him and he recommended that Counter Fraud discuss further with the operational leads. He noted that he had an interest in clinical governance, rather than operational delivery. Tony Hall added that he would be in contact with the operational leads and also would liaise directly with the police; he explained that Counter Fraud had an ongoing remit in this matter as part of helping the wider NHS to mitigate proactively against similar incidents and that the learning from this went beyond the Trust and could apply to other organisations in a similar position operating mass vaccination centres. The Chair added that the Audit Committee should be able to review a documented analysis of what had happened, how it had been allowed to happen, what control weaknesses had existed and what actions had been done subsequently in response to the incident and to prevent further occurrences. Mohinder Sawhney suggested structuring the discussion to focus upon what controls may be within the Trust’s remit and ability to manage. If there were none within the Trust’s ability to manage then this should be explicitly stated and recognised. However, if some controls were within the Trust’s remit then there needed to be understanding of the quantum of the issue and the balance of investment in the controls versus acceptable risk. The Chair asked who would be best placed to undertake a further investigation into this matter and identify any control weaknesses. Tony Hall replied in the first instance that this may sit better with the operational delivery lead Matt Edwards, Director of Clinical Workforce Transformation, who would be able to access more information directly than Counter Fraud would be able to. However, Counter Fraud would need to perform a necessary role as facilitators between the Trust, the NHS Counter Fraud Authority and the police; finally, if necessary, Counter Fraud could report upon the findings. The Chair asked the Deputy Director of Finance to arrange for a call with the Director of Finance, Counter Fraud, the Director of Clinical Workforce Transformation and the Chief Medical Officer to discuss the approach and way forward on this matter. Following which, she requested that an action plan be developed, or analysis undertaken in response to the incident. **The Committee noted the oral update and that further action would be taken out of session to determine next steps, with a view to an action plan or analysis reporting back to the Committee in the future on this incident.** *The Chief Medical Officer, Tony Hall and Sasha Lewis left the meeting*.  | **PM/TIAA** |
| **18.**ab | **External Audit contract**The Chair asked whether the report at paper AC 65/2021 was the same as had been shared with governors. The Deputy Director of Finance confirmed that it was but it also provided an update on confirmation of the panel. **The Committee APPROVED the timetable in the report and to undertake the new appointment of an external auditor and make a recommendation to the Council of Governors so as to allow the auditor to develop a strong understanding of the finances, operations and forward plans of the Trust.** |  |
| **19.**a | **Any Other Business**None.  |  |
| **20.** abc | **Review of Meeting**The Chair asked for any escalations to the Board or risk registers arising from the meeting. The meeting agreed that the PICU should be an item which the Board continued to monitor. The Chair noted that the ED for D&T should complete his root cause analysis and then learning, especially broader learning beyond the immediate project, should be considered. The Chair noted that she would want to revisit Health & Safety in the context of the Fire Safety Assurance Report, and its reporting on fire risk assessments and routine checks and balances, when it could be properly presented.  |  |
|  | **Meeting Close: 12:55** |  |
|  | Date of next meeting: 23 February 2022, 09:30-12:30.  |  |

1. The quorum is 3 members (all Non-Executive Directors) and may include deputies. [↑](#footnote-ref-1)