**Audit Committee**

**RR/App 27/2022**

(Agenda item: 27(a))

**Minutes of the meeting held on**

**21 April 2022 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**) |
| Mohinder Sawhney | Non-Executive Director (**MS**) |
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| **In attendance:** | |
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| *Anti-Crime (Counter Fraud) – TIAA Ltd:* | |
| Tony Hall | Anti-Crime (Counter Fraud) - Senior Anti-Crime Manager, TIAA (**TH**) – *part meeting* |
| *External Audit – Grant Thornton LLP:* | |
| Iain Murray | External Audit – Engagement Lead, Grant Thornton (**IM**) – *part meeting* |
| Ellen Millington | External Audit – Senior Manager, Grant Thornton (**LG**) – *part meeting* |
| *Internal Audit – PwC LLP:* | |
| Karen Finlayson | Internal Audit - Risk Assurance Partner and Regional Lead for Government, PwC (**KF**) – *part meeting* |
| Caitlin Millar | Internal Audit – Senior Associate, PwC (**CM**) – *part meeting* |
| *Oxford Health NHS FT:* | |
| Nick Broughton | Chief Executive (the **CEO/NB**) |
| Charmaine De Souza | Chief People Officer (the **CPO/CDS**) – *part meeting* |
| Jayne Harrison | Lead Nurse for Safeguarding Children – *part meeting* |
| Karl Marlowe | Chief Medical Officer (the **CMO/KM**) – *part meeting* |
| Mike McEnaney | Director of Finance (**MMcE**) |
| Peter Milliken | Deputy Director of Finance (the **Deputy DoF/PM**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (the **DoCA/CoSec/KR**) |
| Atif Saeed | Capital & Financial Accountant – *part meeting* |
| David Walker | Trust Chair (**DW**) |
| Martyn Ward | Executive Director – Digital & Transformation (the **ED for D&T/MW**) – *part meeting* |
| Michael Williams | Financial Controller (**MWi**) |
| Hannah Smith | Assistant Trust Secretary (Minutes) |

The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members, External and Internal Auditors and Anti-Crime (Counter Fraud) services.

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| **1.**  a  b  c | **Welcome, Apologies for Absence and confirmation of items for Any Other Business**  The Chair welcomed observers and attendees to the meeting including David Walker, Trust Chair, for the review of the draft Annual Report and Accounts and supporting documents, and Charmaine De Souza, Chief People Officer.  There were no apologies for absence from Committee members. Apologies from non-Committee members were received from Marie Crofts, Chief Nurse.  No additional items were requested for Any Other Business. |  |
| **2.**  a  b  c  d | **Minutes of the Meeting held on 23 February 2022 and Matters Arising**  The Minutes of the meeting on 23 February 2022 at paper AC 20/2022 were approved as a true and accurate record subject to amending item 3(i) to clarify that there was a cross-cutting theme of actions not consistently being undertaken, whether related to mandatory training or other follow-up actions, and this may indicate issues with: (i) lack of clarity or precision around the action required to be taken, which may therefore invite too much interpretation from staff who may not be recognising the action as mandatory; or (ii) being too quick to jump to identify a potential action or mandate.  ***Matters Arising***  The following actions were noted as complete (with supporting detail in the Summary of Actions document) or on the agenda for this meeting:   * 2(a) amendments to December 2021 minutes; * 2(e) and 3(b) from September 2021 - written audit trail of ideas considered, but not ultimately taken forward, for inclusion in the Internal Audit Plan – complete and now listed in the Internal Audit Plan at paper AC 29/2022; * 3(d) Internal Audit had checked and confirmed that the action/recommendation in relation to statutory and mandatory training had been appropriately closed as this area would be monitored by the People, Leadership & Culture (**PLC**)Committee; * 3(f) progress made (as reported at paper AC 27(iii)/2022), and detailed supporting evidence provided in the Reading Room to the meeting at RR/App 01/2022, on changes in the control environments for Payroll and the development of the Employee Systems Development Programme; * 3(l), (q) and (s) Psychiatric Intensive Care Unit (PICU) further report on the agenda for discussion at paper AC-pvt 33/2022; * 4(a) and (b) updates from Chairs of the PLC Committee and Finance & Investment Committee on the agenda for the meeting at item 10 below; * 5(b)-(c) Internal Audit Plan discussed at the Executive; * 9(a)-(b) June Audit Committee meeting rescheduled; and   *From 09 December 2021*   * 13(c) Clinical Audit further reporting at paper AC 31/2022.   **Item 11(c) Fire Safety – rota of fire wardens**  The DoCA/CoSec confirmed that the Emergency Planning Lead worked closely with the Fire Safety team. The DoF added that the organisation of the rota was more of an operational issue for day-to-day management than for Emergency Planning. The Chair requested that formal assurance still be provided that there was always an appropriate fire warden in place and that it was ensured that the persons in control of sites had an appropriate rota of fire wardens particularly in the event of any situations similar to COVID-19 which could result in sparsely occupied sites whilst staff were mainly working from home (thereby reducing the number of available fire wardens). This action noted as staying on the list to be completed.  The remaining actions in the Summary of Actions document were to be progressed:   * 11(c) Fire Safety – rota of fire wardens; * 12(b) on hold until next regular reporting on Single Action Tender Waivers due in September 2022; * 14(b)&(e) on hold for next overall Board Assurance Framework update; and   *From 09 December 2021*   * 6(d) Statutory & Mandatory training.   *The ED for D&T temporarily left the meeting.* | **HS**  **KR/ MMcE** |
| **DRAFT ANNUAL REPORT & ACCOUNTS AND SUPPORTING DOCUMENTS** | | |
| **3.**  a  b  c  d  e  f  g  h  i  j  k  l | **Draft Financial Statements and Accounts**  The DoF presented: (i) the Draft Annual Statutory Accounts – Year Ending 31 March 2022; and (ii) a high-level analytical review of the Primary Financial Statements from the draft 2021/22 Annual Accounts illustrating variance compared to the 2020/21 Annual Accounts ((i) and (ii) together forming Paper AC 21/2022). The DoF thanked the Finance team for their efforts in compiling the draft Financial Statements in readiness for submission on 26 April 2022, which had been a tight timetable to work to. The audited accounts submission deadline had again been extended to the end of June 2022 therefore there was longer than in pre-COVID years in which to undertake the External Audit although he hoped to be able to conclude the process earlier. In relation to changes to accounting policies, he reported that there had been little change this year although the IFRS (International Financial Reporting Standards) 16 treatment of leases would be coming into effect from 01 April 2022 which would impact upon the FY23 accounts and even during FY22 there would need to be reflection upon what this impact would be.  The DoF referred to the high-level analytical review and highlighted for particular attention: deferred income; and accruals and pre-payments. He explained that the NHS financial framework was more volatile than in pre-COVID years and also adapting to working within Integrated Care Systems. He thanked the Financial Controller for his work to ensure financial rigour and that processes were in place up front, however despite this there was substantial deferred income in the Statement of Financial Position.  *Statement of Comprehensive Income*  The DoF highlighted:   * a substantial 33% increase in operating income largely due to having to fully include income from the Provider Collaboratives. Therefore this was not a direct increase in the Trust’s income but income being passed through the Trust from the Provider Collaboratives; * operating expenses had also increased, by 27%, therefore the net impact was an £8 million operating surplus from continuing operations which was £8 million better than FY21; * finance expenses were largely related to PFI (Private Finance Initiative) costs and an increase in interest payable on the loan for the Whiteleaf Centre; * net assets had increased by £20 million but because cash had also increased, the PDC (Public Dividend Capital) payable had effectively been reduced; * the surplus for the year FY22 was approximately £4 million, compared to a deficit of just short of £4 million last year FY21, with movement therefore of £8 million; and * the adjusted financial performance (on a control total basis and after removal of impairments etc.) was a surplus of approximately £4.5 million for FY22 compared to an adjusted deficit of £220,000 for FY21 and therefore an improvement of approximately £4.7 million. The largest adjustments had related to impairments, such as revaluation of properties based on market values, but these were still at a negligible level compared to last year FY21.   *Operating Income from patient care activities and other operating income*  The Deputy DoF highlighted:   * the increase in income, mainly due to the Provider Collaboratives but noted that the movement between income in FY22 compared to FY21 should be £58,000 not £68,000 as currently shown but this would be amended in the next version. The Chief Executive asked if the 3 separate Provider Collaboratives could be presented separately, especially as they had different areas of focus and geography. The Deputy DoF replied that this may be possible or they could be presented separately in an accompanying table in the Notes section. The DoF added that this could also be shown in the commentary to the analytical review; and * the increase in block contract/system envelope income, largely due to investment in the Ageing Well programme; * the decrease in income from other sources, largely due to underperformance in the School Health Nursing programme; * the inclusion of Elective Recovery Fund income to support additional service developments in Dental services and Electronic Prescribing and Medicines Administration. The DoF explained that although Elective Recovery Fund income had been available this year from the Integrated Care System, this was not expected next year; * the increase in the employer contribution rate for NHS pensions; * similar Research and Development income levels from FY21 to FY22. The CEO added that there could be an increase in Research income, in which case it would be helpful to separate out the strands of that income. The Deputy DoF acknowledged this and noted that this may be useful in a few areas such as Research, Provider Collaboratives and the Oxford Pharmacy Store (**OPS**); * the increase in education and training income, due to: (i) the transfer of the Oxfordshire Training Hub as part of decommissioned OxFed operations; and (ii) an increase in Health Education England income for the Improving Access to Psychological Therapies programme and funding for trainees; and * the reclassification of £23 million of FY21 COVID-19 funding into part of block contract income in FY22.   *Operating expenses*  The Deputy DoF highlighted:   * the increase in operating expenses due to Provider Collaboratives which went live during FY22 and for which the Trust was the delegated commissioner; * the increase in staff and Executive Director costs including through increases in pay awards, pension contributions, investment to address underfunding in Oxfordshire mental health services, Mental Health Investment Standard investment, COVID-19 vaccination centre staff costs and agency costs; * increased drug costs through OPS; * increased transport costs, including patient transport costs, further to easing of COVID-19; * the increase in provisions, predominantly through dilapidations further to Estates review; * the increases in NHS Resolution contributions and HR legal spend; and * the decrease in Research & Development expenditure although this varied between years depending upon the status of grants.   The Chair noted that whilst the increases in clinical negligence and legal fees were not materially significant, it was still important to ensure that the drivers of this were identified and used to inform learning. The DoCA/CoSec confirmed that legal spend was reported into the Finance & Investment Committee whilst learning was reported into the Quality Committee. She and the Trust Solicitor & Risk Manager had also recently met with the CPO to review the increase in HR legal spend and consider whether increased internal resource would be more cost effective. The DoF confirmed that controls were in place to ensure that requests for legal spend were reviewed and approved to ensure that there was no unfettered access. In addition, he noted that a significant proportion of the increase had related to advice on the Warneford and the legal agreements surrounding it. The CPO added that requests for new lines of HR legal spend were subject to her approval and she would continue to keep these under review.  *Statement of Financial Position*  The Deputy DoF highlighted:   * the healthy cash position due to the operating surplus, increases in payables, deferred income and excess capital funding over expenditure; * the decrease in borrowings but an increase in provisions due to dilapidations and clinical pension liabilities; * the increase in the revaluation reserve further to Estates year-end valuation; * the increase in contract receivables due to accrued income, retrospective top-up payments for the COVID-19 vaccination centres and an increase in outstanding invoices; * the increase in capital payables due to delays in the capital programme; * the increase in accruals due to various accruals in relation to Provider Collaboratives, NHS Property Services, the National Institute for Health & Care Research and residential care and agency; and * the impact upon other current liabilities from the increase in deferred income.   The Financial Controller presented the Draft Annual Accounts and noted that whilst the accounting policies and the Notes to the Accounts remained fairly consistent with the previous year, he highlighted changes in relation to:   * Note 2 (Operating Segments and Adjusted Financial Performance) which had been expanded since last year but which also currently combined all Provider Collaborative operating results together, although that could be refined prior to submission; and * Note 1.20 (Standards, amendments and interpretations in issue but not yet effective or adopted) which expanded on the introduction of IFRS 16 on leases from 01 April 2022, as referred to by the DoF at item 3(a) above. IFRS 16 changed the definition of leases used in previous financial standards. On transition to IFRS 16 on 01 April 2022, the Trust would apply IFRS 16 retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. The estimated impact on the Trust was a £27 million increase in capital additions for new leases commencing in FY23.   The Financial Controller added that further changes to the Draft Annual Accounts were also anticipated in relation to:   * formatting; * updating Note 16 (Disclosure of interests in other entities); * expanding Note 5.1 (Additional information on contract revenue (IFRS 15) recognised in the period) in relation to deferred income; and * clarifying Note 26.1 in relation to pensions and the Buckinghamshire County Council employees who had historically TUPE[[2]](#footnote-2)-transferred over to the Trust.   The DoF invited the Committee to provide any comments on the Draft Annual Accounts separately to the Financial Controller and the Deputy DoF, prior to submission next week. It was noted that a revised version of the analytical review would be circulated.  The Chair reported that the private pre-meeting between the Committee and Auditors had discussed areas of judgement in the Accounts; she noted that it would be useful to provide an update in May on any areas outstanding or not yet agreed in the Accounts and she requested foresight to understand what any issues may be.  **The Committee RECEIVED AND APPROVED the Draft Annual Statutory Accounts and the high-level analytical review of the 2021/22 Annual Accounts Primary Financial Statements (Paper AC 21/2022) and, subject to the comments above and further changes to be made, AGREED that these should be submitted to NHS England/Improvement.** | **MWi/ PM**  **GrantT**  **/MMcE** |
| **4.**  a  b  c  d  e | **Preparation of Statutory Accounts on a Going Concern basis**  The Financial Controller presented the report at Paper AC 22/2022, the draft Going Concern Statement which included, at Appendix 1, references to the sources and documentation to support the going concern basis for preparation of the 2021/22 Statutory Accounts. The Committee was being asked to take a view of the ‘foreseeable future’ (generally understood as including, but not limited to, the next three financial years, and certainly no less than one year from the date of signing the statement i.e. from June 2022 and until May/June 2023). The available options were: clearly a going concern with no uncertainties; going concern with material uncertainties regarding the future provision of services in the public sector; or not a going concern and accounts to be prepared on a different basis. The final version would be presented to the Committee in June 2022 with the Audited Accounts.  The Financial Controller explained that the focus of the Going Concern Statement had shifted from organisational future financial sustainability to anticipated continuity of the provision of services in the public sector. NHS Improvement’s NHS FT Annual Reporting Manual set out that inclusion of financial provision for such services in published financial accounts was normally sufficient evidence of anticipated continuity of services and going concern status. As healthcare services continued to be provided, it was therefore highly unlikely that an NHS body would prepare its accounts on anything other than a going concern basis. The key consideration was whether the services it was providing would continue to be provided in the public sector. The Trust could evidence this by reference to the sources and documentation listed in Appendix 1 which set out NHS commitments to mental health and community services and to Provider Collaboratives.  The Chair asked Iain Murray whether he supported this approach. Iain Murray confirmed that he did and that the Financial Controller had precisely set out the position and considerations; he noted that a more common-sense approach had prevailed nationally in relation to going concern status of NHS bodies.  The DoF added that in previous years Appendix 1 had been more extensive on financial sustainability and continuity; these details on financial sustainability were now picked up through the Value For Money (**VFM**)reporting from External Audit which was anticipated for June 2022. The Chair asked whether the VFM report could be available on the agenda for the meeting in May. Iain Murray replied that this would be unlikely as the work had been programmed to commence in mid-May and whilst it should complete in line with the final Accounts’ submission, or very shortly thereafter, the aim was for the VFM report to be ready in June or as close to June thereafter as possible.  **The Committee noted the report and preparation of the draft 2021/22 Annual Accounts on a going concern basis.**  *Atif Saeed, Capital & Financial Accountant, left the meeting.* |  |
| **5.**  a  b  c  d  e | **Draft Annual Report including Draft Annual Governance Statement**  The DoCA/CoSec presented the report at Paper AC 23/2022 which set out the draft Annual Report including the Annual Governance Statement (**AGS**) on the system of internal control. The draft AGS set out that there had been no significant control weaknesses during FY22. The Committee was invited to focus upon review of the AGS at this meeting and recommend any changes so that it could be confident that the AGS was an accurate representation of the Trust’s work in assuring the effectiveness of controls and managing risk. The report also set out relevant factors for consideration as to whether an internal control issue may be significant, or not. The DoCA/CoSec highlighted the Committee’s role in considering the Trust’s control environment and reviewing the AGS which would be signed-off by the CEO in his capacity as Accounting Officer.  The DoCA/CoSec noted that the draft Annual Report was still a work in progress with submissions still being received; a more advanced draft would be presented to the next meeting in May 2022.  The Chair noted that the Internal Audit review of Patient Safety Incidents could be relevant to include on p.3 before the risk section, in order to provide context. On page 5, she suggested mentioning community services which were also under financial and demand pressures.  The following comments were also made:   * top of p.2 amend to clarify that the CEO was not responsible for risk management but was instead accountable for it as a responsibility he did not discharge directly; * p.6&11 update to clarity that the Information Management Group was monitored by the Finance & Investment Committee; * p.7 bullet point on short-term staffing gaps – clarify that filled where possible by use of bank, and then by agency staff if bank staff not available. Acknowledge the progress made in growing the staff bank and not just defaulting to agency; and * p.14 impact on BAME (Black, Asian and Minority Ethnic) communities – clarify what might be done to address disproportionate impact and take this beyond rhetoric and into strategic plans.   **The Committee noted the report, supported the direction of the narrative, and noted that further comments on the AGS in particular should be provided to the DoCA/CoSec.** | **KR**  **KR** |
| **AUDIT AND COUNTER FRAUD REPORTS** | | |
| **6.**  a  b  c  d | **External Audit Plan 2021/22**  Iain Murray presented the External Audit Plan at paper AC 24/2022 and noted that the areas of significant risks were consistent with those used in previous years and recommended in auditing standards: management override of controls; fraud in revenue recognition; fraud in expenditure recognition; and valuation of land and buildings. The reasons for risk identification and the scope of the External Audit response were as set out in the report.  He reminded the meeting that last year’s VFM report had not found any significant recommendations or weaknesses; he noted that this would be the starting point for this year’s VFM report.  Although the report set out on p.16 that the External Auditor’s Annual Report was due for the Audit Committee meeting in September 2022, he noted that the aim was to make the report available earlier.  **The Committee noted the External Audit Plan.** |  |
| **7.**  a  b | **External Audit 2021/22 – Informing the Audit Risk Assessment**  Iain Murray presented the ‘Informing the Audit Risk Assessment’ report at Paper AC 25/2022 and explained that this was the Committee’s opportunity to sense-check the responses provided by management to External Audit and ensure that these aligned with the Committee’s understanding of the organisation. The Committee was not being asked to sign-off on every point of detail but to highlight any inconsistencies or omissions.  **The Committee noted the report and had no issues to raise with the responses in the ‘Informing the Audit Risk Assessment’ document.** |  |
| **8.**  a  b  c  d  e  f  g | **Anti-Crime Service (Counter Fraud) annual report**  Tony Hall presented the report at paper AC 26/2022 which set out activity carried out against the Counter Fraud Plan 2021/22, in line with the Government Functional Standard 013: Counter Fraud. He noted that the Committee had been kept fully updated throughout the year on progress against the Counter Fraud Plan therefore most of the detail in the annual report should already be familiar. He highlighted that the Trust’s Counter Fraud Functional Standard Return (**CFFSR**) had been assessed with a proposed overall green rating for 2021/22 and the final submission would be at the end of May 2022, subject to authorisation by the DoF and the Chair. The only CFFSR requirement which had been marked as partially, rather than fully, met related to the fraud bribery and corruption risk assessment as it had not yet been completed, although the Trust had received it and it was in progress. However, he commented that given the lateness with which the Counter Fraud Authority had provided the risk assessment, the Trust was not alone in still having to complete it.  He provided an update on the COVID-19 passport fraud case, further to the summary on p.16, and noted that this had become part of a bigger enquiry which may take some time to fully investigate; this was a national issue, not just an organisational issue, and the Anti-Crime Service was liaising with the police to determine what next steps may be required. The Trust Chair asked whether there was any suggestion that the Trust could have done anything different in relation to the control environment which had been in place. Tony Hall replied that this had not been suggested; the Trust had no responsibility for the employment of most of the vaccination centre staff as they had been provided centrally from agencies and the Trust had been entitled to assume that the information with which it had been provided by the agencies had been accurate. The Trust was now operating a regime of daily checks of the vaccination centre system therefore any further attempts at this type of fraud would be identified within that day.  The CEO referred to the list of fraud alerts at pp.11-12 and asked whether it was sufficient for the action against most of these to be for circulation within the Executive team and Trust staff. Tony Hall confirmed that it was and that mainly the alerts had been provided for information only therefore this level of circulation was appropriate. However, if any particularly specific actions were recommended in the alerts then these would be followed-up. The DoF added that he had a monthly meeting with the Anti-Crime Service, the Deputy DoF and the ED for D&T to review these alerts, check actions and check progress with pro-active work. By way of example, he confirmed that if a specific finance issue or recommendation were included in an alert then the Finance team would review it and register any specific actions against it. There was therefore a process and system to manage relevant actions coming out of fraud alerts as well as circulation and publication for general staff awareness. The CEO replied that this was helpful and requested that some further narrative be included in the Anti-Crime Service annual report, especially around pp.11-12, to provide more detail on actions being taken to identify all potential risks e.g. referencing the monthly meetings with the Finance team to review recent counter fraud alerts and actions being taken.  The Chair referred to the client briefing note on p.14 and the recommendation that audit committees seek assurance that senior staff were compliant with the organisation’s policy on declarations of interest. She asked the DoF to comment or provide an update to a future meeting. The DoF took the action for a response to the next meeting and noted that this area was part of the remit of the DoCA/CoSec.  The Chair referred to p.16 and the case involving failure to declare an order/criminal offence and asked what learning for Disclosure and Barring Service (**DBS**) checks for other staff had resulted from this. The DoF recalled that the case had involved an order which had been made only very shortly before the individual had applied for the role; the DBS check had not picked up such a recently applied order and the issue had involved the time when the register of DBS checks had been updated rather than internal process failure but he and the CPO would check the case and report back if anything different.  The Chair asked whether there were areas of best practice which the Anti-Crime Service would recommend for the Trust in order to strengthen its practices further. Tony Hall replied that he was satisfied and that the Trust was well engaged with the Anti-Crime Service; when there were areas of best practice to draw to the Trust’s attention, these were done promptly and not held until the end of the year.  **The Committee noted the Anti-Crime Service annual report.**    *The meeting took a break for 5 minutes and resumed at 11:00. The Lead Nurse for Safeguarding Children joined the meeting.* | **TIAA**  **MMcE**  **/KR**  **MMcE/ CDS** |
| **9.**  a  b  c  d  e  f  g  h  i  j | **Internal Audit progress report and review reports**  ***Progress report***  Karen Finlayson presented the progress report at paper AC 27(i)-(iii)/2022 which included an update on recommendations from the FY21 IT Employee Data Records audit and the FY22 Payroll audit. She summarised that the report into Safeguarding had been completed and included in the papers to this meeting; fieldwork had completed on the Directorate review; and fieldwork had commenced on the Out of Area Placements review which had replaced the previously planned review into the new IT Data Centre, given the delay in set up and implementation of the new Data Centre. The Internal Audit annual report would be prepared for the next meeting but to date nothing had been identified that would be classed as a significant internal control weakness.  Caitlin Millar took the meeting through the detail in the report on follow-up work and summarised that a good position had been reached where there were no overdue unsubstantiated actions. There were however 3 ‘high’ and 4 ‘medium’ risk recommendations where extensions had been requested to deadlines, several of which related to the IT Employee Data Records and Payroll reviews. To provide more detailed assurance of the actions which were being taken against these, and as these actions were now part of a wider programme with multiple stages, the Head of HR Systems & Reporting had prepared a separate paper for the Committee which referenced progress made against each Internal Audit finding; this was the Employee Systems Development Programme report, with the main report at paper AC 27(iii)/2022 and supporting material available in the Reading Room to this meeting at RR/App 01/2022. Caitlin Millar explained that it had not yet been possible to reduce the risk ratings of the recommendations as there was not yet sufficient progress to provide assurance but Internal Audit would continue to review the work which the Head of HR Systems & Reporting was undertaking. The CPO added that the Learning & Development function had also now transferred into her portfolio, with effect from April 2022, which would strengthen the development of employee systems. She would continue to keep a close eye on the progress of her Internal Audit actions and recommendations.  The Chair referred to the action from the previous meeting (at item 3(f) from 23 February 2022) for Internal Audit and the CPO to give thought to what changes in the control environment(s) supporting amendments to standing data for employees, leavers forms, and controls around shift validation may need to be made in order to improve performance in these areas, as per the recommendations in the Internal Audit review report. The Chair noted that there could be some simple fixes and workarounds which could be deployed in advance of the wider programme work taking place on employee systems and which would help to improve data quality. The CPO replied that she was confident that the Head of HR Systems & Reporting was considering this as she worked through the employee systems development; however, the aim was to increasingly automate and have controls in place that way, and rely much less on manual checking. The Chair supported automation as an end goal but noted that the challenge in the interim was to reduce the high-rated risks and close these down as quickly as possible with interim measures, whilst accepting that those measures may not be a long-term solution.  In relation to the Health, Safety & Staff Security review and the action around implementing training, Caitlin Millar reported that the training had been agreed but until it had been rolled out, the risk rating could not be reduced nor the action closed. The DoF added that work had been taking place to establish better than average training and which would have formal NEBOSH (National Examination Board in Occupational Safety and Health) accreditation; training schedules were now being built for this.  ***Internal Audit Safeguarding review report***  Caitlin Millar presented the final report on the Safeguarding review, at paper AC 28/2022. This had received a ‘medium’ risk rating and the lead Executive was the Chief Nurse. The recommendations from the report had been ‘low’ to ‘medium’ risk and none of the issues identified had presented a clinical risk to child safety; mostly they were linked to data quality.  The CEO asked to what extent issues identified had related to differences in practice and different ways of working with different local authorities who each had their own systems, i.e. potentially they were a feature of the geographical spread of services. Caitlin Millar confirmed that this was precisely a feature of the findings. The CEO asked to what extent variation in local practice was within the Trust’s gift to address, or to what extent this was a reflection of the practices of other organisations which the Trust needed to work with. The Lead Nurse for Safeguarding Children explained that the Trust was dealing with five different local authority areas which all had slightly different processes and not all of the issues were within the Trust’s gift to be able to address. She noted that it had long been an issue to ensure that the Trust’s practitioners were kept notified of the outcomes of referrals which they had made and there could be challenges with social workers having the capacity to let the referrer know what had happened. Although services in Bath, Swindon & Wiltshire (**BSW**) had been singled out as demonstrating good practices around spot-checking referrals and the overall quality of referrals, BSW was a smaller geography and services provided by the Trust there largely focused on Child & Adolescent Mental Health Services.  Mohinder Sawhney noted that it was reassuring to hear that the data quality issues were impacting efficiency rather than effectiveness and therefore that children were not at risk. However, she referred to the findings at p.6 and the implications that if a child’s clinical notes did not indicate that a referral had been made, or information share completed, that this presented a risk that their safeguarding history was not documented for future reference if further referrals were made. She asked what assurance was available that this was not leading to a greater level of risk. The Lead Nurse for Safeguarding Children explained that uploading the referral form to Carenotes helped to provide relevant history of the case to a later practitioner picking up the case; although the same detail may also be in the progress notes, it would take a later practitioner longer to scroll back through the historic progress notes and find this than to find the referral form uploaded into the relevant correspondence section. If the referral form was uploaded then it would be quicker to identify that a referral had been made. This was what the action against that recommendation sought to address but the issue was not that the relevant information was not present at all, it related to the ease with which it could be identified and accessed. The Chair queried whether the related action (on the section of the mandatory training on making a referral) was sufficient, considering that it was unclear how often mandatory training took place and there may be issues with mandatory training compliance rates. The Lead Nurse for Safeguarding Children replied that: quality, operational and governance meetings were used to disseminate this message more quickly so that managers could remind their teams; and the findings of this audit review and its actions were included in the monthly Safeguarding newsletter which collated all key Safeguarding learning.  The Chair asked about high-level ownership of these issues and how the themes would get picked up for sharing best practice. The Lead Nurse for Safeguarding Children replied that pre-COVID there had been workshops for staff on making high quality referrals and a guidance document was also available; these issues were regularly discussed with staff through consultations and supervision. If the Trust’s partners were ever concerned about the quality of referrals then they would also directly contact the Trust to highlight this, as occasionally happened if very short referrals were made which had happened to lack detail. She also noted that the last Trust-wide referrals audit had taken place in 2018/19 and another one was due very shortly.  Mohinder Sawhney added that at a time when it was known that levels of clinical supervision and mandatory training were lower than target, it was necessary to exercise some caution in citing these as controls.  **The Committee noted the Internal Audit progress report and the Internal Audit Safeguarding review report.**  *The Lead Nurse for Safeguarding Children left the meeting.* |  |
| **10.**  a  b  c | **Assurance from Committee Chairs on themes previously identified in Internal Audit reviews**  ***People, Leadership & Culture (PLC) Committee: mandatory training***  Mohinder Sawhney provided an oral update and noted that although the PLC Committee had not met since she had reported upon its February meeting, she had asked for a root cause analysis of what could be leading to long term underperformance in compliance with mandatory training. She acknowledged that the CPO had already addressed updates against the Payroll review report and she noted that these issues would also be considered by the PLC Committee.  ***Finance & Investment Committee (FIC): Information Commissioner’s Office (ICO) audit; and PICU***  Chris Hurst provided an oral update in relation to the ICO audit and noted that although the timing of the most recent FIC meeting had not been able to benefit from a convenient Information Management Group meeting, he had requested and received an update offline instead from the ED for D&T who had arranged for the team to provide him with an update and confirm that actions were being taken forward. The next FIC meeting in May would also provide an opportunity to revisit this.  **The Committee noted the oral updates and assurance from the Chairs of the PLC Committee and the FIC, and that these would be revisited at the next meeting.** |  |
| **11.**  a  b  c  d  e | **Internal Audit Plan FY23**  Karen Finlayson presented the draft Internal Audit Plan 2022/23 at paper AC 29/2022 and confirmed that it had been reviewed and discussed through the Executive and two additional requests had been made in the private pre-meeting earlier with the Committee that:   1. the PICU follow-up review would become a standard follow-up review, rather than a detailed one; and 2. improving waiting lists would become an additional review and replace the Estates review.   The Chair referred to p.8 in the report and noted that the frequency of the reviews suggested may not all be warranted on those timescales, unless the risk profile of the review areas indicated otherwise. Karen Finlayson replied that the risk assessment of the reviews had been rolled forwards based upon historic one undertaken; these had been considered and reassessed to check whether there had been significant changes in their risk profile. Frequency of reviews could be over a cycle of 2-3 years but if an area was not being reviewed over a 3 year period then this suggested that it was consistently low risk or not being flagged on the Board Assurance Framework or assurance was being gained through a different source (such as the Care Quality Commission or the Trust’s internal arrangements on quality) as Internal Audit was part of the Trust’s assurance picture but not its entirety. She noted that the Trust needed to consider the other sources of assurance available to it so that it could be satisfied that there was sufficient coverage.  *The Chief Medical Officer (the CMO) joined the meeting*.  The Chair asked if the draft Internal Audit Plan 2022/23 was reasonable in covering off the key risks. Karen Finlayson replied that it was reasonable to support a Head of Internal Audit Opinion; if a new emerging risk was identified or it became apparent that there was insufficient coverage in an area then there was flexibility to make changes and be agile in response. However, there was a balance to be struck between the Internal Audit resource commitment available and other assurance available to the Trust. The Chair asked whether there could be follow-up work on any areas which may be exposed as not having assurance through the Internal Audit Plan and, if so, consideration as to how the Committee could receive assurance. She commented that separate work may be required by the Board on the Cost Improvement Programme (**CIP**)as this was an area of exposure.  The Chair commented that she was pleased with how the Internal Audit Plan had been collaboratively developed this year.  **The Committee noted the draft Internal Audit Plan 2022/23 and the amendments to be made in relation to: (i) the PICU follow-up review and; (ii) the additional review on improving waiting lists.** | **PwC**  **HS/KR** |
| **12.**  a  b | **Internal Audit thought leadership publication: managing risk in the NHS (Board Assurance Framework benchmarking)**  Karen Finlayson took the publication at paper AC 30/2022 as read and noted that it reflected review of over 50 board assurance frameworks across the healthcare sector and considered emerging risks. The Chair noted that there should also have been a separate risk report to this meeting and asked that the information in this publication be reviewed and sense-checked against the Trust’s Board Assurance Framework.  **The Committee noted the publication.** | **HS/KR** |
| **GOVERNANCE & ASSURANCE** | | |
| **13.**  a  b  c  d  e | **Clinical Audit update on the development of Clinical Audit governance**  The CMO presented the report at paper AC 31/2022 and explained that this provided an update on the significant changes which had been taking place around the Clinical Audit function. The report included an update on the annual ‘special’ meeting of the Clinical Audit Group (**CAG**) on the Trust-wide Clinical Audit Plan for 2022-23 (also provided appended to the report). The CAG had now been dissolved and its work would be incorporated into the agenda of the Clinical Effectiveness Group which would have its first meeting on 26 April 2022 and would report up into the Quality Committee. He highlighted positive feedback from the three CCG Quality Commissioners on the development and proposed focus of the Clinical Effectiveness Group. He emphasised the potential of the Clinical Effectiveness Group to: improve Clinical Audit processes: put physical healthcare on the same footing as mental healthcare in the organisation; and assess the quality impact of service models or changes. He reported that the Head of Quality Improvement (**QI**)was also taking on responsibility as the new lead for Clinical Audit, which would help to combine QI with Clinical Audit and Clinical Effectiveness.  The Chair noted that the Audit Committee would still need some additional information and assurance that the Clinical Audit function was operating effectively, the themes and ramifications from completed clinical audits and the impact upon learning and implementing different ways of working. She asked whether this could be incorporated into the Clinical Audit annual report so as to provide assurance on what the positive changes arising from Clinical Audit activity had been, what had been delivered and what was expected to be delivered.  Mohinder Sawhney noted that she would not be able to articulate, from the reporting provided, how high priority audits were spotted on a radar and what process moved nationally mandated audits and high priority audits through the relevant organisational architecture. The CMO replied that the high priority audits could be identified from Patient Safety Incident reviews or relevant external reports. The Clinical Effectiveness Group would consider the wider context within which clinical audits sat and the impact of resourcing as, whilst resources were limited, the Trust may choose other approaches than clinical audits. He noted that in approximately 3 months’ time he should be able to provide an update on progress and assurance that the organisation had the relevant architecture. The Chair noted that whilst that look forward would be helpful, the Committee was also expecting a look back on assurance from FY22 and which could also be relevant to support the Annual Governance Statement. She asked the DoCA/CoSec to liaise with the CMO on when a retrospective look back on Clinical Audit would be needed.  The Chair noted that the Committee was centrally mandated to consider clinical risks arising from financial pressures, as a result she recommended that waiting times/waiting lists should also be considered from a clinical angle and for potential inclusion in the Clinical Audit cycle. The CMO replied that there was already a separate project reporting into the Quality Committee on waits and any potential impact upon patient safety, therefore he did not believe that this area should also be included within the Clinical Audit cycle. Consideration of waiting times/waiting lists was outside of the routine work of Clinical Audit and was more appropriately dealt with via the separate project reporting into the Quality Committee.  **The Committee noted the report and that a Clinical Audit annual report would be provided to the Committee.**  *The CMO, External Audit, Internal Audit and Anti-Crime left the meeting. Remaining in the meeting were: the members of the Committee, the CEO, the DoF, the Deputy DoF, the DoCA/CoSec, the CPO, the Financial Controller, the Trust Chair and the Assistant Trust Secretary.* | **KM**  **KM/KR** |
| **14.**  a  b  c | **Procurement - External Audit contract update**  The Deputy DoF presented the report at paper AC-pvt 32/2022, explained the proposed procurement route and provided an update on progress. The Chair asked why not return to rerunning the original procurement process. The Deputy DoF replied that now discussions had been initiated on a direct award process; returning to the original process would build in a longer timeframe. The DoF added that the proposed procurement route also provided for greater flexibility and a more dynamic dialogue with the potential providers.  The DoCA/CoSec added that as some governors who had originally volunteered for the proposed selection panel had now stood down, or would shortly be doing so, replacements from amongst the governors would be required for the selection panel. The Deputy DoF acknowledged this.  **The Committee APPROVED the procurement approach detailed in the report to enable compliant selection and appointment of a new External Audit service.** |  |
| **15.**  a | **Review of the Meeting**  The Chair considered items to escalate to the Board from the meeting and asked whether CIP review coming off the Internal Audit Plan led to significant risk exposure. The DoF replied that CIP was more part of performance management processes and did not necessarily require Internal Audit review as much as a robust process/approach to delivery including monitoring performance first through the Executive, FIC and the Board. The Audit Committee’s role should be to validate the effectiveness and robustness of the process/approach. The Chair asked the Trust Chair for his view. The Trust Chair replied that monitoring of CIP performance was an FIC responsibility and the Board’s role was to ensure that it was aware of any risks attached to non-performance of CIPs. CIP was important but the mechanics for delivering it were appropriately within the domain of the FIC which also considered budgetary discipline and application to expenditure. Chris Hurst added that delivery of CIP began with having effective processes to plan for CIPs and which integrated with financial planning and budget setting; he confirmed that the FIC reviewed these. Once in-year delivery of CIPs had been agreed then the FIC would also monitor these as part of its monitoring of overall financial performance. The FIC did not necessarily examine the veracity of the design of CIPs and perhaps it would be worth considering with the Trust chair whether some earlier stage assurance on these could be acquired.  *The ED for D&T re-joined the meeting.* |  |
| **16.**  a  b  c  d  e  f  g  h  i  j | **Psychiatric Intensive Care Unit (PICU) project**    The ED for D&T presented the report at AC-pvt 33/2022 which provided the latest position on: very recently concluded contract discussions; how build momentum was being maintained; extra governance in place to oversee and control the works; responses to the Internal Audit recommendations; and identifying and learning lessons from the experience.  The Chair noted that the report had been good at addressing the Internal Audit recommendations and she reported that it had now been agreed with Internal Audit that the PICU follow-up review would become a standard follow-up review, rather than a detailed one. She also noted that the report had picked up well on what would happen next with learning lessons.  The meeting considered funding and capital requirements, and the impact of delays to the project. The Chair noted that given significant changes to the project, a revised business case should be brought back to the Board; she was still unclear from the report what the final best estimate on total capital costs was and how this was to be funded. The ED for D&T replied that he was currently developing a report for the Board to provide a detailed breakdown of costings. The Chair asked whether VAT had been resolved. The ED for D&T confirmed that it had.  The meeting discussed whether to have a further contingency for the project. The Chair recommended including a contingency, noting that advice from the Internal Audit review had been that this would be appropriate for this type of project.  Chris Hurst noted that he was reassured by the extra governance in place but that it would be sensible for the FIC to review a revised business case and consider whether the financial implications could be accommodated. He noted that although he had originally been concerned that NHS England/Improvement had been assuming a 100% bed occupancy rate in their calculation of bed date price, he was reassured that the assumption had now decreased to 85% (the ED for D&T confirmed 85%) as this reduced some of the risk which he had originally been cautious that the Trust might inherit. He recommended that the next PICU report to the FIC and/or Board include the following to bring all of the Board fully up-to-date:   * a clinical view from the CMO and the Chief Nurse that the clinical model underpinning the design was supported and there was no hidden project creep; * confirmation from the DoF that the finances had been reviewed and he was confident that they were robust; and * a statement from the ED for D&T that noted lessons learned around management, capacity and capability in managing this type of project so as to provide the best chance of delivering to budget.   Mohinder Sawhney added that the paper to the full Board should also include a forward from Chris Hurst with the view/recommendation from the FIC.  The Chair expressed concern that a recent email from the Deputy DoF had suggested that the proposal was significantly different to the original business case and that the unit may provide either no additional capacity in the local system or end up as a more expensive provision which would reduce overall capacity in the system. The CEO replied that there was very significant demand for this service for NHS PICU beds for children and young people in the South East region; there were limited NHS beds although there were private beds in private providers. There was a national shortage of this type of bed therefore the Trust would be able to utilise all of the beds on an ongoing basis, some for local patients and the Trust’s Provider Collaborative footprint and others for patients from other Provider Collaboratives or wider regions. The Trust would also be providing a strong service and it would not be a more expensive provision that would reduce capacity. He emphasised the importance of the project to deliver patient care and address unmet needs, noting that the slower the build, the longer patients may be in Out of Area Placements. The Deputy DoF added that funding and contracting arrangements had moved on from the time when the original business case had been developed and he agreed with the CEO; new funding was being introduced into the system and responsibility was devolving to the various Provider Collaboratives but needed to be worked through. He noted that the change from one way of working to another way of working did not necessarily introduce new risks, if anything it provided better opportunities to control capacity and the way in which the service operated. The Chair noted that the email had implied that capacity in the system would be reduced. The Deputy DoF replied that the opposite had been intended.  The Chair noted that although she was reassured that capacity in the system would not be reduced, there still needed to be discussions with commissioners around funding. The Deputy DoF replied that timing of such discussions was important and it was sensible to commence when support was actually required.  The Trust Chair reminded the meeting that the substance of Executive decisions was not necessarily a matter for this Committee but the discussion had nonetheless been useful before further reporting into the Board in the near future.  **The Committee noted the report** | **MW**  **MW** |
| **17.**  a | **Any Other Business**  None |  |
|  | **Meeting Close: 12:58** |  |
|  | Dates of next meetings:  18 May 2022, 09:30-12:30, and 15 June 2022 09:30-11:00. |  |

1. The quorum is 3 members (all Non-Executive Directors) and may include deputies. [↑](#footnote-ref-1)
2. TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) [↑](#footnote-ref-2)