Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE AUDIT COMMITTEE MEETING
HELD ON MONDAY 16 SEPTEMBER 2024 AT 9.15 AM
(held via Microsoft Teams)

Present: Mr D Moon - Non-Executive Director (Chair)
Ms V Bailey - Non-Executive Director

In Attendance:
Mr L Bond Chief Financial Officer
Mr J Brown - External Audit (KPMG)
Mr P Brookes-Baker – Head of Continuous Improvement (for minute 40/24/7)
Ms B Cassidy - Director of Corporate and Legal Affairs
Mr J Clarke – Local Counter Fraud Service
Ms C Holroyde – Head of Sustainability and Waste (for minute 40/24/6)
Mr S Linthwaite - Deputy Director of Finance (Financial Services)
Mr R Manton – Head of Risk Assurance
Ms K Meats - Internal Audit (360 Assurance)
Mr M Reeves - Corporate and Committee Services Officer
Ms J Robinson - Internal Audit (360 Assurance)
Mr Z Safdar – Deputy Director of Finance
Ms S Sethi – Head of Financial Accounting
Ms S Stanhope – Associate Director of Sustainability and Waste (for minute 40/24/6)
Mr D Streets – Head of Procurement and Supplies (for minute 40/24/3)
Mr C Walker – UHL Clinical Audit Manager (for minute 40/24/7)

RESOLVED ITEMS

35/24 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr I Browne, Non-Executive Director and Mr A Haynes, Non-Executive Director.

36/24 QUORUM

The meeting was confirmed to be quorate.

37/24 DECLARATIONS OF INTERESTS

There were no declarations of interest.

38/24 MINUTES

The Minutes of the Audit Committee meeting held on 24 June 2024 were received.

Resolved – that the Minutes of the meetings held on 24 June 2024 be approved.

39/24 MATTERS ARISING REPORT

The Committee received a summary of the matters arising from previous meetings.

The Director of Corporate and Legal Affairs referred to action 1, regarding a review of low scoring risks noting that this issue would be considered in more detail at the December Audit Committee meeting.

Resolved – that the report be received and noted.

40/24 OVERSIGHT AND RISK

40/24/1 Board Assurance Framework (BAF) and Significant Risk Report

The Director of Corporate and Legal Affairs presented the Board Assurance Framework (BAF) and Significant Risk Register. Assurance was provided that the BAF played a key role in shaping Board Committee agendas and enabled a focus on risks. It was noted that there were no significant changes since the last Audit Committee on the risk register and the themes of key risks remained consistent, including workforce and patient activity. Assurance was also provided that there was no complacency and there being ongoing Head of Internal Audit monitoring of risks, continuous work to improve controls and assistance to committees to seek assurance on the management of risks.

The Head of Risk Assurance also noted that following recent Executive appointments, there had been induction provided into BAF and risk processes.

Ms V Bailey, Non-Executive Director highlighted the fact that a number of risks had been on the risk register for some time, a number of years in some cases and queried whether there could be a different approach to managing or mitigating risks in order to resolve them. The Director of Corporate and Legal Affairs noted that some of the risks were long term in nature and would be addressed in a strategic manner. Assurance was also provided that a new approach had recently been taken in that Clinical Management Groups (CMGs) were now undertaking 'deep dives' into their risks and reporting at the monthly Risk Committee. It was also noted that quarterly meetings took place with CMGs to review risks and any controls or mitigations which were in place.

In summary, Mr D Moon, Audit Committee Chair confirmed that the Committee were assured that systems to manage risk were effective and working well, but there were areas which could be improved further.

Resolved – that the committee is assured that the systems and processes established for the management of strategic and operational risks are functioning as intended.

40/24/2 Escalation Reports from Risk Committee

The Director of Corporate and Legal Affairs presented the Escalation Reports from the meetings of Risk Committee on 2 July, 6 August and 3 September 2024. Assurance was provided that there were no issues of significance to report to the Audit Committee arising from the Risk Committee escalation reports, but stressed the importance of holding collective conversations regarding risk which involved all CMGs.

Mr D Moon, Audit Committee Chair referred to risk 4262, regarding Radiotherapy Physics / Radiotherapy and requested further background information about the risk, to be provided outside of the meeting.

Resolved – that further information regarding Risk 4262 regarding Radiotherapy Physics / Radiotherapy be provided to the Audit Committee Chair. **DCLA / HoRA**

40/24/3 Discretionary Procurement Actions

The Head of Procurement and Supplies presented an update report on the number of procurement waivers that had been approved for the period June 2024 to September 2024 and the reasons for those waivers. There had been 137 in the current year and it was anticipated that the end of year total would be similar to the previous year at 150. Trends noted were a reduction in revenue waivers in Estates and Facilities and the issue of waivers at the end of the financial year when capital funding became available. It was intended to investigate what further actions could be taken to reduce the number of waivers and this would be reported in the next update.

Ms V Bailey, Non-Executive Director referred to the NCP staff car parking which was on the waiver list and seemed to be for some time, querying whether better value car parking could be achieved. The Head of Procurement and Supplies noted that there hadn't been sufficient capital funding available to engage in a 3-year parking contract, but he would consider if there were any other options for more cost-effective car parking. The Deputy Director of Finance (Financial Services) confirmed that the car park contract was a lease contract.

The Chief Financial Officer highlighted the level of payment, £113k to the Health Service Journal. The Director of Corporate and Legal Affairs confirmed that this contract was a 3-year contract which covered UHL as well as both Trusts within University Hospitals of Northamptonshire NHS Group.

Mr D Moon, Audit Committee Chair referred to the reasons for use of waivers noting that most types were reducing in number, but highlighted the reason, 'competitive tender would be impossible, impractical or unbeneficial to the Trust', noting use of this reason had almost doubled compared to the previous year. The Head of Procurement and Supplies commented that these were most likely due to the use of capital funding late in the year or going outside of a framework to obtain a better price, but he undertook to review the reasons in detail and provide a report back. **HoP&S**

Resolved - that analysis be undertaken of the waivers using the reason, "competition by way of competitive tender be impossible, impractical or unbeneficial to the Trust", and provide details to the Committee..

40/24/4 Confidential Report of the Deputy Director of Finance

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

40/24/5 Data Security and Protection Toolkit Update

The Chief Information Officer presented a report which provided an update regarding the annual Data Security & Protection Toolkit return, a self-assessment provided to NHSE of how the Trust judged itself against National Data Guardian standards. The report also included plans for further cyber security improvements over the next 12 months, as well as the feedback of a recent audit into the data security and protection toolkit.

The Chief Information Officer provided assurance that the Data Security & Protection Toolkit self-assessment annual return had been submitted by the deadline following validation by 360 Assurance, Internal Audit. There were 7 low risk actions identified in the action plan arising from the assessment. Other points highlighted were that there were no data breaches deemed reportable to the Information Commissioners Office in the past 12 months, but also that information asset register training and awareness was behind the desired level. Overall, the risk of a data incident remained high, with ransomware a particular threat, but assurance was provided that the Trust was not complacent in relation to these risks and work was ongoing to ensure that processes were in place to manage risks.

Ms V Bailey, Non-Executive Director commented that the report appeared to provide a positive position but noted that performance in many areas was behind the level it should be. She queried whether the Data Security and Protection Toolkit audit had been carried out correctly, querying whether it had reviewed security and protection measures in the most effective way. The Chief Information Officer noted that despite a positive audit, that there shouldn't be complacency. The new assurance framework was designed to address concerns and provide a deeper level of assurance. There had also been investment in new tools which could better measure risks.

The Chief Financial Officer enquired about compliance with data security training. The Chief Information Officer explained that basic training was part of mandatory staff training, but compliance with specific training for information asset owners was not at the level it should be.

The Chief Financial Officer referred to 'penetration' risks where a cyber attack can penetrate the Trust's security systems. He noted that the Trust could have excellent systems protecting the organisation as a whole, but there was always a risk that individual users could open up the wrong email or attachment. He therefore suggested a test 'phishing' exercise could be undertaken to see how susceptible individuals were to such an approach. The Chief

Information Officer confirmed that such a test had been undertaken previously, but he would review what was scheduled for the next 12 months with a view to undertaking further testing. **CIO**

<u>Resolved</u> – that (A) the recommendations as per the report, be noted;

(B) the good progress made, and comments and concerns raised, be noted; and

(C) the timeline be reviewed for holding a further test 'phishing' exercise in order to assess any vulnerabilities and requirements for further training / awareness raising.

40/24/6 <u>Launch of Sustainability Working Group</u>

The Associate Director of Sustainability and Waste presented a report which provided an update on the launch of UHL's Sustainability Working Group and details of the governance and reporting the Trust's Sustainability and Green Plan objectives. The focus of the Working Group would be to ensure that the Trust met its Green Plan objectives as well as wider commitments such as net zero. The Working Group would have nine key areas of focus with different stakeholders taking lead responsibilities. One of the first activities would be to draw up a baseline report of the Trust's current position. It was also noted that it was intended to report annually to the Audit Committee on progress.

Ms V Bailey, Non-Executive Director noted that progress on the Green Plan had not always been consistent up until this point, therefore the Working Group was welcomed. An annual report to the Audit Committee was felt to be sufficient, but a report was welcomed at any time if there were concerns about any hindrances to progress.

The Director of Corporate and Legal Affairs welcomed the annual report to the Audit Committee but requested that the timeline for this report be in line with the Trust's wider annual reporting timelines. It was agreed to discuss the matter outside of the meeting. **ADoS&W / DCLA**

The Associate Director of Sustainability and Waste noted that there had been positive responses from Clinical Management Groups regarding the Working Group and there was a keenness to be involved.

In summary, Mr D Moon, Audit Committee Chair confirmed that the Committee noted the process and supported the Working Group, noting the importance of its role and future progress reports would be welcomed by the Committee.

<u>Resolved</u> – that (A) the report be received and noted; and

(B) reporting timelines for the Green Plan be reviewed to ensure that they are in line with the Trust's annual reporting timelines. **ADoS&W / DCLA**

40/24/7 <u>Clinical Audit Plan - Update</u>

The Clinical Audit Manager presented a report which outlined the progress of the roll-out of the UHL Audit Quality and Improvement Plan (AQIP) and the work being undertaken to improve national clinical audit results. The development of the AQIP had been an ongoing process where Clinical Audit and Quality Improvement had combined with an aim to improve standards and patient care. This had involved a range of development activities such as training and upskilling for staff to take forward quality improvements.

The Committee received a presentation which covered areas such as the alignment of Clinical Audit with Quality Improvement, and associated benefits, how projects within AQIP were being managed, new information sharing arrangements and better management of the projects regarding the topics they covered, as well as greater use of IT applications. Also covered was the drive to reduce duplication within projects and ensuring they had clear benefits for patients. The importance of benchmarking was stressed, therefore comparative data was now

provided more clearly and action could be taken where comparative performance was low. Also highlighted were the celebration events where the best projects were celebrated and best practice could be shared. The next steps for the programme were the development of the project management system, more benefit analysis, development of specialty priorities and to aim for the achievement of Kitemark certificates.

The updated graphic presentation of the National Clinical Audit results was welcomed, but noted this highlighted areas of concern about performance. Ms V Bailey, Non-Executive Director undertook to raise the matter with the Chair of the Quality Committee to ensure that there was ownership of the areas of concern and they were actively being addressed. The Clinical Audit Manager agreed that the new presentation of data enabled better holding to account and greater Executive oversight. **Ms V Bailey - NED**

The Chief Financial Officer commented on the number of projects, 2600 which were registered on the AQIP system, with a concern raised about the amount of resource which may be directed on these projects, particularly in view of the Trust's financial challenges. He also queried the level to which Quality Improvement informed projects and the extent to which they were in alignment with Trust objectives. The Head of Continuous Improvement noted that a significant number of projects would be undertaken as part of job training, however he agreed that alignment with patient benefits and strategic goals hadn't been as it should, therefore this was the focus going forward. A network of audit leads had also been developed to focus available resources better on priorities. The Head of Continuous Improvement and the Chief Financial Officer agreed to discuss the matter further outside of the meeting.

In summary, Mr D Moon, Audit Committee Chair confirmed that the Committee was assured that progress on the AQIP was moving in the right direction but noted areas for improvement regarding better targeting of projects which delivered clear beneficial outcomes.

<u>Resolved</u> – that the Chair of the Quality Committee be consulted to ensure that performance highlighted in national audits, which was below national standard, was being monitored and addressed. **Ms V Bailey - NED**

40/24/8 <u>Changes to the Audit Committee Handbook</u>

The Director of Corporate and Legal Affairs presented a report on the updated Health Financial Management Association's Audit Committee Handbook along with an assessment of UHL's position in relation to the latest iteration of the Handbook. It was noted that the Handbook included guidance in relation to risk management at a System level which was felt to be an area for possible development within Leicester, Leicestershire and Rutland Integrated Care System. It was intended that further discussions would take place with the Chair about the handbook with a view to implementing further changes to be in line with the Handbook.

Ms V Bailey, Non-Executive Director noted the different roles between Executive and Non-Executive Directors where one of the key competencies of a Non-Executive Director was to ask the right questions, rather than having deep knowledge of subject areas.

Mr D Moon, Audit Committee Chair enquired about forthcoming changes to Global Internal Audit Standards. Ms K Meats, 360 Assurance noted that these changes were due to take place from April 2025. Details of the changes would be reported to the Audit Committee once further details were known.

<u>Resolved</u> - that the report be received and noted.

40/24/9 <u>Sealings Report</u>

The Director of Corporate and Legal Affairs reported that there were no Trust sealings for Quarter 2, 2024/25, therefore it was not necessary to provide a formal standalone report to the Trust Board.

Resolved - that the report be received and noted.

41/24 INTERNAL AUDIT

41/24/1 Progress on Overdue Actions from the Internal Audit Reports (360 Assurance)

The Director of Corporate and Legal Affairs presented a report which provided details of the current status in implementing open 2024/25 and historic 360 Assurance Internal Audit actions. It was noted that 83% of first follow up actions had been completed with 6 actions remaining overdue, but these would continue to be followed up outside of the meeting.

Mr D Moon, Audit Committee Chair noted that 3 of the outstanding actions were linked to waiting list management and suggested that lead officer should be invited to a future meeting, particularly as the deadline for completing the action had been agreed between the lead officer and Internal Audit. Ms V Bailey, Non-Executive Director agreed with this suggestion commenting that these actions had been an issue for some time and there needed to be a way forward. Mr D Moon, Audit Committee chair confirmed this was the recommendation of the Committee.

Resolved – that, should the outstanding actions regarding waiting list management not be completed by the time of the next Audit Committee meeting, the lead officer be invited to the next Audit Committee to explain the position. **DCLA**

41/24/2 Internal Audit Progress Report

Ms J Robinson, Internal Audit, presented the Progress Report on the Internal Audit Plan. 3 reports had been issued in the quarter since the last Audit Committee, one of which received moderate assurance and 2 significant assurance, with 5 actions being agreed. Changes to the Terms of Reference for the Head of Internal Audit Opinion were also outlined, where a separate review of the Board Assurance Framework would be undertaken, and was currently in progress, Ms J Robinson also highlighted that a broader view on action tracking would be undertaken which would include a focus on the implementation of high and medium risk actions. It was noted that current performance was 85% of high and medium risk actions had been completed, and this split according to risk level would be a feature of the Head of Internal Audit Opinion, with one opinion now covering all elements. Assurance was provided that the Internal Audit plan was progressing in line with previously agreed time frames.

Ms V Bailey, Non-Executive Director welcomed the improved performance on action completion. The Clinical Management Group (CMG) governance audits were also referenced, noting that the scope didn't include how key risks were addressed and reported, and asked that this be included in future reviews. Mr J Robinson, Internal Audit in response stated that planning for the 2025/26 Internal Audit programme would commence December 2024 / January 2025 and this proposal would be considered within that process **J Robinson – Internal Audit / DCLA**

Resolved – To include, when auditing CMG governance, the management of risks and how these are reported to committees. **J Robinson – Internal Audit / DCLA**

42/24 LOCAL COUNTER FRAUD SERVICE

42/24/1 Counter Fraud Progress Report

Mr J Clarke, Counter Fraud, presented the Counter Fraud Progress Report. 2 proactive reviews which were being undertaken were highlighted, bank working whilst sick and the NHS Counter Fraud Authority national procurement exercise, where priority submissions were required.

Mr D Moon, Audit Committee Chair referred to the outstanding actions on the actions arising log regarding Counter Fraud. Ms J Clarke, Counter Fraud confirmed that action 6, about figures in relation to fraud and error identified and prevented had now been completed with details included in the report. With regard to action 4, regarding robust processes for valuations for lost property when claims were paid, Ms J Clarke, Counter Fraud agreed to look into this matter further.

The Chief Financial Officer commented that the number of counter fraud incidents under investigation appeared low for an organisation the size of UHL, particularly in comparison to other organisations which he had experience of. Ms J Clarke, Counter Fraud commented that it was important to promote reporting and monthly meetings were being held with People Services colleagues, to clarify what needed to be reported and encourage it to be done. This had increased the number of incident reports, but there was a national trend of reducing referral rates to Counter Fraud. It was however often found that matters referred were not actually Counter Fraud matters. Mr D Moon, Audit Committee Chair also noted that his experience from a different Trust was that there were many more cases of fraud being investigated.

Ms V Bailey, Non-Executive Director referred to the fraud case detailed in the report regarding abuse of position which led to dismissal and recommended that this was an opportunity for internal communications to highlight that the Trust will take serious action where fraud was uncovered. The Director of Corporate and Legal Affairs agreed to discuss the matter with the Director of Communications and Engagement. **DCLA**

In summary, Mr D Moon, confirmed that the report be noted, but stressed the importance of being proactive in seeking counter fraud referrals.

<u>Resolved</u> – that the recent fraud case, where dismissal was the outcome, be considered for use as a communications opportunity to highlight the stringent action that the Trust takes in response to such incidents. **DCLA**

43/24 EXTERNAL AUDIT

Mr J Brown, KPMG presented an update relating to External Audit. The 2023/24 audit had now been fully signed off with confirmation from NHSE that there were no outstanding concerns. A plan for the 2024/25 audit was in the process of being developed. The TGH audit would be reported the TGH Board at the end of September. The process for the 2024/25 audit was expected to be straightforward with no changes to standards.

<u>Resolved</u> - that the report be received and noted.

44/24 ITEMS FOR NOTING

44/24/1 <u>Minutes of Board Committee Meetings</u>

<u>Resolved</u> – that the Minutes of the following Board Committee meetings be received and noted at papers Q1 – Q16 inclusive:

- Operations and Performance Committee - 29 May, 26 June and 31 July 2024
- Finance and Investment Committee - 31 May, 28 June, 26 July 2024
- People and Culture Committee - 25 July 2024.4.
- Quality Committee - 30 May, 29 June, and 25 July 2024.
- Our Future Hospitals and Transformation Committee – 22 May and 19 June 2024
- Charitable Funds Committee – 21 June 2024.

45//24 ANY OTHER BUSINESS

There was no other business.

46/24 ITEMS NOT RECEIVED IN LINE WITH THE AUDIT COMMITTEE WORK PLAN

It was noted that the following items were not received in line with the Committee's workplan.

- Review of IA effectiveness.
- Data Quality Assurance Group

47/24 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following be highlighted to the Trust Board for information. **AC NED CHAIR**

- **Board Assurance Framework & Significant Risk Report** – to confirm the current position and the ongoing improvement in the management of risk.
- **Discretionary Procurement Actions –** to highlight the number of waivers being used and in particular, the number of waivers using the reason, 'competitive tender would be impossible, impractical or unbeneficial to the Trust.'
- **Data Security and Protection Toolkit Update –** to highlight the current position.
- **Launch of Sustainability Working Group –** to note the importance of the Green Plan.
- **Clinical Audit Plan – Update –** to note the number of projects being undertaken and efforts to ensure better alignment with Trust priorities. Also, to confirm assurance of the process but to consider greater scrutiny of outcomes by the Quality Committee.
- **Progress on overdue actions from Internal Audit reports (360 Assurance) –** to note the improvement on the number of actions being addressed, but also the intent to invite people to the committee where actions not completed.

48/24 DATE OF NEXT MEETING

The next ordinary meeting would be on Monday 9 December at 9.15 am.

49/24 CONFIDENTIAL REPORTS

The representative of External Audit and Internal Audit left the meeting.

49/24/1 Confidential Report from the Deputy Director of Finance

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

49/24/2 Confidential Report from the Deputy Chief Executive

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

The meeting closed at 11.51 am Matthew Reeves Corporate and Committee Services Officer

Audit Committee Cumulative Record of Members' Attendance (2023/24 to date):

Members:

Members				*In attendance*			
Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
D Moon (Chair)	3	3	100	L Bond *(from August 2024)*	1	1	100
V Bailey	3	2	67	M Brearley *(from June 2024 until August 2024)*	1	1	100
I Browne	1	0	0	B Cassidy	3	3	100
A Haynes	3	2	67	L Hooper *(until June 2024)*	2	1	50

A Moore *(until July 2024)*	2	1	50	R Manton	3	3	100
B Patel *(until July 2024)*	2	2	100				