Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Audit and Risk Committee

Held on Friday 21 April 2017 at 10.00am, in Seminar Room 4 - HQ

These Minutes are presented for **Approval**

Members and other Non-Executive Directors present

Charlotte Moar (CM) - Non-Executive Director (Chair)
Mark Outhwaite (MO) - Non-Executive Director
Neil Auty (NA) – Associate Non-Executive Director
Malcolm Shepherd (MS) – Non Executive Director
Sarah Elliott (SE) – Non Executive Director

Staff In Attendance

Paul Daniels (PD) - Head of Health, Safety & Operational Risk
Andrew Dean (AD) – Director of nursing & Quality
Vickie Gould (VG) – Assistant Manager, RSM
Kevin Henderson (KH) - Grant Thornton
Pete Tilley (PT) – Deputy Finance Director
Nick Atkinson (NAt) – Head of Internal Audit, RSM
James Shortall (JS) - Counter Fraud Specialist
Kevin Henderson (KH) - Grant Thornton
Sue McKenna (SMc) Operations Director
Barrie Morris (BM) - Grant Thornton
Simon Truelove (STr) – Director of Finance
Jennifer Ward (JW) – Corporate Governance Officer
Carla Carter (CC) - Acting Clinical Audit Manager

AR/17/001 Apologies

1. No apologies were received for the meeting.

AR/16/002 Declaration of Interests

1. In accordance with AWP Standing Orders (s8.1) members present were asked to declare any conflicts of interest with items on the committee meeting agenda: No declarations of interest were received.

AR/17/003 Minutes of the meeting of February 10th

1. The minutes were reviewed for accuracy and approved with a small wording amendment on page one.

AR/17/004 Matters Arising from the Previous Meeting

1. AR/16/50 - STP risks- Strategic and Corporate risks both now include assessment of risks and mitigations around STPs - Complete,
2. AR/16/68 - Gifts and Hospitality policy - SK updated that this will form part of the Corporate Affairs work plan going forward. Charlotte confirmed that the expectation here was that the format of the policy was made more user friendly to encourage reporting of gifts and hospitality but this was not an immediate priority.
3. AR/16/69 and 16/85- Board Assurance Framework – BAF approved by the Board on 29 March 2017 - Complete
4. AR/16/70 - Risk Registers - A plan for the rollout of Riskweb including training is being drafted; CM noted that it was disappointing that this action and.AR 16/085 on a plan to secure the arrangements around risk were still not completed.
5. AR/16/73 - Performance Management Framework –. Complete - SMc confirmed as lead for all performance across the Trust including corporate and Bristol system management. Operational

Governance handbook has been approved - on the agenda

6. AR/16/84 – NHS Improvement (NHSi) letter/BAF & Risk Registers - 2017/18 BAF to March Board meeting for approval. Enables BAF, top risks and internal audit/clinical audit plan to be linked for 2017/18 – Complete.
7. AR/16/086 – CAMHS Risk Register – Complete assurance provided to F & P on 24 March 2017.
8. AR/16/086 – Information Governance (IG) update –on agenda - Completed 31 March.
9. AR/16/89 – Internal audit tracker. On agenda – Complete.
10. AR 16/086 – SMc noted that the work on Riverside would begin in April.
11. AR/16/104 – Internal assurance update report – Complete.
12. AR/16/106 – Internal Audit plan – Complete.
13. AR/16/107 - Governance review presented to March Board and approved. Well Led programme agreed, oversight by A&R Committee - Complete .
14. AR/16/114 – Audit & Risk Annual Work Plan – Complete

AR/17/005 Trust Risk Registers – update

1. AD presented the report which noted changes to the Corporate risk register as follows: Increased risk – Delivery of CIP targets; Integration of quality governance processes
2. Top risks - Delivery of CIP targets; Management pressures from regulator activity; IMT platform; Impact of projected BNSSG financial position; Governance of Places of Safety
3. Charlotte Moar (CM) confirmed that the Board had reviewed the BAF and strategic risks recently; this would be approved at the May Board. The Executive Team were now reviewing the corporate risks regularly which was good progress.
4. Charlotte Moar noted that the actions around developing a plan for improving the functionality of Riskweb, a training programme and confirming all other actions which need to be completed to ensure that we have assurance around our risk management arrangements remain outstanding.
5. SMc explained that any corporate risk with a score over 12 will go on to the Strategic risk register but that where several LDUs have a risk with a score below this, but which when taken together would form a corporate risk, we need a method of ensuring that this will go on the risk register.
6. Paul Daniels (PD) noted that some of the outstanding actions covered in his report. The next stages of the process are to rewrite the policy and strategy, adjust Riskweb and then launch a training programme across the Trust.
7. Sarah Elliott (SE) suggested that we need to have clarity around this fair quickly due to the imminent visit of the CQC.
8. SMC suggested that what will matter is that we are managing the risks on a daily basis which is different from how we are reporting them.
9. It was agreed that Charlotte Moar (CM), Andrew Dean (AD), Simon Truelove (STr), Sarah Elliott (SE), Sue McKenna (SMc) and Mark Outhwaite (MO) will meet outside of the meeting to discuss and draft a clear process on identifying, escalating and tackling risk. **ACTION**

AR/17/006 Annual Governance Statement

1. The Draft Annual Governance Statement (AGS) was presented for discussion.
2. The AGS guidance suggests the following should be considered when assessing if an issue is significant or not: Whether an issue is significant: might the issue prejudice achievement of priorities; Could the issue undermine the integrity or reputation of the NHS; What view does the Audit Committee take on this point; What advice has the internal or external audit given ; Could delivery of the standards expected of the Accountable Officer be at risk; Has the issue made it harder to resist fraud or other misuse of resources ; Did the issue divert resources from another significant aspect of the business ; Could the issue have a material impact on the accounts; and might national or data security or integrity be put at risk.
3. The Committee agreed that the Annual Governance statement (AGS) is currently quite generic and needs to feels more individual around the issues affecting the Trust and how we are tackling them. It doesn't make the point sufficiently that our biggest challenge is cultural. We have the policies and the challenge is the application of those challenges and ensuring everyone applies them. It doesn't currently recognise the significant turnover of Executives and Non Executives and that it needs to be clearer on how we are tackling the challenges that we have clearly identified. We have descriptions of processes but not how we are actually tacking them. The Committee membership should be solely the 16/17 membership.

4. The AGS will be added to the Accounts on Wednesday, with the final version needing approval in May. The Finance section will be updated and the new version will be circulated to the NEDs for comment. **ACTION STr**
5. Barrie Morris (BM) stated that it is more important to get it right than to hit the deadlines.

AR/17/007 Bristol Risk Register

Sarah Branton (SB) presented the Bristol Risk Register highlighting the highest risks.

1. DToC – if these remain high there will be an impact on the use of beds, patient environment and out of areas. Mitigations- weekly conference call to identify DToCs, reasons for delays, and how the system can come together to move people on.
2. If the Local delivery unit (LDU) is unable to operate within activity capacity and the community service contract then the service risks providing service users with low quality care and not achieving financial balance. Mitigations – Scrutiny on recruitment, ongoing caseload profiling in assessment & recovery services, monthly finance reviews with all community services leads, all invoices and requisitions authorised at Managing Director level.
3. If the crisis line is to focus on supporting people in serious mental health crisis then the pathway for other calls need to be developed to reduce the risk for people who have been using the line. Mitigations. The CCG is chairing a co-produced workstream focussing on understanding the data from the crisis line, who uses it and how best to manage these calls in future so that the line can be used for people in mental health crisis.
4. If the police & crime bill is enacted and the time for detention under section 136 reduces to 24 hours then the wider mental health system will need to mobilise to respond to this change by provision of mental health practitioners with whom the police can consult prior to 136.
5. If Aspen ward has different environmental standards applied for ligature reduction to other acute wards, patients may come to harm through increased availability of ligature points. Mitigations-The ward completes a Manchester Tool risk assessment of the environmental with identified risks and mitigation understood by all members of the multidisciplinary team. Plus an individual assessment is undertaken on all patients admitted to determine level of psychiatric observations required.
6. If the inpatient services are unable to recruit to posts, the services will continue to use high bank/agency which is not financially sustainable, not clinically optimal. Mitigations – On call managers support decision making regarding additional staffing and incident management. Inpatient service manager follows up on issues resulting from out of hours. Floating shifts increased to late shifts as well as nights to reduce agency use.
7. If the medical rotas are not provided with sufficient administrative resource and additional cover then the Medical on call rotas will not be able to function efficiently. Mitigations – discussions with the citywide A & R manager, the Bristol medical lead, the managing director. Plan for how to move budget form the team and move to localities.
8. If the LDU is unable to recruit suitable medical staff to deliver the outcomes in the community contract within the financial envelope, it could lead to significant clinical risks and financial instability. Mitigations – Agency doctor requests to come through MD/CD for authorisation. Close monitoring of medical finances.
9. If the LDU is unable to recruit suitable medical staff to deliver and maintain the training environment it will lead to clinical risks and financial instability. Mitigations – Planning with foundation school. Regular monitoring of medical expenditure with management accountant. Agency doctor requests to come through MD/CD for authorisation.
10. CM asked how confident SB feels that staff are recognising and dealing with risks. SB replied that she feels very confident. They have weekly meetings with the service managers, they look at the data regularly to see what is happening in the teams and any issues are taken to the Triumvirate Board meetings. SMc added that all the Managing Directors and Quality Directors meet every month to discuss what needs escalating.
11. SE asked if there is any extra scrutiny on incidents in the Community. SB replied that they do a full review on all of the incidents. They also look at the incidents as a whole to ensure they didn't miss anything individually. She added that one challenge has been the addition of extra supervision which is enabling teams to deliver interventions which help people recover.
12. CM asked how confident they are in being able to deliver their budget. SB said she feels a lot more confident than this time last year. They even had a small underspend in March. The Sustainable

Partnership programme is having an impact, but they are in discussions about merging some areas, such as street triage to help them manage.

13. Following a question from AD on why Callington Road inpatient unit isn't listed on the Bristol risk register, SB explained that it appears in different places eg Aspen Ward and staffing.
14. SB noted that she had not been clear what was required for this presentation as no briefing had been sent in advance. CM confirmed that she would draft a brief to be sent out to those presenting in future. **Action CM**
15. CM thanked SB for her presentation.

AR/17/008 Counter Fraud Progress Report

1. The Committee noted the report and were asked to send in any comments.

AR/17/009 External Audit Progress

1. Barrie Morris (BM) presented the report highlighting that Under Section 30 of the Local Audit and Accountability Act 2014 they are required to report to the Secretary of State for Health if the Trust is about to make, or has made, a decision which involves or would involve the Trust incurring unlawful expenditure, or is about to take or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency. The duty is met if income equals or exceeds expenditure over a three year rolling period, or exceptionally a five year rolling period with the agreement of NHS Improvement.
2. Given the Trust is reporting a deficit this year, the three year, or five year period, starts from 2016/17. The Trust is planning on achieving the control total of a £2.9 million surplus for 2017/18, but the budgeted position for 2018/19 and beyond is not known. On the basis of the information we have to date, they are not proposing to issue a Section 30 referral. However, as the likely position for 2018/19 and beyond is confirmed we will need to consider if a report needs to be issued and will continue to discuss this with the Director of Finance and the Audit Committee.
3. Kevin Henderson (KH) informed the committee that under the Value for money conclusion the work is almost complete. They still need to add some information from savings plans, Nurse mentoring and Procurement. He has received the documentation from STr regarding the savings plans and has met with Amanda Willis regarding Procurement.
4. KH added that he still needs an update from AD regarding Nurse Mentoring and Agency costs, plus the actions response to the CQC report. **ACTION AD/KH**
5. Internal Audit reported that they are looking for an 'Acceptable' value for money conclusion, stating that although there have been challenges, they have been recognised by the Trust and actions have been taken.
6. KD asked for the Committees agreement that they are happy with all the management responses within the report. **The committee agreed the responses**.
7. The final item presented by KH was the Audit plan. This is now updated with 3 small changes including Operating expenses, not finding any issues with their approach noted, and the completion of the Action plan.
8. CM asked for assurance that the Finance department will be submitting a set of accounts on Wednesday April 26th. STr confirmed that they will be submitting accounts confirming a deficit of £8.9m.
9. BM noted his disappointment that there had been some criticism about the work of Grant Thornton, and assured the committee that their work had been inspected by the auditors and they were happy with their progress and reporting.
10. CM and STr both confirmed that they are happy with the work of Grant Thornton. STr added that the team couldn't have seen the financial issues that had occurred without having drilled down further than they are contracted to do.

AR/17/010 Note of any changes to External Audit accounting/practice/reporting

1. No changes noted.

AR/17/011 Internal Audit Progress report

1. Vicky Gould (VG) took the report as read and informed the committee that the Bed Management report was given a reasonable assurance level. She noted that if the report had been done earlier it would only have received a partial assurance. This was changed due to the amount of work that has been completed throughout the year. The Committee were pleased to hear this.
2. There were a number of changes to the original audit plan which were communicated as and when they were requested. The following audits were removed / delayed: Asset management ; Quality Improvement Planning; Contract Management / System Leadership (removed due to commissioner review over System Leadership)
3. The following audits were added to the audit plan throughout the year: Otsuka governance review; Pharmacy Review; Additional days on Key Financial Controls (Month End Procedures.

   CM noted that the medicines management report which had received partial assurance had been received at the last Quality and Standards Committee. The Unexpected Deaths audit would go to the next Quality and Standards Committee.
5. Internal audit are doing their concluding follow up work and have the Pharmacy review to complete, otherwise the work plan for 2016/17 is complete. .
6. **The Committee noted the report.**

AR/17/011a Receipt of Internal audit Reports & Associated opinions

1. Nick Atkinson (NAt) presented the Head of Internal Audit Opinion for 2016/7. He reported to the committee that he now feels a greater openness within the Trust which allows them to use Internal Audit in a more effective way. This has led to a more critical assurance opinion.

   The Committee noted the Head of Internal Audit opinion.

AR/17/011b Internal Audit Tracker

1. 8 actions have been completed and closed on the Internal Audit Action Tracker since the last Committee meeting. There are currently 23 Medium and High risk actions that remain open on the Internal Audit Recommendation Tracker. 9 open actions have passed their deadline date. All 9 actions are more than 90 days passed their deadline. It has now been agreed that Internal Audit will manage the Tracker going forward. The Committee were pleased with progress on this.
2. **The Committee noted the report.**

AR/17/012 Internal Audit Plan 2017/18

1. Nick Atkinson (NAt) presented the report noting that the Executives had reviewed the plan and added some things, plus altered the timings on others. The plan is focused on the key risks facing the Trust and is recommended for approval as part of giving the Audit & Risk Committee assurance for the year. He noted that there is in-year flexibility to change audits if management require.
2. AD commented that he feels Internal Audit are now working much more closely as part of the Trust team which is valuable. .
3. Malcolm Shepherd (MS) asked about the timing of the work and reports as there is a gap between the committee meetings from May to September. NAt assured him that the Executives will receive feedback on the work undertaken during this period.
4. STr added that Internal Audit provide the assurance that the Executives are producing the work and highlight anything that needs addressing. CM asked NAt to ensure that the lead Executive Directors for each report are identified. **Action NAt**
5. **The Audit & Risk Committee approved the Internal Audit Plan 2017/18.**
6. NAt informed the Committee that Internal Audit are actually audited themselves and are reviewed every 5 years.

AR/17/013 Internal Audit Management flow chart

1. The Committee were presented with draft process flow charts. It was agreed that the charts make the process and responsibilities much clearer.
2. **The Committee approved the flow charts.**

AR/17/014 Clinical Audit Plan 2017/18

1. Carla Carter (CC) presented the Clinical audit plan, noting that it is an ongoing cycle of continuous improvement which helps to reflect, review and act to resolve problems and make changes to improve patient care.
2. CM noted that this had been scrutinized by Quality and Standards Committee against the key quality objectives for 2017/18 and they had recommended it for approval.
3. The clinical audit work plan for 2017-18 has been drafted following consideration of the following:
   - Re-audit requirements from previous years audit work plans
   - Quality Schedule 2017-2019
   - National CQUIN template document 2017-2019
   - NCAPOP requirements (national audits including POMH)
   - Trust Policies (annual trust specified audits)
   - Trustwide QI plan (which contains CQC actions)
   - Review actions from RCA's and Thematic reviews
   - Topics requested by Associate Directors within Nurse & Quality Directorate
   - Topics requested by Medical Directorate
   - LDU priority topics requested by Quality and Managing Directors
4. It was noted that is not a static work plan and can be amended and added to throughout the year. The addition of topics as they arise ensures a responsive process to any identified new risks. It also allows for the addition of audits that fulfil a requirement on the evolving Quality Improvement plans or clinician interest to improve practice.
5. There followed a discussion on how thematic risks identified by clinical audit are highlighted to localities. CC emphasised the importance of sharing and learning from locality issues to ensure that if they are Trust wide issues they are picked up. Sue McKenna (SMC) agreed to work with CC to ensure that risks identified from clinical audits are fed into locality and corporate risk registers. . **ACTION SMc/CC/AD**)
6. **The Committee approved the plan.**

AR/17/015 Report on Information Governance 2016/17

1. STr presented the annual Information Governance Toolkit assessment for 2016/17 and the internal audit outcome. He noted that due to the excellent work of Kerrie Darvill, Richard Burge and Julie Benfell there has been more rigour applied, taking it to a new level. Assurance has been given to him as the SIRO that we are abiding by the requirements of the IG Toolkit. The report may look worse than last year but he is confident that it is supported by evidence and a real position.
2. The Information Governance Toolkit (IGTK) is an annual self-assessment commissioned by NHS Digital for all organisations that have access to NHS patient data. Organisations must provide assurances that they are practising good information governance and use the IGTK to evidence this. The information governance requirements are split in to the following 6 areas: Information Governance management; Confidentiality and data protection; Information security assurance; Clinical information assurance; Secondary use assurance; Corporate information assurance.
3. It is clear that the previous mechanisms in place for the management and ownership of the IG toolkit in the organisation weren't adequate in order to effectively comply with the requirements of the IG toolkit. However, the actions that have taken place over recent months in order to ensure that the IG culture in the Trust is robust and the review and QA process that is required for the production of evidence for the toolkit does put the Trust in a strong position moving forward.
4. Information Governance needs to continue to be a focus of the organisation and the work required to meet the national standards should be carried out on an ongoing basis throughout the financial year.
5. STr reported that previously we had fallen short in the area of clinical coding. This has now been addressed. An improvement plan for 17/18 has been devised by the Information Governance Steering Group and the minutes will come to this meeting. We should see an improvement in the scoring going forward. KH stated that Internal Audit are happy with the scoring applied.
6. SE asked how we assure ourselves on whether there are any Clinical risks arising from the coding risks. AD answered that the work being done will be correct, even if the coding applied is not

correct, meaning there is no risk to the patient. SMc added that this will be addressed as part of the programmes during the year, and she will report back. They are currently working up the priorities and plans of action. **ACTION SMc**

7. MO emphasised the importance of ensuring all staff are aware of the IG risks and what training is given. STR assured the committee that all staff undertake annual IG training, plus reminders are put onto computer screen savers. He added that there should be more checks to ensure screens are locked when staff leave their desks, and that there needs to be more rigour around file storage across the Trust. AD added that although staff are told about IG at their Induction, but it needs to be part of the daily routine.
8. **The committee noted the report.**

AR/17/016 Operational Governance Handbook

1. SMc presented the Operations Governance Handbook which is a tool which contains information to support all staff within the Operations Directorate to apply good governance across the Operations Executive portfolio. More specifically, the handbook along with the associated enclosures and appendices provide details of a system of meetings and processes to facilitate: The management of operations; Good governance and assurance; Organisational performance management; Delivery of organisational transformation programmes, including Cost Improvement Plans (CIPs)

2. MO asked the question about how we will know this will work and how it will be measured. SMc replied that so far they have not set any measures. CM suggested that Internal Audit could look at this in a year's time.

3. The Committee noted the report.

AR/17/017 Audit and Risk Annual Work Plan and Annual Review

1. CM noted that the annual report gives an overview of the Audit and Risk Committee's work in 2016/17 and a forward look to priorities for 2017/18. It includes feedback from members of the Committee.
2. **The Committee noted and approved the plan** with the addition of cross committee referencing.

AR/17/018 Well Led Framework – strategy & planning baseline assessment and plan

1. Rachel Clark (RC) presented the report. At the March 2017 Board meeting it was agreed to undertake a Well Led Framework self-assessment in October 2017. This is the assessment of Board leadership developed by Monitor and aligned with the CQC standards. The two main areas are Strategy & Planning and Risk.
2. RC has undertaken an assessment against the Well Led Framework domain - Strategy and Planning. It is an initial assessment which includes a gap analysis and a high level action plan to improve performance against the domain, prior to review by the Board in October 2017. The Well Led table breaks down the required elements of Strategy. Evidence that currently exists has been added, and a RAG rating applied.
3. RC noted that the Board decided the Strategy needed updating due to us now being part of 2 STPs. A 2 year plan has been put in place to address the plan, and the Strategy will be revised by September. An amber/red rating has been added due to the timeliness of the plan.
4. Sarah Elliott suggested that the Staff Survey results should form part of the results in terms of culture. It was also noted that stakeholder engagement will be addressed further during the year.
5. The domain will be further reviewed by the Executive Team in May, following the Executive Team review on 19 May and the Board Development meeting on 10 May 2017, with the need to produce something after the General Election.
6. AD talked to the area of Risk within the Well Led Plan. He noted that all areas had been assessed at an amber /red rating. The Risk process still needs clarifying. There are some areas where there is a lot of work to do. CM suggested that the key issues need to be established before they address the points on the plan.
7. The remaining three domains will be assessed during May, June and July. They will be presented to the Audit and Risk Committee in May and September 2017.
8. RC and AD agreed that this is helpful to have to produce evidence. It enables them to look at things in whole and from a different prospective. .
9. **The Committee supported the Amber Green rating of the Strategy baseline but agreed that**

the Risk rating of Amber Red needed to be confirmed once the risk meeting agreed earlier in the meeting had taken place.

AR/17/019 Update on the FIP

1. Str presented the update:- Following agreement with NHSi it was agreed that a "partner" be sought to aide AWP in the overall objective of the second wave of the Financial Improvement Programme ("FIP2"). This overall objective is: "to provide support to the trust to reduce costs materially thereby significantly improving both their 2017/18 and 2018/19 outturns while maintaining delivery of safe care"
2. Following agreement that AWP would participate in the process, NHSi issued a tender to ensure financial compliance was adhered to. The outcome of the tender was that a number of suppliers responded and NHSi "matched "potential suppliers with NHS trusts. The process was all conducted within the regulations set out within the national framework. Following this matching process AWP and the selected supplier SSG met and discussed the needs of the organisation and agreed a position moving forward.
3. The cost of this contract award is variable based on the agreed phases of work be completed. There are potentially four phases of work, however there are multiple clauses in the contract that ensure that each phase must be fully completed, before the next phase can begin and the AWP can terminate the contract at the end of any phase. Initially phase 1 & 2: £269,100. Phase 3: £1,542,976.
4. As a result of this tender, the matching process and the internal process, it was agreed that SSG were the most appropriate company for AWP to work with. This decision is based on, a number of factors including, value for money, ease of access, understanding of mental health services.

AR/17/019a Waiver of Standing Orders (Listening into action/ Financial improvement plan)

1. **The Committee noted both the waivers.**

AR/17/020 Any other Business AR/17/020 Any other Business

1. AD expressed a need to meet outside the meeting with External Audit as he was sure his team had provided all the information they had been asked for, and he wished to ensure they had or establish what else was required**. ACTION AD/KH**
2. The Committee scored the meeting an average of 3.9 (range 3.5-4). Key comments were

What went well:

Good chairing, well-paced
Good debate
Well-presented Bristol Risk Register
Good scrutiny
Good grip of issues collectively
Good input from new members

What could have been better:
Fewer and shorter papers
Not being reassured on the visibility and control of risk
The agenda was too heavy
Not sure everyone needed to be there

Part 2

1. STr presented a timetable for the appointment of auditors. **The recommendation around this was agreed by the Committee.**