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 26 May 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)
Malcolm Shepherd (MS) – Non Executive Director
Sarah Elliott (SE) – Non Executive Director
Charlotte Hitchings (CH) Chair

Staff In Attendance

Hayley Richards (HRi) Chief Executive
Paul Daniels (PD) - Head of Health, Safety & Operational Risk (part)
Kevin Henderson (KH) - Grant Thornton
Nick Atkinson (NAt) – Head of Internal Audit, RSM
James Shortall (JS) - Counter Fraud Specialist
Sarah Knight (SK) Interim Company Secretary
Bill Bruce Jones (BBJ) - Clinical Director, BaNES
Sue McKenna (SMc) Chief Operating Officer
Barrie Morris (BM) - Grant Thornton
Simon Truelove (STr) – Director of Finance
Jennifer Ward (JW) – Corporate Governance Officer
Jayne Williams (JW) - Head of Financial Accounting and Treasury

AR/17/022 Apologies

1. Apologies were received from Andrew Dean

AR/16/023 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/17/024 Minutes of the meeting of April 21st

1. The minutes were reviewed for accuracy and **approved with two corrections**:-
2. Page 4 bullet five this should read 'External Audit reported that they are expecting an 'except for' value for money conclusion.
3. Page 4 bullet nine should read 'BM noted his disappointment that there had been some unsubstantiated rumours and criticism about the work of Grant Thornton in the wider South West Health Economy, and he assured the committee that the Firm's work had been reviewed by the Regulator who had confirmed that the audit approach and underlying work was robust. 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/17/025 Matters Arising from the Previous Meeting

1. AR/16/086 – CAMHS Risk Register – update 26 May. The service will move to AWP email on 10 July. This is causing some difficulties with Sirona. The Trust Board have supported STr in his stance on this given the importance to the service of working with one email service.

2. AR/16/086 - The Trust submitted a business case to get access to £3m of capital to make significant changes to the unit but has now been informed that this capital was no longer available. The Trust had already allocated £537K within the capital programme and it was decided to progress with the spend as originally planned. This will cover the basic health and safety works identified in the external report commissioned through Estates. The capital allocation is over 2 financial years hence the work will begin in January/February 2018 and continue into 2018/19. A 9th bed was opened in Quarter 2 of 2016/17. The day programme is now operating 5 days a week with 4 places and activities in the evenings and at weekends. The length of stay has been reduced by 15%. A new modern matron has now been appointed. The unit has been re accredited by Quality Network for Inpatient CAMHS. The review team felt that the service was very positively received by young people and their carers.
3. AR 17/009 – KH noted that the information requested from AD had been outstanding as reported to the Audit & Risk Committee but STr and RE had provided it so this matter was now complete.
4. AR 17/012 - Internal Audit Plan. CM asked NAt to ensure that the lead Executive Director for each report is identified. Complete. **ACTION: NAt to circulate to SK to send to Chairs of Board Committees**
5. CM noted that most of the actions arising had been closed. She particularly noted that AR/17/014-Clinical Audit Plan - Sue McKenna (SMc) agreed to work with Carla Carter to ensure that clinical audit themes were fed into locality risk register had been completed.
6. She also noted the response to AR/17/015 – IG report, impact of coding on clinical care. SMcK reported that this has been reviewed and she does not believe that there are clinical risks at present that need to be escalated based on clustering on clinical coding as we do not use clustering to determine care.

AR/17/026 Update on Risk

1. CM confirmed that good progress had been made with improving the risk arrangements. The updated BAF and strategic risks were due to be approved by the Board in May following a Board seminar on this area. The regular review of corporate risks was now embedded in the Executive Team work programme. The links between the BAF/strategic risks/corporate risks and operational risks had been set out in a document which was presented to the Audit & Risk Committee for approval. We now need to complete the rest of the actions to give us assurance that the risk management arrangements are satisfactory.
2. Paul Daniels (PD) presented the report: There were no new corporate risks this month. The top risks were the delivery of CIP targets; management pressures from regulator activity; IMT platform; the impact of projected BNSSG financial position and the governance of places of safety.
3. HRi confirmed that the Executive Team review new corporate risks weekly as they created and the full Corporate Risk register on a monthly basis. In addition they identify systematic risks to add to the corporate risk register. All users of RiskWeb now have the ability to view ALL risks currently held on the RiskWeb Database.
4. Directors and Heads of Service (HoS) having reviewed the operational risk registers that sit within their services will identify risks that are to be escalated to the corporate risk register. Escalation to the corporate risk register will be based on the certain criteria including a high risk score and the risk occurring in different places.
5. The Local delivery units (LDUs) and support service departments will identify and report risks on risk web. Actions will be identified and monitored through risk web with a view of reducing the risk and achieving the targeted mitigated risk level. It is expected that the Director / HoS will review the operational risks that have been identified by their services to ensure that actions are happening to reduce the risk and also to consider whether any of their risks should be considered as a thematic risk if similar risks are happening elsewhere in their services or the rest of the organisation. Operational risks will be reviewed through the normal performance management processes of the organisation. The operational risk registers will be periodically reviewed by the Audit and Risk committee (A&R) and Quality and Standards committee (Q&S) as part of their deep dive assurance work.
6. Board Assurance Framework: - Directors will establish whether any of the corporate risks could potentially affect the delivery of the Trust's strategic objectives if not mitigated. These would be classified as strategic risks and will be recommended to the Board for inclusion on the BAF.
7. The audit committee will be responsible for reviewing the contents and controls of the BAF and

providing assurance to the Board that the BAF is being managed appropriately.

8. CM commented that she felt reassured that the Executives add the corporate risks. She added that she would like to see the top risks presented on an easier to read sheet. PD agreed to bring a condensed version to the meeting. **ACTION PD**
9. Charlotte Hitchings (CH) asked about progress with recruiting to the Risk Manager post which was key in terms of delivering the next steps in the programme. HR confirmed that this had been confirmed as a priority post and it was now being identified if anyone internal was able to fill it. **ACTION: HR to move forward with identifying someone to fill this post.**
10. CM summarised that there had been good progress made but it was important now that there was a clear plan, with timescales, resource and ensuring that actions were undertaken in order to finalise the system changes around Riskweb, the Riskweb training, ensuring the right teams held their registers on Riskweb, updating the policy, strategy and risk matrix and ensuring that all staff understood their responsibilities in relation to risk identification, mitigation and escalation. **ACTION AD/CM/PD/STr to meet re this.**
11. CH agreed that good progress had been made and thanked PD and the Risk team.

The Committee noted the report and approved the Managing Risk process.

AR/17/027 BaNES Risk Register

1. Bill Bruce Jones (BBJ) presented the BaNES risk register, highlighting the top risks.
2. If the problems related to the roll out of LIQUID LOGIC are not resolved there will be risks to day to day functioning of teams including related to safeguarding as well as risks to the timely provision of packages of social care. This will have a potential impact on DTOC numbers in BANES. The actions being taken are:- Teams undertaking manual work to reconcile records. Training continues although there are insufficient places at present.
3. The referral and allocation system in Therapies is to be reviewed following a recent failure to correctly process a referral. There is a potential for referral and allocation information to be missed by a referrer. The actions being taken are that CSM liaising with Team Manager to supervise referrals. Referrals meetings are taking place on a weekly basis; All referrals, including ward based, are now processed now via single track with one form. Therefore referrals all have specific staff allocated.
4. There is an increase in the number of referrals that require a medical opinion. If the demand for medical capacity exceeds the capacity within the team. This may have an impact on the timeliness of patients receiving the most appropriate care for their presenting needs. Mitigations in place are that currently clinicians in the team will undertake clinical review where need is identifiable as medical input. These assessments are then discussed in weekly medical supervision where the clinician identifies that more urgent medical input is required. Where there is not capacity, the team will approach other medical staff within the locality to assist.
5. There is a lack of professionally registered staff due to vacancy levels. If there are insufficient professionally registered staff then this may impact on the quality of mental health service provision and the ability to provide a timely service. The actions being taken are:- proactive recruitment taking place; twilight shift temporarily ceased to enable core 24 service; use of overtime, bank and agency staff to cover gaps in the rota; and recruitment is proceeding. We have recently recruited a band 5 rotational post. In addition they have successfully appointed to 2 band 4 unregistered practitioner posts. If there are no staff available from the intensive team the junior doctors on call will provide assessment supported by the on call consultant.
6. Assessment capacity within the team is potentially reduced for the next few months due to staffing issues in the team. If we do not have sufficient staffing then our ability to offer timely assessments will be reduced. Patients who are waiting longer than the 4 week referral to assessment time will be reviewed in the weekly care pathway meetings. Mitigations include reviewing triage processes to see if they can signpost more effectively. They will then prioritise referrals based upon clinical risk. This may require more routine referrals to be deprioritised.
7. Sycamore Ward:-If local beds are not available to BaNES Patients following the action taken as a result of CQC compliance action the a) Patients will need to be admitted out of area and the quality of their Care will be potentially compromised and b) Older adults and their carers may need to travel inappropriate distances for their in-patient care. All efforts are made to locate beds as near to home as possible. There is agreement in the Trust that beds for older adults with functional

disorders can be utilised trust wide. The Intensive team consider all options for home treatment. 5 beds at Bristol Priory are ringfenced for BaNES to compensate for loss of 8 beds on Sycamore Ward.

8. If the CQC determine that guidance for Single Sex Accommodation for Ward 4 is not altered and mitigations are not adequate then compliance actions will be required. The CQC hospital inspection stated that: "On some acute units there were not clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA 'Code of Practice". This included Ward 4 at St Martin's hospital – a subsequent internal review using the NHS Institute for Innovation & Improvement tool confirmed that the ward was not compliant with single sex accommodation guidelines. There is therefore a Risk of compromised safety and dignity of patients, and a reduced ability to use beds flexibly. Plans include reviewing Operating Procedure for Eliminating Mixed Sex Accommodation to give clear guidance to localities on required standards, plus an internal review using Institute tool and review by CCG and RUH.
9. Physical Health CQUIN - If the January audits for cardio metabolic assessments within the recovery and CITT teams do not meet the required target full funding will not be received. There are currently no controls possible as they cannot make retrospective changes as the audit is of practice in June 2016.
10. If the Trust does not fully support a smoke free policy and they are unable to supply bad weather shelters then there is a risk that smoke will continue to blow down the ward corridor. Staff are offered smoking cessation alternatives such as such as patches or vapes. They also encourage service users to stop smoking.
11. The female lounge on Sycamore ward is not sufficient in size or within the female only area of the ward. A possible new area in the female bedroom corridor has been identified however there will need to be new buildings works employed to make this into an acceptable space. If the a new build is not forthcoming then the environment of the ward will need to be supported to make best use of the space. If a new build does not occur and the current building continues to deteriorate, there is a significant risk to the health and welfare of both service users and staff. This includes the lack of a suitable female only lounge, and the raised flooring in the male bedroom corridor. Incident caution trip hazard signs are now in place in affected areas. They are also awaiting a report from Stuart Hammond on options to fix this.
12. If AWP do not successfully engage in Your Care Your Way (YCYW) BaNES Community tender there is risk of all community services going to another provider. BaNES CCG are undertaking a phased consultation and market testing process with the purpose of redesigning all community services including mental health by 2017. Preferred Prime provider status was awarded to Virgin Healthcare which means that risks are increased with regard to effect on recruitment as well as lack of clarity regarding model of care. AWP has engaged with the phase 2 consultation both at corporate and LDU level. AWP has signed a strategic memorandum of understanding with 3 other provider organisations. BaNES is in the process of developing a mental health 'provider alliance' comprising AWP, Sirona, DHI. RICE & BEMS+). The aim of this is to make best use of resources and position the existing service providers to be able to respond to any tendering process. Following the award of preferred provide status to Virgin cCare the CCG decided to continue to contract with AWP for specialist MH pathways.
13. The team have recently closed a four year long outstanding risk on Safeguarding in relation to meeting the requirements of partners.
14. CM asked if workforce was a key risk in B&NES and BBJ commented that at present it was not a high risk however the LDU continued to monitor this.
15. CM asked if BBJ was confident that all staff understood their responsibilities in relation to risks and that the process of mitigation and escalation was working. BBJ said that he was not fully confident as it took time to understand what risks are and how to identifying them. However the culture is developing on this and risks are considered formally at the locality meeting every month.

AR/17/028 Counter Fraud Progress Report with Annual Report and 2017/18 work plan

1. James Shortall (JS) presented the Local Counter Fraud Specialist (LCFS) Annual Report 2016-17. This Report covered the period 1 April 2016 to 31 March 2017 and comprises a total of 100 days of contracted activity, broken down into the preventive and reactive activities.
2. The Trusts Anti-Fraud, Bribery and Corruption Policy was reviewed and updated in 2016. It

contains the contact details for the LCFS and NHS Protect reporting hotline, which is also available via the Trust's website. The LCFS also supported the Trust in revising and updating the policies concerning the management of conflicts of interest, and gifts and hospitality.

3. JS reported a case of fraud where the individual was working somewhere else whilst off sick. The Crown Prosecution Service after nearly a year had confirmed that they would not take this case any further. The Committee discussed the learning from this.
4. The Committee noted the 2016/17 self-assessment which was green but with a few amber areas relating to staff awareness of fraud and measuring the fraud awareness culture. JS noted that he regularly presents to groups of staff on fraud. HRi suggested that he links with the Learning into Action roadshows to ensure visibility, he could also explore putting questions into the staff survey, or internal audit could undertake an audit of budget holders's awareness of fraud. It was agreed that JS/ST would consider what actions would be taken around this. **ACTION JS/ST**
5. JS then presented the 2017-18 LCFS work plan. This is centred round Strategic Governance; Inform & Involve; Hold to Account; and Prevent & Deter. This was approved.

The Committee approved the 2016/17 annual report and 2017/18 workplan.

AR/17/029 External Audit Progress

1. Kevin Henderson (KH) presented the report which he took as read.
2. The External Audit report will be sent to all the non-Executive Directors for information each meeting as the backing information is useful. **ACTION SK**

AR/17/030 Presentation of the Annual Accounts & Annual Report 2016/17

1. STr presented the Annual Accounts. He noted that the Trust Board has delegated the approval of the Annual Accounts to the Audit & Risk Committee. He also thanked Jayne Williams (JW) and her team for their hard work.
2. The draft annual accounts have been subject to an external audit by Grant Thornton which commenced on 26 April and lasted for approximately 3 weeks. The audit ran very smoothly, with all standard working papers, both electronic and paper being provided to the auditors on the first day of the audit.
3. The headlines from the audit findings report were:- Good quality accounts and working papers; prompt responses to audit queries; no significant issues identified; the audit did not identify any control weaknesses that are required to be highlighted for our attention; and accounting policies, estimates and judgements were assessed as green and adequately disclosed.
4. Some final audit queries are expected to be concluded by week commencing 22nd May.
5. Sarah Knight (SK) presented the Annual Report: This paper sets out the Trust's Annual Report and Accounts for signature. The Report includes the Annual Governance Statement.
6. STr also presented the Letter of Representation:- This representation letter is provided in connection with the audit of the financial statements of Avon and Wiltshire Mental Health Partnership NHS Trust for the year ended 31 March 2017 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.
7. Charlotte Moar (CM) asked about the paying of suppliers. STr explained that at present the they are happy with the cash forecast up to Q2 and this will only change if the control total changes.
8. Following a question by Malcolm Shepherd on the potential cash requirement figure within the report, the Committee discussed and decided that the term 'most likely' should be removed from the report
9. The Committee expressed their thanks to JW and the finance team and SK and the governance team for their hard work on this. .

The Committee noted the documents

AR/17/031 Audit findings report

1. Barrie Morris (BM) presented the report and said that delivering on its savings plans and achieving

its cash targets will be a major challenge for the Trust over the coming year. It is imperative that the Board has a tight grip on the financial position, on the delivery of cash and savings targets on a monthly basis, and on the Trust's ability to continue as a going concern. He recommends that the Board gives this its critical attention both in its formal Board meetings and through its wider programme of risk and financial management.

2. BM reported that they have reviewed the Directors' assessment and are satisfied with the management assessment that the going concern basis is appropriate for the 2016/17 financial statements.
3. KH explained that under Value for Money, except for the matters identified in respect of financial planning around budget setting and delivery of the financial plan and workforce planning, the Trust had proper arrangements in all significant respects. They therefore proposed to give a qualified 'except for' conclusion on the arrangements for securing economy, efficiency and effectiveness in use of resources, although it should be noted that the qualification only related to financial planning.
4. KH noted that they had followed a couple of Out of Area cases and were happy that the Trust was following appropriate procedures. The Committee discussed an individual out of area patient where no commissioner will take responsibility for paying. CM suggested that we stop paying the invoices as long as we keep paying then no one else will take responsibility. However we must sustain all care management to ensure patient safety. **ACTION ST.**
5. KH noted that Grant Thornton were also happy with the progress with the CQC recommendations and the robust arrangements in place to address the Meridian and Otsuka findings**.**

The Committee approved the Annual Report, the Annual Governance statement and the Letter of Representation.

AR/17/032 Charitable Funds Annual Report & Accounts

1. Jayne Williams (JW) presented the Charitable Funds Annual report and Accounts. She gave thanks to Tia Shortall, The Fundraising Manager for her work.
2. The Charity changed its name in April 2017 to Headlight Mental Health charity.
3. The Charitable Fund received £64,000 income in 2016-17 compared with £11,000 in 2015-16. The donations received were £63,800 (£11,000 in 2015-16). The charity received grant funding of £2,800 from Merlin Housing for a Recovery Festival in South Gloucestershire. A donation of £1,000 was received for the STEPS inpatient ward and £1,123 for CAMHS Riverside. The remaining donations were of smaller amounts given throughout the year.
4. The remaining balance of £55,300 came from the transfer of two restricted funds from other NHS
5. Trusts accompanying the transfer of services. The two funds received were: - CAMHS Riverside Fund and Wiltshire Learning Disabilities Fund.
6. There was a small income from fundraising; however this is not shown on the face of the accounts due to rounding. This is planned to increase in 2017-18 with the recruitment of a Fundraising Manager in December 2016.
7. Net expenditure was £74,000 compared with £45,000 in 2015-16. Main sources of expenditure were:-

   Recreation and therapies £14,000 (£35,000 in 2015-16). This reflected the needs of both inpatients and other service users in the community and included expenditure on various items such as artwork materials, video games and TVs, music and gardening equipment. This also funded events for the benefit of service users and the raising of mental health awareness that would not otherwise be possible from NHS funding.

   Furniture and fittings £19,000 (£2,000 in 2015-16). This money was used to improve the environment within wards and grounds.

   Other £41,000 (£7,000 in 2015-16). This includes the governance and administration costs of the funds, including recruitment and salary costs for a full time member of staff, paid for by the Trust and recharged to the Charitable Fund. It also includes design fees and promotional materials incurred during the relaunch.
8. The draft annual accounts have been subject to an independent review by Grant Thornton during May 2017. The audit ran very smoothly, with all working papers being provided to the auditors on the first day of the audit.
9. The independent review did not reveal any issues or errors. Requested changes to the draft

accounts included the following:-an amendment to a fund balance of less than £1k; the extension of a note to give more clarity around the significant funds that were transferred to the Trust during the year.

The Committee approved the Charitable Funds Accounts and Annual report.

AR/17/033 Audit findings report on the Charitable Funds accounts.

1. Grant Thornton confirmed they had completed their independent examination and had no matters to raise.

AR/17/034 Internal Audit Progress report

1. Nick Atkinson (NA) presented the report: He explained the Head of Internal Audit Opinion was that there are weaknesses in the framework of governance, risk management and control such that it could be, or could become, inadequate and ineffective.
2. Whilst there has been good evidence of management of operational risk registers evidenced through the deep dives undertaken at the Audit Committee, there has not been a consistent and effective Board Assurance Framework in place throughout the year. Work is being undertaken to develop the Framework which will provide greater confidence that systems and controls are in place to mitigate the risks identified. Additionally, whilst many systems were found to be appropriately designed during our audit work, we identified a number of examples where controls were not being applied as intended and designed.
3. More recently they have seen evidence that Management is using Internal Audit to focus on areas where they know there may be weaknesses, acknowledging the issues raised by Internal Audit and taking steps to close the identified gaps in internal control.
4. During the Unexpected Deaths (draft) audit, we identified that a lack of resource meant that actions arising from the Root Cause Analyses into unexpected deaths were not being followed up. We were provided with a detailed update on plans to implement locality and Trust-wide Quality Improvement Plans which will include actions from RCAs, as well as a central team that will be responsible for undertaking and following up all RCAs. It was noted that this audit would be received at Quality and Standards Committee in June: **ACTION SK**
5. NA also noted that during the course of this financial year there have been some delays highlighted to the Audit & Risk Committee over the failure to implement agreed actions on time and they are working closely with Management to ensure improvements by the Trust of timely implementation moving forwards. As part of this they have agreed a revised approach to follow up and Internal Audit is taking greater ownership of this process.

The Committee noted the report.

AR/17/035 Internal Audit Tracker

1. One action has been completed and closed on the Internal Audit Action Tracker since the last Committee meeting. There are currently 22 Medium and High risk actions that remain open on the Internal Audit Recommendation Tracker. 16 open actions have passed their deadline date. 8 actions are more than 90 days passed their deadline.
2. The Internal Audit Tracker will be taken over by Internal Audit from 5 June 2017.

AR/17/036 Well Led – Strategy & Planning

1. SK presented the Well Led document
2. The Audit and Risk Committee reviewed the self-assessment framework in April and determined that further information in relation to Board awareness of risks to quality, sustainability and delivery of current and future services (question 2) was required. Compliance has been reviewed against Monitor and CQC standards as amber red in view of the need to further embed revised risk management arrangements.
3. CM confirmed that the strategy element had been discussed in detail at the last Committee and confirmed as amber-green on the basis that the strategy development was well underway.
4. SK explained that with the speed of change with the Cost Improvement Programme the Quality

Impact assessments need updating regularly. Sue McKenna and Rebecca Eastley explained that each project will have a Nursing and Quality member. Board and the Committees will be reassured with regular reports on the process. The Transformation Board will receive the QIAs for all projects.

The Committee confirmed the Well Led Risk assessment as amber-red.

AR/17/037 ICO follow up audit report

1. STr presented this. The original audit took place at Trust premises in January 2016 and covered data protection governance, and records management (manual and electronic). The ICO's overall opinion was that there was limited assurance that processes and procedures were in place and being adhered to. The ICO identified considerable scope for improvement in existing arrangements in order to achieve the objective of compliance with the DPA.
2. Of the 47 recommendations, 45 have been completed and 2 are partially complete; these are that the Trust should ensure that its overarching business plan is accessible and transparent and that there is a clear link between the plan and the Trust's agenda for IG. This action has been assessed by the Trust as ongoing – Rachel Clark, Director of Strategy has been informed of this requirement.
3. Secondly, the Trust should ensure backup data is checked regularly to confirm the data remains intact and capable of being restored to operational use. Review of backup data for each key information asset to be undertaken by IAO/IAAs in Q2 and 3 2017.
4. The ICO does not require any further response from the Trust.
5. STr thanked Richard Burge and his team for the timeliness in their response to the Cyber-attack. We had some issues, mainly due to the number of PCs in remote locations we were unable to switch on to test for any problems. It was noted that the recent cybersecurity audit had given assurance that appropriate arrangements were in place. A summary of lessons learned will come back to this Committee. **ACTION STr**

AR/17/038 Any other Business

1. Jayne Williams presented some Self Certification sheets from NHSI. The Committee asked how often these have to be completed. This isn't clear so JW will bring back to the Committee in September. **ACTION JW**

2. The Committee scored the meeting an average of 4.15 (range 4-4.5). Key comments were

What went well:

Good chairing, well-paced
Clear reporting on the Annual Accounts
Good debate
Well-presented BaNES Risk Register
Better grip of Risk issues
Timely papers
Thanks to STr and JW and team

What could have been better:
Fewer and shorter papers- summaries instead of so much detail