Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a meeting of the Audit and Risk Committee Meeting

Held at 3pm on 25 October 2013 at Jenner House, Langley Park, Chippenham. SN15 1GG

These minutes are presented for **approval**

Members Present

Tony McNiff (TMcN) – Non-Executive Director (*Chair*)

Paul Miller (PM) – Director of Finance and Deputy Chief Executive

Karen Williams (KW) – Baker Tilly Business Services Limited

Victoria Gould - Baker Tilly Business Services Limited

Peaches Golding (PG) - Non-Executive Director

Hayley Richards (HR) – Executive Medical Director

Sue Hall (SH) – Interim Director of Business Development

Kristin Dominy (KD) – Director of Operations

Simon Garlick (SG) – Grant Thornton

Kevin Henderson (KH) – Grant Thornton

Staff In attendance

Ann Tweedale (AT) – Head of Quality and Information Systems

Hannah Dennis (HD) – Corporate Governance and Risk Manager

1 – Apologies

1.1. Apologies were received from Hazel Watson, Carol Lenz, Emma Roberts and David Taylor

2 – Minutes of Previous meeting

2.1. The Committee **approved** the minutes of meeting held on 15 August 2013.

3 – Matters Arising

3.1. 24/04/2013 – 10 – Update on changes to Standing Orders – JR advised that work is ongoing to ensure all delegated authorities are correct following implementation of Agresso. It was agreed this action should be **closed**.

3.2. 03/06/2013 – 5 – Internal Audit actions – TMcN stated that he felt improvement could be seen in the speed with which internal audit recommendations are being dealt with and responded to. This action was **closed**.

3.3. 15/08/2013 – 2 – Committee administration – it was agreed this action would remain open.

3.4. 15/08/2013 – 2 – Bribery Risk Assessment – KW had confirmed outside of the meeting that The review did not include CCGs and GP as this was outside the scope of the audit review. This action is **closed**.

3.5. 15/08/2013 – 2 – Quality Accounts – it was confirmed this audit has now been scoped and the action **closed**.

3.6. 15/08/2013 – 3 – Training – TMcN highlighted that there should be a distinction between staff having completed training and staff understanding what they do. This is an issue that is picked up in the Regularity Reviews as there is evidence staff do not understand processed. KD stated that there is a review underway to streamline statutory and mandatory training. TMcN stated that the Committee should receive feedback on this. **Action:** Director of Operations

3.7. 15/08/2013 – 3 – IT – PM confirmed 800 devices have been deployed. It has been decided that those in healthcare and domestic services do not have a significant need for IT access. TMcN asked if this should be looked at and PM confirmed the Executive Team would consider this. KD highlighted that some Trust staff do not work on our premises, for example those in prisons and their IT access is therefore hosted elsewhere, so a uniform solution is not appropriate. TMcN stated that an assessment should be undertaken to identify what staff need IT for their roles as not being able to access Trust systems could impact on morale. PG affirmed that accessing Trust systems is a cultural requirement as it should make staff feel part of working for the Trust. TMcN stated that the importance of this issue should not be underestimated.

3.8. 15/08/2013 – 4 – Pressure Ulcers and Patient Falls – a report went to Quality and Standards Committee on 22 October 2013 and the Committee is to report into Audit and Risk on the issue. **Action:** Medical Director

3.9. 15/08/2013 – 9 – Change to CIP allocation – PM confirmed all corporate budgets have been validated and KD confirmed operational budgets are currently being validated. TMcN asked if localities are happy with the budget position and to what extent localities needed to buy in to the process. PM confirmed information is held in Finance for reporting.

3.10. 15/08/2013 – 10 – Terms of Reference – TMcN agreed to consider relationship with Quality and Standards Committee with regard to horizontal reporting. **Action:** Chair

4 Internal Audit

4.1. Internal Audit Progress Report

4.1.1. KW presented the progress report, highlighting an error in the table on page 1 which stated that the Income and Debtors report contained a total of 6 recommendations – 3 high, 2 medium and 1 low – as it actually contained only 1 low priority recommendation.

4.1.2. KW stated that the majority of reports issued so far for 2013/14 had positive assurance opinions.

4.1.3. TMcN stated that, in the past, he had asked for all reports with a red assurance opinion to be sent to him directly, and asked that this process be continued moving forward. **Action:** Corporate Governance and Risk Manager

4.1.4. KW drew to the Committee's attention a change to the audit plan to

incorporate a review of the Quality Accounts which had been scoped with PM on 7 October 2013.

4.1.5. PM asked whether Internal Audit felt assured by the new processes in place within the Trust for managing Internal Audit reports. KW stated that the Trust had improved its turnaround time for retuning draft reports to Baker Tilly and the process seems much improved and there is greater clarity in terms of responsibility. KD thanked HD for her management of this process.

4.1.6. KW also highlighted the NHS updates included as an appendices to the progress report. The Committee noted the recent publication of the Monitor Risk Assessment Framework as this will impact on the Trust's FT journey.

4.2. Receipt of Internal Audit Reports

Income and Debtors/Cash and Treasury Management

4.2.1. KW presented the Income and Debtors and Cash and Treasury Management reports, highlighting that both included 1 low priority recommendation and had a green assurance opinion. The recommendation related to an update to a process document to reflect the implementation of the Agresso system. TMcN questioned the stated amount of £25 million invested by the Trust during 2013/14. PRS advised that this was not a total value as some funds would have been invested and reinvested.

Action: Interim Director of Business Development to provide short report on investments to the next meeting

Payments to Staff

4.2.2. The report was discussed by the Committee. Issues regarding access levels to ESR were highlighted in the report with a recommendation that access be reviewed to ensure access was appropriate for all staff.

Action: Head of Financial Control to provide update on review of access to relevant staff based on segregation of duties at next meeting

4.2.3. KW also highlighted a recommendation regarding overpayments to staff. PM confirmed that controls are in place to manage this, however reliance is on Managers to inform the Payroll team of staff leaving the Trust.

Creditors and Ordering

4.2.4. KW presented the Creditors and Ordering report which included 7 recommendations and an amber/green assurance opinion. TMcN asked why the Trust pays its creditors sooner than terms require. PRS confirmed that the recommendation is payment within 10 days and SH confirmed this is a public sector practice recommendation. PRS stated cash reserves are considered as part of complying with this recommendation.

4.2.5. The Committee discussed recommendation 4.1a which related to use of suspense accounts and which had not been accepted by the Trust. The report indicates that the issue is related to the Agresso system. SH stated that the Agresso system is implemented and working, however recruitment of a member of staff to support the system and effect necessary changes to this is ongoing. External support is minimal. PM stated that it is important we recruit an individual with the required operational skills and system knowledge. PG asked if support from Agresso was part of the contract. PM stated that it was not and that we can access support from Agresso at a cost of £1000 per day. A band 8a member of staff had been appointed, however they had pulled out at short notice, causing the current delay. It was noted that to close this recommendation the member of

staff will need to be appointed and then this issue can be addressed.

4.2.6. Recommendation 4.2 relating to £220,000 of unallocated credit notes was also discussed. PRS stated that she would investigate the reasons for this as there is a process for allocating credit notes regularly, however PRS had not seen the report before it was finalised.
Action: Deputy Director of Finance to feed back to next meeting on allocation of credit notes and those outstanding at the time of the audit/ HD to ensure all draft Finance internal audit reports are copied to PRS when circulated

Regularity Review – Amblescroft North and South/Cove and Dune Wards

4.2.7. The Committee noted that both the Regularity Review reports for Amblescroft North and South and Cove and Dune Wards had a red assurance opinions, with the main concerns raised as: payments to on call staff members not being paid in line with Trust policy; not all staff had completed training on information governance; the Trust's policy on Patients Own Drugs (PODs) was not being followed and; sickness absence is not being managed in line with Trust policy.
Action: Director of Operations to address issues and provide update at next meeting**.**

4.2.8. TMcN questioned whether the three additional Regularity Review reports yet to be issued as final drafts would also have red assurance opinions. KW affirmed this was likely. KD stated that she had chosen five teams to be audited which she had concerns about in order to highlight an issue with compliance as she sees audit as a mechanism to do this. PM stated that the recommendations relating to on-call payments are already being addressed through work underway to standardise the process. KD confirmed. **Action:** Director of Operations to include in update, as per above action.

4.2.9. TMcN asked what the Trust policy is on patients own drugs. HR confirmed there is a process which requires wards to use the patient's own drugs but the issue is with compliance due to a lack of resource from pharmacy. It was noted this was seen as a Trust-wide issue. **Action:** Medical Director to report back on use of own drugs.

Expenses Follow-up

4.2.10. It was noted that 40% of total recommendations made were confirmed to be implemented. JR confirmed that since responsibility for payroll and expenses has moved into Finance the team is working on improving processes.

General Ledger/Asset Management/Charitable Funds

4.2.11. KW presented the General Ledger, Asset Management and Charitable Funds reports, highlighting that there was a theme in the recommendations relating to changes in process through the implementation of Agresso.

4.2.12. The main concerns noted by the Committee were around Payment to Staff, and the Regularity Reviews at Amblescroft North and South and Regularity Reviews at Cove and Dune Ward.

5 External Audit

5.1. Grant Thornton is yet conduct the IT risk assessment and it was agreed that they would prepare a timetable with John Ridler and report back at the next meeting of the Committee via the progress report.

5.2. The external audit plan is not yet due to start, as reflected in the progress report.

5.3. KH drew the Committee's attention to page 10 of the progress report which summarised the move to Integrated Care which the Department of Health (DoH) published a document on in May 2013. A question was raised as to whether this issue has been captured on the Trust-wide risk register. SH confirmed that the CCG have plans in place to manage these changes, and that through the Bristol tender the Trust is moving its services into the community. PM stated that this will reinforce the direction of travel and it is therefore not felt this presents a risk to the Trust currently. SH confirmed that integrated care working with local authorities is on directorate risk registers where required.

5.4. JR requested that Grant Thornton provide the 2014/15 audit plan by end of February 2014.

5.5. KH also highlighted the issue for consideration on page 8 of the progress report regarding data quality. The Committee noted that Grant Thornton can provide a review of data quality in addition to the audit plan. SH stated the Trust would consider the need for this.

6 Assurance, Risk and Control

6.1. Progress against Internal Audit Recommendations

6.1.1. TMcN stated that he felt assured that control is improving as audit recommendations are being confirmed as closed through the tracking process.

6.1.2. KW confirmed that as part of Baker Tilly's follow up audit work they will verify management assurances that recommendations have been implemented, but that their initial work will focus on high priority issues, including medicines management and patient safety.

6.2. Trust-wide Risk Register and Board Assurance Framework

6.2.1. PM presented this report, confirming that the risk registers are reviewed on a regular basis with key risks and lessons learned captured. The process is in place and is being followed. HD confirmed risk registers have been reviewed by SMT and this will continue on a monthly basis. The Committee did not feel there were any risks requiring any further discussion at this meeting.

6.2.2. KD stated that with HD she had undertaken a complete review and challenge of all locality risk registers and that this would continue on a quarterly basis.

6.2.3. TMcN stated he was impressed with how things were being dealt with now.

6.2.4. HD confirmed she had scheduled meetings with Executive Directors to facilitate a complete review of the Board Assurance Framework ahead of mapping assurances Trust-wide on to the document. This is to be complete by the end of December 2013 and will show us what assurances we have and therefore what the gaps are.

6.3. Detailed Risk Review

6.3.1. PM presented the deep dive review of IBP05, stating that this updated review confirmed what had occurred to impact on expected achievement of savings targets. Issues will be picked up at Finance and Planning Committee on 29 October 2013 and Lee O'Bryan will report to Board.

6.3.2. There was some challenge of the original risk captured and whether this was

what the Trust was not achieving against. PM confirmed Executive Directors are confident revised plans will address the issue and the CIP Delivery meeting and Programme Management Office (PMO) is supporting this. Plans for 2014/15 will be improved through the business planning process.

6.3.3. TMcN queried the reasons for the current risk score being higher than the inherent risk score. PM stated that this reflects the urgent need to respond and get a grip on mitigating the risk, as we have not yet got complete plans to close the gap.

6.3.4. TMcN asked whether localities were buying in to the revised processes. KD confirmed that localities are working to implement new plans and this is being managed.

6.4. Wiltshire Risk Register

6.4.1. Norman Atkinson, Head of Profession and Practice, for Wiltshire was scheduled to present the Wiltshire risk register via teleconference, however due to the agenda overrunning Norman was not available.

6.4.2. KD presented the Wiltshire risk register. The Committee discussed risk WILTS1. TMcN asked why the risk score had gone up as the controlled risk should not be greater than the inherent risk. It was felt that the risk could not be clearly understood as the risk seemed to belong to the commissioner rather than to AWP. TMcN requested that the risk register be reviewed again with Wiltshire to seek greater clarity around the risks captured and returned to the next meeting. TMcN also proposed that the next meeting be held in Wiltshire and the Committee agreed this.
Action: Agenda

7 IG Toolkit Report

7.1. PM presented the report. The Committee noted that the Trust needs to achieve a level 2 score by the end of the financial year. The IG toolkit assessment is used to directly support the wider NHS Compliance Framework including Care Quality Commission, NHS Litigation Authority, the Mental Health Contract, and the NHS Operating Framework. Additionally to bid for tender opportunities the Trust must have achieved compliance at level two.

7.2. The Committee noted that the Trust is currently achieving only level one compliance with IG Toolkit requirements and agreed that the Trust should work to achieve level two by the close of quarter three. This is to be addressed by the Executive Team.

Action: Interim Director of Business Development to take forward through Executive Team

8 Audit Committee Review: Committee Evaluation

8.1. The report drew on best practice on how we self-assess our Committees and proposed the use of the checklist within the NHS Audit Committee Handbook to assess the performance of this Committee, with a shortened version for the other Board Committees.

8.2. SG questioned whether the current version of the Handbook had been used as some terminology was incorrect. JR stated that this seemed a good practice to adopt to ensure the Committee was operating within its Terms of Reference.

8.3. TMcN welcomed this as a way forward to improve the self-assessment process across Committees and the Board.

9 Finance: Update on Ordering Compliance

9.1. The Committee noted that the Trust has set a target of 90% compliance whereby all goods and services are procured with a Trust official order number. This is in line with the Trust's Standing Financial Instructions. At the end of 2012/13 this stood at around 75% compliance. The data produced, at this stage, will not give a fair reflection of compliance due to significant issues currently being experienced by Agresso users around training and on-going support of the Agresso system.

9.2. There is a review process to identify those that are not compliant but there are issues with the system which are stopping this from happening currently. It was highlighted that although we are not where we need to be we understand the issues and we are able to monitor what is being done.

Action: Interim Director of Finance to provide update on progress to next meeting

10 Any Other Business

10.1. No other business was raised.

11 Date of Next Meeting

11.1. The date of next meeting will be 19 December 2013 in the Learning Centre at Green Lane Hospital, Marshall Lane, Devizes.

11.2. Meeting closed at 4:15pm