East Suffolk and North Essex NHS Foundation Trust

Key Issues Report

Issues for referral to reporting Committee/Group

Originating Committee/Group and meeting date:	Audit and Risk Committee, 8 November 2023
Chair:	Mark Millar, Non-Executive Director
Lead Executive Director (as appropriate):	Adrian Marr, Director of Finance

Subject	Details of Issue	Action*
Meeting the Terms of Reference	The Committee's Terms of Reference require an assessment of the level of assurance that can be gained from the clinical audit (outcomes) function. The report provided to the Quality and Patient Safety Committee (QPS) in August and the approved minute was presented for assurance. The Chief Medical Officer provided further context in relation to the revised process and next steps to improve compliance, the focus on the right clinical audits, SMART objectives and learning, and considering this alongside other clinical effectiveness and improvement work. Members questioned whether this Committee is gaining assurance that the process being led by QPS is robust and working appropriately, recognising the areas for improvement and the risk being carried with 34% compliance against plan. Further context was provided including six monthly reporting to QPS and via the Clinical Effectiveness Group. There was confidence of compliance and optimising the use of the learning from audits. The Chair of the Committee had liaised with the Chair of QPS as the approved minute did not fully reflect that discussion, the number of audits and appropriateness to the size of the organisation and disappointment at current compliance was raised. The new framework provided more assurance, although significant improvement was required, and the work on quality improvement was noted, which QPS had considered in detail. The matter was referred to QPS to ensure more clarity on the assurance required including the number of audits of the right quality. This would be reported to this Committee. The six-monthly review of the work programme was received. Some progress had been made on completion of procedural documents and 95% are within their set review date. Performance had improved in every division except Medicine Ipswich and Women's and Children's. The process to review policies was described to include a policy on a page, with over 300 policies now removed from the register, and seeking to amalgamate and downgrade to guidelines as appropriate. A new policy review group is in place and a revised policy template is being considered. Support has been offered to divisions, including a session with Women's and Children's, taking a risk-based approach to prioritise those areas most in need. Committee members were encouraged by the work being undertaken and the	**Alert**

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	improvements being made, questioned the opportunity to create common policies rather than taking a site-specific approach, the position regarding a long-standing overdue policy, and the risk in relation to those that are overdue. Expectations were clear regarding incomplete policies and an action was taken to review progress regarding the long outstanding policy.	
Internal Audit	The full reports were presented for completeness following review of summaries at the previous meeting - Data Security and Protection Toolkit (DSPT), Medical Devices Management and Discharge Planning. Four reviews had been completed, and the remainder were scheduled for delivery in line with expectations: **Waiting List Management** – partial assurance, with management actions agreed. There is an element of maintenance and it was suggested that a re-audit may be required to ensure that processes are embedded. The Director of Elective Care attended to discuss the control weaknesses and management action agreed, with six of the eight actions closed representing swift and comprehensive action. The final action on rebooking of appointments is undergoing sample testing. Several months of proactive change were described and reference was made to reports to the Performance and Finance Committee (P&F). Staff had not previously undergone the right level of training nor had the necessary experience. There will be significant changes in terms of data quality accuracy and reporting as part of the Electronic Patient Record (EPR) implementation. With the Director's role, the new Head of Access and a different governance process in place for elective, there was confidence of delivery, whilst the Director would be supportive of another audit. Reference was made to the work of the P&F Committee and the elective recovery checklist considered at every meeting. The Chair of PFC confirmed that when triangulating the Committee's consideration of the reasons for the audit and this report, he was assured and was supportive of further work at the right time. The importance of learning was highlighted, and questions were raised regarding prioritising patients with learning disabilities and, from a clinical perspective, the education of current and new staff to fully understand the requirements, and how that is assessed on an ongoing basis. It was confirmed by Internal Audit that the evidence of action taken counteracts this negative assessment and this was unlikely to have a significant impact on the audit opinion at year end. The focus of a subsequent audit was discussed, and members would be involved as the scope was developed to ensure that ongoing training and inequalities were included. The Director confirmed that this had been a positive experience, alongside Intensive Support Team and Tier 1 guidance. The Committee welcomed the response to the agreed actions, and it was agreed to review this again in a future audit programme. Consideration should also be given regarding the interface with EPR implementation. **Medical staffing rostering Colchester Emergency Department** – partial assurance, and liaison underway to progress actions to completion. The key outcomes related to lack of guidance regarding rostering, approvals via email and gaps in shifts being agreed outside Medirota and not subject to a formal process, no standard reporting for sickness or scrutinising additional payments for overtime and extra shifts. The Associate Director of Operations, Medicine Colchester, confirmed that a Standard Operating Procedure is now in place for formal approval later this month. All processes were described including review of rosters twice weekly to include clinical competence and skill mix. The policy for absence has been reinforced and a	**Assurance**

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	process has been established for additional payments. Completion of the five actions was progressing well, embedding good practice and seeing the benefits. The Committee recognised the positive response whilst a question was raised regarding the Medirota system and its ease of use. This had been identified as a higher risk area and is a combination of COVID-19 practice continuing and a need to reset grip and control. There had been extensive consultation on the use of Medirota and members questioned whether the next review should focus on Medicine Ipswich. Embedding this as a team is important, ensuring visibility, transparency and good governance. The Committee thanked the Associate Director for the positive response and assurance provided. **Mandatory Training and Workforce Reporting Key Performance Indicators (KPIs)** – substantial assurance, with generally well-designed and consistently applied controls in relation to training. There was reasonable assurance on KPIs, with an approved People Strategy and suite of KPIs, and sound reporting arrangements. A question was raised regarding time to hire, which is included within the Accountability Framework rather than the Integrated Performance Report. **Divisional Governance Medicine Ipswich** – reviews have been undertaken on a rolling basis over the last three years representing the positive approach taken with divisions and shared learning from each review. This is the most positive outcome received to date, with substantial assurance. A robust business plan is in place and robust budgetary and cost improvement programme reporting. Members questioned when a community services review would be undertaken, and it was suggested that this may be in relation to North East Essex for the second review this year. The action status report was received confirming that 32 actions had been closed since the previous meeting. Progress regarding the DPST actions due for completion by the end of October was questioned. There is a lot of work to be done and Internal Audit was working closely with the team with a positive response received. Progress regarding discharge management, the use of paper-based systems within community services and link to discharge processes and Executive Leadership Team review of outstanding actions was considered, confirming appropriate focus and evidence of improvement.	
Counter Fraud	The annual national benchmarking report described the risks facing the sector and investigations underway. A benchmarking report on the single tender waiver usage during 2022/23 demonstrated that the Trust compares very well. There have been 12 new referrals since March 2023, a small increase, whilst remaining below the average. This indicates the continued vigilance to fraud and bribery risks and awareness activity to embed the anti-fraud culture. Members questioned how the training numbers could be increased and if there is anything that can support the ambition to enhance a freedom to speak up culture and the training provided. This would be discussed further with the Freedom to Speak Up Guardian regarding potential changes to the training, attendance or provision of material at those sessions. Alerts and the process for dissemination to relevant staff were highlighted, and a response was provided to a question regarding a specific case and the process for those relating to another organisation.	**Assurance**

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External audit	The BDO partner reported on the audit progress and recognised the awkward position that ESNEFT was in and the inconvenience of cancelling the scheduled Annual General Meeting. The report was structured around the risks previously reported to Committee and attention was drawn to there being no material misstatements that impact the primary statements, one disclosure in relation to capital commitments has been raised and management has agreed amendments in the final version of the accounts. This does not affect the financial performance or the Trust's position. Unadjusted audit differences in the previous year have rolled forward, subject to the final work being undertaken. The work performed and progress was described in more detail. Revenue recognition is significant, and this is well progressed with no issues to bring to the Committee's attention. Valuation of land and buildings is going through initial review, for IFRS16 it is the first year it impacts on primary statements and there are no matters to highlight at this stage. The potential impact of mismatches on reporting will be revisited. Members were asked if there was anything further regarding fraud that the auditors should be aware of in addition to the report already considered. Those matters that remained outstanding were outlined, manager, partner and quality review processes are ongoing which may generate more queries. BDO continues to be in regular contact with the finance team with the aim of closing the audit as soon as possible. The Chair received the update, and the additional explanation was accepted but this provided no assurance with regard to achieving a deadline. Concern was expressed at this position when reflecting on the original audit timetable and this was not a useful basis for further conversation. The Deputy Chief Executive sought confirmation that there was nothing further that the Trust should have done to provide the relevant information, which was confirmed by BDO. This is the message being provided to NHS England (NHSE). BDO accepted the comments made and the intention was to provide transparency on the remaining work. The extent of the new requirements had been far more than anticipated and income had not been given sufficient supervision, requiring redirection of senior resource which impacted on the remaining work. A timetable for completion had been discussed with the Director of Finance and additional resource had been confirmed to bring the audit to a conclusion as quickly as possible, with day by day review against the outline timetable, and completion anticipated by Monday 20 November. The Chair questioned the level of confidence and assurance on meeting this date bearing in mind previous years' delays and expressed the view that this was not credible. BDO confirmed that the timescale was tight and a guarantee could not be provided until the full extent of primary review was completed at the end of this week. It is the best programme of work based on the planning of resources, with a final check on 14 November at which point a decision on the timing for an additional Committee, Board of Directors and Annual General Meeting could be reviewed. The Chair recognised the Senior Partner's accessibility and engagement with the Trust whilst more senior BDO personnel had given no degree of comfort on capacity and progress, to this Trust or NHSE. The BDO annual report was provided in draft for discussion and was complete except for the final audit position. Assurance had been received regarding data quality and the waiting list issue, and the recent Care Quality Commission report in maternity, confirming that these are not areas of pervasive significant	**Escalation**

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	weakness. The Executive Leadership Team would review the draft next week. The Chair questioned the impact if completion was not possible by the end of November. This is contributing to the delay in laying the national NHS accounts which represents significant pressure for ESNEFT and attention from NHSE. The Trust's obligation to governors and its members was also taken very seriously. In conclusion, work is continuing, and the Chair requested attendance at the review meeting on 14 November to enable a view to be taken on next steps.	
Trust Charity	The final management report and signed letter of representation were received from Ensors, the charity auditors, for completeness.	**Assurance**
Governance	The full Board Assurance Framework (BAF), risk owners, process for update and the deep dive template and guidance were considered to ensure consistency when deep dives at Committees begin in November. Members felt this process was much improved. Each risk template is a living document with the risk owner updating it at any point in the year. Members questioned how assurance is provided that this is the case and controls are added as required, the distinction between risk appetite and risk tolerance and scope for a more dynamic risk heat map. This would be considered further in the Board Seminar session. It was confirmed that Committee Key Issues Reports are provided to support ongoing discussion with risk owners and future BAF updates. The Chair advised that the BAF is one of the best he had seen, and huge credit was due to the Director and his team. The Committee would continue to assess how it operates to consider the long-term strategic risk. This represents significant progress in governance and control. The first full report to meet Committee oversight requirements linked to cyber security was deferred due to sickness.	**Assurance**
Reports by consent	Received in relation to declarations of interest. The Committee was advised that work to fully implement the new Standards of Business Conduct policy was behind schedule and a full update would be provided to the January meeting. Compliance is currently slightly reduced whilst it remains the intention to significantly increase the level of declarations. Tender waivers and losses and special payments were also received. Members questioned a specific waiver and next steps and an increase in pharmacy losses would be raised at the Divisional Accountability Meeting to consider whether there were any control issues to resolve.	**Assurance**

*Key:			
Escalation	Support/decision required by reporting committee to resolve an issue within its remit	**Approval**	Positive action required regarding an item of business or support for a decision
Assurance	Evidence or information to demonstrate that appropriate action is being taken within a reporting committee's remit	**Alert**	Proactive notification of subject matter/risk that reporting committee is currently dealing with or mitigating which may require future action/decision
		Information	No action required. Reporting to update on discussion within a reporting committee's remit