REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD/08/18**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2017/18: QUARTER 3 REPORT** **APPENDIX 2: IAGC TERMS OF REFERENCE (ToR)**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Audit and Governance Committee (IAGC) is the high level committee with overarching responsibility for risk. The role of the IAGC is to scrutinise and review the Trust's systems of governance, risk management, and internal control. It reports to the Board of Directors (herein shown as the Board) on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

The report seeks to answer the following questions in relation to risk, governance and assurance:

- What positive assurances were received?
- What concerns in relation to assurance were identified?
- Were any risks identified?
- What other reports were discussed?

Positive assurance received in relation to:

- The Committee received and discussed the Board Assurance Framework (BAF) and Annual Priorities 2017/18: Quarter 3 report and is attached (Appendix 1) for information. This was a positive report and presented the current position of the Trust, which was as expected. More timely updates were being provided on the risks and progress but further work was still required to ensure that timely updates for all risks were provided.
- The Committee received and discussed an effectiveness report on the work of the IAGC against its terms of reference (ToR). The results of the effectiveness survey were positive and that the Committee was meeting its objectives within its ToR. The Committee reviewed and approved its ToR with some agreed minor amendments, and is attached (Appendix B) for approval by the Board.
- The Committee received and discussed the highest mitigated risks, and noted that the Strategic Risk Register (SRR) 5 risk: Failure to achieve financial plans as agreed by NHS Improvement under the Financial Special Measures regime, had crystallised. The updates provided on the risks in the register were much improved in relation to progress but there remained some risks where there was insufficient and late updates, and target dates had not been met and no progress updates had been provided with details of the reasons for these not being met. It was noted that timely updates had not been provided particularly in relation to the HR and workforce risks. It was noted that regular meetings were held with the Executive Director leads of the

risks to update the risk register on progress.

- The Committee received and discussed a deep dive report on the Cost Improvement Programme (CIP) scheme regarding the Endoscopy Service Line Reporting (SLR) review. The Committee acknowledged the positive progress and achievement that had been made, the process followed, and the hard work and support from staff.
- The Committee received and noted the Standard Operating Procedure (SOP) that sets out the process to be followed during periods of intense operational pressure in relation to meeting cancellations and the meetings that are essential and should continue to be held. The key message was noted that no Governance Board meetings should be cancelled and teams are requested to ensure that the most appropriate people attend the meetings to ensure these are quorate.
- The Committee received, discussed and approved an approach to managing collaborative risks between the Trust and its partners. This would tease out issues in relation to resourcing, governance and risk transfer, along with providing a clear documented process as part of the planning and continuing risk assessment/management process.

Concerns in relation to assurance identified:

- The Committee received and discussed a report regarding the Emergency Department (ED) Governance Structure and the implementation of a focussed Programme Management Office (PMO) supported by Carnall Farrar. Five key workstreams had been identified by Carnall Farrar to ensure focus of improvement delivery and impact. This is around the A&E Improvement Plan and the work being undertaken, the processes in place to improve performance against the A&E 4 hour wait target and ensure improvements are sustained. This work includes reducing activity inflow, optimising site management, optimising discharge processes and times and East Kent system-wide capacity. Positive work was being taken forward, around the supporting metrics, robust governance systems are in place to monitor and address any underperformance. Performance at William Harvey Hospital (WHH) Emergency Department (ED) has seen a much improved position than at Queen Elizabeth the Queen Mother Hospital (QEQMH). There needed to be improved patient flow through the hospital and improved discharges. The Committee was not assured and felt it was improbable that the improvements would be sustained to ensure the Trust achieved the 87.7% performance target.

Other reports discussed:

- The Committee received and discussed a report regarding the Validation System (Operational Issues) – A&E 4 hour wait target and Referral to Treatment data. The report had also been discussed previously at the Quality Committee. This is around improving the processes and provision of more accurate quality data information, as well as improving patient safety following the implementation of an electronic eCasCard system in A&E.
- The Committee received and approved an EKHUFT Constitution Advisory Report. This was regarding the requirement to approve the waiver of standing orders, as the normal notice period of six clear days before a Board of Directors Closed Part II meeting held on 10 November and Board of Directors Development Day meeting held on 11 January had not been fulfilled due to the meetings being called at short notice.
- The Committee received, noted and approved the 2017/18 annual accounts process and accounting policies for 2017/18, the deadlines for submission and the process for the production of the 2017/18 annual accounts.
- The Committee received, noted and approved the process and timetable for the production and submission of the annual report for 2017/18.
- The Committee received and noted an update report regarding whistleblowing cases.
- The Committee received and discussed the External Audit report and approved the external audit plan 2017/18.
- The Committee received and discussed the Internal Audit Report, which was a very

positive report as there were no outstanding actions. Although it was disappointing that partial assurance had been provided in relation to the induction of temporary staff. This was around the inductions not being appropriately recorded and learning for the divisions to ensure local inductions are recorded and provide the necessary evidence.

- The Committee received and noted the Counter Fraud Report and approved the strategic workplan 2018/19

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to

i) Discuss and note the report.
ii) Approve the revised ToR.