MINUTES OF THE AUDIT COMMITTEE HELD 22nd JANUARY 2014, 10AM- 12PM AT THE KING'S COURT, CHAPEL STREET, KING'S LYNN

Present:	Hilary De Lyon (HDL)	Chair & Lay Member, Audit
	Penny Sutton (PS)	Lay Member, PPI
In Attendance:	John Ingham (JI)	Chief Financial Officer
	Graham Copsey (GC)	Head of Corporate Affairs
	Mike Tweed (MT)	Counter Fraud
	Eleni Gill (EG)	Counter Fraud
	Daniel Hellary (DH)	Deloitte, Internal Audit
	Rob Murray (RM)	Ernst & Young, External Audit
	Sarah Boxall (SB)	(Minutes)

ACTION

1 APOLOGIES

Mike Clarkson, Helen Devlin, Dr Tony Burgess.

HDL raised Dr Burgess's absence as a concern. As there were only three members of the Audit Committee, there could easily be an issue of quoracy.
Dr Burgess brings the clinical expertise and as he has been absent for two meetings, it did present a risk if another member were unable to attend at short notice.

The committee discussed whether a deputy could be appointed or whether an additional member could be appointed to the committee in instances when members could not attend.
HDL/ PS raised the issue of other committees not being quorate within WNCCG due to their size, which did present an organisational risk.

GC would investigate this issue **GC**

2 DECLARATIONS OF INTEREST

None to declare

3 IDENTIFICATION OF AGENDA ITEMS UNDER THE FREEDOM OF INFORMATION ACT

Item 11 was exempt under the Freedom of Information Act on the basis that the information discussed was confidential pending an on-going investigation.

4 NOTIFICATION OF ANY ITEMS OF URGENT BUSINESS

There were no items or urgent business.

5 MINUTES OF THE PREVIOUS MEETING FOR CONFIRMATION

Page 2, 7 – The acronym should read Data Service for Commissioners Regional Offices (DSCRO) not DRSCO.
Page 4, 9d: This should read "the CSU holds the contract on the CCG's behalf".

Page 6, 11a: This should read "CF had merged with the West Midlands internal audit consortium and has been renamed the West Midlands Audit Service"

Page 10, 16: This should read The Healthcare Financial Management Association (HFMA) not HMFA.

The minutes were approved pending amendments.

6 MATTERS ARISING (NOT COVERED ELSEWHERE ON AGENDA)

JI updated the Committee on the NHS Anglia's CSU's status.
North East London CSU were appointed as NHS Anglia CSU's partner organisation in December 2013 and were going through a mobilisation phase for the next three months, which included understanding how the organisation works and how synergies could be put in place. From 1st April 2014, there should be a changing CSU model.

EG asked whether staffing arrangements within the CSU would change.
JI explained that the mobilisation phase included a review of this and one of the North East London's strengths was their interest in moving staff from London into Norfolk, to reinforce what was currently there.
DH explained North East London was interested in East Anglia CSU's accommodation as it was considerably cheaper.

PS asked for an update on the CSU's Safe Haven status.
GC explained they were now an accredited Safe Haven and were in the process of achieving the appropriate financial management status so that they could manage data on the CCG's behalf.

7 ACTION LOG

JI and GC had previously looked over the action log and did not identify any items which were critical to the Audit Committee at this time. JI and GC would update the action log and provide a narrative of the updates, which would be sent to the committee. **JI/ GC**

HDL asked whether whistleblowing data was available.
EG had spoken to NHS Protect and they had responded stating that, because individuals report via the National Fraud and Corruption line, not all allegations lead to fraud, therefore it was difficult to monitor and so no data was available.

HDL said that she had attended an event at which Sir David Nicholson had stated there was plenty of whistleblowing data available via public websites. HDL would like to have some information on a wide range of whistleblowing data. EG would look to investigate this data. **EG**

8 REVIEW OF RISK MANAGEMENT FRAMEWORK

GC introduced his paper. The current Integrated Risk Management Strategy and Framework would need to be reviewed as it was written for authorisation purposes and as the organisation had moved on it needed updating.

GC asked the Audit Committee to delay the formal review of the document for a number of reasons:

- The Governing Body development day in December 2013 had focused on risk. This indicated that there needed to be a fundamental review of the risk management strategy based around the strategic objectives, (which were being developed). CCG's were required to develop a five year strategic plan by June 2014, so the risk framework would need to be aligned to this.

- Internal Audit would be doing a review of the risk framework, taking place in February 2014.

HDL had had a discussion with the WNCCG Chair following the development day at which members had agreed that there needed to be a clear link between strategic objectives and the risk management system and that this alignment was missing. When the original strategy was agreed not all Governing Body members had been appointed, so not all had been involved in developing the organisation's strategies. There would be another Governing Body development day in April 2014 where organisational strategies would be discussed and set, in doing so the framework would be put in place to focus on the risk strategy.

PS raised her concern that not all Governing Body members attended the development day so were not aware of all discussions. GC had circulated a resume of the day that had been prepared by the facilitator – Aidan Fallon.

The Audit Committee agreed to delay the review of the Integrated Risk Management Strategy and Framework until the strategy had been reviewed, as they believed it would be a logical approach to determine the strategy before aligning the assurance framework.

JI asked whether the outcome of the risk management strategy would need to be reconsidered by the committee in July 2014. HDL agreed this would be appropriate. **GC**
GC would revise the timetable to reflect this in preparation for the Governing Body meeting, which takes place on 30th January 2014.

HDL noted that the WNCCG would need to continue to use the same risk process until a revised framework was in place to ensure all risks were monitored.

Governing Body Assurance Framework (GBAF):
GC confirmed that the Audit Committee were responsible for ensuring the GBAF remained robust.

PS explained that the Patient Safety and Clinical Quality Committee reviewed the clinical risk registers regularly and had recently completed work on removing duplications and changing the risks to ensure they were valid.
GC stated the quality team specifically had done a very good job on the risk registers and would encourage other colleagues to follow this example.

HDL picked up on risk 1.7, Action Plan and Progress Report stating that it was optimistic to say a new member of staff 'would' reduce the risk significantly; it would be better phrased as

'should' or 'may'. GC agreed to amend this risk.

There was considerable discussion on the risk registers and the Audit Committee decided they it would be appropriate to have a brief report on a particular area of risk brought to the committee so they could be reassured the organisation was dealing with it appropriately and would ask the Governing Body to identify an appropriate risk. **HDL**

Corporate Risk Register (CRR):

PS felt that there needed to be more time between the Patient Safety Committee and the Audit Committee. GC explained that the meetings were timetabled in order that the major sub-committees met in the period leading up to the monthly Governing Body meeting. This inevitably meant that some meetings were closer to each other than was ideal.

HDL raised a couple of issues:

Point 1.1, gaps in control: This was not a gap; this was more about how it could be dealt with. The 'Description Risk' was not consistent with the 'Gaps in Control' and the 'Progress with action plan'.

Point 1.2, gaps in control: The relationship between the 'Gaps in Control', 'Description Risk' and 'Progress with action plan' was not consistent.

GC said this would be reviewed and become part of the learning process with the registers. GC stated the Corporate Risk Register is small and believed there were a number of risks, which were not being put on to the register and encouraged colleagues to identify risks. The Audit Committee agreed,

HDL questioned point 3.2 and whether this risk was too high in comparison to others.
There was considerable discussion over how risks should be escalated to the Governing Body Assurance Framework and whether a qualitative judgement needs to be made when moving risks.
RM explained that, if something was red in the operational risk register (CRR), then it becomes a strategic risk.

The Audit Committee agreed that, when reviewing WNCCG's strategy, the Governing Body would need to think about the organisation as a fit for purpose organisation and this would ensure the strategy links with the daily operations.
GC said this would be reviewed outside of Audit Committee along with the risk strategy.

MT asked about the empty 'Gaps in 'Control' columns, GC explained the identified risk owner had not completed the register fully.

9a INTERNAL AUDIT – CHANGE OF OWNERSHIP

Deloitte has now changed ownership; they were now part of the 'Mazar Group'.
The transaction was a share sale; the contracting legal entity was still 'Deloitte and Touche Internal Audit Ltd. Mazar Group had just purchased the shares, the legal entity remained Deloitte, it was solely a name change.

PS asked whether documents needed to be changed. DH said no as the legal entity still remains.

9b INTERNAL AUDIT – PROGRESS REPORT

The report was prepared in December 2013 when half of the days had been delivered, one draft report had been issued since the last Audit Committee in the area of Continuing Healthcare costs, this was a collaborative audit across the five CCGs. Internal Audit would attend the Chief Financial Officer's meeting on the 27th January 2014 to discuss this.

Page 4 set out the detailed status of the audits. All audits had been scheduled; the contingency days would be taken up by completing an IG Toolkit audit.

DH apologised regarding the performance indicators on page five, they had not been changed to give a more accurate reading of the plan's progress. DH would make these changes on the next report. **DH**

HDL asked if the audits would be duplicated across the CCG's due to similar systems being used.
DH explained that only the CSU's systems were the same, each CCG had different controls so each audit would be relevant to the individual CCG.

JI stated that the accounts payable and commissioning draft report (page 4) was issued in October 2013 and the CCG were currently behind on responding to this and would expedite this shortly. **JI**

GC asked how should the CCG report back on the recommendations given by Internal Audit.
DH explained the recommendations would go on to a follow up schedule and Internal Audit would contact the CCG to check whether changes had been implemented.

9c INTERNAL AUDIT – FOLLOW UP REPORT

DH stated at the last Audit Committee meeting that there were a number of PCT legacy recommendations left, these had now been finalised. There were still two outstanding, one related to QIPP, which was being conducted at the time of the Audit Committee meeting. There were a further five recommendations, which had been added to the schedule as a result of the final two audit reports.

DH confirmed the legacy recommendations were coming to an end and further recommendations would be transferred over to the CCG.

9d INTERNAL AUDIT – CCG RISK AWARENESS

DH explained the paper had been produced for information purposes, it was a summary of risks which Internal Audit believe were key and should be considered when developing and reviewing the risk registers.

GC would share the paper with the Governing Body, along with the development day report which had been produced. The two documents would be useful when developing the risk strategy and framework. **GC**

PS asked what ISFE was.
JI explained that ISFE was the new financial ledger, which was used within the CCG.

10a EXTERNAL AUDIT – 2013/2014 AUDIT PROGRESS REPORT

RM talked through the paper. Page 3 and 4 showed External Audit's focus for the year, they related to the financial position of the CCG and the health economy in general. External Audit were obliged to give the CCG an opinion on the value for money (VFM) in these areas, ensuring that there were arrangements in place for financial resilience.

RM explained that when organisations have had significant financial pressure, there could be pressure on individuals within the organisation when it came to estimates of accounts so it elevated the risk for audits going forward.

Opening balances would not be transferred through to CCG's, with the exception of property, plant and equipment (PPE) and a few small related balances, which are not material for the CCG.

At the time the document was written about the treatment of Continuing Healthcare provisions, there were discussions taking place between the auditors and the Treasury. The expectation was that the opening balances would not go into 2013/14 year's accounts for CCGs.

There could still be audit risks associated with this as, there may have been transactions against those balances even though they had not been transferred into the CCG, External Audit were not yet clear whether the National Audit Office would require them to complete work on those balances on behalf of NHS England. The National Audit Office would be consolidating those balances into the Department's accounts and there was no assurance over those numbers, therefore External Audit were expecting to complete work on this area.

As CCG's were newly established there would be checks as it would be the first year that CCG's had produced financial statements and there was risk associated with this, although they did anticipate extra capacity from the CSU would mitigate this.

RM explained that information on VFM was included in the report as members may not have been aware of this aspect of their work. There had been detailed guidance from the Audit Commission on risks relating to this. At the sent time there was not a significant risk regarding VFM within the CCG.

RM explained that External Audit relied on Internal Audit's reviews. They were expecting service audit reports from three sources in relation to the general ledger, payroll and systems at the CSU.

RM

External Audit would report back to the Audit Committee on the 28th May 2014.

JI stated there could be extra pressure on WNCCG due to the financial problems within The Queen Elizabeth Hospital (QEH) and Monitor may look to the CCG to help resolve this.

RM said that because the QEH had difficulties this did not mean the VFM conclusion would be linked to the CCG. External Audit would be more concerned with the arrangements the CCG have in place for dealing with external pressures.

JI explained that the Norfolk wide CCGs were having on-going discussions with the CSU about the support they would offer at year end. The draft annual reporting manual has been

published and CFO's would have further discussion on Monday 27th January 2014 with the CSU. There were experienced staff to help; it was a question of capacity.

HDL asked whether there would be enough physical space for auditors to work.
JI said there would be discussions regarding this, but it would be manageable.

PS asked about quality of data.
RM stated this would be reviewed within their work.

10b EXTERNAL AUDIT – NOV 2013 HEALTH SECTOR AUDIT COMMITTEE BRIEFING

For information only.

11 COUNTER FRAUD INTERIM REPORT

The Counter Fraud and Corruption policy had been amended and would be going to the Governing Body for approval.

Two Counter Fraud training sessions had been completed within the CCG, there were still three staff members outstanding, but there was a collaborative training session taking place with Norfolk wide CCGs to try and capture the staff that have not had the training, this had been scheduled for the 24th January 2014.

There was discussion over Governing Body Counter Fraud training.
HDL suggested online training maybe worthwhile for Governing Body members due to time.
EG explained she would look into an e-learning pack as Counter Fraud no longer offers this. **EG**
EG would email out a copy of the presentation with some added notes, which would provide further explanation.

The Audit Committee agreed that Counter Fraud training for the Governing Body could be achieved by sending out the presentation for members to read; if they had further questions, they could be raised with EG. Members would have to report back to state they had read and understood the information; a formal process would need to be set. **EG/GC**
EG would send this to GC for distributing.

EG would issue a staff survey in the future to monitor how employees had taken the Counter Fraud information on board.

EG asked for comments on the Counter Fraud newsletter.
GC stated this was a useful piece of information and the CCG would upload it on the staff intranet and circulate it via email to staff. **JI**
MT asked JI for a short message on the importance of reporting fraud.

There were currently no Counter Fraud investigations.

EG talked through the fraud investigation, which was discussed at the previous Audit Committee.

Due to the ongoing investigation this item would need to be marked as exempt under the Freedom of Information Act

EG gave JI a hard copy of the Procurement Manual, this was not available electronically.

MT gave an overview on Inform and Involve within the paper under 3.1 and 3.2. The contracts were being looked at and MT would shortly be reviewing home care and Domiciliary contracts. **EG**

MT would be reviewing joint contracts such as NCC and the CSU to ensure it stated who had responsibility for investigations.

12 POLICIES

GC introduced his paper on policies stating that the Audit Committee had overarching responsibility for approving CCG policies prior to going to the Governing Body.
There were a number of essential Information Governance policies brought to Audit Committee for reviewing.

GC stated he would ask JI as SIRO to review IG policies prior to Audit Committee in the future.

GC showed the Audit Committee NHS Anglia's Commissioning Support Unit's (CSU) Information Security Policy explaining the CSU had policies in place regarding IT security as they provide support in that area on behalf of the CCG.

GC asked the Audit Committee whether they were happy to approve the policy. **GC**
The Audit Committee agreed the policy and asked GC to circulate it to members for reviewing.

12a INFORMATION GOVERNANCE STRATEGY

Page 10, 4.1: This should be changed to "The Head of Corporate Affairs shall be secretary to the Committee and responsible for the minutes", not responsible for "taking the minutes".

Page 4, 4.3: This should be changed to "The strategy will be accessible via West Norfolk CCG's website"

The Audit Committee agreed point 4.1 could not be amended until the Constitution was changed, but would be noted.
The Audit Committee agreed and recommended the Information Governance Strategy to the Governing Body for adoption, subject to point 4.3 being amended.

DH would put Internal Audit's IG toolkit contact in touch with GC regarding publishing policies. **DH**

12b RECORDS MANAGEMENT FRAMEWORK

JI raised point 6.1 of the policy, stating the CCG did not have access to all patient heath records and suggested it should be changed to "any patient health records, where appropriate"

The Audit Committee agreed the policy subject to amendments and recommended it to the Governing Body for adoption.

12c FREEDOM OF INFORMATION POLICY

JI stated as SIRO he would like confirmation of how FoI's were monitored within the CCG and who has oversight of them.

GC explained the Corporate Affairs team had a FoI tracker internally, which tracked the progress of each FoI which was sent to the CCG, this was continually checked by GC and the Corporate Affairs Support Officer.
The CCG's Chief Officer has also asked for a weekly update to be given at the Senior Management Team meeting.

DH asked whether the CCG had received a report on FoI's from the CSU. **DH**
The CCG had not, DH would look into this.

The Audit Committee agreed the policy and recommended it to the Governing Body for adoption.

12d SUBJECT ACCESS REQUEST POLICY

PS raised the question of patient identifiable data in relation to this policy. JI explained this policy related to individuals asking for their own personal information.

GC explained individuals were able to request their own details from the CCG. The CCG did not hold the records, but the policy explained the process in which the details could be obtained.

PS asked over point 7, page 7, Deceased Persons.

GC would contact the CSU's Governance Team to confirm whether this section should state "deceased member of staff" or "deceased persons".

The Audit Committee agreed the policy and recommended it to the Governing Body for adoption once confirmation had been given

12e COUNTER FRAUD & CORRUPTION POLICY

The amendments from EG and TW had been incorporated.

The Audit Committee agreed the policy and recommended it to the Governing Body for adoption.

13 INFORMATION GOVERNANCE

GC highlighted the Information Governance Toolkit. The Toolkit required the CCG to collate key documents relating to information governance, it had three levels and the CCG were required to meet level two by the 31st March 2014.

There was on-going work bringing together information mapping flows and information asset registers, which would be imperative to the CCG's Information Governance agenda. Records Management was another key task, which had been identified and would be reviewed in conjunction with the Records Management Framework.

The CCG's Senior Management Team had been identified as Information Asset Owners (IAO) and the next step was to complete IAO training which would take place on the 28th January 2014.

The key roles within the Information Governance structure were the Caldicott Guardian, the Senior Information Risk Owner (SIRO) and the Information Governance Manager. The CCG had identified the following staff/ governing body member to fill these roles:

Caldicott Guardian: Dr Tony Burgess, GP Member of the Governing Body. This was particularly important as he would have responsibility for any issues over patient data.
SIRO: John Ingham, Chief Financial Officer. JI would have overall responsibility for Information Governance within the organisation.
Information Governance Manager: Graham Copsey, Head of Corporate Affairs. GC would maintain information on a daily basis.

Information Governance could have a lot of associated risks, such as Freedom of Information and patient identifiable data, the roles within the Information Governance structure would be fundamental to ensuring rules and regulations in these areas were followed appropriately. The Information Commissioners Office (ICO) could fine up to £500,000 if the correct procedures were not in place, but this would shortly be changing to unlimited fines.

GC asked the Audit Committee whether they thought it would be wise to set up a further Information Governance Committee where such issues could be monitored closely.
The Audit Committee agreed it would be useful for the Caldicott Guardian, SIRO and Information Governance Manager to meet as a sub-committee where they could have protected time to discuss and have an overview of all Information Governance related subjects.

GC

GC would organise this.

GC shared the Caldicott Guardian Log with the Audit Committee on behalf of Dr Burgess, stating that the log identified any issues that need to be bought to the attention of the Caldicott guardian and details the actions taken and associated timescales, this was an on-going process within the CCG and was monitored within the Corporate Affairs Team.

GC shared the Information Governance Awareness Raising and Training Plan for 2013/2014. The plan demonstrated the CCG's plans for Information Governance training and how it takes place, along with stating if any specialist training is needed e.g. Caldicott Guardian training, SIRO training and FoI/ SAR training. This document had been endorsed by the CCG's SIRO and distributed to CCG employees and was also available for viewing on the staff intranet.
GC stated all CCG employees were required to undertake Information Governance Training when they commence employment and it should be renewed annually. GC stated it was a requirement for all Governing Body members to undertake the IG online training to ensure everyone was aware.
JI asked who would inform the Governing Body members they need to complete the training. **JI**
HDL agreed for JI to email the Governing Body stating the Audit Committee Chair requires them to complete Information Governance training by the end of February 2014.

GC shared the Information Governance – Guidance for Staff document. The document had been created for staff so they had a "go- to" guide on overall Information Governance. This

document had been endorsed by the CCG's SIRO and distributed to CCG employees and was also available for viewing on the staff intranet.

14 ANNUAL REPORT AND FINAL ACCOUNTS PLAN

GC explained the paper was purely for information. The annual plan was being reviewed and the timetable would be amended to reflect the recent guidance which had been produced.

JI explained that in the past the Annual Report which was available for auditors in April was a draft and the final report was published in September, it was a new requirement for the report to be completed by April.

15 REVIEW OF CHANGES TO PRIME FINANCIAL POLICIES & ACCOUNTING POLICIES

JI explained the accounting manual had only been sent the previous week and there had not been enough time to digest it as it was a large document. This would be an agenda item for the next Audit Committee. **GC**

16 ISFE (INVOICING) SYSTEM

This would be an agenda item for the next Audit Committee. **GC**

17 MANDATORY & STATUTORY TRAINING UPDATE

HDL was concerned that the two statutory training modules (Fire Awareness and Health and Safety) were still not at 100% compliance.

The Audit Committee wanted CCG employees to be clear they must complete the statutory training; employees who had not completed the statutory training would be subject to disciplinary action as they had previously been issued with a clear deadline to complete this. The Audit Committee wished to state the importance of this training and re-iterated that it was a legal requirement to complete it. **GC**
GC would follow up the employees who have yet to complete their training.

Mandatory Training compliance was still poor and the Audit Committee stated they hoped the CCG managers were completing the training otherwise they were setting a bad example to their staff.
GC would contact staff members, stating the importance of all training. **GC**

Internal and External Audit both stated that within their organisations, if both mandatory and statutory training was not completed, it was a disciplinary offence.

In future HDL would like staff members to be split to demonstrate new starters, temporary employees and employees who had been in the organisation over three months, which would give an accurate picture of who had and had not completed the training.

PS asked why was 'Safeguarding Children' training only required and not 'Safeguarding Adults' training. **GC**
GC would check.

18 ISSUES ARISING FROM THE PATIENT SAFETY & CLINICAL QUALITY COMMITTEE

PS did not have any comments.

There was a safeguarding issue with learning disability patients who were placed out of area; there would be a report to the Governing Body.

19 REVIEW OF LOSSES & SPECIAL PAYMENTS

There were none to report

20 REVIEW OF TENDER WAIVERS

There were none to report

21 AUDIT COMMITTEE FORWARD PLANS

JI would send this out subsequent to the Audit Committee. **JI**

22 REVIEW OF EFFECTIVENESS OF INTERNAL AUDIT & COUNTER FRAUD

GC stated Jean Clark (CSU) would be attending the next Governance Leads meeting (31st January 14) and could offer advice on this issue. **GC**
GC would report back.

RM stated External Audit conduct a review of the effectiveness of Internal Audit as a formality; this was slightly different to what seemed to be required for this point. RM suggested to review client service the CCG needed to look at the documentation Internal Audit produce for when they re-tender as this would state how effective they had been over the last couple of years.

The review was something which would be conducted in the future.

23 UPDATE ON INTERNAL AUDIT PROCUREMENT

JI explained the invitation to quote went out the week beginning the 13th January 2014; with responses to come back the end of week beginning the 20th January 2014, this was on a short timescale due to it being on a national framework.
Responses had already come in and there would be an evaluation process happening over the next couple of weeks, by the end of February 2014 a decision would have been made on who would have the contract.

JI asked HDL whether any member of the Audit Committee would like to be involved in the process.~~?~~
HDL said she thought this would be a good idea and explained Norfolk-wide Audit Chairs believed they should be involved in each procurement exercise.

RM stated it would be wise to have a good balance between Officers and Audit Chairs.

JI would discuss this with colleagues and find out who would sit on the panel. **JI**

24 DATE OF NEXT MEETING

26th March 2014, 10am – 1pm, meeting room 2, King's Court.

The meeting has been extended one hour to ensure enough time was dedicated to the agenda.