NHS
West Norfolk
Clinical Commissioning Group

# MINUTES OF THE AUDIT COMMITTEE HELD ON 24TH JULY 2013, 10AM-12PM AT THE KING'S COURT, CHAPEL STREET, KING'S LYNN

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| **Present:** | Hilary De Lyon (HDL) | Chair & Lay Member, Audit |
| | Penny Sutton (PS) | Lay Member, PPI |
| | Dr Tony Burgess (TB) | GP Member |
| **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 |
| | Chris Smedmor (CS) | Deloitte, Internal Audit |
| | Rob Murray (RM) | Ernst & Young, External Audit |
| | Sarah Boxall (SB) | Admin Support (Minutes) |

**ACTION**

**1 APOLOGIES FOR ABSENCE**

None

**2 DECLARATIONS OF INTEREST**

None. **HDL**

HDL to amend her declaration of interest

**3 IDENTIFICATION OF AGENDA ITEMS UNDER THE FREEDOM OF INFORMATION ACT**

None

**4 NOTIFICATION OF ANY ITEMS OF URGENT BUSINESS**

None

**5 MINUTES OF THE PREVIOUS MEETING FOR CONFIRMATION**

Dr Tony Burgess was under 'present' and 'in attendance'; he should only be in the present column.

With this amendment, the notes of the previous meeting were agreed as a true record.

**6 MATTERS ARISING (NOT COVERED ELSEWHERE ON AGENDA)**

None

**7 ACTION LOG**

The action log numbers should be amended. **SB**

Ref 4: Minutes of previous meeting – HDL still to confirm changes with SB **HDL/SB**

Ref 5: HDL and TB had not been in contact since the last meeting.
TB raised concerns regarding information governance; the quality team may not be able to review clinical audit until the issues surrounding patient identifiable data had been resolved.
The committee agreed to change the action to, 'HDL & TB will be in regular contact regarding clinical risk including clinical audit.' **SB**

Ref 10: The action should be amended to reference Internal Audit.

Ref 18: The counter fraud plan had been to the Executive Team and should be agreed by the Audit Committee. This would be reviewed under agenda item 12.1. **SB**

Ref 21: HDL questioned how clinical risks were monitored by the Governing Body. TB said it was work in progress, the Clinical Executive Team was in its infancy and time would tell whether it delivers what was expected.
HDL said the Audit Committee should track the progress of clinical risks and proposed they do so in January. The committee agreed to close action 21 and add a new action stating the Audit Committee's commitment to check the progress of clinical risks. **SB**

Ref 22: Still to be completed.

Ref 23: JI had communicated with the IFR panel, this action could be closed.

Ref 24: JI to share this with the committee **SB**

Ref 25: Action could be closed. **JI**

The Audit Committee agreed the minutes did not need to be verbatim; they needed to capture the discussions and decisions. **SB**

## 8 TERMS OF REFERENCE (ToR)

The ToR's were circulated after the previous meeting for comments, no comments were sent.
HDL suggested 'Frequency & Notice of Meetings' would need to be added into the ToR when they were next amended and this was agreed. **GC**

EG raised point 3.3 'Attendance'. Security management did not sit under Counter Fraud.
JI and GC would investigate this. **JI/GC**

7.2.3) 'Secretary of State Directions', this should be NHS Protect. GC would amend this when the ToR were reviewed. **GC**

The Audit Committee formally accepted the Terms of Reference, with amendments to be made in the future.

## 9 AUDIT COMMITTEE TIMETABLE

The Audit Committee discussed the revised timetable at length, with the following outcomes:

- Governance section, Review the Risk Management System:

The audit committee agreed it would be appropriate to review this once a year in January.

- Governance section, Review of other reports and policies as appropriate, for example, changes to standing orders:

It was agreed this item should feature on every meeting agenda as it does not specify what reports and policies would be reviewed, only 'as appropriate'.
'Changes to Standing Orders' should be removed from this box and a separate item created called 'Annual Review of the Constitution'.
GC would check whether the process had been established for the review of the constitution before confirming the target date as May 2014.

**JI/GC**

- Governance section, Review of annual governance statement and review of annual report:

The audit committee agreed to amend the timetable to state March/ April 2014 (review of annual governance statement) and May/ June 2014 (review of annual report).
It would be appropriate to set the meeting dates when external audit had agreed their timetable for the year.

**JI**

- Internal Audit, Review and approve annual internal audit plan:

The audit committee agreed this should be moved from May 2013 to July2013.

- External Audit, Review the effectiveness of the external audit:

The audit committee agreed it would be sensible to review this in July 2014.

- External Audit, External audit plans and fees:

The audit committee agreed this should be split into two items:, 'agree audit plans', which would be reviewed in Jan 2014/15 and 'agree audit fees', which would be reviewed in July 2014/15.

**JI**

**JI**

- External Audit, External auditors report to those charged with governance:

The audit committee agreed to move this to May/June 2014.

**JI**

- Clinical Audit, Review the minutes of Patient Safety & Clinical Quality Committee (PSCQ):

It was previously agreed that rather than reviewing the minutes, the audit committee would receive a report with areas of concerns and review the minutes if necessary. Therefore the item should be amended to 'Review report of areas of concern from Patient Safety & Clinical Quality Committee (review the minutes if necessary)'

**JI**

**JI**

- Counter Fraud, Review the organisation's assessment against CFSMS qualitative assessments:

CFSMS should be replaced with NHS Protect. RM said NHS Protect were not reviewing CCG's this year. The meeting columns should remain blank until NHS Protect have set the standards and assessments.

- Counter Fraud, Review the effectiveness of the local counter fraud specialist:

The audit committee agreed January 2014 would be a preferable time to review.

JI

- Audit Committee, private discussion with internal and external audit:

HDL questioned if October 2013 a good time.
CS stated this depends on what the audit committee wanted to achieve from it and thought later on in the year maybe more suitable. Internal and external audit recommended moving it to January 2014. JI

The audit committee discussed further items, which should be added on to the timetable:

- 'Meeting with the accountable officer' - May/ June 2014
- 'Meeting with the chair (invite to attend)' - October 2013
- 'Mandatory & Statutory Training' – this would need to be a standing item on the timetable JI
- 'Review the Information Governance Toolkit' – October 2013

JI

**10 INTERNAL AUDIT PLAN**

CS gave an overview of the plan.

Internal Audit proposed CHC should be worked on collaboratively with other Norfolk CCG's, this had been accepted by the other CCG's and~~,~~ JI strongly supported this method.
Internal Audit stated the other CCG's have asked them to review risks regarding patient identifiable data and how it appeared on invoices as soon as possible.
JI said he had significant concerns surrounding the management process within CHC and he would like this reviewed, JI was unclear who would look into this, the CSU or Internal Audit.
Internal audit would like to book some scoping meetings as soon as possible to ascertain which key areas West Norfolk CCG would like reviewed.

HDL said the internal audit plan should not be static; it should very much be a dynamic document and questioned how the audit committee could ensure the internal audit plan remained dynamic, picking up on issues which were important and dropping ones which were no longer needed.~~?~~
It was agreed there would be regular contact between CCG executives and internal audit in between committee meetings to ensure risks were constantly reviewed.

The audit committee discussed clinical areas of risk. TB believed mental health services and urgent care were significant areas for review.

It was agreed that if the internal audit plan needs to change in the future, internal audit would have discussions with JI and TB, which may involve seeking advice from other CCG committees. The outcome could be agreed by the Chair outside of the meeting and then ratified at a future audit committee.

JI questioned the testing of the ISFE system, asking whether there were days left over to do further testing on the system? CS explained internal audit were having an early look at this and would provide recommendations. JI/TB/CS
NHS England (Deloitte) would be auditing the CSU and would produce an assurance report for

CCG's in quarter three and four to give assurance over the CSU's control environment. Internal audit would be providing assurances on the current state of the CSU and NHS England's report would demonstrate the control environment over a period of time.

Discussions took place regarding further areas which could possibly be tested:

- IG toolkit: Ernst & Young's IT auditors usually undertake this audit and would recommend the steps the CCG should take to reach certain levels. The committee agreed it would be helpful to gain external assurance on how this process should be managed and would look to re-visit this area in the future.

- Performance of Acute Trust/ Stroke Care on page four of the plan would not need to be reviewed.

- The impact of the mental health trust cost improvement plan would need to be reviewed.

The audit committee stated that for future meetings it would be useful if internal audit pointed out the key issues which needed to be discussed, rather than talking through the report. CS would provide a summary of the report and an updated version of the plan to the next audit committee.

**10.1 INTERNAL AUDIT CHARTER**

The Internal Audit Charter would need to go to the Governing Body for approval. GC would put this on the agenda for the next meeting, with a strong recommendation from the audit committee to approve the charter in the covering paper.

**11 EXTERNAL AUDIT CHARTER (PRESENTATION & FEE LETTER)**

The audit committee were happy to agree the fees now they had clarity.

Introduction to external audit – if any members had questions regarding external audit, they could be raised directly with RM outside of the meeting.

**12 COUNTER FRAUD**

Counter Fraud training for WNCCG staff had been booked for the 22nd August 2013. Staff members who do not receive face to face training would not have the option to do e-learning as this was no longer available. EG would keep in contact with the CCG if an employee had missed the training and with HR regarding any new employees so future training sessions could be arranged. Any counter fraud presentations which are used would also be put into the new starters induction pack. **GC** **SB**

EG believed it would be good practice for governing body members to undertake counter fraud training, to raise awareness. HDL suggested this should be arranged for a future governing body meeting. **GC**

EG explained that NHS Protect would provide training for CSU staff within the next month. EG had expressed concerns about the process for identifying fraud issues in the CSU. NHS

Protect have agreed that if there were issues which concern the CCG, they would be forwarded on to EG.

EG referred the committee to page two of the interim report, Inform & Involve. There were two local proactive exercises suggested, EG recommended the second point regarding CHC was adopted. JI agreed with this route.

EG would forward copies of NHS Protect's contract and procurement manual to the CCG when she received them.

**EG**

**12.1 APPROVAL OF THE COUNTER FRAUD PLAN**

EG explained she had added NHS Protect standards into the plan.

The audit committee believed it should be changed to Evidence of Implementation. EG will do so. EG agreed to amend the 'intended outcomes' column to read 'Evidence of Implementation'. **EG**

The Audit Committee agreed to formally adopt the plan once the title had been changed.

**13 ASSURANCE FRAMEWORK**

Discussions took place on who should be challenging the register. GC expressed his concerns that the risk register was at the bottom of the agenda for the majority of meetings and it did not get addressed. TB stated it would be a good idea to rotate agenda items so they were addressed at governing body meetings.
HDL and TB would discuss this issue at the governing body's development day on the 25th July 2013. **HDL/TB**

RM stated the role of the audit committee should be to challenge the process rather than the review the content. Internal Audit re-iterated external audit's point from the previous meeting stating the CCG's assurance framework was a high quality document.

The following risks were discussed:

1.1 - Reputational Risk through adverse media reports:
HDL asked if the media training had been cost effective. GC believed it was as individuals from other organisations attended and were re-charged for attending. HDL's concern was how many governing body members were speaking to the press, and suggested that there needed to be clear guidance on who should speak to the press.
GC would write a guidance note regarding dealing with the press for governing body members. **GC**

2.17 – HDL noted the risk had increased.
Discussion took place on the risk ratings; it was agreed that the current risk rating should not be higher that the inherent risk rating.
The committee agreed this risk should be amended to show a higher risk. **GC**

The audit committee expressed high concern to all those updating the risk registers, stating it

was vital they were regularly updated and what was taken to the audit committee was the most up-to-date the CCG had. If this document was not updated it could potentially damage the CCG's reputation as it was a public document.

For future governing body meetings, GC would point out the key risks on his assurance framework covering paper so the governing body members recognise the risks.
The audit committee agreed that, within the target risk rating column, it should also state the target timescale in which the risk should be met. GC would follow this up. **GC**

The audit committee agreed the corporate risk register should be viewed by the audit committee twice a year to monitor the process. This should be added to the audit committee timetable. **JI**

## 14 ISSUES ARISING FROM THE PATIENT SAFETY CLINICAL QUALITY COMMITTEE

TB highlighted the main quality concerns.

The QEH was problematic as they had received a visit from CQC and their urgent care performance was poor. The CCG were aware of the problems and had plans in place to mitigate the risks. The CCG had good engagement with senior management in the trust and regularly attended clinical quality review meetings. A meeting was being arranged between clinical members of the governing body and clinical leads within the hospital.

There were issues with the Norfolk & Suffolk Foundation Trust (NSFT) and the CCG were less confident the Trust was managing the problem. There had been poor engagement with senior management.
The reporting of Serious Incidents (SI's) and deaths had been poor; this was partly due to NSFT's reporting and the CSU's processing.
TB stated that the CCG were tackling the problems as there were concerns that quality issues were not being addressed whilst the Trust was going through their radical re-design.

TB explained the other areas of concern were with providers where the CCG have less influence, especially the ambulance Trust. Their performance in the West was poor, the quality issues undefined and the contractual process was not clear due to the fact that the CCG was represented by the CSU on a consortium basis. There was a need to understand processes and contractual levers that were in place and make sure individuals were following the correct process on the CCG's behalf. The CCG needed to do piece of work around ambulance response times and gain an understanding of where the problems lie, whether it was contractual issues or how the service was commissioned.
JI stated the CCG now had a Quality Improvement Lead who provided extra support to address these issues.

TB asked the audit committee to note these concerns and make sure the governing body were aware the risks were being reviewed.

**15 POLICIES FOR APPROVAL**

The committee reviewed the policies and suggested the following changes:

- Counter Fraud & Corruption Policy, point 2.2.2: Counter fraud training should be added to Inform and Involve. **GC**

- Information Governance & Data Protection Policy: Page 7, GC to check whether the NHS Operating Framework 2010/11 still stands or whether it needed updating to a newer version. **GC**

- Whistleblowing: Page 8, point 7, the counter fraud specialist needed to be changed to Eleni Gill. **GC**
  Page 8, point 8, the Norfolk designated doctor and nurse was not correct, this should read: **GC**

  "WNCCG has a named nurse and doctor for child protection and safeguarding children to support and help with this process."

  Norfolk Named Doctor: Dr Anthony Burgess
  Norfolk Named Nurse: Maggie Carter

  Norfolk designated doctor: Sue Zeitlin
  Norfolk designated nurse: Jane Black

Safeguarding Adults also needed to be added to the policy, TB would address this outside of the meeting. **TB**

- Disciplinary Policy: Page 4, point 2.6. At the end of first sentence, there needed to be a sentence added stating "not a qualified legal professional", **GC**

- Grievance Policy: Page 4, point 2.2. At the end of first sentence, there needed to be a sentence added stating "not a qualified legal professional", **GC**

The policies would need to be circulated to staff, GC would do so. **GC**

The audit committee wish to make it clear to the governing body that the policies had been reviewed and scrutinised and strongly recommend them for adoption.
GC would be setting a clear process to ensure all policies were logged, reviewed and tracked for future reference.

**16 REVIEW OF LOSSES & SPECIAL PAYMENTS**

N/A

**17 REVIEW OF TENDER WAIVERS**

N/A

**18 INFORMATION GOVERNANCE**

GC would bring a paper to the next committee meeting to provide an update on patient identifiable data. **GC**

**19 DATE OF NEXT MEETING**

*28th October 2013, 10am – 12pm, Meeting Room 1, King's Court, King's Lynn*