NHS
West Norfolk
Clinical Commissioning Group

MINUTES OF THE AUDIT COMMITTEE
HELD 28th OCTOBER 2013, 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
	Helen Devlin (HD)	Ernst & Young, External Audit
	Dr Ian Mack (IM)	Chair, WNCCG
	Sarah Boxall (SB)	(Minutes)

ACTION

1 APOLOGIES FOR ABSENCE

Chris Smedmor, Mike Clarkson, Dr Tony Burgess

2 DECLARATIONS OF INTEREST

None. **HDL**

3 IDENTIFICATION OF AGENDA ITEMS UNDER THE FREEDOM OF INFORMATION ACT

Item 11a 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

HDL welcomed Dr Ian Mack, Chair of WNCCG to the Audit Committee.

5 MINUTES OF THE PREVIOUS MEETING FOR CONFIRMATION

Page 4 – Internal Audit Plan: this should read "Deloitte would be auditing the CSU", not "NHS England"

Page 8 – Item 16 and 17: This should read "There were none to report"

With these amendments, the minutes 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 would be changed to reflect the previous meeting held in July. SB

GC would bring the Internal Audit Charter to a future Governing Body Meeting. GC

Counter Fraud Training – Half of CCG staff have completed face to face training, another training session had been scheduled for the 18th November.
WNCCG's Governing Body members have yet to complete Counter Fraud training; GC would aim to incorporate this into the Governing Body development day on the 19th December 2013. GC

EG was still awaiting copies of NHS Protect's contract and procurement manual.

GC would prepare a guidance note for Governing Body members on dealing with the press. GC

Assurance Framework – There was still an outstanding risk in which the current risk was greater than the inherent risk; GC to amend. GC

GC would check who should monitor clinical risks on the Assurance Framework. GC

Information Governance – CCG's were procuring services from the Data Services for Commissioners Regional Offices (DRSCO); this was an arm of the Health and Social Care Information Centre, who were authorised to access patient identifiable data (PID), they were able to complete checks the CCG were not authorised to do.
A joint procurement exercise had taken place with Norfolk, Suffolk, and Cambridgeshire CCG's to enable CCG's to view PID, which had resulted in a contract being awarded to a body in the North East. The implementation and mobilisation phase was taking place in October 2013 and would hopefully be running by the end of November 2013.
There would be a retrospective validation exercise for data dating back to 1st April 2013.
JI would bring an update to the next Audit Committee JI

GC explained that a modern data service is being developed for the NHS that will provide NHS organisations, citizens and researchers with accurate, timely information which will radically transform the way we care for and treat people and continuously improve the services we offer. Patient data will be extracted directly from GP computer systems (appropriately pseudonymised) and collated by the new service – care.data. This information will be available for analysis both within the NHS and externally (at a cost) to commercial enterprises.

PS asked about the CSU's Safe Haven status. GC explained that the CSU had to obtain level 2 on the Information Governance Toolkit by the 31st October; the CSU Governance team were confident that they would achieve this (subsequent to the meeting this was confirmed by the CSU Team).

8 AUDIT COMMITTEE TIMETABLE 2013/14

The Audit Committee agreed the amended timetable.

9a INTERNAL AUDIT PROGRESS REPORT

DH gave an overview of the progress report, stating the main summary of the Internal Audit plan was on page 3.
The CHC audit commenced the week beginning 21st October.

Page 4, Appendix A demonstrated the progress made by the individual auditor.
Page 5, Appendix B demonstrated Internal Audit's key performance indicators to date. Within Appendix B, one of the performance indicators sat at 0%, DH said the information had now been obtained.

DH highlighted there were issues within the CSU's control environment; this could affect the Head of Internal Audit's annual opinion report if the issues were not improved substantially. Internal Audit was also aware of control issues within the ISFE financial ledger system, the system was still in the implementation stage and this could impact on internal audit opinion. DH would liaise with JI to arrange to attend a future Norfolk-wide Chief Financial Officer (CFO) meeting to discuss the issues. JI/DH

JI asked if there were concerns as a result of work already completed within the CSU. Internal audit had plans to produce a report on the CSU, but they have been unable to so due to the current issues around the future of the CSU.

The CSU have been informed they would need to find a partner organisation to be viable, and DH felt that this would reduce Internal Audit's concern as and when they did so.
JI stated the plan was for the CSU to find a partner organisation by December 2013, to go through implementation and mobilisation in March 2014 and to be in place by April 2014.

IM asked if Appendix B was on track as he felt that the document did not demonstrate this. DH stated the plan was on track and he would amend the document to show more realistic quarterly targets. DH

JI/DH would discuss the 13 days contingency outside of the Audit Committee. JI/DH

9b INTERNAL AUDIT FOLLOW UP REPORT

DH said the key issues were outlined on page 3.

The report was positive and out of the 21 outstanding legacy recommendations, 17 have now been closed.
With regards to the remaining 3, one would be followed up during the QIPP audit and the remaining 2 were in the process of being implemented and a revised deadline had been agreed.

HDL asked for clarification on the QIPP recommendation reference as they differ in the follow up report and the appendix. DH said the reference should read NW1308-QIPP.

HDL asked for confirmation on what Transformational KPI's were.
DH explained these refer to how the service could be improved.

IM asked who was responsible for the KPI's and was the timetable realistic.
JI stated it was an internal responsibility and was part of the procurement exercise with the CSU's future partnership organisation. The timescale was realistic as the CSU would like to have identified a partner organisation by the end of the year and to have the main aspects of the contracts and SLA in place in preparation for implementation and mobilisation.

9c INTERNAL AUDIT FINAL REPORT – FINANCIAL LEDGER

DH stated the financial ledger was a positive report and offers substantial assurance.
Three priority 2 recommendations have been made, which were listed on page 5 of the report.
All recommendations have been accepted and reasonable action plans have been put in place.
The recommendations would go on to the follow up report so they were monitored.

IM asked what the impact of change of a CSU provider was.
JI stated it should not change anything, but future discussions would need to take place to review the new CSU arrangements (which the CCG would like in place by the 1st April 2014) to ensure they pick up earlier recommendations made by Internal Audit. JI/DH would pick this up during discussions over contingency days. JI/DH

The final report would remain current until the end of the financial year and the new partnership organisation would be reviewed as part of Internal Audit's annual review.

9d INTERNAL AUDIT FINAL REPORT – PAYROLL LEDGER

The CCG holds a contract with the payroll provider Serco; the CSU manage the contract on behalf of the CCG.
DH stated the key issues were on page 4.

The wording within the recommendation on page 4 would need to be written into the SLA, but amended to ensure each party was clear about their duties.
GC had a meeting set up to discuss the payroll audit with CSU and CCG members and would amend the SLA. GC

Priority 2 recommendation:
The expenses policy was being reviewed by the CCG's Finance Manager and JI was confident it would be ratified by the end of November 2013. JI would discuss this with Emma Kriehn-Morris. JI

10a EXTERNAL AUDIT PROGRESS REPORT

HD gave an overview of the report.
Page 2 sets out the main comments on the planned approach to External Audit's system of work.

There would be more testing on the numbers in the actual accounts rather than relying on control accounts this year. External Audit thought this was a positive way of reviewing the accounts given the issues within the CSU during this financial year. HD and RM plan to liaise with Internal Audit to learn about the systems in place.

Page 2 shows comments on new guidance set by NHS England on the transfer of opening balances from legacy organisations. HD/ RM would be discussing this further with JI outside of the meeting. JI/RM/HD

One key deadline from the guidance was for the CCG to confirm their opening balances by the

18th October 2013. External Audit were aware of slippages on this timetable due to the CSU not being able to provide the information, therefore finalisation of the balances was expected by the 15th November 2013.
External Audit would not be in a position to look at opening balances till early in the New Year.

Page 3 contained comments on value for money and whether External Audit had assurance that the CCG had put in place the correct arrangements to secure economy, efficiency and effectiveness in the way it uses its resources.

HD explained that the new NHS guidance set out a different approach for CCG's, recognising that they were new entities. As a result External Audit were not required to provide an opinion on the usual two specified criteria, (financial resilience and challenging how an organisation uses its resources to secure economy, efficient and effectiveness) .
External Audit would look at the CCG's Annual Governance Statement, accounts;~~;~~ works carried out by other regulatory bodies and also consider local risks (financial difficulties, problems with CSU's).
HD encouraged members of the committee to start reviewing the Annual Governance Statement.

HDL asked if there were plans in place to review the Annual Governance Statement. JI/GC
There was a meeting scheduled in early November to discuss the Annual Report; JI and GC would use this meeting to discuss the Annual Governance Statement.

10b EXERNAL AUDIT UPDATE

HD explained the report was a general update on the health sector, CCG specific where possible and was produced on a quarterly basis.

The Audit Committee agreed this update was useful.

11a COUNTER FRAUD INTERIM REPORT

EG referred the committee to page 2, section 3.2 and explained the CSU were currently working on putting a database together which lists all contracts in place. Counter Fraud (CF) had sourced a spreadsheet from the CSU which lists every contract, EG would review this and report the outcome to the next Audit Committee. EG

EG said if CSU staff suspect fraud they should contact the National Fraud and Corruption line, NHS Protect would then make a decision whether this was a CSU or CCG fraud and inform the appropriate Local Counter Fraud Specialist.

Since the Counter Fraud paper was completed there had been one possible contract fraud reported, JI was aware as it affects all 4 CCG's.

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

MT explained CF had merged with the West Midlands internal audit consortium and have been renamed the West Midlands Service, therefore the CF team had now doubled in size. EG/JI
The team had been shortlisted for a HMFA Governance Award, regarding work undertaken in

collaboration with Health Education England on bursary fraud.

MT had requested benchmarking data from NHS Protect regarding all Trusts in England. The data would show the number of referrals each Trust had received, the number of referrals which were investigated and fraud was proven and the number of referrals which were passed to HR for disciplinary action. The CF team would use this data to identify the key risks.

MT explained none of their clients should be subject to NHS Protect Quality Assurance visits this year due to the high standard of work completed by the CF team.

IM asked whether the CF service provided was tendered or state employed.
MT explained that the CF team were NHS employed; they had worked with NHS Norfolk & Waveney and so it had been agreed the service would be carried forward into the 2013/14 financial year.

11b UPDATED COUNTER FRAUD & CORRUPTION POLICY

NHS Protect had introduced a new template of standards. EG had amended the policy to suit, the key principles of the policies remained the same. The main changes were:
Section 3.4 – clarified NHS Protect responsibility;
Section 4 – set out each member's roles and responsibilities;
Section 4.4 – Audit and Governance Committee – this needed to be changed to solely 'Audit Committee';
Section 8 – monitoring and reviewing – reiterated the importance of this function.

The Audit Committee agreed to approve the policy subject to the change on section 4.4. EG would amend the policy and GC would complete the document control sheet. EG / GC

GC would take the policy to the next Governing Body meeting to formally adopt the changes. GC

12 POLICIES

GC gave an overview of the policy log which had been set up which included:

- a log of policies the CCG have had approved, the policy owner, the relevant dates for review, which committee reviews the relevant policy, policies which have been identified;
- a log of policies which need to be reviewed and amended for the CCG's use and thereafter to be adopted by the Governing Body;
- a further log which showed policies which were obtained by Norfolk PCT, these policies would need to be reviewed to ascertain whether they were relevant for the CCG's use.

GC would be reviewing policies as a priority over the next couple of months.

GC asked the committee whether the policies could be agreed virtually via the Chair. GC would look to finalise the policies, circulate them to the committee for review and comments and then formally ask the Chair of Audit to have delegated authority to approve them before taking them to the Governing Body for formal ratification.

The Audit Committee agreed.

HDL suggested that the Audit Committee should have the overarching responsibility for reviewing policies and this was agreed. GC
It was agreed GC would bring a paper to the next Audit Committee on progress with policies to allow the committee to review and comment on what was outstanding.

IM asked if Internal and External Audit would play a part in policies.
DH explained from an Internal Audit point of view the only point they would look at a policy would be when an audit of a particular area was being undertaken. They would not take an overall view of policies.
External Audit stated that the link would be through the Annual Governance Statement, which would describe the overall control environment within the CCG.
Counter Fraud would "fraud-proof" policies if necessary.

12a POLICIES - PUBLICATION SCHEME

The Publication Scheme would need to go on to the CCG website. The document provided an overview of the CCG and gave instructions to the public of how they could submit Freedom of Information requests, complaints etc.

Page 3 – "Trust" needs to be changed to "CCG."

Page 5, section 1 – Reads "Norfolk and Waveney Mental Health NHS Foundation Trust" but should read "Norfolk and Suffolk Foundation Trust". Norfolk Community Health and Care needs to be mentioned.

Page 7, section 4 – "Board" needs to be changed to "Governing Body"

The Audit Committee approved the Publication Scheme subject to the minor amendments. GC
GC would make the amendments and take this to the next Governing Body for ratification.

12b POLICIES - RECORDS MANAGEMENT POLICY & STRATEGY

The strategy and policy had been inherited from NHS Norfolk.

GC explained the strategy was an overarching document and contained an action plan; he raised his concerns on the vast amount of work needed with records management.
GC explained the CCG were looking into document management software which retains electronic records of documents. Norfolk-wide CCG Governance teams were working together regarding archiving and were in contact with the ex- NHS Norfolk provider, Archive Solutions, regarding rolling on the contract for another year to ensure continuity.

The policy is a description of what the CCG should be doing.

Page 5, section 4.1.6 of the strategy – this needed to be removed as it was not a part of the current Internal Audit plan. This should be replaced with "Internal Audit would review certain policies when individual audits were taking place".

IM stated the action plan was very challenging. GC would review the action plan and share it with HDL before it was taken to the Governing Body for ratifying. GC

13 ASSURANCE FRAMEWORK

HDL asked that the formatting be corrected before sending out to the committee. GC

Risk 1.1 needed to be amended to ensure the inherent risk rating and the current risk rating were the same; the current risk rating could not be more than the inherent.

Risk 1.3 – New risk identified

Risk 1.8 – The CCG's Executive Team recommended increasing the risk rating

There was a risk regarding urgent care on the Assurance Framework which had been moved on to the holding section:
"Urgent care performance may not receive the focus required due to competing priorities"
The CCG's Executive Team felt this risk had been mitigated as there were weekly urgent care group and board meetings which were addressing the issue.

JI/GC need to review the Assurance Framework to ensure the QEH's A& E performance was captured. JI/GC

There were two risks on September's Assurance Framework, which were duplicated; these have now been amalgamated into one, risk 4.1.

Risk 5.1 – This had been increased due to issues surrounding the QEH.

Risk 6.1 – This had been escalated due to the issues surrounding the CSU.

Risk 6.4 – Newly identified risk regarding recruiting to West Norfolk, something which was not unusual to other organisations in the area.

Risk 6.5 – this had been escalated from Corporate Risk Register.

IM challenged risk 1.4; he thought there was still a significant amount of risk surrounding this issue as the CCG's quality lead had been unable to secure meetings to discuss CIP with the providers, which highlights whether CIP was being addressed, IM suggested the current risk rating should be higher.
GC would pick this up with the risk owner and highlight to the Patient Safety & Clinical Quality Committee. GC

GC stated that getting quality time with each risk owner was proving difficult as the assurance framework was often quite low on the priority list.
HDL said that if a message from the Audit Committee was not strong enough then she would like letters drafted to the risk owners pointing out that the Assurance Framework should be treated as a high priority and necessary for the Governing Body to have a view of up to date risks; HDL would sign the letters. IM was in full agreement. GC/HDL

IM and HDL agreed that senior management within the CCG needed to address how they keep the risk registers updated. Each risk should be clearly articulated so when reviewed, risks

can be easily identified. GC would relay this information to risk owners. GC

14 REVIEW OF INFORMATION GOVERNANCE TOOLKIT

GC explained the Toolkit, stating the CCG had a requirement to meet level 2 by the 31st March 2013.
West Norfolk CCG was working together with Norfolk-wide CCG's to complete the toolkit.
GC would bring a report which maps out the governance structure of the CCG (SIRO, Information Governance Lead, and Information Asset Owners) and information on the toolkit to the next Audit Committee. GC
The Audit Committee agreed mapping out a structure would be beneficial as the work resulting from the toolkit could be distributed amongst the organisation.

GC stated he would identify Information Asset Owners (IAO) in the CCG in the near future. GC

IM asked how did the SIRO link to the toolkit.
JI explained that the SIRO's role was to have an oversight of the toolkit.

15 MANDATORY & STATUTORY TRAINING

HDL noted that the modules should be split so staff could determine which modules were statutory and mandatory. Statutory modules were Fire Awareness and Health & Safety, which were a legal requirement.

HDL proposed and the committee agreed that CCG staff must complete the two statutory training requirements by the end of November 2013; otherwise it would become a disciplinary matter.
PS proposed and the committee agreed that the CCG staff should have diary protected time to complete the modules.

JI asked whether the Audit Committee would monitor workforce issues such as sickness, vacancies etc. HDL said this question would need to go to the CCG's Executive Team. JI

16 SELF ASSESSMENT OF THE AUDIT COMMITTEE'S EFFECTIVENESS

JI stated this agenda item stemmed from the HMFA timetable, it allowed the Audit Committee to take a step back and assess if they were adequately fulfilling their duties.
There was a self- assessment checklist within the HMFA handbook, JI and HDL would discuss this outside of the meeting and bring it back to the next Audit Committee meeting. JI/HDL

17 ISSUES ARISING FROM PATIENT SAFETY & CLINICAL QUALITY COMMITTEE

HDL explained it was previously agreed that there would be a covering paper by Dr Burgess, which would list the key issues and the minutes were purely for reference.

HDL asked how the CCG ensured that their providers employed people who recognised quality and whether there was national data on whistleblowing. EG
EG would ask NHS Protect if they held data on whistleblowing.

IM stated all organisations have Whistleblowing policies and quality meetings which include non-exec directors who provide the challenge over quality data. Commissioners have to seek assurance whether the policies were viewed by employees.

JI explained the CCG were encouraging GP's to submit Quality Incident Reporting forms (QIR's) when they have issues. This was something that could be put into future contracts so providers could develop similar processes internally, a possible CQUIN scheme.

Discussions took place over care in the community. IM stated the CCG did not commission community care as this was dealt with by the County Council.

18 REVIEW OF LOSSES & SPECIAL PAYMENTS

None to report

19 REVIEW OF TENDER WAIVERS

None to report

20 DATE OF NEXT MEETING

22nd January 2014, 10am – 12pm, meeting room 5, Kings Court, Chapel Street

21 INTERNAL AUDIT PROCUREMENT FROM APRIL 2014

JI explained that Internal Audit and Counter Fraud were procured for a one year extension as a follow on from NHS Norfolk & Waveney for continuity. This extension ends 31st March 2014.

Norfolk-wide CCG's were working on a collaborative basis and had support of the collaborative procurement hub, which allowed the CCG's to access framework agreements from suppliers of these services, which helps speed up the process. It had been advertised on the basis that suppliers could apply for one or both services.

IM asked who formed the panel to decide which supplier gained the contract.
JI explained Norfolk-wide CFO's would be involved and it would be useful to have Audit committee representation, this had not been decided yet.
JI would discuss audit committee representation and scorings outside of the meeting. JI/HDL