NHS
West Norfolk
Clinical Commissioning Group

Minutes of the Audit Committee
Held on 23rd May 2013, 10am - 12pm
At King's Court, Chapel Street, King's Lynn

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

ACTION

1 Apologies

Colin Larby (Counter Fraud), Helen Devlin (External Audit), Mike Clarkson

2 Declarations of Interest

No declarations were made. RM was asked to complete a declaration of interest form as he was new to the committee. **RM**

3 Minutes of the previous meeting held on 25th March 2013

HDL/ JI requested that, in future minutes, the list of those present should only reflect the members of the committee; those in attendance would be listed separately

HDL would liaise with SB regarding grammatical errors. **HDL**

With the grammatical errors noted, the minutes of the previous meeting were agreed as a true record.

JI and HDL agreed the previous audit committee minutes would be presented to the CCG's Governing Body meeting for information.

3.1 Action Log

Log number 1: DH gave a verbal update of the internal audit plan. The internal audit

plan had been discussed with the Chief Financial Officers (CFOs) and Governance Leads of the Norfolk CCG's and it had been agreed that three systems are key – accounts payable, commissioning and payroll / financial ledger. DH stated Internal Audit would like approval to proceed on the basis of the three systems mentioned and look to do this in early July. DH undertook to bring back the full plan to the next committee meeting. **DH**

HDL stated it would have been helpful to have had something in writing in advance of the audit committee's meeting today. The CCG's audit committee needed to be clear from the beginning as it was a new committee. She emphasised the need for good communication and any changes/updates must be put formally in writing to the committee members.

Log number 2: RM said he was unsure of what was agreed at the last committee meeting as he was a new attendee, but external audit was not ready to bring a plan as it was in the early stages of planning. External audit would ordinarily do this later on in the year in November/ December. RM said external audit would ordinarily provide progress reports to the committee. RM/JI would discuss the plan outside of audit committee.

Log number 3: JI and GC had met to discuss Clinical Negligence and agreed to include this cover as part of the NHS Litigation Authority (LA) Insurance package. [Secretary's note: GC had now confirmed that the West Norfolk CCG was a member of the NHS LA insurance scheme.

Log number 4: DH said there was slight confusion over the action and believed the action was regarding risk benchmarking.

Log number 5: This meeting took place on 7 June.

4 Matters Arising

Item 7 page 4: HDL stated that, on page 4 of the minutes it read that there needed to be clear links between the audit committee and clinical audit. HDL and TB had discussed this and would have regular contact via the telephone between meetings to ensure they liaise on all issues, as well as reviewing reports at the audit committee. **HDL/TB**

5 Terms of Reference

GC distributed copies of the Audit Committee's Terms of Reference (ToR) to the members and explained that the ToR were taken from the CCG's Constitution. The full constitution was available on the CCG's website (www.westnorfolkccg.nhs.uk). The purpose of bringing the ToR to the committee was to review and formally adopt them.

HDL suggested the committee members read the ToR outside of the meeting and emailed comments to GC (g.copsey@nhs.net). All comments would be reviewed and brought to the next audit committee with a view to adopting the ToR. **All**

GC stated the ToR had already been adopted as part of the Constitution by both the Council of Members and the Governing Body. If any committee members had significant comments then GC would look to amend the constitution later in the year.

6 Audit Committee Timetable 2013/14

GC gave an overview of the timetable which was based on a template from the HMFA Audit Committee Handbook.

GC and JI had drafted a plan for the audit committee agenda throughout the year identifying the key issues and at what point in the year each item would need to be discussed. JI explained that some items related to the financial figures from the previous year; this would not be relevant to the CCG as it was in its first year, but would remain on the timetable to review in the second year. He suggested the timetable could be rolled on to May 2014 to capture the whole financial year. The committee members agreed.

HDL raised concerns that a few agenda items had not been addressed at the March meeting due to it being the first audit committee. RM pointed out that some of March's agenda items would have gone to the PCT cluster audit committee so would not be relevant to the CCG's committee. GC and JI suggested the timetable be made into a rolling chart so it was relevant to each meeting. The committee members agreed.

There was a discussion around the issue of clinical audit. TB felt that the Patient Safety & Clinical Quality Committee minutes would not be relevant to the Audit Committee and agreed to report any key issues to the audit committee. The members of the audit committee agreed.

EG referred members to '*Counter Fraud, review the effectiveness of the local counter fraud specialist*', on page 2 of the timetable and asked how this would be assessed. JI/GC/EG would discuss this outside of the committee. **JI/GC/EG**

RM referred members to '*External Audit*' on page 2 of the timetable and said the reports for this year would relate to the PCT. HDL felt it was unnecessary to read through reports which were not relevant to the CCG. RM suggested removing the two External Audit items on page two and instead he would provide an update in the next progress report which was brought to the committee. This was agreed.

7 Review of NHS Norfolk & Waveney Audit Committee Legacy Actions

GC referred the members to the review of NHS N&W Audit Committee legacy actions paper, minutes of the last meeting of the Cluster Audit Committee and accompanying action points and the Deloitte PCT Legacy recommendations. DH gave an overview of the Deloitte legacy recommendations report. The report showed the internal audit recommendations that were outstanding at the time of the PCT's demise.

DH explained there were a total of 42 recommendations, 5 of which pre-dated Deloitte's time, but still considered to be relevant. There were also recommendations which related to the

Commissioning Support Unit (CSU); DH suggested the CCG should continue to monitor these as well as their own. DH undertook to work on the report with JI and allocate the recommendations against each CCG, highlighting those that were specific to WNCCG. DH would bring this to the next audit committee meeting in July. **DH**

TB asked for a definition of the priorities. DH explained that high priorities were of major importance and would need to be actioned by senior management. Low priorities tended to be housekeeping matters.

8 Internal Audit Plan

DH would put together a broad overview of the internal audit plan and send this to the committee members in the next couple of weeks for comments. He was keen to gain approval on the three systems they would like to start work on: accounts payable, commissioning and payroll and financial ledger. **DH**

JI raised the issue of Continuing Healthcare (CHC), stating Norfolk-wide CCG's were highly concerned about this and he felt that a common piece of work should be completed on systems, controls and processes as soon as possible.

8.1 Internal Audit Charter

DH explained there was a requirement for all organisations to have an internal audit charter. The charter set out the nature and purpose of the internal audit role, the roles & responsibilities of the Head of Internal Audit (Mike Clarkson), the scope of work internal audit would carry out and the relationship between internal and external audit.

GC said he was acutely aware, as the CCG was a new organisation, that there are a number of policies that should be in place. Some have been identified, but there was a need to prioritise what policies need to be adopted by the CCG. GC asked DH for advice and feedback on this matter. **DH**

EG stated there were two policies that were currently being worked on, Counter Fraud & Corruptions and Sanctions & Redress. EG agreed to review what was needed from the counter-fraud point of view and send information on relevant policies to GC. **EG**

JI questioned page 3 of the charter, where it stated the internal audit budget was reported to the Governing Body. DH stated internal audit would report to the audit committee as this function was normally delegated by the Governing Body, JI also noted at the bottom of page 3 it states the Chief Executive and the Accounting Officer. For West Norfolk CCG this should read the Chief Officer and the Chief Financial Officer respectively. DH would amend appropriately. **DH**

9 External Audit – Outline of work 2013/14

RM explained that Ernst & Young was the main external auditor to NHS bodies in the East and South East of England. RM would be looking after four CCG's, 3 in the Northampton area and

West Norfolk CCG.

RM referred to the audit timetable and stated that December 2013/January 2014 would be a sensible time for external audit to bring their plan to the committee. The plan would outline the scope of work of external audit which would go beyond the audit of financial statements and extend into value for money and regularity. An opinion would be formed on the financial resilience of the CCG and the arrangements in place for securing value for money.

The emerging risks that would be reviewed by External Audit would largely be around the new CCG, such as opening balances and what the CCG had inherited, the number of inherited financial risks from the PCT, QIPP delivery and financial pressures. RM explained that external audit recognised there was an emerging issue regarding Continuing Healthcare provisions and this would be monitored.

The Audit Commission had consulted on fees and had set a range of fees depending on the size of the organisation. WNCCG fell at the bottom of this, so the fee would be £60,000. There would be an extra provision of 10% in the first year, as it had been recognised there might be some unusual risks in the first year of the CCG. Thus the fee would be £66,000 in the first year; this would be outlined in the plan. JI stated we should get the extra 10% refunded by NHS England, he would confirm this with external audit. **JI**

10 Counter Fraud

EG apologised that the plan provided for this meeting of the audit committee was the wrong plan and the one presented at the audit committee in March was correct. EG would circulate the up-to-date plan to the committee. **EG**

EG explained counter fraud used to look at 7 different areas, but NHS Protect changed this last year and now looked at 4 areas: Strategic Governance, Inform and Involved, Prevent and Deter and Hold to Account. Strategic governance covered anything regarding audit, papers, formal documentations, training events; Inform and Involved covered fraud awareness; Prevent and deter covered prevention, policies, processes, any measures Counter Fraud put in place to prevent fraud; Hold to account covered any investigations counter fraud take on and sanctions and re-dress.

HDL asked for a more detailed breakdown of how the time would be allocated. EG would break down each section of the plan to make sure it was clear for the committee members. **EG**

GC asked whether the CCG had access to the counter fraud training e-learning module. EG said the e-learning module was available to the PCT, but she did not believe e-learning was the best way forward for CCG's and preferred face to face training. HDL was not sure this was the best way forward. JI/GC/EG would discuss the issues around training outside of the meeting and incorporate this into the plan. **JI/GC/ EG**

EG explained that counter fraud would be attending the Audit Committee workshop on the 7th June to give an overview of the Counter Fraud service.

JI was concerned about waiting until the next audit committee in July before the plan was reviewed. TB suggested that once JI, GC and EG had met, the plan should be taken to the Executive Team meeting to approve. This would provide the audit committee with assurance that the plan was being reviewed and information disseminated through to the management team. The committee members agreed. **JI**

EG raised a concern on behalf of Colin Larby regarding Continuing Health Care (CHC). NHS Protect had identified possible weaknesses in CHC systems. EG asked for clarity on who was responsible for patients in care homes. JI stated each CCG was responsible for the patients in their area. South Norfolk was leading on commissioning for community services, part of which was continuing healthcare. The commissioning support unit supported the CCG on actions such as contracts, packages for patients, payments etc, but ultimately the responsibility sat with the CCG. HDL asked that counter fraud work together with Norfolk-wide CCGs to review the potential weaknesses. EG agreed that the plan would be Norfolk wide. PS raised concerns concerning CHC restitution claims and where they are sitting? JI stated this process was being run by the CSU on behalf of the CCG. The CSU employ nursing staff to review the cases to view their eligibility. JI highlighted this as an area which could have problems.

TB said personal healthcare budgets would need to be reviewed as they are new and the CCG would need assurance the correct procedures are in place so the same mistakes were not made.

TB asked which member of the audit committee would focus on value for money. JI said there was a piece of collaborative work being done Norfolk wide and this would most likely come up in the QIPP audit.

11 Assurance Framework

HDL felt that the Assurance Framework should reflect high level risks only. There followed considerable discussion around the format of the Governing Body Assurance Framework. As a result it was agreed that GC would look to re-group all of the risks within 5 or 6 main headings and would review the current risks to see which could be transferred to the Corporate Risk Register. This would ensure that only the high level strategic risks would be shown on the Assurance Framework. GC would also re-group the Corporate Risk Register in the same way for consistency. **GC**

DH agreed to send some examples of other assurance frameworks reflecting best practice. **DH**

RM felt that this was one of the better Assurance Frameworks that he had seen from a CCG and recommended that we retain the basic structure.

HDL raised her concerns that there was no overarching strategy for checking and updating the clinical area that each GP member was responsible for. HDL would raise this issue at the CCG's Governing Body meeting. HDL to raise at the Governing Body the question as to how the Audit Committee can be assured that there was a mechanism to achieve consistency across clinical areas, since each clinical area was led by an individual clinician. **HDL**

12 West Norfolk CCG Seal

GC explained that the CCG had taken advice from Mills and Reeves and had ordered a Seal for the formal sealing of appropriate documents. The Seal had not yet arrived; GC would advise the Committee when it was received so that it could be formally adopted.

13 Scheme of Delegation

JI gave an overview on the scheme of delegation paper which was based on the operational scheme of delegation from the PCT. The CCG's Constitution incorporated the high level scheme of delegation, but did not recognise the operational detail of what members of staff could authorise. HDL asked how the figures were determined. JI stated they were based on the PCT figures and amended for CCG use. DH pointed out that some delegations stated "greater than £50,000" but he felt that there should be a maximum level from an audit point of few.
DH recommended there should be more than one signatory at this level of expenditure. EG stated if there are contracts over a certain figure there should be two delegated members of staff to keep consistency. HDL also felt there should two signatories for approval of higher level contracts and financial commitments. It was agreed that JI should amend the scheme of delegation accordingly. **JI**

JI would make the changes to the Scheme of Delegation and report this to the Governing Body on the 30th May explaining that the Scheme was subject to a number of changes. The committee all agreed that the Governing Body should be asked to delegate responsibility to HDL to approve the revised document as chair of the Audit Committee.

JI asked members if they were happy to delegate powers to the CSU to make payments on behalf of the CCG (point 23) and any payments outside of Norfolk (point 24) would have to come through the CCG to authorise. The committee agreed.

14 Review Minutes from Patient Safety Clinical Quality Meeting

Covered in Matters Arising

15 Review of Losses & Special Payment

JI stated this was a standing item on the agenda to report to the committee if there were any losses or special payments. In this instance there was a nil return.

16 Standing Orders & Prime Financial Policies

GC explained that the audit committee was required to formally note these documents which form part of the Constitution. The committee did so.

17 Proposal for Financial Risk Sharing

JI explained the paper had been brought to the audit committee for approval before going to the Governing Body on the 30th May. It had been discussed by Norfolk-wide CFO's and CO's. The proposal laid out the principles for an approach to sharing the risks so no single CCG was exposed to high financial risks in the year. JI explained that NHS Great Yarmouth & Waveney CCG had taken a different view on how they share the risks as they are a larger organisation. GC asked if this paper would be going to other CCG audit committees, to gain assurance that they are committed to the principles. JI confirmed that it would.

RM asked what an Inter-Authority Transfer was. JI explained that this was a terminology meaning the transfer of funds from one organisation to another. NHS England must approve this.

PS asked about Individual Funding Requests (IFR) and who would be responsible for payments. JI said the cost would be charged to the relevant CCG but an adjustment would be made to share the cost. PS raised the concern of having very few IFR requests in the West, which potentially meant the CCG would be liable to pay for requests that were not directly related to them. She was also concerned about payment for the IFR panel and would like an answer by the next IFR panel, 30th May 2013. JI undertook to pick this issue up outside the meeting. **JI**

18 Bank Mandates

JI tabled a paper on bank mandates – this would be circulated to the committee with the minutes. JI gave an overview of the paper stating the bank accounts that have been established for the organisation. The audit committee approved this.

19 HMFA – Audit Committee Handbook

For information only.

20 Any Other Business

HDL asked that in future all papers are circulated at least a week in advance. **GC**

21 Date of Next Meeting

HDL stated that, depending on when the Governing Body meeting was set, the Audit Committee date for October 2013 may have to be adjusted, but currently the next meeting was planned for 24th July 2013, 10 – 12pm. Venue to be confirmed.