AUDIT & ASSURANCE COMMITTEE

Meeting held on Tuesday 8th July 2014, 10:00am – 13:00pm
Venue: Room AD77, Trust HQ, East Surrey Hospital

Present:		
Richard Durban	RD	Acting Committee Chair / Non Executive Director
Richard Shaw	RS	Non Executive Director
John Power	JP	Non Executive Director
Paul Biddle	PB	Paul Biddle
In attendance:		
Michael Wilson	MW	Chief Executive
Paul Simpson	PS	Chief Finance Officer
Gillian Francis-Musanu	GFM	Director of Corporate Affairs
Jamie Bewick	JB	Grant Thornton (External Audit)
Marcus Ward	MW	Grant Thornton (External Audit)
David May	DM	Baker Tilly (Internal Audit)
Sarah Pratley	SP	Local Counter Fraud Specialist (LCFS)
Sacha Beeby	SB	Notes

			Action by
1	1.1	**Welcome and Apologies for absence** RD welcomed members to the meeting and introduced Paul Biddle (PB) to the committee as newly appointed NED and future Chair of the Audit & Assurance Committee. No apologies for absence had been received.	
	1.2	**Minutes of last meeting** The minutes of previous meeting held on 30th May 2014 were reviewed and agreed as a true record.	
	1.3	**Actions from previous meetings:** The action tracker was reviewed and updates noted. The following actions from the May committee were closed due to completion; 1; 2; 4.1; 4.2; The committee was asked to accept closure of actions 1; 8, due to completion. All agreed. Action 6 – Clinical Governance Review to be c/f to the next AAC meeting, due to staff absence.	**CP**

2	2.1	**Review of BAF** GFM presented the latest revision of the BAF to the committee for review, prior to its monthly submission to the Executive Committee and Trust Board. The Board last reviewed and agreed the BAF in June, with the exception of risk 3B1 in relation to Recruitment & Retention, which the Chief Nurse was tasked to review and update in time for the next submission to the board. **RISK 3B1 / 4E** RS noted that risks 3B1 and 4E were not indifferent as they both achieve the recruitment strategy however, the consequence differed. FA was asked to review both risks to ensure consistency. **RISK 5A3** JP felt that the BAF was introspective as it was not explicit in recognising a reconciliation of CCG and Trust intentions in terms of activity and strategic issues. PS agreed to reconsider the wording in relation to risk 5A to make it more specific and to include a gap in control to align CCG and Trust plans in the medium term, and what actions are being taken to reconcile indifferences between intention plans. **RISK 2A1** RS noted a general observation from the Deep Dive process undertaken by the Executive Committee with each of the clinical specialties that there was insufficient benchmarking available nationally and that internal data was limited. MW commented that where data was available, it worked well. However, the quality and accessibility of these benchmarking tools continues to develop and evolve and providers will continue to look to the wider-system to produce an effective and reliable benchmarking data collection toolkit. ACTION: RISK 2B1 - PS requested a change in commentary – replace reference to *ICS* with *Sussex MSK Partnership.* ACTION: PS to review and update risk 5A to specify action in relation to aligning CCG and Trust expectations. ACTION: FA to review risk 3B1 alongside 4E to ensure consistency.	**GFM** **PS** **FA**
	2.2	**Review of SRR** GFM presented the latest revision of the SRR to the committee, ahead of its submission to the board in August. RS was surprised by the balance of the significant risk register, which	

		presented a majority of financial risks over clinical care risks. MW responded that this was a positive reflection of the trusts position and performance at the current time and accurately conveys the organisations biggest risks as identified within the BAF. The committee noted that the board had recently discussed and concluded with this interpretation. MW further added that, the board will not compromise clinical risk for financial risk under any circumstance and the organisation will not lose focus on its clinical risks as a result of a finance-heavy risk register. GFM informed the committee that she was assured by the governance structures in place to mitigate complacency in the management and response to risks within the organisation and recognised greater challenge and consideration by sub-committees and the trust board in relation to the BAF and SRR. ACTION: Consistency in language; 'Residual Rating' should be replaced with 'Target after Action'.	**CP**
3	3.1	**Clinical Governance** This item was not discussed by the committee and will be carried forward to the next Audit & Assurance Committee meeting.	
4	4.1	**Internal Audit Annual Plan** DM presented the Internal Audit Annual Plan for committee approval. In summary, the report sets out the approach taken to develop the Trust's internal audit strategy for 2014/15-2017/17 and the annual plan for 2014/15. The Trusts objectives and Board Assurance Framework were key contributors in the development of the strategy for delivery of internal audit services and linked previous findings on risk management processes with the Trust's own Internal Control System Map which has been aligned to Board Committees. Evident in the report was greater emphasis on benchmarking with organisations used from a Baker Tilly client base which demonstrate similar compositions. PS suggested benefit in using the 26 organisations identified by McKinsey in a similar benchmarking exercise. ACTION: PS to share list of organisations identified by McKinsey for benchmarking.	**PS**

		Internal Audit fees and accountable days for 2014/15 will be maintained within the agreed envelope and the resource team supporting Internal Audit will remain unchanged. From the report, DM highlighted the updated strategy for internal audit for the next 3 years and the detailed audit plan for 2014/15. It was noted that the report made no reference to the joint ventures which SASH was undertaking and that there would be benefit in representing these within the Internal Controls Framework Map. ACTION: GFM to update the committee with a revised Internal Controls Framework Map, demonstrating joint ventures by SASH, for committee management and assurance purposes. The Internal Audit Plan was approved by the committee.	**GFM**
	4.2	**Internal Audit Progress Report** The internal audit plan for 2013/14 was approved by the Audit and Assurance Committee on 3rd September 2013. The Internal Audit Progress Report provides an update on progress against the plan and summarises the results of work to date. The committee discussed the position of the progress in completing the Internal Audit Plan for 2013/14, with a detailed breakdown of assignments completed or due. There are 4 assignments currently in progress and due to be reported to the next AAC meeting, including; Clinical Governance, Internal Structures (Board and Committee), NICE Guidance, Claims Handling. Internal Audit have finalised its Cash & Treasury Management audit and concluded the audit as Green. The rest of the audit plan is currently due for completion and any outstanding audits will be reported to the committee in September. It was noted that the Committee agenda in September may be dominated by all outstanding audits.	
	4.3	**External Audit Review of Quality Account** The Quality Account is an annual report to the public from providers of NHS healthcare about the quality of services they deliver. The primary purpose of the Quality Account is to encourage boards and leaders of healthcare organisations to assess quality across all the healthcare services they offer. It allows leaders, clinicians, governors and staff to show	

		their commitment to continuous, evidence-based quality improvement, and to explain progress to the public. External Audit is required by the Audit Commission to perform an independent assurance engagement in respect of the Quality Account for the year ended 31 March 2013 and certain performance indicators contained therein. Their responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to their attention that causes them to believe that: • the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations • the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission ("the Guidance") • the indicators in the Quality Account identified as having been the subject of limited assurance, are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance Based on the results of its procedures, with the exception of the matters reported, nothing has come to their attention that cause concern in respect of the above. VTE and Serious Incident (SI) Indicators were matters identified by the audit which recommendations have been made for trust consideration. Overall, the Auditors concluded that the Quality Account was a good report however, the timeliness of producing its content for Audit review could be improved. The Auditors accepted the trust's recommendation to ensure clear timelines to receive the report for review in future in order to meet expectations. The Auditor for reviewing next year's Quality Account has not yet been agreed. The Committee will receive a public report at the next meeting summarising the work it has undertaken on behalf of the Trust. The trust agreed that further focus was needed on timeliness of responding to SI escalation more promptly and in deciding which incidents to escalate. This relies on the authority of the on-call Director or Clinician and Datix entry. The trust admits that it is less proactive in the de-escalation of SI's, than escalation itself. The action plan identifies the need to review and improve recording of SI's	

		on Datix on a timely basis, however it was agreed that the wording attributed to this action should be revised to remain consistent with the overall report and accurately reflect the number of SI's it refers to. ACTION: The committee agreed that the Trust's response to each of the recommendations should be included within the report.	**GFM/JB**
	4.4	**LCFS Annual Report** The committee received the Local Counter Fraud Specialist Annual Report in advance of the meeting. The report summarises the work conducted by the Local Counter Fraud Specialist (LCFS) for the year 1 April 2013 – 31 March 2014 and SP summarised some of the updates and changes since the last report. 3.7 Following the submission of the LCFS Self Review Tool (SRT) for 2012/13, the Trust was not selected by NHS Protect for any focused review. The closing date for the 2013/14 submission is 30 June 2014. SP confirmed that the deadline for submission has now been extended to 17th July. 4.4 The LCFS placed posters throughout the Trust which provided direct contact details for them. New branding has meant a new set of posters and promotional material for the trust display. Details have also been added to the internal E-Bulletin. 4.8 The LCFS maintains regular liaison with external agencies, including NHS Protect, Local Police, Local Authorities, Department for Work and Pensions (DWP) and the Home Office to assist in investigations and sharing of best practice, in addition to the participation in the bi annual National Fraud Initiative (NFI). SB confirmed that, in previous years the trust had made personal data requests via staff payslips. It is mandatory for these requests to be responded to and any issues or concerns in relation to data protection should be made to SP. SP added that, during 2013/2014, two fraud cases at the Trust were reported on in several national newspapers. This publicity was excellent for Trust as it shows how seriously the Trust takes fraud offences. SP updated the committee on sanctions and redress which occurred during 2013/14. An investigation remains open relating to overtime claimed by a locum. The police have had difficulties tracking the offender and a Wanted file has	

		been opened and shared with border agencies. RD recognised a pattern in the nature of cases / incidents reported and asked whether the trust was able to benchmark against other trusts and learn from eachother in the way of processes, response, mitigations etc. SP agreed to share a recently undertaken benchmarking exercise with the committee at the next meeting and assured the committee that the trust was proactive in managing and prosecuting offenders, this is consistent with other trusts. The committee challenged whether the LCFS recognised any groups of staff who may have less exposure to the LCFS and whether we were proactive in informing staff appropriately in terms of fraud and the escalation of fraudulent concerns. Overall, staff appear to be well informed and understand how and where to escalate any concerns in this respect. The committee recognised that staff survey response rates need improving and the LCFS is considering proactive means to achieve this. The LCFS are awaiting sign-off from the CFO to agree service provision for next year. The trust accepts 100-days of service provision in order to support the trust is appropriate. ACTION: PS to action sign-off and present plan to committee at next meeting for discussion. The plan should detail the breakdown of costs for the agreed 100-days of service provision.	**PS**
5	5.1	**AOB** No further business was discussed. The committee agreed that the availability of papers should be made sooner in order to allow sufficient pre-reading in advance of the meeting.	
6	6.1	**Date of Next Meeting:** 9th September, 09:30 pre-meet, 10:00 meeting start.	