

**Report to the Meeting of the Oxford Health NHS Foundation Trust**

**Board of Directors**

**To receive and approve**

**BOD 83/2014**

(Agenda item: 15)

**25 June 2014**

**Audit Committee Annual Report 2013/14**

**Executive Summary**

The Board receives an Annual Report from the Audit Committee summarising the performance and work programme of the Audit Committee during the previous financial year (01 April 2013 – 31 March 2014). As part of this Annual Report, the Audit Committee considers its Terms of Reference and recommends any changes. The Audit Committee considered its Annual Report at its meeting on 22 May 2014 and now recommends it to the Board of Directors. No changes are recommended to the Terms of Reference which were last amended by the Board in January 2013 and last reviewed by the Board in May 2013 as part of the consideration of the 2012/13 Annual Report of the Committee.

**Recommendation**

The Board of Directors is asked to receive the Audit Committee Annual Report 2013/14.

**Alyson Coates, Chair of the Audit Committee**

*A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*

**Audit Committee Annual Report**

**For the period 1 April 2013 – 31 March 2014**

The Audit Committee’s key responsibility is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control. In doing so the Committee shall ensure that there is an effective control assurance process (including an effective Internal Audit function), review the work and findings of External Audit and review the findings of other significant assurance functions. The Committee’s Terms of Reference were last reviewed by the Board of Directors at its meeting on 29 May 2013 as part of the consideration of the 2012/13 Annual Report of the Committee.

**Frequency of meetings and attendance**

The Terms of Reference state that the Committee should meet not less than three times a year. In the reporting period the Committee met five times (compared to five occasions in 2012/13 and six occasions in 2011/12).

The Terms of Reference also state that the Audit Committee should meet privately with the External Auditors and Head of Internal Audit at least once a year. The Minutes of the meetings indicate that a private meeting had taken place on four occasions.

The members of the Committee are all Non-Executive Directors and during the reporting period were as follows:

* Alyson Coates (Chair)
* Sue Dopson
* Anne Grocock
* Roger Reed (part year)
* Cedric Scroggs
* Lyn Williams

With the exception of Roger Reed, all were members of the Committee for the entire period of reporting. Roger Reed’s term of appointment as a Non-Executive Director and, therefore, his membership of the Committee expired with effect on 30 April 2013.

The Terms of Reference of the Committee state that the membership should consist of not less than three members. The Committee membership was six members on 01 April 2013 (this reduced to five from 30 April 2013 when Roger Reed’s tenure as a Non-Executive Director ended). The quorum is three members. A quorum of members was available for all meetings. Attendance by the members has been as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Meeting | 19/04/13 | 23/05/13 | 19/09/13 | 05/12/13 | 06/02/14 |
| No. Attending | 3 | 4 | 4 | 4 | 3 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Director** | **19 April 13** | **23 May 13** | **19 Sept 13** | **05 Dec 13** | **06 Feb 14** |
| **Alyson Coates** | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sue Dopson | X | X | ✓ | X | ✓ |
| Anne Grocock | X | ✓ | ✓ | ✓ | ✓ |
| Roger Reed | X | N/A | N/A | N/A | N/A |
| Cedric Scroggs | ✓ | ✓ | X | ✓ | X |
| Lyn Williams | ✓ | ✓ | ✓ | ✓ | X |

**Key:**

✓ - attended

X - apologies

N/A – not a member of the Committee at this time

Internal Audit, External Audit and the Local Counter Fraud Specialist (**LCFS**) were invited to attend every meeting of the Committee. Both the Internal Auditors and External Auditors attended five meetings. The LCFS attended four meetings and sent a representative in her absence to attend one meeting.

The Chief Executive and Director of Finance were invited to attend every meeting of the Committee. The Chief Executive attended three meetings and the Director of Finance attended five.

The Chair of the Committee had extended an open invitation for the Chair of the Trust to attend meetings, should he so wish. The Chair of the Trust attended two Committee meetings for: (i) the presentation of the Annual Report and Annual Accounts on 23 May 2013; and (ii) at the specific request of the Committee and in his capacity as the Chair of the Integrated Governance Committee to present an oral update on assurance gained by the Integrated Governance Committee, the minutes of the Integrated Governance Committee and discussion on clinical audit on 05 December 2013.

The Trust Secretary attended four meetings of the Committee to provide governance advice where required and ensured that formal minutes were taken. The Assistant Trust Secretary assisted in this duty and attended five meetings.

The following officers of the Trust were invited to attend meetings, often only for single items. The number of attendances for each over the reporting period shown in parentheses:

* Director of Nursing and Clinical Standards (1)
* Deputy Director of Finance (4)
* Head of Financial Services (2)
* Senior Accountant (2)
* Head of Communications and Involvement (2)
* Head of HR Systems and Payroll (1)

**Integrated Governance Committee**

The Committee’s Terms of Reference set out the option for the Committee to receive at least once a year a report on the operation of the Integrated Governance Committee, to be presented by the Chair of the Integrated Governance Committee (currently the Chair of the Trust), or to consider having a joint meeting with the Integrated Governance Committee. There was no formal joint meeting during the reporting period. The Committee received an oral update from the Chair of the Trust (in his capacity as the Chair of the Integrated Governance Committee) of the assurance gained by the Integrated Governance Committee at the meeting on 05 December 2013.

## Business conducted by the Committee during 2013/14

Set out below is the remit of the Committee together with a report on the main business transacted over the period of the annual report.

1. ***Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non-clinical) that supports the achievement of the organisation’s objectives***

The Terms of Reference state that the Committee should review the adequacy of all risk and control related disclosure statements, in particular the Annual Governance Statement (formerly the Statement on Internal Control) and Head of Internal Audit Opinion together with any external assurance prior to being submitted to the Board.

As part of the review of the annual financial statements the Committee considered the Annual Governance Statement together with the Head of Internal Audit Opinion. Through regularly considering the Board Assurance Framework (**BAF**), the Committee gains ongoing assurance of compliance against Care Quality Commission (**CQC**) registration requirements as well as action being taken to mitigate risks. As part of the annual Internal Audit plan, the Committee is assured of the effectiveness of the BAF processes and the process for establishing compliance against CQC Outcomes.

In fulfilment of the remit to review the underlying assurance processes in indicating the level of achievement of the organisation’s objectives, the Committee received BAF update reports at each of the five meetings. These reports developed from setting out the moderate to extreme risks to the Trust failing to achieve its objectives to setting out the strategic risks to the Trust failing to achieve its strategic objectives, together with mitigating action to be taken, assurances, gaps in controls and assurances and gross, net and target risk ratings. Prior to the reporting period, the process by which the Trust managed the BAF had changed on three occasions: from first being part of the former Director of Corporate Management’s responsibility, to the remit of the Director of Nursing and Clinical Standards and, most recently, to the remit of the Chief Executive. The BAF and its support structures were subsequently reviewed and the Committee kept informed of progress.

The members of the Committee also received, out-of-session, Internal Audit reports, as part of the 2013/14 Internal Audit plan, on key systems of internal control including the BAF, CQC Registration, Finance, Integrated Governance and Policy Scrutiny.

The LCFS attended meetings and/or provided written reports providing the Committee with regular updates on ongoing investigations, outcomes of investigations and awareness raising activities.

In January 2013 the Terms of Reference were updated to include a new duty for the Committee to assure itself on the adequacy of the governance and procedures relating to the Charitable Funds. Until January 2014, during this reporting period, the membership of the Charitable Funds Committee was comprised of all the members of the Board. With effect from January 2014, however, the Charitable Funds Committee was restructured and the membership reduced. The Committee will start to receive the annual report of the Charitable Funds Committee (by October 2014) but this will not be available during this reporting period.

The Terms of Reference were received with no changes by the Board at its meeting on 29 May 2013.

1. ***Ensure that there is an effective Internal Audit function established by management that meets mandatory Government Internal Audit Standards and provides appropriate independent assurance***

The Committee had approved the Internal Audit Plan for 2013/14 at its meeting in February 2013. The Committee was assured that the Internal Audit Plan had been developed in line with the BAF and risk registers, previous audit coverage of fundamental systems and accumulated Internal Audit knowledge and experience. At its regular meetings, the Committee received updates on progress against plan, updates on the performance of Trust management in meeting any overdue recommendations and monitored implementation by management of medium and high priority recommendations.

The table below sets out the number of reports which had received a “limited” or lower, “satisfactory”, “good” or “excellent” assurance level during the reporting period 2013/14 and compared to the previous reporting periods 2012/13 and 2011/12 (no reports received an “unacceptable” assurance level; one report in 2011/12 received a “poor” assurance level)[[1]](#footnote-1):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Period** | **Limited or lower** | **Satisfactory** | **Good** | **Excellent** |
| 2013/14 | 0 | 5 | 9 | 3 |
| 2012/13 | 6 | 8 | 6 | 3 |
| 2011/12 | 5 | 6 | 5 | 1 |

The graph below sets out the number of high, medium and low priority recommendations received over several reporting periods and the decrease in recommendations over the more recent reporting periods[[2]](#footnote-2):

The Committee received the Head of Internal Audit Opinion for 2013/14 and the Internal Audit annual report for 2013/14 in April 2014. The overall Head of Internal Audit Opinion for 2013/14 was of “good” assurance as a generally sound system of internal control was in place, designed to meet the Trust’s objectives, and controls were generally being applied consistently and effectively. Some areas for improvement had still been identified, as the Committee was aware of from the Internal Audit reports which had been produced in-year although during this reporting period, no Internal Audits had received “limited” or lower assurance levels; the lowest assurance awarded had been that of “satisfactory”. This was a positive opinion and an improvement on the Head of Internal Audit Opinion for 2012/13 (which had been received during the reporting period in April 2013) which had awarded overall “satisfactory” assurance. “Satisfactory” assurance had also been awarded in the Head of Internal Audit Opinion for 2011/12. In 2012/13 and 2011/12, the Trust’s assurance level had slipped from earlier reporting periods, when “good” levels of assurance had been awarded. The Committee had agreed that the assessments had been fair based upon the findings of Internal Audit during 2011/12 and 2012/13.

All members of the Committee and other relevant Trust officers received, out-of-session, copies of the Internal Audit reports issued throughout the year. The Committee has a policy that all Internal Audit reports that receive a “satisfactory”, “limited” or lower assurance level are discussed at a Committee meeting with the relevant Executive Directors in attendance. The Committee considered the following reports at formal meetings during the reporting period 2013/14 and compared to the previous reporting period 2012/13:

|  |  |
| --- | --- |
| **Meetings during 2013/14** | **Meetings during 2012/13** |
| * Estates (2012/13 Internal Audit) * Data Pseudonymisation * Integrated Governance * Research & Development * Policy Scrutiny | * Payroll * Payroll Provider * Electronic Expenses * Payroll Internal Systems – Data Capture * Estates (on two occasions: one final version and one draft version) * Oxford Pharmacy Stores * Control Self-Assessment (HR) * Oxford Cognitive Therapy Centre * Facilities |

The Committee received a 2013/14 Counter Fraud annual report in April 2014 and a 2012/13 Counter Fraud annual report in April 2013 in addition to regular update reports throughout the reporting period.

During the reporting period 2013/14, a tender process was conducted to market test Internal Audit and Counter Fraud Services; the Committee was kept informed of progress. 2014/15 Internal Audit and Counter Fraud Plans were not, therefore, presented during the reporting period pending the outcome of the tender process. A preferred bidder to provide Internal Audit and Counter Fraud Services was appointed with effect from 01 April 2014, subject to contract.

1. ***Review the work and findings of the External Auditors appointed by the Council of Governors and consider the implications and management’s responses to their work***

The Committee received a planning report from the External Auditors in December 2013 which set out the focus for the External Audit for 2013/14, with an update report being provided in February 2014 which set out the principal changes following Monitor’s updated NHS Foundation Trust Code of Governance and the 2013/14 Annual Reporting Manual.

At its regular meetings, the Committee received progress updates against the External Audit.

The Committee received the following reports from the External Auditors which they considered in formal session:

* Specimen Letter of Representation
* Report on the 2012/13 Annual Report and Financial Statements
* Report on the 2012/13 Quality Report
* Guidance on maintaining the BAF and risk registers

In considering the Report on the 2012/13 Annual Report and Financial Statements in May 2013, the Committee was advised that there were no significant audit risks which required correction, no significant deficiencies in the financial reporting system and no significant uncorrected misstatements. The External Auditors made recommendations, all of which had been responded to by management in the Report, on:

* reviewing the systems and structures in place to deliver Cost Improvement Programmes;
* maintaining the fixed asset register;
* maintaining a current list of all contracts/projects;
* ensuring contracts were appropriately approved and signed-off prior to their commencement date;
* calculating holiday pay accruals;
* reconciling patient monies;
* verification of areas supplied to the district valuer;
* releasing a proportion of the provision held in respect of closed legal cases;
* resolving cases where the Trust owns a building on land over which it has no legal rights;
* obtaining legal rights to use land and access roads prior to purchasing or beginning construction on future capital projects; and
* recording dates on journals.

1. ***Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation***

The Committee considered the findings of:

* the BAF (internal to the Trust) throughout the reporting period; and
* NHS Protect (external to the Trust) in relation to a Counter Fraud referral from 2010 regarding alleged corruption/bribery. The NHS Protect investigation found no evidence to substantiate the allegations made.

The members of the Committee were also able to gain assurance from other means outside of their direct Committee membership as full members of the Board. Until January 2014, all of the members of the Committee were also members of the Charitable Funds Committee; from January 2014, some remained members of the Charitable Funds Committee. In particular, the presentation of the monthly finance and performance reports, CQC compliance declarations and Monitor quarterly reports to the Board and the consideration of the Integrated Governance Committee minutes and the Charitable Funds Committee minutes by the Board provided Committee members with assurance.

The Integrated Governance Committee minutes are also presented to the Audit Committee for information.

1. ***Request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control***

The Committee requested the attendance of Directors and managers to assure itself on the action being taken to mitigate any outstanding risk to the organisation on the following areas during the year:

*Payroll Function*

As in the previous three years, this item continued to be discussed at all main Committee meetings during the reporting period. The Director of Finance had taken on responsibility for the HR function and was present at all meetings for discussion of this item. On one occasion, the Head of HR Systems and Payroll was invited to attend and provided a detailed update on performance in relation to the Trust’s payroll function, including overpayments. At the end of the reporting period, the Committee noted the positive improvement demonstrated in reporting on payroll and noted that if improvement could be sustained, monitored through reporting in April and, if required, May 2014, then it may no longer be necessary to bring payroll reporting as a standing item to future meetings.

*Bank Mandate Fraud*

Following the report in the previous year on a bank mandate fraud, the LCFS presented an update on the review of the revised Finance procedures to counteract bank mandate fraud. The LCFS confirmed that the revised process was being operated as designed and that the process, if followed, was robust enough to detect and, therefore, prevent fraudulent attempts to change supplier bank account details from being successful. The Director of Finance confirmed that more proactive attention had been given to fraud issues and the interaction between the Finance and Procurement teams was more dynamic.

*Information Governance incidents*

Following an update in the previous year on Information Governance incidents, the Director of Finance reported twice on the progress which the Information Management Committee (**IMC**)was making to restructure and consolidate Information Governance policies and procedures and to focus on information incidents. The Committee noted the progress being made on information management and that the Integrated Governance Committee regularly received the minutes of IMC meetings. The Committee requested that it also receive, for information, the annual report of the IMC which was submitted to the Integrated Governance Committee.

*Clinical Audit and assurance from the Integrated Governance Committee*

Following concerns raised by the Committee and the Integrated Governance Committee about the number of clinical audits receiving “poor” or “satisfactory” ratings and the need for assurance that the findings of the clinical audit programme were being responded to, the Chair of the Trust (in his capacity as the Chair of the Integrated Governance Committee) attended the meeting in December 2013 to: (i) present an oral update on assurance gained by the Integrated Governance Committee and present the minutes of the Integrated Governance Committee; and (ii) discuss clinical audit. The meeting discussed in detail: the improved level of engagement between teams undertaking clinical audits and teams operating services and responding to clinical audits; the role of Clinical Directors attending meetings of the Integrated Governance Committee to change the focus of scrutiny from teams undertaking clinical audits to teams delivering services; and the role of the Committee in considering clinical objectives and risks and understanding the programme of clinical audit work, as set out in the NHS Audit Committee Handbook.

The Committee sought further assurance from the Integrated Governance Committee on the design, implementation and review of the clinical audit programme. Further reporting is scheduled for the next reporting period.

1. ***Review the Annual Report and Annual Accounts before submission***

The Committee reviewed the 2012/13 Annual Report text and Financial Statements (with analytical review) in April and May 2013, prior to formal presentation to the Board of Directors in May 2013. As part of this review the Committee also considered the Annual Governance Statement (formerly the Statement on Internal Control), Statement of the Chief Executive’s responsibilities as the Accounting Officer, the Head of Internal Audit Opinion and a Going Concern Statement. This statement involved a detailed analysis to support the conclusion that a going concern basis of accounting was appropriate.

1. ***Other business transacted***

The Committee has also received the following reports during the reporting period:

* Updates on CEAC’s (Internal Auditors) financial position and consortium arrangements
* Updates on the Internal Audit and Counter Fraud tendering
* Reviewing the Scheme of Delegation
* Regular Single Action Tender Waivers Reports
* Losses and Special Payments (including annual schedule of write-offs) Report
* Report on the National Reference Cost Return Costing Process (for its 2012/13 return the Trust was required to provide confirmation from the Board or a representative sub-committee that it was satisfied with the Trust’s costing processes and procedures)

## Reporting

Meetings are formally recorded by the Trust Secretary, assisted by the Assistant Trust Secretary. Minutes were circulated in line with the terms of reference and presented to the following meeting of the Board of Directors.

**Updates to the NHS Foundation Trust Code of Governance (the Code) with effect from 01 January 2014 and “Managing Public Money” (MPM) guidance**

Monitor issued the updated Code on 19 December 2013 to apply from 01 January 2014, during the reporting period. With the exception of certain statutory requirements, the Code sets out best practice advice, rather than mandatory guidance, against which organisations should comply or explain. Non-compliance can be explained by illustrating how actual practice is consistent with the principles of the relevant provision(s) and whether deviation is expected to be limited in time. The Trust is required to report on compliance with the revised Code in the 2013/14 Annual Report of the Trust.

The revised Code extends guidance around audit committees’ responsibilities for oversight of whistle-blowing arrangements, including that this should allow for reports from individuals who are not members of staff and should include appropriate safeguards to protect whistle-blowers, at provision C.3.8 and as set out below:

*C.3.8. The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee’s objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions*.

Provision C.3.8 is subject to the basic comply or explain requirement to explain any reasons for departure from the Code and how alternative arrangements continue to reflect the main principles of the Code.

The Trust’s approach to whistle-blowing is set out in the Public Interest Disclosure (Whistle-blowing) Policy (HR07) which was revised and approved by the Board in December 2011 and the Trust has a designated Non-Executive Director to whom whistle-blowing cases can be reported. Although not currently a regular feature of the Committee’s work plan, the Committee considered the Trust’s whistle-blowing arrangements at its meeting in February 2014. The Committee was informed that whistle-blowing was monitored by HR, cases were brought to the attention of the Executive, outcomes were followed-up by the Executive and a summary of whistle-blowing processes, cases and outcomes would also be included in the regular HR reporting to the Board. The members of the Committee would, therefore, also be able to gain assurance on whistle-blowing arrangements from other means outside of their direct Committee membership as full members of the Board.

At its meeting in February 2014, the Committee also considered revisions to the MPM guidance and the increase in the level of disclosures required on Losses and Special Payments. The Committee noted that losses should include “constructive losses” where expenditure had been appropriately incurred but subsequent decisions, such as to discontinue a project, had led to a loss. The Committee requested, and the Finance Team agreed, that future reporting on Losses and Special Payments would include reporting on constructive losses. The next report on Losses and Special Payments is due outside of the reporting period, in September 2014.

**Self-Assessment against the NHS Audit Committee Handbook checklist**

The Committee has reviewed its self-assessment against the HFMA & Department of Health NHS Audit Committee Handbook (revised in 2011) self-assessment checklist. The outcome of the Assessment is attached at Annex A. Last year, the self-assessment indicated that the Committee met all requirements and this remains the same for this year. A revised version of the NHS Audit Committee Handbook will be available during the next reporting period, from June 2014, but for the current reporting period the version of the checklist from the 2011 Handbook still applies.

Alyson Coates

Chair, Audit Committee

**Annex A: Self-Assessment Checklist**

**Status Key**

**1 -** Must do

**2** - Should do

**3** - Could do

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Status** | **Issue** | **Yes** | **No** | **N/a** | **Comments** |
| **Composition, Establishment and Duties** | | | | | |
| **1** | Does the Audit Committee have written terms of reference that adequately define the Committee’s role in accordance with Department Of Health/Monitor guidance? | √ |  |  | Terms of Reference last updated January 2013. Presented as part of Audit Committee Annual Report 2012/13 and received (with no changes) by the Board in May 2013. |
| **1** | Have the terms of reference been adopted by the Board? | √ |  |  |  |
| **1** | Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation? | √ |  |  |  |
| **1** | Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently? | √ |  |  | 5-6 NEDs, External / Internal Audit. Terms of Reference approved by the Board. |
| **2** | Are changes to the Committee’s current and future workload discussed and approved at Board level? | √ |  |  | Board regularly reviews Committee workload through receiving Committee minutes and an oral report from Committee chair. |
| **1** | Are Committee members independent of the management team? | √ |  |  | NEDs |
| **1** | Does the Committee report regularly to the Board? | √ |  |  |  |
| **1** | Has the Chair of the Committee a prior understanding of, or received training in, finance and internal control or other relevant expertise? | √ |  |  |  |
| **1** | Are new members provided with appropriate induction? | √ |  |  |  |
| **1** | Does the Board ensure that members have sufficient knowledge of the organisation’s business to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters? | √ |  |  | NEDs are full members of the Board and serve on other Committees, thereby gaining wide understanding of the business of the Trust. |
| **1** | Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board? | √ |  |  |  |
| **1** | Does the Committee assess its own effectiveness periodically? | √ |  |  | Through developing its annual report to the Board, the Committee assesses its performance and effectiveness. |
| Meetings | | | | | |
| **1** | Has the Committee established a plan of matters to be dealt with across the year? | √ |  |  | Committee Work Plan developed and maintained by Assistant Trust Secretary. |
| **1** | Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussion? | √ |  |  | Extraordinary meetings can be held when required. |
| **1** | Does the Committee’s calendar meet the Board’s requirements and financial and governance calendar? | √ |  |  |  |
| **2** | Are Committee papers distributed in sufficient time for members to give them due consideration? | √ |  |  |  |
| **2** | Are Committee meetings scheduled prior to important decisions being made? | √ |  |  |  |
| **2** | Is the timing of Committee meetings discussed with all the parties involved? | √ |  |  |  |
| Compliance with the law and regulations governing the NHS | | | | | |
| **1** | Does the Committee review assurances and regulatory compliance reporting processes? | √ |  |  |  |
| **3** | Has the Committee formally assessed whether there is a need for the support of a ‘Trust/Company Secretary’ role or its equivalent? | √ |  |  | The Trust has in a place a Trust Secretary. |
| **2** | Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues? | √ |  |  | The Board members are kept up to date through their briefings and information provided out-of-session by Trust Secretary and other officers.  Additional briefings / reports provided at Committee meetings by other officers (e.g. Counter Fraud and External Audit update reports). |
| Internal control and risk management | | | | | |
| **1** | Has the Committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management and clinical governance? | √ |  |  | Board Assurance Framework and action plan takes a Trust-wide approach.  Committee regularly considers minutes from Integrated Governance Committee. |
| **1** | Has the Committee formally considered how its work integrates with wider performance management and standards compliance? | √ |  |  |  |
| **1** | Has the Committee reviewed the robustness and effectiveness of the content of the organisation’s Assurance Framework? | √ |  |  | Regularly reviewed by Committee. |
| **1** | Has the Committee reviewed the robustness and content of the draft Statement of Internal Control before it is presented to the Board? | √ |  |  | Now known as Annual Governance Statement – reviewed at April and May meetings. |
| **2** | Has the Committee reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge its internal control and risk management responsibilities? | √ |  |  | Committee receives copies of all audit reports and a progress report from each of: external audit, internal audit and the Local Counter Fraud Specialist.  Committee provides regular feedback on the timeliness and quality of reports. |
| **1** | Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board? |  | √ |  | Committee has not explicitly reviewed but Board regularly discusses data robustness. Internal Audit reporting during 2013/14 included reports on The Cube and Data Pseudonymisation. |
| **1** | Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation’s responsibilities? | √ |  |  | Minutes of all meetings reported to the Board, including the annual audit plans. |
| **1** | Is the Committee’s role in reviewing and recommending to the Board the annual report and accounts clearly defined? | √ |  |  |  |
| **1** | Does the Committee consider the External Auditor’s report to those charged with governances including proposed adjustments to the accounts? | √ |  |  |  |
| **1** | Does the Committee review management’s letter of representation? | √ |  |  |  |
| **1** | Is there clarity over the timing and content of the assurances statements received by the Committee from the Head of Internal Audit? | √ |  |  |  |
| Internal Audit | | | | | |
| **1** | Is there a formal ‘charter’ of terms of reference, defining internal audit’s objectives, responsibilities and reporting lines? | √ |  |  | In SLA and annual plan. |
| **1** | Are the terms of reference approved by the Committee and regularly reviewed? | √ |  |  | In SLA approved by Committee and signed by DoF. |
| **2** | Are the key principles of the terms of reference set out in the Standing Financial Instructions? | √ |  |  | The SFI requires that it is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed. The key principles are in the Committee’s Terms of Reference. |
| **1** | Does the Committee review and approve the internal audit plan at the beginning of the financial year? | √ |  |  |  |
| **1** | Does the Committee approve any material changes to the plan? | √ |  |  |  |
| **2** | Are audit plans derived from clear processes based on risk assessments with clear links to the Assurance Framework? | √ |  |  |  |
| **1** | Does the Audit Committee receive periodic reports from the Head of Internal Audit? | √ |  |  |  |
| **1** | Do these reports inform the Audit Committee about progress or delays in completing the audit plan? | √ |  |  |  |
| **3** | Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation? | √ |  |  |  |
| **2** | Does the Committee effectively monitor the implementation of management actions arising from audit reports? | √ |  |  | All high and medium risk recommendations are monitored. |
| **1** | Does the Head of Internal Audit have direct line of reporting to the Committee and its Chair? | √ |  |  |  |
| **2** | Is internal audit free of any scope restrictions and, if not, what are they and who establishes them? | √ |  |  |  |
| **2** | Is internal audit free from any operating responsibilities or conflicts of interest that could impair its objectivity? | √ |  |  | Internal Audit (CEAC during reporting period) not involved in Trust operation / management. |
| **2** | Has the Committee determined the appropriate level of detail it wishes to receive from internal audit? | √ |  |  | All reports, progress reports, all outstanding high risk / medium risk recommendations.  Committee continually reviews its position and discusses with Internal Audit. |
| **1** | Does the Committee hold periodic private discussions with the head of Internal Audit? | √ |  |  |  |
| **2** | Does the Committee review the effectiveness of internal audit and the adequacy of staffing and resources within internal audit? | √ |  |  | Through considering the Internal Audit annual plan, progress reports and SLA. |
| **2** | Has the Committee evaluated whether internal audit complies with the *NHS Internal Audit Standards (or Government Internal Audit Standards* in an FT)? |  | √ |  | No formal documented assessment.  However, internal audit provides assurance through each audit report, its annual report and Head of Internal Audit Opinion (all submitted to the Committee). Further, the internal auditors in place during the 2013/14 reporting period (CEAC) operated in accordance with their own quality management system (which had ISO 9001 certification). |
| **3** | Has the Committee agreed a range of internal audit performance measures to be reported on a routine basis? | √ |  |  | Progress reports contain performance measures requested by the Committee. |
| **1** | Does the Committee receive and review the Head of Internal Audit’s annual report and opinion? | √ |  |  |  |
| **2** | Is there appropriate cooperation with the external auditors? | √ |  |  |  |
| **2** | Are there any quality assurance procedures to confirm whether the work of the internal auditors is properly planned, completed, supervised and reviewed? | √ |  |  |  |
| External Audit | | | | | |
| **1** | Do the external auditors present their audit plans and strategy to the Committee for approval? | √ |  |  |  |
| **2** | Has the Committee satisfied itself that work not relating to the financial statements is adequate and appropriate? | √ |  |  |  |
| **2** | Does the Committee receive and monitor actions taken in respect of prior years’ reviews? | √ |  |  |  |
| **1** | Does the Committee review the External Auditor’s annual audit letter? | √ |  |  |  |
| **1** | Does the Committee review the External Auditor’s use of resources conclusion? | √ |  |  |  |
| **1** | Does the Committee hold periodic private discussion with the external auditors? | √ |  |  |  |
| **2** | Does the Committee assess the performance of external audit? | √ |  |  |  |
| **3** | Does the Committee require assurance from external audit about the policies for ensuring independence and compliance with staff rotation requirements? |  | √ |  | Recent tender process ensured policies were in place and compliance with staff rotation. |
| **3** | Does the Committee review the nature and value of non-audit work carried out by the external auditors? |  | √ |  |  |
| Clinical Audit | | | | | |
| **1** | Is the Committee clear about where clinical audit assurances are received and monitored? | √ |  |  | Integrated Governance Committee. |
| **2** | If it is the Audit Committee that receives and monitors clinical audit assurances  Does it:   * Review the clinical audit plan at the beginning of each year? * Confirm that clinical audit plans are derived from clear processes based on risk assessment with clear links to the Assurance Framework? * Receive periodic reports from the person responsible for clinical audit? * Effectively monitor the implementation of management actions arising from clinical audit reports? * Ensure that the person responsible for clinical audit has a direct line of access to the Committee and its Chair? * Hold periodic private discussions with person responsible for clinical audit? * Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit? |  |  | √ |  |
| **2** | * Evaluate clinical audit against the Healthcare Quality Improvement Partnership’s publication *Clinical Audit: A simple guide for NHS Boards?* * Confirm that there are quality assurance procedures in place to confirm whether the work of clinical auditors is properly planned, completed, supervised and reviewed? * Confirm that there are terms of reference for clinical audit that define its objective, responsibilities and reporting lines? * Review clinical audit’s terms of reference regularly? |  |  | √ |  |

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| Counter Fraud | | | | | |
| **1** | Does the Committee review and approve the counter fraud work plan at the beginning of the finance year? | √ |  |  |  |
| **1** | Does the Committee satisfy itself that the work plan adequately covers each of the seven generic areas defined in NHS counter fraud policy? | √ |  |  |  |
| **1** | Does the Committee approve any material changes to the plan? | √ |  |  |  |
| **2** | Are counter fraud plans derived from clear processed based on risk assessment? | √ |  |  |  |
| **1** | Does the Audit Committee receive periodic reports from the Local Counter Fraud Specialist? | √ |  |  |  |
| **2** | Does the Committee effectively monitor the implication of management action arising from counter fraud reports? | √ |  |  |  |
| **1** | Does the Local Counter Fraud Specialist have a right of direct access to the Committee and its Chair? | √ |  |  |  |
| **1** | Does the Committee review the effectiveness of the local counter fraud service and the adequacy of its staffing and resources? | √ |  |  |  |
| **1** | Does the Committee receive and review the Local Counter Fraud Specialist’s annual report of counter fraud activity and qualitative assessment? | √ |  |  |  |
| **1** | Does the Committee receive and discuss reports arising from quality inspections by CFSMS? |  |  | √ | None received. |
| Annual Accounts and Disclosure Statements | | | | | |
| **1** | Is the Committee’s role in the approval of the annual accounts clearly defined? | √ |  |  | Scheme of Delegation / Terms of Reference |
| **2** | Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit? | √ |  |  |  |
| **1** | Does the Committee specifically review:   * Changes in accounting policies? * Changes in accounting practices due to changes in accounting standards? * Changes in estimation techniques? * Significant judgments made? | √ |  |  |  |
| **3** | Does the Committee review the draft account before the start of the audit? |  | √ |  | Committee reviews draft accounts but not before the audit commences. |
| **1** | Does the Committee ensure it received explanation as to the reason for any unadjusted errors in the accounts found by the external auditors? | √ |  |  |  |
| **1** | Does the Committee receive and review a draft of the organisation’s Statement on Internal Control? | √ |  |  | Now known as Annual Governance Statement – reviewed at April and May meetings. |
| **2** | Does the Committee receive and review the evidence required to demonstrate fitness to register with the Care Quality Commission? |  | √ |  | Occurs through Integrated Governance Committee and Board. Committee does receive assurance on quality / non-financial matters through External Audit review of Quality Report. |
| **2** | Does the Committee receive and review a draft of the organisation’s annual report? | √ |  |  |  |
| Other Issues | | | | | |
| **3** | Has the Committee considered the costs that it incurs: and are the costs appropriate to the perceived risks and the benefits? | √ |  |  | See Annex B below. Previously considered as part of the 2012/13 Audit Committee Annual Report and prior to that in 2008. |
| **2** | Has the Committee reviewed its performance in the year for consistency with its:   * Terms of reference? * Programme for the year? | √ |  |  | Through annual report. |
| **3** | Does the annual report and accounts of the Authority/Trust include a description of the Committee’s establishment and activities? | √ |  |  |  |

**Annex B: Audit Committee Costs 2013/14**

The NHS Audit Committee Handbook (2011) suggests that audit committees consider the costs that they incur and whether the costs are appropriate to the perceived risks and benefits. The NHS Audit Committee Handbook affords this suggestion a “could do” (rather than a “must do” or “should do” status).

The Committee last undertook this exercise as part of the 2012/13 Audit Committee Annual Report, and prior to that in 2008.

To assist with this exercise in 2013/14, a review of the costs attributable to the operation of the Audit Committee in 2013/14 has been undertaken, based on the number of meetings held and estimated time required to support and attend meetings. The estimate includes the direct costs of Trust Directors and staff in relation to the production of papers, time required in preparing for and attending meetings based on salary costs (including employer overheads). A similar estimate is also included for audit and counter fraud, based on composite day rates. The costs exclude any Trust overheads, for example, in relation to accommodation costs. It should be noted that these costs are indicative based on estimates of likely input of time, as timesheets are not maintained in relation to these activities.

A summary of costs estimated for 2013/14 is shown below together with the estimate for 2012/13 by way of comparison:

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1. Data for the table from the Internal Audit annual reports for 2013/14, 2012/13 and 2011/12 [↑](#footnote-ref-1)
2. Graph from the Internal Audit annual report for 2013/14 [↑](#footnote-ref-2)