**Audit Committee**

**Minutes of the meeting held on**

**RR/App 54/2021**

(Agenda item: 27(a))

**17 May 2021 at 10:00   
virtual meeting via Microsoft Teams**

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| **Present[[1]](#footnote-1):** |  |
| Lucy Weston | Non-Executive Director (the **Chair/LW**) |
| Chris Hurst | Non-Executive Director (**CMH**) |
| Mohinder Sawhney | Non-Executive Director (**MS**) |
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| **In attendance:** | |
| *Counter Fraud – TIAA Ltd:* | |
| Dean Docherty | Counter Fraud - Senior Fraud Manager, TIAA (**DD**) |
| *External Audit – Grant Thornton LLP:* | |
| Iain Murray | External Audit – Engagement Lead, Grant Thornton (**IM**) |
| Laurelin Griffiths | External Audit – Manager, Grant Thornton (**LG**) |
| *Internal Audit – PwC LLP:* | |
| Sasha Lewis | Internal Audit – Director and Engagement Lead, PwC (**SL**) – *part meeting* |
| *Oxford Health NHS FT:* | |
| Nick Broughton | Chief Executive (the **CEO/NB**) - *part meeting* |
| Karl Marlowe | Chief Medical Officer (the **CMO/KM**) - *part meeting* |
| Mike McEnaney | Director of Finance (the **DoF/MME**) |
| Neil McLaughlin | Trust Solicitor & Risk Manager (**NMcL**) – *part meeting* |
| Kerry Rogers | Director of Corporate Affairs and Company Secretary (the **DoCA/CoSec/KR**) |
| Martyn Ward | Director of Strategy & Chief Information Officer (**the DoS/MW**) - *part meeting* |
| Hannah Wright | Risk Manager (**HW**) – *part meeting* |
| Nicola Larkam | Executive Project Officer (**NL**) (Minutes) |
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The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members, External and Internal Auditors and Counter Fraud.

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| **1.**  a | **Welcome and Apologies for Absence**  The Chair welcomed all to the meeting. Apologies were received from Hannah Smith, Assistant Trust Secretary. |  |
| **2.**  a | **Confirmation of items for Any Other Business**  None requested. |  |
| **3.**  a  b  c | **Minutes of the Meeting held on 21 April 2021 and Matters Arising**  The Minutes of the meeting at paper AC 30(i)/2021 were approved as a true and accurate record. The blackline version of the Minutes from 24 February 2021 at paper AC 30(iii)/2021 was also received with no comments.  ***Matters Arising***  The following actions were noted as complete or on the agenda for this meeting:   * 3(a) amendments to the Minutes from 24 February 2021; * 4(g) draft accounts – completed net impairments and 529% change relating to the decrease in estate valuation; * 4(h) frequency of legal reporting; * 8(b) informing the external audit risk assessment – use of other firms of solicitors; * 10(c), (g), (j) draft internal audit plan 2021/22; * 11(i) Internal Audit action updates from the Executive Management Director for Primary & Community Care and from the Chief Nurse now circulated; * 11(j) Internal Audit finding relating to evidence of consistent discussion of the Community Directorates risk register during management meetings (and see item 8(j) below); * 11(k) Ulysses system and links with Learning & Development systems; * 13(b)-(c) discussion between the Director of Finance and HR has taken place and HR are reviewing their response to the Counter Fraud investigation into working whilst sick; * 14(e) the Medical Director has fed back comments on the Clinical Audit annual report to the Lead for CQC Standards & Quality; * 4(c) from 24 February 2021, recording conflicts of Interest for agency staff; and * 3(e) and 14(a) from December and September 2020, Board and Board Committee mapping to ensure no unnecessary duplication – action now part of Board Development action plan.   The remaining actions in the Summary of Actions document were to be progressed:   * 4(f) increase in staff costs to be considered by the Finance & Investment Committee; * 14(f) other trusts’ reporting on clinical audit; * 15(d) Cyber Security and checking accreditations of partners; * 4(d) from February 2021, Counter Fraud awareness training figures; * 6(b) from February 2021, Internal Audit COVID-19 review; * 6(b) from December 2020, publication of Counter Fraud COVID-19 Fraud Risk thematic review; and * 8(b)-(c) from December 2020, Clinical Audit assurances – albeit now in the remit of the new Chief Medical Officer. |  |
| **4.**  a  b  c  d  e  f | **Annual budget setting process - update**  Chris Hurst provided an update from a Finance & Investment Committee (**FIC**) perspective and explained the timing of the budget setting process. Two challenges were set for the team last autumn: (1) was around bringing the process forward as far as possible; and (2) integrating Cost Improvement Planning more into the budget setting process rather than it being an adjustment to budgets later. It was on that basis that the DoF had reported to the FIC.  The DoF provided an oral update explaining that the planning process from NHS England was very different this year and very late; the Finance team had nonetheless been working on baseline budgets, which was normal practice, and 61% were signed up currently. On top of this the team had created their financial plan, using requirements set by NHS England, which would achieve a break-even position for the full year. Additional budget requests were also being collated e.g. a considerable amount of investment in mental health was anticipated and these detailed budgets were currently being finalised.  The Chair asked the DoF for his perspective on the 61% as the concern from the Audit Committee was for the financial plan to be clearly developed at management level. She also asked what the processes were for addressing requests for additional budget and assessing against strategic priorities.  The DoF replied that whilst it was challenging to nail down individual budgets whilst the Trust was currently running at a deficit, ultimately this year’s detailed budgets should be available to support the aggregate build up to the financial plan.  The DoF confirmed that the prioritisation process would commence on Monday at the Executive Meeting where evaluation of all requests and their importance would be discussed. They would be guided by the strategic priorities and immediate priorities for this year when making decisions. The result of this process would be reported to FIC.  **The Committee noted the oral update.** |  |
| **5.**  a  b  c  d  e  f  g  h | **Draft Annual Report including draft Annual Governance Statement**  The DoCA/CoSec presented the draft Annual Report, paper AC 31/2021, and confirmed this was a working draft of the report with submission anticipated for 15 June; she thanked the Risk Manager for her support with the content and formatting. She confirmed that COVID-19 had been included within the Annual Governance Statement as discussed at the last meeting and that there were no significant control issues to report.  Mohinder Sawhney asked whether the Annual Report could more clearly describe what the Trust was trying to achieve in terms of outcomes and how it could then account for performance against those planned outcomes, which could help to show stakeholders what the Trust had spent its funding on. She cited Equality, Diversity and Inclusion work as an example and noted that it could be more effective to shift from describing inputs and instead describe outputs/outcomes and more about what the Trust was trying to achieve, how much progress had been made, how much of the journey was left and what ambitions were moving forwards.  The DoCA/CoSec responded that in part the absence of the Quality Account from within this year’s national requirements for the Annual Report had impacted upon the focus of the Annual Report and its ability to provide detail on quality and clinical outcomes.  The Chair commented on the Governance Statement, and the heading on page 10 ‘Data Quality in Governance’, she felt that this maybe a little confusing and should be checked to ensure its meaning was clear.  The CEO confirmed that, going forward, the expectation was that the Annual Report would reflect performance delivery against the 4 overarching strategic objectives in the Trust Strategy. The DoCA/CoSec agreed and added that potentially next year a separate and more accessible Annual Review document may be produced and published alongside the Annual Report (which remained a regulatory requirement). The Chair commented this felt appropriate.  Mohinder Sawhney made the following suggestions:   1. contextualise numbers wherever possible e.g., the figure for digital consultations had been given without any context or previous year previous year; and 2. discuss COVID-19 testing and vaccination in the context of key risks and consider whether the Trust was treating testing and vaccination as a required item or taking a more proactive stance towards it.   The DoCA/CoSec noted Mohinder Sawhney’s points.  **The Committee noted the progress which had been made with the Draft Annual Report.** |  |
| **6.**  a  b  c  d | **Counter Fraud annual report 2020/21 including Government Functional Standards submission**  Dean Docherty reported on the Counter Fraud annual report at paper AC 35/2021 which was taken as read. He highlighted the following:   * Government functional standards which were due for submission 31 May; * there were 12 standards, and the Trust had achieved 8 green and 5 amber ratings, a summary report had been issued detailing the areas where additional compliance work was required; * a Survey would change some of components to green rated; and * on the Hold to Account section – there was one case this year relating to a working whilst sick which had resulted in a conviction for fraud by false representation, contrary to Section 2 of the Fraud Act. The Trust would receive financial compensation for its loss.   The Chair raised the following questions:   1. Page 12 of the report referred to fraud prevention notices which were listed subsequently. It would be helpful to know what happened with them. 2. Thematic Review of fraud risks during COVID-19 - there were a number of only partial assurances listed on page 12; clarity was needed on what would be required to gain full assurance and what the outstanding risk was from only receiving a partial assurance. 3. Fraud Prevention Guidance Impact assessment had been submitted in time for the deadline but it needed to be clear in this annual report what the result of this had been.   Dean Docherty responded as follows:   1. There was a log and a recommendation tracker, everything sent out was tracked on this and any follow up was completed. He met with the DoF bi-monthly to discuss this and would add more detail into the report to cover this. 2. Thematic reviews, he confirmed he would look into this and feedback to the Chair. 3. Feedback was still awaited from the Counter Fraud Authority.   **The Committee noted the report.** | **DD** |
| **7.**  a  b | **External Audit – interim progress report**  Laurelin Griffiths provided an oral update confirming that the External Audit was currently underway, three weeks in and making good progress. Their aim was for it to be substantively complete by the end of the month. Most of the sample testing was in progress. The property valuations had just started as they had been awaiting external information on indices. There were no issues to report currently and the Finance team had been very responsive. The Value for Money work was also in progress, albeit less progressed than the Financial Statements Audit but it was anticipated to be mainly complete by mid to end June. As discussed at the last meeting there was an extra 3 months to finalise the reporting on this work.  **The Committee noted the oral update.** |  |
| **8.**  a  b  c  d  e  f  g  h  i  j  k | **Internal Audit Progress report, action tracker and final reports from 2020/21 plan**  Sasha Lewis presented the Internal Audit progress report at paper AC 32/2021.  ***Progress Report***  Sasha Lewis confirmed that fieldwork had been completed for the follow up review and the draft report was with the DoF for review. The fieldwork for the Health & Safety review had been completed and the relevant team members had been taken through the findings; the draft report would presently be shared with management. The Data Security & Protection (**DSP**) toolkit review had been completed and the draft report would be shared with management. The fieldwork for the directorate review of Forensic Services was due to be completed this week and the draft report should be available by the end of the week. Work had started on the Trust-wide COVID-19 review and by the next meeting in June there should be a good sense of the outcomes and findings from the review.  The Chair commented that her understanding was that June was not a regular Committee meeting but had been set up to support this year’s timing of the External Audit of the Annual Report & Accounts; it may not therefore receive any Internal Audit reports, which may instead need to be received out of session and then discussed in September.  ***Internal Audit Plan 2021/22***  Further to previous discussion as to why certain areas had not been included in the scope of the 2021/22 Plan:   1. the IT review had two potential areas of focus: (a) new Data Centre; and (b) Cyber Security. Previously, the new Data Centre had been preferred. Sasha Lewis had followed this up with the DoS who had agreed the new Data Centre should be the preferred option and, therefore, the focus of the IT review; and 2. Directorate review: the suggestion had been to cover Learning Disabilities this year but following further discussion between the Chair and management the conclusion had been to now look at the Oxfordshire and South West Mental Health directorate.   Sasha Lewis confirmed that the other areas previously discussed had been listed on the action tracker. The DoF added that a number of the areas discussed were developmental, including:   * Provider Collaboratives which should be embedded before reviewing how well they were functioning; * BOB ICS as currently in a transitional stage; * Workforce planning – also still developmental and in early stages; * Warneford redevelopment - pending planning permission which may be the time for review. The Chair thought the Warneford redevelopment could be subject to review in the context of a wider Estates review. The DoF acknowledged the point but commented that Estates including the Warneford was a large topic and there would need to be clarity on what specifically about Estates should be tested; and * use of TOBI (Trust Online Business Intelligence tool) which was work in progress. The Chair commented that this may link with focus on Data Quality and performance monitoring, potentially for next year.   The Chair asked if these particular areas had been discussed at the Executive and rejected. The DoF explained it was more a case of the nature of these requests being developmental areas. The concern was that an Internal Audit review on an area still in development and known to be a work in progress would only point out the obvious and therefore provide limited value. The Chair noted that it was important to document the reasons why these areas may be considered developmental or were not suitable for inclusion in this year’s Internal Audit plan, especially as it was ultimately a responsibility of this Committee as to whether to direct Internal Audit resource. There needed to be clarity on the reasons for prioritising this resource into particular areas. The DoF confirmed that there would be a written audit trail against all the items considered for inclusion in the 2021/22 plan.  ***Data Security & Protection (DSP) toolkit***  Sasha Lewis explained that the framework for the DSP assurance that the organisation was required to get by NHS Digital had changed. It now required an increased level of assurance which meant that the whole of the toolkit should now be included in the scope and the scope had also been expanded to look more at the processes and the controls in place around the completion of the toolkit, not just a review of a sample of assertions. A few different options were available but for PwC to undertake the full scope of work now required by NHS Digital would require a fee increase (as set out in more detail in the report). There were options including taking that piece of work out of the audit programme completely and going to tender to complete this work separately; or continue to do the work and bring the whole of the scope into the Internal Audit programme. She sought the Committee’s views on the options.  The Chair felt this was an operational management decision and asked for the DoF’s perspective. The DoF suggested for the time being keeping the Internal Audit programme as it was, then reviewing the NHS Digital requirements and considering alternative means of validation. The DoF and Sasha Lewis to explore this further outside of the meeting.  ***Internal Audit review reports and action updates***  The Chair referred to the follow-up report which had not yet been received but that Sasha Lewis was anticipating being a medium risk. The Chair asked the DoF what could be done to accelerate the process. The DoF confirmed that the report only came through last week and he would like to review the report with the Executive team because it needed joint executive responsibility.  The Trust Solicitor & Risk Manager joined the meeting and provided an oral update on the progress of relevant risk management actions. He also referred to the action from item 11(j), as per the Minutes of the previous meeting from 21 April 2021, and the update in the Summary of Actions document which provided a table which set out the various clinical directorate governance meetings which reviewed local clinical directorate risk registers.  **The Committee noted the report** | **MMcE/ SL** |
| **9.**  a  b  c  d  e | **Update on progress against recommendations from the Internal Audit review into Employee Data Records**  The DoS provided an oral update confirming that an audit had been carried out 6 weeks ago and the findings were as expected. From a ‘people perspective’, the data itself was not joined up. Each internal system had its own view of people data and its own processes; although individual systems were kept up to date, when considering the overall position the data was not aligned. The DoS had been working with HR, IT, Finance and Learning & Development and have created a virtual team to review the situation. A proposal was being developed to go to the Executive in the next few weeks.  The meeting discussed the relative urgency of this situation. The CEO considered that it was a priority to have a single overarching system and thanked DoS for his work in this area and his work on the 9-point plan. The Chair acknowledged the urgency of the actual work to be carried out but noted that there was no further urgent need to report back against the Internal Audit review report. Mohinder Sawhney sought clarification of the time frame for the 9-point plan. The DoS confirmed that somewhere between 12-18 months was a realistic target to develop a single integrated system.  Chris Hurst asked what success might look like in terms of domains of expectations and the end of the 9-point plan. The DoS shared the diagram explaining this on screen.  The Chair speculated to what extent all of this work had been triggered by the Internal Audit review or had already been in train for some time. The DoS confirmed the Internal Audit review had been helpful in focusing on the issues.  **The Committee noted the report.** |  |
| **10.**  a  b  c  d | **Clinical Audit – introduction to Chief Medical Officer and discussion of reporting requirements for Audit Committee and Quality Committee**  The Chair welcomed the Chief Medical Officer (**CMO**) to the meeting and explained that the Committee was reviewing its role in relation to Clinical Audit and the type of assurance it would require, as well as understanding how that would differ to the requirements of the Quality Committee (**QC**) and FIC. Although the CMO was new to the Trust, the Committee would value his experience of Clinical Audit in other trusts and his thoughts on how he may be able to provide assurance on the process and results from Clinical Audit to this Committee.  The CMO confirmed that the Clinical Audit report had been presented last week to the Quality & Safety Committee (**QSC**), which was able to focus upon the more clinical aspects of assurance to be gained from this, such as compliance with NICE guidance, medicines management and any required national audits. He considered that setting the direction of focus for the Audit Committee in relation to Clinical Audit should be done in discussion with Internal Audit given their oversight and experience of a large number of NHS organisations. He noted that the Trust also had a Clinical Audit Group (**CAG**) with a wider remit of clinical effectiveness which reviewed the outcomes of clinical audits. The CMO suggested that the Audit Committee should take assurance that all of this activity was happening without needing to review clinical audits and be assured that monitoring was taking place to ensure that required national audits were happening. He recommended that the QSC be the interface to provide assurance for the Audit Committee that relevant learning was taking place.  The Chair explained that the Audit Committee needed assurance that effective Clinical Audit processes existed and that follow-up work was carried out. The CMO noted that in his previous organisation he had designed a Clinical Audit programme which could be used to provide visibility on the work being undertaken and the planned cycle for that work; similar could be helpful for the Audit Committee and he would explore further with the Lead for CQC Standards & Quality and work with the Chair to find a way forward.  **The Committee noted the oral update.**  *The CMO left the meeting* |  |
| **11.**  a  b  c | **Risk Appetite approaches**  *The Chair confirmed that for the Risk Workshop she wanted the members of the Audit Committee and the associated supporting Executives only in attendance. Auditors and Counter Fraud left the meeting.*  *10-minute break*  The Committee held a private discussion on Risk Appetite and agreed that, given limited time remaining today, this should be taken forward in a private workshop for 2-3 hours to allow for more meaningful conversation and consideration as to what, if any, Risk Appetite to recommend to the Board.  The Chair felt a small group looking at this would work – perhaps not beyond six people so as to avoid stagnation.  The following points were made for future consideration:   * development of a Risk Appetite Statement may lead to too much focus on the final product and insufficient time on preliminary questions/considerations as to the purpose of Risk Appetite and the trade-offs; * a Risk Appetite Statement could either be a tool to set out the organisation’s stance and accountability to the outside world, for example in relation to what the organisation may be prepared to tolerate/not tolerate on patient safety, or it could be a tool to assist with decision-making (albeit then it could risk over-simplifying situations in order to make them fit); * a Risk Tolerance, rather than a Risk Appetite, Statement as per the Care Quality Commission; * not developing a Risk Appetite Statement in the absence of, or in isolation from, detailed plans setting out what the organisation was trying to deliver, otherwise the statement could also become bland or generic; and * a framework for Risk Appetite discussion, including domains for discussion, was useful but a formula for scoring may not be as it could lead to a perfunctory approach being taken. Risk Appetite discussion within a framework however may provide for more discretion than focus upon scoring and a more realistic approach which better mirrored the live reality of daily risk management.   **The Committee noted the discussion.** | **HW/**  **KR** |
| **12.**  a  b  c  d  e  f | **High-rated risk(s) review of controls, mitigations, and processes – focus on Board Assurance Framework (BAF) risk 1.6 on the theme of demand and capacity**  The Chair noted there was not sufficient time to discuss BAF risk 1.6 at length, as set out in the report at paper AC 36/2021, and asked for any meaningful comments on this risk to be provided separately. In terms of Audit Committee oversight, she was not sure at what point the Committee could come back to this and see when actions were closed but it would be good to see accountability and timescales.  Mohinder Sawhney commented that the demand and capacity challenge operated at two levels. In the short term, the issue was how to manage fluctuations in demand at a ward or unit level. At a more strategic level, there was a larger and more difficult piece of work concerning how the Trust was transforming itself to meet demand.  The DoS confirmed there were two elements to addressing demand and capacity, one was within the organisation’s control and the other would require a partnership-based approach (with delegated commissioning and Provider Collaboratives providing the best opportunity to move forwards). He confirmed that the wording of the risk had been redrafted and that there were plans that sat alongside it.  The Chair commented that within one of the Provider Collaboratives which the Trust was involved with (around eating disorders) that there was significantly more demand than capacity and there had been issues with admittance criteria increasing. The Trust appeared to be taking a necessity-driven approach, rather than a strategic approach, in that instance.  The DoF agreed with the DoS and added that from an operational perspective, demand and capacity issues would impact waiting times, stress on staff and should be an essential part of the management of services. Head of Service should be reviewing demand and capacity on a weekly basis as it informed daily activity. From a more strategic and long-term perspective, demand and capacity considerations should inform plans for future service provision to meet population needs and provide appropriate population health management. Although things were moving in the right direction, the long-term perspective and the operational perspective of demand and capacity needed to be considered separately.  The Chair drew the conversation to a close. |  |
| **13.**  a | **Any Other Business**  No other business |  |
| **14.**  a | **Review of Meeting**  The Committee commented that the meeting had progressed well but more papers needed to be available in advance and not fed through piecemeal. |  |
|  | **Meeting Close: 13:10** |  |
|  | Date of next meeting: 2 June 2021, 09:00-11:30. |  |

1. The quorum is 3 members (all Non-Executive Directors) and may include deputies. [↑](#footnote-ref-1)