**Audit Committee**

**Minutes of the meeting held on**

**18 May 2022 at 09:30   
virtual meeting via Microsoft Teams**

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| **Present[[1]](#footnote-2):** |  |
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| Lucy Weston | Non-Executive Director (the **Chair/LW**) |
| Chris Hurst | Non-Executive Director (**CMH**)  **RR-App 51/2022**  (Agenda item: 22(a)) |
| Mohinder Sawhney | Non-Executive Director (**MS**) |
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| **In attendance:** | |
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| *External Audit – Grant Thornton LLP:* | |
| Iain Murray | External Audit – Engagement Lead, Grant Thornton (**IM**) |
| *Internal Audit – PwC LLP:* | |
| Karen Finlayson | Internal Audit - Risk Assurance Partner and Regional Lead for Government, PwC (**KF**) |
| Reena Bajaj | Internal Audit – Manager, PwC (**RB**) |
| *Oxford Health NHS FT:* | |
| Katrina Anderson | Service Director for Oxfordshire & BSW Mental Health Services (**KA**) – *part meeting* |
| Amélie Bages | Executive Director of Strategy & Partnerships (the **DoS&P/AB**) – *part meeting* |
| Charmaine De Souza | Chief People Officer (the **CPO/CDS**) |
| Mike McEnaney | Director of Finance (the **DoF**/**MMcE**) |
| Peter Milliken | Deputy Director of Finance (the **Deputy DoF/PM**) |
| Kerry Rogers  Ben Riley | Director of Corporate Affairs & Company Secretary (the **DoCA/CoSec/KR**)  Executive Managing Director for Primary & Community Services (**BR**) – *part meeting* |
| Hannah Smith  Nicola Gill  **Observing:**  Geraldine Cumberbatch | Assistant Trust Secretary (**HaS**) (Minutes)  Executive Project Officer (Minutes)  Non-Executive Director |
| Andrea Young | Non-Executive Director |

The meeting followed private pre-meetings between: (i) the Committee members; and (ii) the Committee members and External and Internal Auditors.

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| **1.**  a  b | **Welcome and Apologies for Absence**  The Chair welcomed observers and attendees to the meeting.  There were no apologies for absence from Committee members. Apologies from non-Committee members were received from Nick Broughton, Chief Executive and Anti-Crime/Counter Fraud services from TIAA Ltd. |  |
| **2.**  a | **Confirmation of items for Any Other Business**  No additional items were requested for Any Other Business. |  |
| **3.**  a  b  c | **Minutes of the Meeting held on 21 April 2022 and Matters Arising**  The minutes of the meeting on 21 April 2022 at paper AC 34/2022 were approved as a true and accurate record.  ***Matters Arising***  The following actions were noted as complete (with supporting detail in the Summary of Actions document), being progressed or on the agenda for this meeting:   * 3(j) – draft Annual Statutory Accounts and analytical review – circulated by the Financial Controller on 29 April 2022; * 3(k) – areas of judgement in the Accounts – on the agenda for the meeting at item 6 below; * 5(c)-(d) – Annual Report – complete and on the agenda for the meeting at item 5 below; * 8(d) – Declarations of interest – publicly available on website; * 11(a) – Internal Audit Plan FY23 – on the agenda for this meeting at item 8 below; * 16(e)-(f) – Psychiatric Intensive Care Unit (**PICU**) report to the Board – being progressed with reporting due to the Finance & Investment Committee (**FIC**)and the Board in May 2022;   *From 23 February 2022*   * 3(l) – Internal Audit Review on the PICU – on the agendas for FIC on 17 May 2022 and Board in private on 25 May 2022; and * 3(q)-(s) – PICU report to Board – on the agenda for the Board in private on 25 May 2022.   The remaining actions in the Summary of Actions document were to be progressed:   * 2(c) (and 11(c) from February 2022) – Fire Safety – rota of fire Wardens – the DoF reported that this was a business-as-usual responsibility for the Fire Safety team, now part of the remit of the Executive Director for Digital & Transformation, to be clear across all sites that there was an appropriate rota of fire wardens. Action for the Executive Director for Digital & Transformation to confirm; * 8(c) – Anti-Crime Service additional narrative in their annual report -to be confirmed when the Anti-Crime Service next delivers regular reporting to the meeting in September 2022; * 8(e) – Anti-Crime (Counter Fraud) case involving failure to declare an order/criminal offence – the DoF did not recall this case involving any internal control failure at that time, as the issue had involved the timing when the (external) DBS register had been updated, but would follow up with TIAA and feedback to Committee; * 11(c) – Internal Audit Plan FY23 – to consider whether any areas may be exposed as not having assurance through the Internal Audit Plan; * 12(a) – Internal Audit thought leadership publication – review and sense-check; * 13(b)-(c) – Clinical Audit annual report – the Chair considered that this report might be at the point where it needed escalating;   *From 23 February 2022*   * 12(b) – Single Action Tender Waivers; and * 14(b)&(e) – Board Assurance Framework (BAF). |  |
| **DRAFT ANNUAL REPORT AND SUPPORTING DOCUMENTS** | | |
| **4.**  a  b  c  d  e | **Draft Internal Audit annual report 2021/22 including draft Head of Internal Audit Opinion**  Karen Finlayson presented the Draft Internal Audit annual report 2021/22 at paper AC 35/2022 confirming that most of the work had been concluded and that they were currently waiting to conclude the report on the Out of Area Placement review. She highlighted the following:   * they had concluded the Trust was generally satisfactory with some improvements required. This was consistent and comparable with other health sector organisations and was a good position to be in; * the basis of opinion had considered all the work undertaken during the year, follow up actions and ensured key risks had been considered; and * it was a good opinion and good outcome for the Trust and that would not change in the final report.   She highlighted the following areas which had received more high risk recommendations which would be subject to routine follow-up: key financial systems and payroll. In addition, there had been: 9 medium risk recommendations overall; 10 low risk findings overall; various good practice and weaknesses had been highlighted; and, as of 14 April, there were no overdue actions but some extensions to deadlines had been agreed.  Overall, she summarised that a total of seven reviews were undertaken during the year and the majority of this work had been concluded. There had been an improvement in the overall system of internal control therefore there were fewer recommendations than previously, but a slight increase in terms of the number of recommendations which were high risk but not significantly so.  The Chair queried the following from Page 4 of the report:   * Internal Child Safeguarding Referral Testing - We reviewed a sample of 25 Trust/internally generated referrals from across the Trust and noted issues with referral forms containing insufficient detail, referral details not being included on Carenotes, and referral forms including information in error.   She sought clarification as she believed it was not that referral details were not included but that the referral form had not been uploaded and there was a subtle difference between the clinician not knowing a child had been referred versus having to do a bit more work to find details about it. She suggested that it was more about an efficiency rather than a safety issue. Karen Finlayson agreed with this interpretation and that it was consistent with previous discussion and presentation of that review.  **The Committee noted the report.** |  |
| **5.**  a  b  c | **Further draft Annual Report including draft Annual Governance Statement**  The DoCA/CoSec presented the report at Paper AC 36/2022 which set out the draft Annual Report including the Annual Governance Statement (**AGS**) on the system of internal control. She confirmed that the comments made at the last meeting had been reflected in the current version of the AGS and that the version of the Annual Report received was more extensive than previously but highlighted that it was still a working document. Updates would be made reflecting the discussions during this meeting regarding the Internal Audit report.  The CPO referred to the section which set out the Trust’s activity against the developing workforce safeguarding recommendations and commented that she would be providing data to complete refresh the section, rather than highlighting the bullet points from the previous year, so as to take a complete view of the original recommendations and how much progress had since been made. The DoCA/CoSec confirmed the report would be tabled at the Executive meeting the following week and any items still with Executives to update and comments on the wider version would be picked up then.  **The Committee noted the report.** |  |
| **AUDITORS** | | |
| **6.**  a  b  c  d  e | **External Audit – interim progress update**  Iain Murray provided an External Audit interim progress update highlighting the following:   * with the Trust’s turnover increasing this year they had had to increase the risk categorisation of the audit and there would be an impact upon materiality; and * an auditor’s expert would be providing support in reviewing the Trust’s property valuations.   In terms of areas of judgement, he referred to deferred income and accounting for some of the collaborative arrangements during the year and confirmed that both areas were well progressed, and they understood the rationale around the accounting treatment in each of these areas in the financial statements. They believed these judgements appeared reasonable and they were currently evidencing the judgements.  In terms of the Value for Money work, he confirmed that this was underway, and a draft auditor’s annual report was scheduled to be shared with the Committee at the June Meeting.  The Chair commented that earlier in the private pre-meeting, prior to the main meeting, the Committee had noted that the work around judgements had not yet been finalised and had asked if External Audit could flag any emerging issues to the Committee in advance of the June meeting as they occurred.  **The Committee noted the oral update.** |  |
| **7.**  a  b  c | **Internal Audit Plan 2022/23**  Karen Finlayson presented the Internal Audit Plan 2022/23 at Paper AC 38/2022 and highlighted the following changes already made:   * following the last Audit Committee meeting there had been a request for the waiting list review to replace the Estates review; and * a further request from the Chief Executive had been received to add in an additional review on the processes in place to respond to Prevention of Future Death notices from coroners.   Karen Finlayson confirmed their preference for follow-up work on actions/recommendations would be to do this twice a year rather than for every Audit Committee. The Chair confirmed that in the pre-meet this approach had been agreed but that they would instead ask the Deputy DoF to coordinate management to attend the intervening meetings, if required, to provide updates on progress against those actions due for completion in the interim. The DoF and the Deputy DoF confirmed their acceptance of this approach.  **The Committee ACCEPTED the Internal Audit Plan.** | **PM** |
| **8.**  a  b  c  d  e  f  g  h  i  j  k | **Assurance from Committee Chairs on themes previously identified in Internal Audit reviews**  ***People, Leadership & Culture (PLC) Committee: mandatory training***  Mohinder Sawhney provided an oral update and confirmed that the PLC Committee had received a report from the joint Heads of Learning setting out what could be leading to long term underperformance in mandatory training. She highlighted that there continued to be significant system issues with recording accurately. The report identified issues with training matrices which had now been reduced from 4,000 to approx. 450 and would be streamlined further. Work was also taking place to disentangle requirements for mandatory training from opportunities for Continuing Professional Development. They had asked for some additional reflection on the quality and accessibility of mandatory training.  She confirmed that PLC had been assured that some updated bitesize cyber risk training had been developed and would be rolled out; a further update on the roll out would be provided at the next PLC meeting.  The Chair asked the following questions:   1. what assurance there was that, considering ongoing issues around completion of mandatory training, there were workarounds that ensured safe working practices, particularly on wards but across clinical practice in the Trust, and whether there was confidence that they were working; and 2. the latest Internal Audit Directorate review had highlighted, in relation to mandatory training, that service directors who had not approved the matrices were contributing to holding the process up, she therefore queried if a different range of issues were being encountered in resolving mandatory training.   Mohinder Sawhney responded that:   1. following the conversation at the last Audit Committee meeting, the Chief Nurse had provided a description of what was happening at ward and shift level to demonstrate that appropriate numbers of staff who had completed mandatory patient safety training were present on each shift; and 2. there were a complex number of factors affecting mandatory training compliance and that was the work that the joint Heads were now undertaking. To unpick what had led to these low levels of compliance would take time.   The CPO confirmed that she had also received confirmation from the Chief Nurse that the manual workarounds were ensuring that each shift had the correct skill set needed.  *The Executive Director of Strategy & Partnerships and Katrina Anderson, the Service Director for Oxfordshire & BSW Mental Health Services, joined the meeting*.  ***Finance & Investment Committee (FIC): Information Commissioner’s Office (ICO) audit; and PICU***  Chris Hurst provided an oral update and confirmed that the FIC meeting had received a formal update on information governance matters which included a section on the continuing work around the ICO audit recommendations/action plan and had been formally assured that the actions were being completed in accordance with the plan. He highlighted Information Governance training commenting that it was a concern that current performance was around 72% against a 95% targeted level of compliance.  A formal update had also been received on the PICU, and he highlighted:   1. a structured piece of work was being undertaken around lessons learned which should be completed in 4 weeks and would need to go back to FIC and Audit Committee; and 2. the Trust had crossed a significant milestone in terms of managing the project and its risks, especially as the prime contractor had now been engaged under contract, and was in a much better position than it had been.   In addition, he asked the Committee to note that financial challenges this year had changed shape, and the challenge to achieving the Cost Improvement Programme (**CIP**) was £8 million greater than in previous years. Even more challenging however was the need to wean the organisation away from the short-term funding provided by COVID-19 resources which had supported the provision of additional staff, new ways of working and enhanced Infection Prevention & Control (**IPC**) practices. This would require the FIC to look at things slightly differently in addition to some of the regular scrutiny it provided around progress against CIP. The DoF added that there was a contingency reserve available which was healthier than it had been in previous years, even after allowing for funding for improvement and transformation.  The Chair asked how the risks around this had been considered and whether these needed to be updated on the Board Assurance Framework. Chris Hurst replied that these had been considered at the most recent FIC meeting, and the BAF and relevant operational risks were regularly considered at FIC meetings, and it had been concluded that the financial risks as reported were accurate and their ratings did not need to change. He explained that he had been trying to highlight that although the financial risks and challenges to the Trust were significant, so too was the Trust’s ability to respond and manage the situation, especially in light of the additional COVID-19 funding which had been received but the challenge would be to return to managing without this in due course.  The Chair asked if any assurance could be given regarding specific extreme and high risks emerging out of the ICO report and whether they had been prioritised and cleared. The DoF confirmed that findings from the ICO audit were reviewed at the Information Management Group and there was an action plan for each of the risks.  **The Committee noted the oral updates and assurance from the Chairs of the PLC Committee and the FIC, and that these would be revisited at the next meeting.** |  |
| **9.**  a  b  c  d  e  f  g  h  i | **Internal Audit – Confidential report from 2021/22 plan: Directorate review report**  Reena Bajaj presented the report at paper AC-pvt 37/2022 and confirmed it was rated a medium risk overall; with four medium risk findings and two low risk findings. She highlighted medium risk findings (with more detail set out in the report) in relation to:   * staff skills mix - as clinical staffing levels and skills mix were not defined at a national level for community services, the Trust determined resource requirements with the clinical leads and senior management team based on demand and activity, and budget constraints. Some routine staffing reviews had been put on hold to prioritise clinical demand and IPC measures as part of the response to the COVID-19 pandemic; * system issues with the Learning and Development (L&D) Portal whereby training requirements and compliance data for individual staff members had not initially migrated across to the new system. Management therefore had had limited oversight to address instances of non-compliance within their service teams; * staff surveys as some local surveys on staff satisfaction had not taken place since 2019 as clinical work had been prioritised during COVID-19 whilst in other areas there was an absence of documented action plans; and * relationship with a sample of corporate services (business performance, HR and Estates) as there may be some lack of clarity around how Directorate staff could most efficiently and effectively engage with corporate services and a need for business partners to be better embedded within Directorate teams.   The Chair invited Katrina Anderson, Service Director for Oxfordshire & BSW Mental Health Services, to give her feedback on the report.  Katrina Anderson commented that a lot of the issues that were identified did not come as a surprise and there were some immediate actions which could be taken. Progress was already being made in relation to staff survey feedback and action plans were now in place and listening meetings were being undertaken.  The Chair asked about those actions that were outside of Katrina Anderson’s control and asked whether she was happy on reflection of how responsibility was spread in meeting those challenges, that it sat with the right people and reflected the full range of support needed from across the organisation to address them. Katrina Anderson confirmed that this was the case.  The Chair sought the views of the CPO and the DoF as to whether a piece of work was needed to consider how to embed Corporate Services across the organisation and not just this Directorate. The CPO confirmed that at the end of this month, HR would have a full complement of HR business partners and then fuller engage with teams could be worked out. The DoF confirmed that Finance was looking at changing the way they worked with the Directorates and getting more involved in productivity, including developing 5-year trend views. He noted that if a Service or Directorate had a concern about support from Finance then he hoped that it would be escalated to him so that it could be considered and addressed.  The Chair asked Katrina Anderson whether she felt assured. She confirmed she did to some extent. In terms of Finance her perception was that if there was an issue then it was around capacity, not quality of finance support.  Mohinder Sawhney, in her capacity as Wellbeing Guardian, sought clarification on the reference to awareness of service-led staff well-being initiatives, from slide ten, and asked if there was a differentiation between ‘service-led’ and Trust-wide well-being offers, or both. Reena Bajaj confirmed that they were referring to both.  Mohinder Sawhney asked whether there was an opportunity to improve the Corporate Services experience for service/directorate colleagues. The Chair agreed and suggested a listening exercise might be worthwhile. The DoF agreed in principle but felt if it were done as an audit, it would have a negative and detrimental impact on teams, he suggested using a customer survey. The Chair felt it was part of a Quality Improvement approach to Corporate Services. The DoF and CPO agreed to consider this and develop a consistent approach to include all Corporate Services. Katrina Anderson confirmed that she felt her colleagues would find this an engaging way of moving forwards.  **The Committee noted the report.**  *Katrina Anderson and the CPO left the meeting. The Executive* *Managing Director for Primary & Community Services joined the meeting.* | **MMcE /CDS** |
| **RISK, GOVERNANCE & ASSURANCE** | | |
| **10.**  a  b  c  d  e  f  g | **Board Assurance Framework (BAF) and Trust Risk Register – focus on demand and capacity risks**  The Executive Managing Director for Primary & Community Services presented the report at paper AC 39/2022. He highlighted current challenges and risks:   * the majority of services faced capacity challenges, as evidenced by growing waiting lists, ‘rolled-over visits,’ staff and patient feedback and the content of some significant incident reports; * the pandemic had exacerbated capacity gaps and generated significant activity, making data analysis and benchmarking more challenging; * the Activity and Demand app provided the latest data on waiting times, but much performance data was based on historical contract measures which provided limited information about quality and safety impacts or underlying causes; * although the causes of capacity gaps were usually multi-factorial, there was a widespread perception that a key factor was insufficient staffing in the context of an ageing population and increasing acuity of need/complexity of care in the community setting; and * the Trust currently had limited dedicated expert resource to enable a systematic, data-driven approach to root cause analysis and capacity planning. Service teams undertook most of this work individually which could be challenging when trying to maximise service delivery and led to considerable variability in approaches.   He also highlighted the following recent successes:   * Community Hospital inpatients – a comprehensive improvement plan including international recruitment/agency reduction, leadership development and Quality Improvement (**QI**), plus improved system working leading to reduced lengths of stay and positive system feedback; * Community Hospital outpatients and administration – a review leading to improved outpatient capacity, new services, and administrative support for clinical staff; * District Nursing – an improvement plan including recruitment and a QI programme; * Health Visiting – changes to skill mix and other innovations to improve access to early years’ assessment and parental support; * Children’s Integrated Therapies – additional funding secured from commissioners to address waiting lists and support service transformation; and * Children’s Bladder & Bowel service – proactive review process for children on pathway with Universal Services (e.g., Health Visitors) informed when children are on waiting list.   He highlighted the following ongoing capacity challenges:   * the Directorate had recently completed a review of the management of possible clinical harms for people waiting for assessment or treatment across its services; * this had revealed comprehensive risk management processes in place in many services (e.g., Children’s Bladder & Bowel service) although there was inconsistency to be addressed across services (e.g., management of DNAs); and * services identified for focused work included: * some Tier 4 services (including Tissue Viability – in the Quality Outcomes for 22-23); * Out-of-Hours GP service – facing significant service demand and cost challenges; * ‘Children We Care For’ services – up to sixty new asylum seeker children had been referred in the past month alone; * Podiatry – would be part of the Provider Collaborative programme with Oxford University Hospitals NHS FT; and * Continuing Health Care services.   The following Data work was planned for the next 3 months:   * updates to waiting time data standards and reports had been agreed with the Business Intelligence Team and were imminent, to provide more accurate and meaningful information on different categories of waits; * workshops were planned for each community pathways on analysing the refreshed data, investigating root causes, and agreeing actions plans; and * roll-out of the EMIS Community electronic records system which could improve data quality and risk management and free up staff time and capacity through more efficient workflows.   He concluded by highlighting the following:   * there were examples of good risk management in many services, but the recent review indicated a need for a more systematic and data-driven approach with more shared learning (e.g., a ‘QI approach’); * a number of strategic developments over the next year would focus on optimising capacity and efficiency (e.g., the Provider Collaborative and Oxfordshire integrated improvement programme); and * there may be a need for more protected resource and expertise to: enable root cause analysis of capacity gaps (as a specialised area of QI-type work); and implement systematic approaches to manage these causes.   The Chair summarised that the Executive Managing Director for Primary & Community Services would need to further develop his risk on the BAF further to the above and consider in more detail whether the one current risk on both demand and capacity should continue to stand, or whether there was a separate risk around demand. There also needed to be consideration, within the current funding envelope, of capacity for each individual service and ability to invest in innovation or prioritise this. Where it was clear that funding was not forthcoming then there would be a need to do things differently, perhaps involving workforce planning to proactively meet some of those challenges or managing some risks differently in order to align with available financial resources. She concluded that the Executive Managing Director for Primary & Community Services consider further with the wider Executive to enable further articulation of the risk(s).  **The Committee noted the report.** | **BR** |
| **AUDIT COMMITTEE EFFECTIVENESS WORKSHOP WITH INTERNAL AUDIT (PwC)** | | |
| **11.**  a  b  c  d | **Audit Committee annual report**  The Assistant Trust Secretary presented the report at Paper AC 40/2022 commenting that the Committee had, like everyone, had a difficult year due to COVID-19 but nonetheless it had completed all its core requirements under its Terms of Reference. She drew the Committee’s attention to the appendices setting out the Terms of Reference and the Overview Plan showing the main reports scheduled for the year ahead. She also highlighted the link with the following item at the meeting on the independent external assessment of the Committee’s effectiveness, which this annual report also supported. The DoCA/CoSec added that this was part of the Committee’s self-assessment, and it may be useful to consider what assurance this provided to the Board of their effectiveness, rather than themselves.  The Chair referred to section 2.1 on page 6 of the report on how, as part of the annual Internal Audit plan, the Committee was assured of the effectiveness of the BAF processes and the process for establishing compliance against Care Quality Committee (**CQC**)outcomes. She asked if this could be clarified or rephrased to set out how the Committee gained further assurance to meet those wider assurance requirements. Karen Finlayson reminded the Committee that in relation to CQC outcomes and compliance, the Committee was receiving assurance through the work of the Quality Committee, Clinical Audits and previous Well Led reviews amongst other mechanisms which focused more upon the detail of CQC standards and compliance. These and the BAF were also taken into consideration when developing the annual Internal Audit plan and deciding what to focus upon as well as what the Committee was separately able to receive information and assurance on. The Assistant Trust Secretary noted that the report at section 2.4 further below also already set out the Committee’s work to review the findings of other significant assurance functions, but this link would be further made clear in the version of the report to be presented to the Board.  The Chair referred to page 8 and the reference to the work of the Committee which had taken place during 2021-22 to review the External Audit, Internal Audit and Counter Fraud contracts, noting that the External Audit contract was due to expire a year before the other two and therefore the work on this would be running ahead of the others.  **Subject to the comments above, the Committee APPROVED the report and RECOMMENDED it to the Board.** | **HaS** |
| **12.**  a  b  c  d | **Audit Committee Effectiveness survey**  The Chair thanked PwC for their support in undertaking the Committee’s Effectiveness survey. She proposed to follow up with those who had responded to the survey to understand their feedback and suggested contributions for improvement.  Karen Finlayson and Reena Bajaj presented the report at Paper 41/2022 and confirmed that overall the responses were positive in all areas apart from points (set out in more detail in the report) in relation to: meeting members expressing views and opinions; proportionality on agendas and focus on operational items potentially over strategic items; induction and training for new members; the Committee actively considering the performance and quality of Internal and External Auditors; and administration in relation to conciseness and timeliness of reports and formal appraisal of the Committee’s own effectiveness. The meeting discussed the feedback and the context for some of the comments and noted that this and the above item on the annual report was the Committee’s appraisal of its own effectiveness and that the Chair would be following up in more detail separately on the comments.  The meeting discussed other organisations’ practices in assessing the effectiveness of audit services provided. Karen Finlayson confirmed this could be achieved in a number of ways including questionnaires or a feedback meeting between an independent partner or director with a Chair and DoF. The Chair noted that the DoCA/CoSec could liaise separately with Karen Finlayson and Iain Murray on any additional standard practice that could be implemented.  **The Committee noted the report and was assured by the usefulness of the exercise.** |  |
| **13.**  a  b | **Any Other Business (AOB)**  No AOB.  Review of meeting/escalations to Board/Executive:   * review of the demand and capacity BAF risk by the Executive Managing Director for Primary & Community Services, with the Executive; and * improving the Corporate Services experience for service/directorate colleagues, further to the most recent Internal Audit Directorate review, subject to consideration by the DoF and the CPO. |  |
|  | **Meeting Close: 12:18** |  |
|  | Dates of next meetings:  15 June 2022 09:30-11:00 and 14 September 09:30-12:30. |  |

1. The quorum is 3 members (all Non-Executive Directors) and may include deputies. [↑](#footnote-ref-2)