The Shrewsbury and Telford Hospital NHS
NHS Trust

AUDIT COMMITTEE ANNUAL REPORT

April 2010 – March 2011

Quality | Integrity | People | Excellence | Community

1. Introduction

The Audit Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economy, efficiency and effectiveness (value for money).

In order to discharge this function the Audit Committee has approved an Annual Report for the Board and Accounting Officer. This Report includes information provided by Internal Audit, External Audit and other Assurance Providers, including the Trust's Risk Group.

2. Audit Committee's opinion

Members of the Board should recognise that assurance given can never be absolute, but the Board is still responsible for ensuring there are robust systems in place. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

The opinion of the Committee is that with the exception of the internal control issues set out in section 3 below, the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed.

3. Information supporting opinion

Summarised below is the key information/sources of assurance that the Committee has relied upon when formulating their opinion.

3.1 *Internal Audit*

The Head of Internal Audit's Opinion is that based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk

Based on the work Internal Audit have undertaken on the Trust's system of internal control they do not consider that within these areas there are any issues that need to be flagged as significant issues within the SIC.

The Trust objectives and specific limited assurance opinion which may have put the achievement at risk of the Trust objectives fall within the two areas:-

- Enhancing safety, effectiveness and patient experience; and
- Ensuring a clinically viable and financially sustainable organisation.

Control weaknesses were identified regarding the findings of:

- Catering,
- Data Quality (for the chosen indicators, 62 day cancer and Thrombolysis),
- Charitable Funds
- Junior Doctors – Management of Planned Absence

All of the weaknesses identified are being addressed through the recommendation tracking process monitored by the Audit Committee.

This opinion was formed following:

- an assessment of the design and operation of the underpinning Assurance Framework and supporting processes
- an assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
- an assessment of the process by which the organisation has arrived at its declaration in respect of the Care Quality Commission Essential Standards; and
- any reliance that is being placed upon third party assurances.

The Internal Audit Operational Plan for 2010/11 was approved by the Audit Committee on 18 February 2010.

The Trust received the following opinions during 2010/11

Green	Amber Green	Amber Red	Red
9	7	3	1

There have also been 7 follow-up audits;

- Data Management - Good Progress
- IT – back up & recovery - Adequate Progress
- IT – network security - Adequate Progress
- Nursing bank & agency (22.09/10) - Reasonable Progress
- Nursing bank & agency (11.10/11) - Good Progress
- Catering - Good Progress
- Recommendations - Good Progress

There were also three Advisory audits – nurse agency staff invoices, carbon management, and information governance

A summary of topics is attached at Appendix 1.

Whilst positive opinions were issued in respect of the majority of audits for the period, red or amber/red opinions were provided in four instances:

- **Data Quality** (62 Day Cancer and Thrombolysis) – AMBER/RED opinion – there were two medium recommendations and the follow up audit demonstrated that management have taken action to address these two issues.
- **Junior Doctors** – Management of Planned Absence - AMBER/RED opinion – there were five medium level recommendations made and a detailed action plan is in place

Internal Audit concluded that until the agreed actions within these two reports are fully undertaken there remains a risk to the following Trust objectives

- enhancing safety, effectiveness and patient experience; and
- ensuring a clinically viable and financially sustainable organisation.

The remaining two opinions are within systems that are very specific in nature and are not considered fundamental systems to the achievements of the Trust's objectives. These related to:

- **Catering** – RED opinion – this review resulted in three high, seven medium and three low level recommendations. The key weaknesses included the lack of operational procedure notes, the need for staff training and the need to ensure that goods and services required are procured through approved suppliers.

- **Charitable funds** – AMBER/RED opinion – this opinion related to the non-adherence of procedures at ward level and resulted in one high and two medium recommendations.

There have been no common weaknesses identified through Internal Audit reviews.

There have been 116 recommendations made by Internal Audit. Only one recommendation has not been accepted in relation to a 'low' recommendation. This did not impact on the overall opinion.

High	Medium	Low
9	59	48

The Trust has further refined its system of recommendation tracking to follow-up all internal and external audit recommendations. All outstanding recommendations are discussed at Executive Directors prior to presentation to the Audit Committee to ensure full ownership of recommendation implementation across the Trust.

An advisory review on Substantive Testing of Paid Nursing Agency Staff Invoices found

"From our sample of 100 paid Nursing Staff agency invoices we have not found any major issues for concern. We have not found, as has been in the case from Fraud Solutions Team investigations within other NHS organisations, any spurious, unknown or unclear elements being put through for payment on the invoices that we examined in detail.

We have not identified any cases of false claims, inaccurate claims or overinflated payments. In our chosen sample payments were claimed for the hours worked"

An audit of the Trust's information governance toolkit assessment scores covering the Information Governance (IG) Toolkit submission in October 2010 for the period March 2010 to October 2010 was undertaken. The review took place in two tranches:

- Initial assessment in January 2011 (based on the October 2010 return) in order to assist the Trust in it preparedness; and
- Final discussion review in March 2011 to update the Trust position at year end.

Initial Review:
During the initial review of the toolkit information gathering and submission processes adopted by the Trust, a number of weaknesses were noted. Where the Trust has submitted a toolkit attainment level of below 2, the Information Governance department had documented an improvement plan to ensure that level 2 attainment was reached by the March 2011 submission.

Final Review
All recommendations made in the original review were completed by the Trust. The Trust declared level 2 achievement in all of the 22 primary key information governance toolkit requirements.

An advisory review on carbon management made one medium level recommendation relating to the need to ensure that risk assessments are completed as part of the corporate risk appraisal process to assist with the development of plans for carbon reduction action.

The Internal Audit Plan for 20011/12 is attached at Appendix 2

3.2 *External Audit*
The revised Audit Plan was presented to the Audit Committee in March 2010. The following risks were identified:

During 2010/11 External Audit reported their Interim Audit findings for 2010/11 in April 2011.

The **Audit Memorandum** for year ending 31 March 2011 was submitted on 9 June 2011 and made five recommendations; one high risk, one medium risk and three low risk.

- The high risk recommendation related to financial plans and breakeven duty. External Audit stressed that the Trust would not meet its five year breakeven duty and must deliver its CIP by ensuring that robust plans are put in place with assigned accountability for the delivery of CIP.

- The medium risk recommendation covered robust checking of nominal rolls by managers.

- The low risk recommendations covered the calculation of year-end provisions; the Whole of Government Accounts process; and the timetable for production of the annual report.

- Two outstanding medium risk recommendations were carried forward from 2009/10 and related to achievement of financial plans and breakeven duty; and disclosure of operating segments

There was a full programme of audit work in 2010/11 to support External Audit in their audit opinion and to form a view on the statement of internal control. An unqualified opinion on the Trust's accounts was issued in June 2011 highlighting that in their opinion the accounts give a true and fair view of the financial affairs of the Trust and of the income and expenditure during the year. However, an 'except for' opinion was issued on the Trusts Value for Money arrangements due to the Trust

not having robust systems and processes to manage effectively actions to achieve cost reductions. The Trust achieved only £3.7m (30%) of its total cost improvement plan of £12.1m in 2010/11, and required non-recurrent financial support of £5m to achieve breakeven in 2010/11.

In accordance with ISA260, External Audit reported one uncorrected misstatement in the accounts to the Audit Committee. This had no material effect on the financial statements.

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The 20010/11 Annual Audit Letter was submitted on 22 September 2011. The key messages were *"that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources with the exception that:*

- *In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness we identified that the Trust does not have robust systems and processes to manage effectively actions to achieve cost reductions. The Trust achieved only 30% of its total cost improvement plan of £12.1m in 2010/11, and required non-recurrent financial support to achieve breakeven in 2010/11.*

- *The Trust is reviewing their strategy at the moment through the 'Keeping it in the County' agenda. The successful delivery of this will be key for the provision of sustainable clinical services"*

In addition to the recommendations described previously in the Audit Memorandum, External Audit made 11 recommendations (4 high, 5 medium and 2 low risk) within their CIP report; and eight recommendations (3 medium and 5 low risk) as part of their review of the Quality Account.

3.3 *Other Assurance Providers*

3.3.1 *Other Committees*

The Audit Committee also receives assurance from the Risk Group. This is a multi-disciplinary group that meets monthly to receive and validate all risks identified across the organisation for the previous month. The Group tests the evidence and controls in place and ensures that risk scoring is consistent and validated. All validated scores are presented to the Audit Committee along with an updated version of the Corporate Risk Register.

3.3.2 *Local Counter Fraud Service (LCFS)*

In line with the Secretary of State's Directions to NHS Bodies on Counter Fraud Measures, the LCFS has produced a written report on the activities undertaken during 2010/11. This includes the activities agreed with the LCFS and Finance Director at the beginning of 2010/11. It covers the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual. It also includes an analysis of the Trust's compliance with the Secretary of State's Directions, which has not revealed any significant areas of non-compliance.

The key activities carried out over 2010/11 by the LCFS were:

- Carried out a staff survey which identified that continued fraud awareness training was required, especially amongst staff with a number of years of service. The LCFS attending monthly inductions; delivered presentations at a number of key staff meetings and held fraud awareness surgeries at both hospital sites.
- Undertaken a number of local proactive exercises into the receipt of patient valuables and monies; prescription charge exemptions and waiting list initiative payments.
- Completed the annual review of the NHS Protect Risk Assessment Tool and has carried out a full Fraud Risk Assessment at the beginning of the financial year.
- Reviewed a number of key trust policies. These reviews have identified a number of areas where best practice guidance has been shared to enable the policies to be amended to adequately reflect counter fraud arrangements.
- Drafted an anti-bribery policy for the Trust to consider ahead of the inception of the Bribery Act 2010 and provided a number of amendments to existing key policies to ensure that they refer to the Trust's new anti-bribery policy.

Qualitative Assessments (QAs) are a self assessment tool developed by NHS Protect to measure the effectiveness of the Local Counter Fraud resource provision, which must be completed and included as part of LCFS annual report. QAs are used to rate NHS organisations on a scale of 1 – 4 with 1 being 'inadequate performance' and 4 being 'performing strongly'. SATH was awarded a rating of 2 – 'adequate performance'.

The LCFS has continued received six referrals throughout the year. One of the investigations is currently with the West Mercia police and is expected to progress to a criminal case. The other five investigations were dealt with by internal investigation or disciplinary procedures within the Trust.

The LCFS has spent 90.5 days delivering the 2010/11 operational work plan, including investigations. The LCFS has continued to build close working links with key departments in the Trust to enhance the effective development of an anti-fraud culture across the organisation addressing all new staff on their Induction Course, staff meetings and at all wards and departments across the Trust speaking to staff and distributing posters and leaflets to raise fraud awareness.

3.3.3 *Management*

The Audit Committee also received assurance through the Trust's audit recommendation tracking system. All internal and external audit recommendations are followed-up with the lead manager through the Director of Compliance and Risk Management before each Audit Committee meeting to ensure progress against implementation is monitored. All responses and non-responses are shared with the relevant Executive Director so they can ensure that appropriate management action is taken. The Audit Committee receives a full report on the recommendations and progress to implement the identified improvements, with particular attention paid to any outstanding actions. The Trust has implemented a web-based recommendation tracking system. During the year, there was a deterioration in the responses received from managers. The Executive Directors have agreed a robust approach to recommendation tracking which includes high level audit recommendations being reviewed by the Hospital Executive Committee.

The Audit Committee has also introduced presentations from Divisional General Managers outlining systems and processes in place. A full programme across the Divisions was agreed. A Governance/Risk Management Key Performance Indicator has been developed and is in place across the Trust.

The committee structure was reviewed during 2010/11 leading to the proposal to strengthen risk management arrangements. The Risk Management Executive will be established in May 2011, chaired by the Chief Executive. In addition, managers will be invited to attend Audit Committee to present updates on risks and their mitigation.

3.4 *Assurance Framework*

The Assurance Framework was reported regularly to the Audit Committee in 2010/11 and is thoroughly scrutinised by the Committee. The Committee's view is that the Framework identifies the key risks, controls and sources of assurance. Each Executive Director is responsible for ensuring the accuracy and completeness of the Framework in relation to Trust objectives

The Audit Committee reviewed the framework at meetings in April, June September and December 2010, and February 2011 In line with year-end reporting requirements, the Audit Committee reviewed the final version of the 2010/11 assurance framework at its April 2011 meeting.

Internal Audit reported that the Assurance Framework and related processes and found that "Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective"

The Audit Committee has relied on the Assurance Framework to provide assurance that systems, policies and people are in place to drive the delivery of objectives by focusing on minimising risk. The Audit Committee believes that the Assurance Framework provides a comprehensive method for the effective and focused management of the principal risks to meeting objectives and provides a structure for evidence to support the Statement on Internal Control.

The Audit Committee had some concerns that the presentation of the Assurance Framework needed to be simplified and clarified so to improve its effectiveness. A new approach has been agreed for 2011/12 which will see the introduction of a high-level summary sheet and heat map alongside the Board Assurance Framework and Action Plan

3.5 Corporate Risk Register

The Corporate Risk Register and the associated controls and assurances have been overseen by the Audit Committee throughout the year. The Corporate Risk Register was reported to every meeting of the Audit Committee between April 2010 and March 2011. It was formally reported to the Trust Board in November 2010 and February 2011.

3.6 Care Quality Commission's Essential Standards of Quality and Safety

The Trust is registered with the CQC without conditions and is compliant with the essential standards of quality and safety. Internal Audit reviewed the process of monitoring compliance with the CQC standards and gave an opinion of substantial assurance.

3.6.1 *CQC Responsive Review*

The CQC carried out a responsive review during 2010. The overall judgment of the CQC is that they had minor concerns in two outcome areas – outcome 4 'care and welfare of people who use services' and outcome 13 'staffing'. The CQC judged the Trust compliant with outcomes in seven additional areas.

The CQC concluded that people who use services were receiving the right care, at the right time, from the right people. However, they found some inconsistencies in the planning and delivery of care, particularly around the prevention and management of pressure sores. The Trust was already aware of this problem and has developed a plan of work to improve prevention and management of pressure sores.

The CQC also judged that there were areas within the trust where there is not a sufficient number of qualified and experienced staff in post to meet the needs of the service. This related particularly to staffing in the maternity unit. Again, the Trust was aware of this issue and is in the process of recruiting additional medical and midwifery staffing in obstetrics and gynaecology.

3.6.2 *CQC visit - Dignity and Nutrition standards*

The CQC carried out a number of randomly chosen inspections across the country during March 2011. The inspection reviewed standards relating to dignity in care and nutrition. The CQC judged that there was a minor concern about care at the Trust in relation to the treatment of vulnerable adults. Although a formal report has not been received from the CQC yet, a number of actions have already taken place to improve this area of care. A formal action plan will be submitted to the Trust Board early in 2011/12.

4. The Role and Operation of the Audit Committee

4.1 *Membership of the Committee*

The members of the Committee during the period of the report were as follows:

Mr Dennis Jones (Chair)
Mr Peter Vernon – until September 2010
Mrs Sue Assar
Dr Simon Walford – from December 2010

Other Non-executive directors are able to attend this meeting and also in attendance are key senior Trust personnel and Internal and External Audit.

The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:

- Mr Dennis Jones None

(Chair)

- Dr Peter Vernon (until Sept 10) — Managing Director of Alberi Limited; Director of H10 Limited; Related to Directorate Manager of Facilities
- Mrs Sue Assar — Director of Assar Consulting which seeks to do business with the NHS;
- Dr Simon Walford (from Dec 10) — Governor, University of Wolverhampton; Director, Wolverhampton Academies Trust; Chairman of Governing Body, Wolverhampton Grammar School; In receipt of an NHS Pension

4.2 *Operation of the Committee*

4.2.1 *Meetings and Attendance*

The Committee is required to meet at least three times a year. Six meetings took place during this period and were attended by members as shown below:

	16 April 2010	21 May 2010	11 Jun 2010	17 Sep 2010	18 Dec 2010	19 Feb 2011	TOTALS	
							No of meetings	%
Dennis Jones	✓	✓	✓	✓	✓	✓	6/6	100
Peter Vernon (until Sept 10)	✓	✓	✓	✓	N/A	N/A	4/4	100
Sue Assar	✓	x	x	✓	✓	✓	4/6	66.6%
Simon Walford (wef Dec 10)	N/A	N/A	N/A	N/A	✓	✓	2/2	100
TOTAL	**3/3**	**2/3**	**2/3**	**3/3**	**3/3**	**3/3**	**16/18**	**88%**

Key – ✓(Present) / **x** (Absent) from meeting / - N/A not a member at this time

4.2.2 *Performance Indicators*

RSM Tenon provide progress reports at each meeting and an annual report which records:-

- dates of debrief, draft reports and final reports to ensure delivery to timescale
- numbers of recommendations made and agreed
- planned vs actual days

RSM Tenon also produces an annual satisfaction survey for all their clients, to which the Trust contributes.

The main performance indicator for external audit is performance against the Audit Plan. All issues are met in line with the Plan. In addition the Audit Commission submits a satisfaction survey to clients to enable them to comment on performance.

This Committee considers that there are no issues with Internal and External Audit that affect their ability to support this Committee in discharging its duties.

The Committee has met in private (management excluded) with auditors to enable any other issues of concern to be raised by either party but no such issues have been raised in addition to the matters discussed in open meetings.

5. Conclusions

Based on information presented and discussed at the Audit Committee meetings during the year we have concluded the following;

5.1 Risk Management

The Audit Committee concludes that the Trust's system of risk identification, recording, reporting arrangements are adequate. The Trust has a comprehensive organisation-wide risk register that records clinical risk, organisational risks and financial risks. The risk register provides evidence that the Trust is using a common methodology to evaluate risk for both strategic and operational risks. It also maps to the Integrated Business Plan. However, the Audit Committee shares the concern that risks have not always been managed effectively or that the format of the risk register was such that it aided the ready identification of all key risks. The Audit Committee welcome the establishment of the Risk Management Executive in 2011/12 which will be chaired by the Chief Executive. The Audit Committee also welcomed the reformatting and evaluation of risk formatting.

However, the Audit Committee have been concerned over the effect of restructuring on risk management resulting in a temporary inability to report on risk to the Committee in the March – June period 2011.

Risk assessments are done on an ongoing basis within the Divisions, and whenever a process change is about to occur, or a new hazard is identified. Risk Management processes link the highest risk issues to the strategic objectives, and the Care Quality Commission's Essential Standards of Quality and Safety.

5.2 *Assurance Framework*

The Audit Committee have reviewed the Assurance Framework throughout the year and consider it fit for purpose. It reflects the key risks facing the organisation and all assurances over the controls mitigating the risks have been considered and any significant gaps in either the assurances or in controls have been addressed. The Audit Committee has sought improvements in the presentation of the Assurance Framework to ensure greater clarity of gaps and weaknesses and welcomes the progress made.

Internal Audit's opinion is that the Board can take reasonable assurance that the Framework is suitably designed, consistently applied and effective.

5.3 *Governance Arrangements*

The Audit Committee believe that the Trust's governance arrangements are robust. There are a number of different components of governance, in particular corporate governance, clinical governance, research governance, information governance and financial governance and the Audit Committee scrutinises the processes to ensure they are effective. The Audit Committee were pleased to note the

establishment of the Quality and Safety Committee in December 2010. This Committee is a formal sub-committee of the Board and is chaired by a non-executive director. It has key responsibilities in relation to providing assurance to the Board on clinical quality and safety; and driving an improvement culture to promote excellence in patient care.

The Audit Committee welcome the establishment of the Risk Management Executive chaired by the Chief Executive in May 2011

5.4 *Statement of Internal Control*

The Statement of Internal Control was considered by the Audit Committee at its meeting in June 2011 and its contents were consistent with the conclusions above. It considers that the Assurance Framework sets out the Trust's objectives and provides a clear template to identify any risks to achieving those objectives and a clear framework against which to measure progress.

It also recognises that there is a Risk Management Strategy in place, endorsed by the Trust Board. It clearly defines the risk management structures, accountabilities and responsibilities throughout the Trust. It also incorporates consideration of the Trust's stakeholders.

During 2010/11 the Audit Committee received the minutes and outcomes from the Clinical Governance Executive, with the Medical Director attending meetings as required to address issues raised by the Committee.

External Audit have audited the financial statements to consider whether they have been prepared in accordance with the relevant accounting policies and whether the annual report is consistent with the statements, that the Remuneration Report is properly prepared and information on the SIC is consistent with the financial statements and reflects compliance with NHS guidance.

There were some issues which caused particular problems in year including issues with cancer waiting times, 18 week waiting times and outpatients. There were gaps in control which where not immediately apparent. The Trust had placed an overreliance on management assurances. More robust controls have now been put into place and independent assurances sought alongside management assurance. There is an ongoing review into the circumstances of the gaps in the control process.

The Trust is also reviewing its performance reporting processes to ensure that there is clear evidence-based reporting to the Board. The Trust had a financial plan to achieve a surplus of £2.6m but delivered a small surplus of £26k following support of £5m from the SHA.

With the exception of the internal control issues highlighted, the SIC concluded that SATH has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed

6. Recommendations

Given the issues identified in Section 4 and our conclusions in Section 5, we recommend that the Board acknowledges that:

- With the exception of the internal control issues described in this document, the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and those control issues have been or are being addressed

- It has a system in place that identifies any actions that need to be taken to remedy either gaps in control/assurance but this needs to be constantly reviewed

- To strengthen risk management arrangements, the Risk Management Executive will be established in May 2011, chaired by the Chief Executive and welcomes the revised format of the Board Assurance Framework and Risk Register

- Managers will be invited to attend Audit Committee to present updates on risks and their mitigation.

- The Trust will continue to review its recommendations tracking processes to ensure management continues to deal appropriately with any significant assurance provider in a timely manner, including review of recommendations at Hospital Executive Committee.

- The Trust has a system to identify and implement actions that need to be taken re scope of work plans from assurance providers and will continue to ensure delivery, but will consider the development of key performance indicators to further enhance this.

- The Trust develop its Assurance Framework to review and provide challenge to management assurances

Dennis Jones
Audit Committee Chairman

Appendix 1: Summary of Audit Reviews

Clinical Governance
Data quality part 1
Treasury management
Catering: ordering and receipt of provisions
Recommendation follow up review
IT financial controls
Data management follow up
Budgetary management
Carbon management
Nursing bank and agency follow up
Procurement
Follow Up of Previous Internal Audit Recommendations
Charitable funds
IT Backup and Recovery
General ledger
Creditors
Payroll
Network security follow up
Asset management
Follow up - catering
Income and debtors
E rostering
CQC registration
Capital programme - programme management
Information Governance
Management of junior doctors absence
Risk Management and Assurance Stocktake
Nurse agency invoices
Data quality

Appendix B: Detailed Internal Audit Plan 2011/12

Audit	Overview of Internal Audit Coverage	Internal Audit Approach	Days
Assurance and Advisory Work to Address Specific Risks			
Workforce compendium report covering:- ▪ Waiting List Initiatives - follow up ▪ Junior Doctors absence management ▪ Consultant Job Planning - E & Y report recommendations ▪ Agency and Bank - European Working Time Directive	Over the last two years of audit coverage, a number of reports have concentrated on resource planning and scheduling. At the request of the audit Committee, we will revisit all of these areas to provide assurance over progress. In addition, the area of European Working Time Directive will be covered	Follow-up and key control testing	20
Restructuring to 11 Centres Initial review of control framework	The restructuring form Division to 11 centres is a key imperative for Trust management. At the request of the Audit Committee, we undertake a high level advisory review of the control framework and provide advice as required on high level controls for in the revised 11 centre model	Advisory	8
Restructuring to 11 Centres Subsequent review of compliance with control framework to include:- ▪ Accountability ▪ Performance management	Following on from the Advisory review, later in the year we will undertaken a review of compliance with the established control framework across a sample of the centres, concentrating on the areas of accountability and performance management systems	Key controls	11
Data Quality (4 audits covering up to 8 KPIs)	To sample test a number of KPIs to ensure that the data reported is accurate. Whilst the priority KPIs including A&E, cancer waiting times, may receive external scrutiny by external audit; there are a number of other KPIs where IA offer an effective assurance mechanism. Our review would include: ▪ Map the data flow processes and the internal data quality procedures within the system; ▪ Validate the reported KPIs to the underlying systems data; ▪ Review the reporting systems for the KPI, including the risk and sensitivities around the KPI; and ▪ Reporting and tracking agreed actions. We anticipate four reviews covering 8 KPIs in this year.	Risk based assurance	50
Financial assumptions in strategy / business plan	At the request of the Director of Finance, we will provide challenge ob the assumptions underlying the strategy / business plan. This work will be undertaken using our health specialist team.	Advisory	10
Continuous Improvement Team – delivery of projects on	The Trust has in place a number of continuous improvement teams	Risk Based Assurance	10

Audit	Overview of Internal Audit Coverage	Internal Audit Approach	Days
▪ Theatre Utilisation ▪ Length of Stay	looking at specific projects. Our work will provide assurance that the teams are delivering on the outcome intended for the projects in the areas of:- ▪ Theatre Utilisation ▪ Length of Stay		
Clinical/Discharge Letters (compare process across Trust)	To review procedures for clinical/discharge letters to provide assurance on consistent process across the Trust.	Risk Based Assurance	8
New Governance Structure	The Trust is currently reviewing its governance structures. Our review will examine the governance structures and provide advice based upon good practice.	Advisory	14
Clinical Audit	review clinical audit process to provide assurance on its effective application and delivery of clinical assurances	Risk Based Assurance	8
Compliance with NICE guidance	To determine what assurances the Trust has that all relevant data/forms are being completed (particularly by Doctors), what action is taken where forms are not completed, what are the Trust Board doing to ensure compliance, what assurances are received from other providers or commissioners.	Risk Based Assurance	10
Section subtotal			**150**

Audit	Overview of Internal Audit Coverage	Internal Audit Approach	Proposed timing
Coverage for External Audit Reliance or to meet Regulatory Requirements			
General Ledger	To review the ledger transactions	Key controls Testing – one report	Q3
Treasury Management and Cash Receipting	To review the Trust's treasury management processes including the preparation of Cash flows. To test the key controls to enable External Audit to place their planned level of reliance on our work.		Q3
Creditor and Debtors	To review the system for processing and payment of suppliers invoices and the key controls over the issuing		Q3
Capital Programme	To review the ongoing governance arrangements throughout the year in regard to changes to individual schemes and costs		Q3
Asset Management	To review the controls for the :- accurate recording and assessment with the Trust's asset register; and External Audit high level controls		Q3
Payroll	To review the Trust payroll system and the ESR HR element of this system. The ESR element will consider the adequacy of registration	Key controls Testing	Q3

Audit	Overview of Internal Audit Coverage	Internal Audit Approach	Proposed timing
	checks being undertaken on a sample of staff. This review will test the key controls to enable External Audit to place their planned level of reliance on our work.		
Treasury Management and Cash Receipting	To review the Trust's treasury management processes including the preparation of Cash flows. To test the key controls to enable External Audit to place their planned level of reliance on our work.	Key controls Testing	Q3
Charitable Funds	To review the arrangements for receipt, investment and expenditure of funds donated	Key controls Testing	Q3
IT controls with the Key Financial Systems	To test the key controls to enable External Audit to place their planned level of reliance on our work	Key controls Testing	Q3
Assurance Framework and Corporate Risk Register	Maintaining Our understanding of the Trust's development, use and reporting of its assurance framework	Compliance / Advisory	Q4
Quality Governance Framework	Dependant upon the on Trust's self assessment against the framework, we will either undertake assurance work to test and challenge the evidence to support the statement given. or If a potential gap is identified then advisory work on how the systems could provide this evidence / assurance	Compliance / Advisory	Q4
Section Subtotal			**60**

Audit	Overview of Internal Audit Coverage	Internal Audit Approach	Proposed timing
Other Internal Audit Input			
Contingency	For coverage of risks and changes in assurance needs as these arise during the year		As directed (20 days)
Follow Up	To meet internal auditing standards and to provide management with ongoing assurance regarding implementation of recommendations	Follow Up Review	As required
Management	This will include: ▪ Annual planning ▪ Preparation for, and attendance at, Audit Committee meetings ▪ Regular liaison and progress updates ▪ Liaison with external audit ▪ Preparation of the annual internal audit opinion		Ongoing
Section subtotal			**60**

Grand Total	**270**

The Shrewsbury and Telford Hospital NHS Trust

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