Report to:	Trust Board, June 6th 2013

Enclosure 2

Title	Audit Committee Annual Report
Sponsoring Executive Director	Director of Corporate Governance
Author(s)	Head of Assurance
Purpose	To receive the Audit Committee Annual Report
Previously considered by	Audit Committee (April 2013)

Executive Summary

It is good practice to review the business of corporate committees annually. The annual report (attached) outlines the work of the Audit Committee over the year 2012/13.

It describes the role and operation of the Committee including attendance rates; reporting to and from the committee and summarises the reports received from Internal and External Audit

Related SATH Objectives	**SATH Sub-Objectives**
Related to all SATH objectives	C5: Meet regulatory requirements and healthcare standards

Risk and Assurance Issues	Describes the systems in place throughout the year to manage risk and gain assurance
Legal and Regulatory Issues	Supports the Annual Governance Statement

Action required by the Trust Board

To **RECEIVE** the Audit Committee Annual Report.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Audit Committee Annual Report

2012/13

Putting Patients First | Honesty and Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

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 Accountable Officer. This Report includes information provided by Internal Audit, External Audit and other Assurance Providers, including the Trust's Risk Management Executive.

2. The Role and Operation of the Audit Committee

2.1 Membership of the Committee

The Audit Committee is the senior Board committee taking a wide responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee met 6 times during 2012/13. It is chaired by a Non-Executive Director, who is a qualified accountant. The members of the Committee disclosed their interests, which included the following, in the Trust's register of interests:

▪ Mr Dennis Jones (Chair)	None
▪ Dr Simon Walford	Governor, University of Wolverhampton Director, Wolverhampton Academies Trust Director, Wolverhampton Grammar School Ltd. In receipt of an NHS Pension
▪ Mrs Sue Assar (until 31.5.2012)	Director of Assar Consulting which seeks to do business with the NHS
▪ Mr Robin Hooper (from Sept 2012)	Director of Holy Cross Limited Director of Enterprise Prospects Limited Director of Global Enterprise Solutions Limited Director of Face-2-Face Solicitors Director of Sports Booker Limited Director of Action Mill Care Farm Limited Director of Verity House Limited

Other Non-Executive directors are able to attend this meeting and key senior Trust personnel and Internal and External Audit are also in attendance. The Finance Director, Medical Director, and Director of Corporate Governance normally attend the Committee.

The Director of Corporate Governance provides support to the Chair and Committee members.

2.2 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 overleaf:

	19 April 2012	10 May 2012*	07 Jun 2012	20 Sep 2012	13 Dec 2012	14 Feb 2013	TOTALS	
							No of meetings	%
Members								
Dennis Jones	✓	✓	✓	✓	✓	**x**	5/6	83%
Sue Assar (until 31.5.13)	✓	✓	n/a	n/a	n/a	n/a	2/2	100
Simon Walford	✓	✓	✓	✓	✓	✓	6/6	100
Robin Hooper (from 30.9.13)	n/a	n/a	n/a	n/a	✓	✓	2/2	100
TOTAL	**3/3**	**3/3**	**2/2**	**2/2**	**3/3**	**2/3**	**15/16**	**94%**
Other attendees								
Chief Exec			**x**					
Dir Corporate Governance	✓	✓	✓	✓	**x**	✓		
Finance Director	✓	✓	✓	✓	**x**	✓		
Medical Director	**x**	✓	✓	✓	**x**	**x**		
Other Directors / Very senior managers	Deputy COO		DoT			Chief Info Officer		
Ass Dir of Finance	✓	✓	✓	**x**	✓	**x**		
Head of Assurance	✓	**x**	✓	✓	**x**	**x**		
Centres	Ophth Surgery							
Corp Depts	Estates							
Internal Audit	✓	**x**	✓	✓	✓	✓		
External Audit	✓	**x**	✓	✓	✓	✓		
Counter Fraud	✓	**x**	✓	✓	✓	✓		

Key – ✓ (Present) / X (Absent) from meeting

*The May 10 meeting was a special meeting held to review the annual accounts and the draft Statement of Internal Control.

2.3 Terms of Reference

Following recommendations made by Grant Thornton as part of the Trust's HDD phase 1 review and a review of committee structure undertaken by Deloitte, a proposed structure was presented to the Board in August 2012. The Terms of Reference were subsequently reviewed in September 2012 when the name the Committee was changed.

This Committee structure was discussed in greater detail at the Board Development session in October and a number of principles agreed in order to ensure that the formal subcommittees of the Board focus on key strategic imperatives, assurance of systems, reduce duplication and ensure delivery against robust plans. Consequently the Terms of Reference were reviewed again in December 2012. The further changes related to the change in title of the Committee and other Trust Committees; and minor amendments to bring the Terms of Reference in line with those recommended in the NHS Audit Committee Handbook (2011)

2.4 Reporting from the Committee

An outcome summary of the Audit Committee is formally reported to the public session of the Trust Board. (Contained in the Information pack). In addition, the Chair of the Audit Committee summarises the key issues following each meeting in an update to the following Trust Board. Examples of issues brought to the attention of the Board during the year are:

- **Clinical Equipment replacement.** Whilst recognising the pressures upon capital resources the Committee expressed concern at the Trust's inability to meet scheduled and planned capital equipment replacement requirements across its range of services and the relative priority against other capital demands.

- **Medical records** The Committee was concerned that there did not appear to be a structured project plan to address the wide range of issues previously identified. There remains the expectation of a prolonged period (2 years?) before the service is likely to have completed its work to make the required improvements across the range of issues previously identified. In the meantime the risks remain high in respect of clinics not being supported by medical records, a failure to locate records, with perhaps 25% untracked, and poor storage.

- **Staffing and job planning.** Many risks relate to insufficient staffing or rota cover despite the Trust having significant budget overspends in staff costs. Risk mitigations refer to the need for job planning. It is important for management to ensure that the most effective use of scarce staff resources is made and effective job planning and appraisal procedures need to be applied and completed consistently across the Trust to take full advantage of available resources**.**

- **Booking and scheduling**. At the start of the year, the committee expressed concern at the lack of clarity, responsibility and accountability for improving the delivery and governance of systems in respect of patient access within the transformation programme. Towards the end of 2012, a single, centralised, booking team was created. In February, the committee received a detailed review of the work to date. The report provided clear evidence of substantial progress in improvements to the Patient Administration System, substantially reducing the risks that have been a source of concern. The audit committee will maintain regular oversight of progress to completion of the remediation programme.

2.5 Reporting to the Committee

In line with the terms of reference there are a number of standing items on each Committee agenda. The following were presented at each meeting with the exception of the special meeting in May

- External Audit Update
- Internal Audit Update
- Counter Fraud update
- Audit Recommendation Tracking

The following reports were also presented to the Committee:

- Board Assurance Framework (Apr, Jun, Sept and Dec 12)

- Corporate Risk Register (Apr, Jun, Sept and Dec 12)
- Security Annual Report (Jun 12)
- Annual Accounts (May and Jun 12)
- Risk Management Annual Report (Apr 12)
- Annual Report (Jun 12)
- Annual Governance Statement (Apr and May 12)
- Audit Committee Annual Report (Apr 12)
- Audit Committee Forward Plan (Jun 12)
- Audit Committee Self Assessment (Sept 12)
- HDD Action plan (Sept 12)
- Terms of Reference (Sept and Dec 12)
- Losses and Special Payments (Apr and Jun 12)
- Expenditure over £100k (Apr and Jun 12)
- Standing Financial Instructions and Standing Orders waived (Apr and Jun 12)

3. 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 4 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.

4. Information supporting opinion

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

4.1 Internal Audit

4.1.1 Head of Internal Audit's Opinion

The Head of Internal Audit's Opinion is that based on the work undertaken in 2012/13

***"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 / or inconsistent application of controls put the achievement of particular objectives at risk.*

Whilst the Trust has continued to develop and strengthen its control framework during 2012/13, there remains significant scope for improvement and the Trust should continue to strengthen controls in the areas of weakness identified by our work during 2012/13 as a priority. In delivering our 2013/14 Annual Internal Audit Plan, we will continue to work with the Trust as it seeks to develop and improve its risk, governance and internal control framework"

4.1.2 Internal Audit Reports and recommendations

The Internal Audit provider changed at the end of 2011/12. The Internal Audit Operational Plan for 2012/13 was approved by the Audit Committee on 7 June 2012. The Trust received the following opinions during 2012/13

Full Assurance	Substantial Assurance	Limited Assurance	No Assurance
0	9	4	0

There has also been one follow-up audit of Cash and Treasury management and 4 advisory audits. One further advisory audit was planned but not completed in year.

A summary of topics is attached at Appendix 1.

Whilst positive opinions were issued in respect of the majority of audits for the period, limited opinions were provided in four instances:

- **Statutory/Mandatory Training – Limited** opinion. There was one Priority 1 recommendation with respect to ensuring the Board has visibility of statutory and mandatory training compliance levels. Actions have been taken to address this and compliance levels are now reported by Centre as part of Centre Performance Reports which are summarised for each meeting of the Trust Board.
- **Savings Plans – Limited** opinion. There was one Priority 1 recommendation with respect to the completion of Quality Impact Assessments (QIAs) for all Cost Improvement Plan (CIP) schemes. This is being proactively addressed.
- **Creditors and Payments – Limited** opinion. There was one Priority 1 recommendation with respect to limited segregation of duties in the purchase to pay process. Mitigating controls are being implemented to address this weakness.

- **Cash and Treasury Management – Limited** opinion. There were two medium and one low priority recommendations. A follow up review was undertaken towards the end of 2012/13 which resulted in **substantial** assurance.

In addition, Internal Audit carried out four performance reviews during 2012/13 all of which included Priority 1 recommendations as follows:

- **Mortality Indicators**: Three Priority 1 recommendations with respect to formalising the business of the Mortality Group, ensuring Consultant review of case notes where mortality has occurred in hospital under the care of a locum consultant and increasing focus on actions to address high incidence, high mortality diagnoses.

- **Quality Governance Framework**: Two Priority 1 recommendations with respect to providing members of the Trust Board responsible for reviewing the framework with access to the centralized evidence file so that they may scrutinize it and increasing the senior management focus on assurance through delegation of collection of evidence.

- **Accident & Emergency and Cancer Waiting Times Quality Indicators**: One Priority 1 recommendation relating to implementation of Standard Operating Procedures for the validation of Emergency Department 4 hour breaches.

- **Clinical Coding**: One Priority 1 recommendation relating to validating current coding guidance notes to ensure they have not been superseded.

Formal actions plans have been agreed to address the significant control weaknesses in these areas. There have been no common weaknesses identified through Internal Audit reviews.

There have been 86 recommendations made by Internal Audit. All the recommendations were accepted by management.

Priority 1 High	Priority 2 Medium	Priority 3 Low
10	46	30

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

4.1.3 Internal Audit Performance

The Trust underwent a tender process for during 2011/12 and Deloitte were appointed as Internal Auditors commencing 1 April 2012. They have provided progress reports from September 2012 which included

- Draft and final reports issued to ensure delivery to timescale
- Overall assurance by report

The Committee expressed concern about the number of reports which were submitted at the end of the Financial year. This is addressed in the 2013/14 audit plan. Internal Audit Performance Indicators will be introduced in 2013/14 to monitor progress.

4.2 External Audit

The refreshed Audit Plan was presented to the Audit Committee in June 2012. There were no areas of high audit risk identified for the year going forward.

External Audit reported their Interim Audit findings for 2012/13 in April 2013. These are summarised as follows:

"There are no significant findings from our controls testing to report to the Audit Committee at this time. The overall design and operation of controls was found to be effective. However, we did identify an issue relating to the Trust application of the Construction Industry Scheme (CIS) for capital projects"

4.2.1 External Audit Performance Indicators

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.

4.3 Audit 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.

4.4 Other Assurance Providers

4.4.1 Other Committees

The Audit Committee also receives assurance from risk management committees. The Risk Management Executive met from April to October 2012 and was chaired by the Chief Executive. From November 2012, the Risk Committee was established. This Committee meets quarterly to review and update the Board Assurance Framework. It also has an overview of the most significant risks on the Trust risk registers to ensure there are robust controls and mitigation actions in place.

To strengthen the relationship between the two main assurance committees (Finance, and Quality and Safety) there is a reciprocal arrangement whereby the Chair of the Audit Committee attends Finance Committee and Quality and Safety Committee once per year.

4.4.2 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 2012/13. This includes the activities agreed with the LCFS and Finance Director at the beginning of 2012/13. 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 2012/13 by the LCFS were:

- Carried out Fraud Risk Assessment Workshops with Payroll and Human Resources.
- Facilitated a Bribery Act Risk Assessment Workshop with senior managers
- Completed two fraud awareness sessions with the Trust's Pharmacy departments.
- Reviewed a number of policies and identified some areas where best practice guidance could enable the policies to be enhanced to reflect counter fraud arrangements.
- Carried out work on the data matches provided by the National Fraud Initiative.

4.4.3 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 Corporate Governance 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. A heat map highlights areas where implementation of recommendations is delayed.

This approach has seen a significant improvement in the timely implementation of recommendations, with only 2 recommendations overdue at year end, compared with 39 at year end 2011/12.

The Executive Directors have agreed a robust approach to recommendation tracking which includes high level audit recommendations being reviewed by the Hospital Executive Committee. Any red opinions are also discussed at Operational Risk Group.

4.5 Assurance Framework

The Assurance Framework was reported regularly to the Audit Committee in 2012/13 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 Director is responsible for ensuring the accuracy and completeness of the Framework in relation to Trust objectives. The framework has been simplified and clarified to improve its effectiveness during the year with the development of a high level overview (Board Assurance Framework on a page) and a heat map linking the Board Assurance risks to the risk matrix.

The Audit Committee reviewed the framework at meetings in April, June, September, and December 2012. In line with year-end reporting requirements, the Audit Committee reviewed the final version of the 2012/13 assurance framework at its April 2013 meeting.

Internal Audit reported that the Assurance Framework and related processes and noted "the significant amount of work undertaken by the Trust during 2012/13 to develop the format of the BAF and the overall risk management process, and are confident this provides an adequately designed framework to facilitate robust risk management and assurance arrangements going forward"

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 Annual Governance Statement.

4.6 Corporate Risk Register

The Corporate Risk Register and the associated controls and assurances have been overseen by the Risk Management Executive and Risk Committee throughout the year. The Corporate Risk Register was reported to the Audit Committee in April, June, September, and December 2012.

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 and Performance Report.

Risk assessments are done on an ongoing basis within the Centres, and whenever a process change is about to occur, or a new hazard is identified. Quality Impact Assessments are carried out for all cost improvement schemes. 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 Committee welcomed the new format which simplified and clarified the presentation.

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 Quality and Safety Committee 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. To facilitate close working between the committees, one member of the Audit Committee is also a member of the Quality and Safety Committee and the Medical Director attends both Committees. In addition, the Chair of the Audit Committee attends a meeting of the Quality and Safety Committee each year and similarly the Chair of Quality and Safety Committee attends Audit Committee annually.

The Audit Committee welcomed the establishment of the Risk Committee chaired by the Chief Executive in November 2012.

5.4 Annual Governance Statement

The draft Annual Governance Statement was considered by the Audit Committee at its meeting in April 2013 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.

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 Annual Governance Statement is consistent with the financial statements and reflects compliance with NHS guidance.

Performance against national standards for access to care remain a serious concern. In 2012/13 the Trust failed the 95% A&E target, the RTT targets and the cancelled operations target. Factors contributing to affect performance are:

- an increase in the number of ED attendances
- an 8% increase in the number of non-elective admissions
- a significant cohort of patients who are fit to transfer but remain in a hospital bed
- a lack of available capacity (beds to meet expected demand)

There were a number of workstreams to reduce the risk including the Emergency Access Action plan; the whole system Action plan and the work to transform Booking and Scheduling systems.

During 2012/13, the total number of patient falls and the number of RIDDOR reportable falls decreased when compared with 2011/12. However, the Trust has seen an increase in falls which which contributed to patient deaths. A comprehensive action plan to ensure ongoing reduction of falls and the impact/harm for patients was presented to the Trust Board in February 2013. The Quality and Safety Committee are monitoring the impact of those actions.

With the exception of the internal control issues highlighted, the Annual Governance Statement 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

- Continue the processes for recommendation tracking to ensure timely completion of action plans following audit.

Dennis Jones
Audit Committee Chairman

Appendix 1: Summary of Audit Reviews

Report Title	Assurance	Date issued	Date to Audit Committee
Income and Debtors	Substantial	04/02/2013	Feb-13
Cash and Treasury Management	Limited	05/02/2013	Feb-13
Cash and Treasury Management Follow up	Substantial	09/04/2013	Apr 13
Statutory and mandatory training	Limited	05/12/2013	Dec-12
Assurance Framework	Substantial	08/03/2013	Apr-13
Budgetary Control and Financial Reporting	Substantial	26/04/2013	May-13
Payments and Creditors	Limited	09/04/2013	Apr-13
Savings Plans (Cost Improvement Programme)	Limited	09/04/2013	Apr-13
Clinical Centres-Internal Controls	Substantial	03/05/2013	May-13
Payroll	Substantial	03/05/2013	May-13
Payroll analytics	Substantial	28/05/2013	Jun-13
IT – assets security	Substantial	08/05/2013	May-13
IT security - Information leakage	Substantial	08/05/2013	May-13
Accident & Emergency and Cancer Waiting Times Quality Indicators	Advisory	12/04/2013	May-13
Quality Governance Framework	Advisory	05/12/2013	Dec-12
Summary Hospital Mortality Indicator (SHMI)	Advisory	05/12/2013	Dec-12
Data Quality – Clinical Coding	Advisory	*not yet issued*	
Data Quality Report Follow Up (Finnamore)	Advisory	*Deferred to 2013/14*	