Yorkshire Ambulance Service NHS
NHS Trust

Audit Committee

Venue: Kirkstall/Fountains, Springhill 1, Wakefield, WF2 0XQ
Date: Tuesday 16 July 2013
Time: 0930 hours

Chairman:

Barrie Senior	(BS)	Non-Executive Director

Attendees (members):

Pat Drake	(PD)	Non-Executive Director & Deputy Chairman
Erfana Mahmood	(EM)	Non-Executive Director
Mary Wareing	(MW)	Non-Executive Director

In Attendance:

Rod Barnes	(RB)	Executive Director of Finance & Performance
Steve Page	(SP)	Executive Director of Standards & Compliance
Nicky Cook	(NC)	External Audit (EA)
Benita Jones	(BJ)	Internal Audit (IA)
Paul Webster	(PW)	Internal Audit (IA)
Stephen Downs	(SD)	Senior Business Consultant, NHS TDA (Observing)
Fiona Hibbits	(FH)	Delivery & Development Manager, NHS TDA (Observer)

In Part-Time Attendance:

Anne Allen	(AA)	Director of Corporate Affairs & Trust Secretary

Apologies:

Elaine Bond	(EB)	Non-Executive Director
Shaun Fleming	(SF)	Counter Fraud
Anna Rispin	(AR)	Associate Director of Finance
Paul Thomson	(PT)	External Audit (EA)

Minutes produced by: (MG) Melanie Gatecliff, Board Support Officer

The meeting commenced at 0930 hours.

		Action
1.0	**Introduction & Apologies** BS welcomed everyone to the meeting. For the benefit of the two guests from NHS TDA who were attending the meeting as part of their observation process brief introductions were made round the table.	

		Action
	Apologies were received as above. It was noted that BJ would provide the report on Counter Fraud on behalf of SF.	
2.0	**Declaration of Interests** No declarations of interest were made relating to items on the agenda.	
3.0	**Minutes of the last meeting, 4 June 2013** The minutes of the last meeting were reviewed and agreed as a true record of the meeting with the following amendments: Page 10, paragraph 2 – “back” on line one deleted. Page 10, paragraph 4 – replace “a series of workshops” with “a workshop”. Page 21, paragraph 3 – sentence amended to read “SP stated that it would be difficult to change one sentence without altering the context of the report.”	
4.0	**Action Log and Matters Arising** The action log was reviewed and updated. **2012/31 – Bribery Act Compliance Report** BJ confirmed that this work, which was still in progress, was covered under item 11.2. Action remains open. **2012/43 - Fleet Management Actions** BJ stated that part of this work related to fuel cards. The follow up work had been completed and the majority of actions implemented but it would still need to be monitored. A further report would be provided at the October meeting. Action remains open. **Actions:** **BJ to meet with BS outside of meeting to ensure detailed audit trail on this item, and to meet with RB outside of meeting to discuss control issues and spot check follow up work.** **2012/61 - Internal Audit & Counter Fraud Update** BJ confirmed that this action was discussed at the IA workshop and reference would be made to it in the IA section of the meeting. Action closed. **2012/67 - Contract Award Activity & SFI Waivers** RB stated that the new report format changed the amount of detail provided and was covered at agenda item 14. Action closed. **2012/68 - Board Assurance Framework** SP stated that this was covered at agenda item 6.0. Action closed,	**BJ**

		Action
	2012/71 & 72 - F&IC Assurance Report These actions were covered at agenda item 6.1. Actions closed. **2012/73 & 74 - Quality Committee Assurance Report** These actions were covered at agenda item 6.1. Actions closed. **2012/76 - Committee Assurance - Standards & Compliance** This action was covered at agenda item 6.1. Actions closed. **2012/87 - Counter Fraud Progress Report** Reference to this item and an update on progress to date was due as part of agenda item 11.2. SF remained reliant on further information coming from a national source so would provide a further update at the October meeting. **2012/93 - Assurance regarding accuracy & completeness of IPR** BJ confirmed that this item was covered in the IA progress report. Action closed. **2013/1 - Terms of Reference** This action was covered at agenda item 6.1. Action closed. **2013/3 - Quality Committee Report** BS confirmed that, in addition to the last Audit Committee meeting, this item had also been discussed at the Quality Committee meeting the previous week. Reassurance had been forthcoming that the Trust was maintaining its Level 1 status. Action closed. SP stated that he had received an update letter from the NHSLA. The Trust had been anticipating change for some time and the letter had confirmed this. The NHSLA stated that, following their recent review, it had been agreed that, from 2014/15, the body would be moving away from risk management standards. During this time they would be working with members to manage financial implications, etc. Level 1 would therefore be used as the basis for going forward. **2013/5 - Audit Committee Work plan** This action was covered at agenda item 5. Action closed. **2013/6 & 2013/7 - F&IC Risk Assurance Report** These actions were covered at agenda item 6.1. Actions closed. **2013/9 - QC Risk Assurance Report** This action was covered at agenda item 6.1 and by the Quality Report at item 9. Action closed. **2013/10 - Committee Assurance - Clinical Governance, Clinical Risk Management & Clinical Audit** BS stated that although he had not attended the BDM on 25 June, he had read the minutes and noted that JM had provided an overview.	

		Action
	He asked those who had been present whether the presentation had sufficiently handled the matter. PD stated that the overview had basically been a reiteration of the discussion at the Quality Committee meeting. The position had not changed: the Trust was doing what it needed to be doing to meet its statutory requirements but was unable to do anything extra due to technical issues, etc MW stated that the presentation had covered all of the issues currently being faced by the Trust but it would be good if the items discussed could have been further crystallised. **Action:** **BS to meet with JM to clarify his understanding of the current situation.** Action remains open until October. **2013/11 - Committee Assurance - Clinical Governance, Clinical Risk Management & Clinical Audit** See note in **2013/10**. Action remains open until October. **2013/23 - IA Plan/Counter Fraud Plan** Item covered at Section 11 of the agenda. Action closed. **2013/26 - Review of SFIs/SOs** Item covered at item 14.2 of the agenda. Action closed. **2013/27 - Review of Members' Expenses** Item covered at item 17 of the agenda. Action closed. **2013/29 – Internal Audit Annual Report & Head of Internal Audit Opinion** BS stated that this was largely covered off during the June meeting and the remainder of the action would be addressed as part of agenda item 11. Action closed. **2013/30, 2013/31, 2013/32, 2013/33, 2013/34, 2013/35** Actions all closed. **2013/36 – Annual Report** BS stated that this action had been covered during the June Audit Committee meeting and the follow up that had taken place later that same week. Action closed. **2013/37 – Annual Governance Report to Those Charged with Governance** NC confirmed that she would summarise this action as part of agenda item 10.1. Action closed.	**BS**

		Action
	2013/38 - Annual Governance Report to Those Charged with Governance BS confirmed that the final version had been received. Action closed. **2013/39 – Quality Account** BS confirmed that the report had been received. Action closed. **2013/40 – Reference Cost Approval** RB confirmed that the paper had been revised and would be circulated outside of the Committee. Action closed. SP asked whether the action log could be printed in a larger font for future meetings. It was agreed that this would be useful. **Action:** **JW to print off action log in larger print for future meetings.** BS thanked everyone for their updates.	**JW**
5.0	**Audit Committee Workplan** BS stated that the reason for including the Workplan at that day's agenda was to request Committee approval of some minor changes as discussed between BS and RB in the lead up to the meeting. These changes were: • Deferment of consideration of Workforce and Strategy assurance until the October meeting to allow the new Interim Executive Director of Workforce and Strategy to settle in to his role. This would mean that there would be two assurance updates at that meeting. • Working Capital Review was scheduled for consideration at the July and December Audit Committee meetings but as this item had been transferred to the F&I Committee's ToR and would form part of its reporting it no longer needed to be a specific Audit Committee agenda item. • As the NEDs had already met with IA on 10 July and RB was still to have his audit "wash up" meeting with EA it seemed appropriate for the IA/EA meeting with the NEDs, originally scheduled for that day's meeting to be postponed until a more appropriate time. **Approval:** **The Audit Committee approved the proposed changes to the Workplan.**	
6.0	**Assurance regarding Board Assurance Framework – Quarter 1** SP stated that at the last Audit Committee meeting the BAF 2012/13 close down had been reviewed and it had been agreed that the contents for current year should be discussed at a Board Development session.	

		Action
	Mark Hall, Associate Director, Risk & Safety had led on a substantial review of controls, assurance gaps, etc with the lead Director for any given risk plus one additional Director who carried out a peer review. The review had firmed up dates for actions and completion dates. Additional information had been added to a number of risks which would allow cross reference to CQC and NHSLA standards and the BAF had therefore been heavily tidied up to give a clearer picture of the Trust's current position. PD stated that she was appreciative of the action taken to address gaps and requested an update on the actions in risks 6a and 6b on pages 12 and 13 that were due for completion in July 2013. RB stated that the Chief Executive had picked up 6b action 3 with Nick Cook (NC), the Interim Executive Director of Workforce and Strategy and the appropriate Associate Director, Graham Jackson. It had been confirmed that if there was to be further industrial action there would need to be a re-ballot. SP stated that the two resourcing actions were being dealt with through the Transformation Programme Management Group (TPMG) and would be revisited at the following day's TPMG meeting. BS asked whether NC's induction had included helping him to get an understanding of the key risks, controls and control gaps in the BAF which he needed to oversee. SP replied that although he was yet to have a specific meeting with NC about the BAF, SM had updated NC prior to his departure. He added that NC had also been having 1 to 1 meetings with individual Executive Directors to go through some of the key issues, etc. PD asked whether the actions with June and July completion dates on page 16 needed to be refreshed. SP replied that the action with the June 2013 deadline had been completed and he was currently in the process of re-evaluating of costs of 111. In addition, on-going discussions, led by RB, were taking place with the commissioners. Discussions were also on-going with the Associate Director responsible for 111 to decide what else could be done to reduce operating costs without damaging the service. Some measures were due to be introduced in August with others, which were dependent on the outcome of the discussions with commissioners, due later. MW asked whether intermediate steps could be added for the considerable number of control gap actions all with end of year completion dates to give a greater degree of assurance.	

		Action
	SP acknowledged that a number of actions in the final column of the BAF were at a high level and encompassed many different lower level actions. He stated that he could report on them in narrative terms but it was the Executive team's view that they were unlikely to have a significant impact to reduce the risk in-year. MW stated that, whilst she understood setting up the higher level controls, it was her belief that reference should be made to where items were being reviewed in other forums to show what other safeguards were in place to manage the risk until the high level deadline date was reached. PD stated that although she agreed with MW she was unsure how much more assurance could realistically be asked for. SP agreed to take the matter away for further consideration, although it was his belief that that the level of assurance being requested was more appropriate for the Quality Committee to consider. **Action:** **SP to reconsider the breakdown of high level risk actions in the BAF to provide the Audit Committee with further assurance.** BJ stated that this linked in with the IA report. The BAF had been reviewed and comments had been provided to SP in relation to formatting, gaps, etc. This would be discussed later in more detail. EM stated that the categorisation of risk on page 13 had moved quickly from a score of 16 (red/red) to amber/green but the information in the BAF did not really drill down into the reasons for this. It was her belief that the Committee needed a more cohesive understanding of how it had happened. She acknowledged that the BAF should not be too unwieldy but it did need more information. SP stated that the risk score, both initial and current, showed that there was still a significant risk on page 13. The Assurance rating was different and related to the level of organisational confidence that the risk was being managed appropriately. Sometimes therefore there would be very different risk scores. EM stated that she felt relatively assured because she had the background information from the Quality Committee. However, from an external person's point of view, they would not necessarily get that impression or level of understanding. There were no other comments. **Approval:** **The Audit Committee noted the current position and approved forward plans for the effective management of risks.**	**SP**

		Action
6.1	**Streamlining Review** SP provided a brief update following the recent streamlining meetings, adding that further information would be available at that afternoon's Board Development Meeting. Mark Hall and SP had met with the NED chairs of the Committees for discussion about how risk information flowed through them. SP stated that the core of the current risk management process was through the Executive management function to the operational functions of the organisation which was where the individual risk registers sat. Management of additional specific risks was through groups such as the Clinical Governance Group (CGG); the Health & Safety Group; the Transformation Programme Management Group (TPMG), etc. The Board Committees had specific responsibility for assurance on the risk management process and through their respective work plans they would include relevant sections of the Board Assurance Framework (BAF) and, in the case of the Quality Committee, locality and department level assurance presentations and reports. SP stated it was the organisation's intention going forward that risk management assurance would be underpinned by a single risk report which captured all risks and tailored reports could be created if necessary. SP recommended that next steps would include the cessation of the production of the cyclical Executive Directors' assurance reports coming in to Audit Committee, which was a duplication of other reports, to be replaced by the production of a single risk report to include Committee assurance cover papers. SP acknowledged that there was still some work to do to ensure the Audit Committee received a comprehensive coverage of risk but progress was being made in the right direction. This work would include a review of the timing of Committees through the work programme to ensure sequencing and spacing was correct, etc. SP confirmed it was intended to introduce the new reporting process in September 2013. BS stated that these changes could provide an opportunity for further streamlining, discussions about which had been on-going for some months. He further stated that although this was about efficiency, it would also provide added assurance that there were no gaps, as duplication could sometimes hide the need for more focus in certain areas. PD stated the Trust was now seeing a new maturity in the workings of its Committees.	

		Action
	It had taken 6-9 months to develop the new approach to reporting in Quality Committee but such developments had meant that the streamlining meeting had been an easy and productive meeting with complete agreement from everyone present. MW stated her belief that the Trust had made massive progress but with the streamlined use of risk registers the organisation would need to ensure that it did not lose the focus that currently existed. SP replied that making sure there was ownership at departmental, executive and corporate level was very important going forward. BS thanked SP for his thorough update.	
6.2	**Feedback from CQC Visit** BS stated that the Trust had received an unannounced inspection visit from CQC the previous week and invited SP to provide the Committee with a verbal update. SP stated that the three-day unannounced inspection had involved a team of inspectors, with specialist support from an expert patient and pharmacist. They visited a number of stations, training facilities, A&E Departments across the region, as well as the EOC and NHS111 call centres at Wakefield. The inspection had involved extensive conversations with patients, carers, staff and managers and observations of practice and review of supporting documentation. The inspection process would not formally conclude for another week, as the inspectors were reviewing additional evidence collected from observations in the field and supplied by YAS. Although this meant that SP could not report a definitive outcome, he could share some of the initial feedback from the lead inspector in relation to the six outcomes which formed the focus of this visit: **Outcome 1 – Respecting and involving people who use services** • Positive feedback from talking to patients, YAS staff, other NHS staff and observation of practice. Excellent, caring approach to patients and Trust well engaged with service user representatives. • Some negative comments relating to waiting times for return PTS journeys and vehicle comfort. **Outcome 4 – Care and welfare of people who use services** • Inspectors found evidence that care delivered was good and staff appeared knowledgeable and informed, clear about their roles and how to access support if necessary. • The ECA role appeared well planned and implemented. • Processes for reporting of incidents appeared clear.	

		Action
	Outcome 7 – safeguarding people who use services from abuse • Very good policies and procedures in place and staff aware of how and when to use them. • Positive feedback about the specialist safeguarding team and Trust developments and communication with other agencies and wider networks. **Outcome 9 – Management of medicines** • Positive feedback on Trust policies and procedures for CD and other medicines management. • They recorded a number of observations from stations about variation in practice for checking and auditing of drug stocks. • Further information was requested and the standard would be subject to further review by the CQC pharmacist. • Low level of non-compliance might be forthcoming. **Outcome 14 – Supporting workers** • Staff feedback from EOC and 111 call centres was very positive, training was good and staff felt supported. • Feedback from road staff was more mixed, with issues about consistency of clinical supervision and quality of the PDR process highlighted by some staff. • Good evidence in relation to training and development • Some perceptions that feedback from corporate departments could be improved. • Positive feedback from staff of other NHS Trusts. • Overall positive although further information to be provided to CQC on progress in embedding the Clinical Supervisor supervision and PDRs. Outcome of standard as yet unknown. **Outcome 16 – Assessing and monitoring the quality of service provision** • Positive feedback on the evidence provided in support of this outcome. • Good evidence of auditing and monitoring. • Query about frequency of staff survey and the plan for development of monthly staff 'pulse survey' was discussed. The written report in draft form was due for receipt in a couple of weeks and the information should then feed into the wider TDA Quality Challenge process, as part of the Trust's FT application process. Overall, whilst there were a number of areas where further work was required, the provisional feedback looked to be a positive reflection of the quality of care that YAS provides for its patients. BS asked how much overlap there had been between the July and January visits.	

		Action
	SP replied that overlap to some extent was always expected as each visit would revisit areas of the previous inspection. Specific overlaps this time had been outcomes 4 and 14. It was SP's belief that this was an understandable risk based decision as there was a lot of work in progress in January. MW asked if there were any surprises. SP replied that the degree of variation around the auditing of medical stock since the last visit had been a surprise. CQC had received more information from the Executive Medical Director, Julian Mark and YAS's pharmacist so they might well have been able to address their concerns. PD stated that putting the patient at the forefront of its work meant that YAS took a very sensible approach to workforce issues and would have an even more effective workforce in the future to allow individuals for example to have career progression which was not currently available for all. She welcomed the robust challenge and was pleased with the outcome to date. SP reported that YAS had stepped up the rigour of its internal inspections, and peer reviews with other ambulance services were being carried out whenever possible. For example, the safeguarding team had recently been reviewed against agreed criteria by the national ambulance service quality group. In terms of reassurance to the Audit Committee, SP stated that there were possibly one or two standards that might be non–compliant at a low level but if that were the case, it was entirely manageable. BS stated that it was important to learn lessons and back track if necessary. EM stated that the Quality Committee had received a more detailed report and it was comforting to know that that YAS had responded to the CQC challenges. She felt positive about the inspection, which had clearly been more thorough and in depth than the previous visit. BS thanked SP for his update.	
7.0	**Finance and Investment Committee Risk Assurance Report** BS reported that unfortunately EB, the Chairman of F&IC, was sick that day and would be unable to provide her planned verbal update and PD would provide a verbal update instead. PD stated that key items included: • The Committee had worked through the F&I Workplan to ensure that there were no gaps; • There had been robust discussion around items including CIPs, 111 and PTS;	

		Action
	• It had been good to see the Chief Executive giving an oversight and reassurance regarding CIP delivery; • The overspend on PTS and the plans for improving its performance was one of the main concerns; • It had been reported that 111 might receive some additional funding but how much was still unclear. MW agreed that this was a fair summary of the meeting. BS stated that he had attended the meeting as an observer and it was his belief that the upon reading their papers, members of the Committee had initially felt extremely concerned but when they left the meeting, although they knew that there was still a lot of work to do, they had much more assurance about CIP delivery in particular. BS questioned whether F&I should wait a full 2 months before it received a further update, or should an earlier update be requested. RB provided an update: • Some risk to CIP delivery had been identified dependent on where activity lay, which in July was around 6-7% above plan; • The MI team were current working on the last 5 years of trends, which had been a Board action; • RB had held a useful meeting with Unison and the PTS management team to discuss how the Trust could bring the PTS CIP actions back on track. Unison had been supportive in their approach and several areas where the Trust thought it could advance CIP delivery had been identified; • A meeting had taken place with the lead commissioner to discuss 111 and it seemed unlikely that YAS would receive full income for Q1 from North and South Yorkshire due to the service not being fully rolled out. It looked as if around £1.1m of income would be at risk with c£600k secured. It was also likely that the commissioners would look favourably at the request for extra funding re WYUC; • The risk of c£1m loss of income was better than some of the risk scenarios previously presented to the Board but could still potentially reduce the planned surplus of £2.6m by £1m; • The risks around 111 were in-year risks rather than rolling on to year 2; • On a positive note, the lead commissioner gave assurance that, as the 111 contract was a commercial contract, it would not be subject to NHS efficiency gains over the life of the contract; • SP and Keeley Townend had identified some mitigating actions to be implemented from August; • A list of potential cost saving measures had been identified, which included: staffing; estate; and other support costs. SP stated that the main challenge was delivering within a service which was not yet fully achieving its KPIs.	

		Action
	The quality impact aspect was being looked at closely to ensure that that Trust was able to reduce costs with adversely impacting on the safety of patients. EM stated it was disappointing that the Trust would have to take this unfortunate hit, as 111 in Yorkshire and Humber seemed to be performing better than the other 111 services around the country. The effective management of 111 remained even more important. MW asked whether any of the WYUC income would go to LCD. RB replied that it would be divided between the Trust and LCD. SP stated that he had been liaising heavily with the commissioners in relation to support for the wider patient pathway such as dental care in the DoS, linking in to the national leads of the Urgent Care Review **Approval:** **The Audit Committee had adequate assurance regarding the management of financial risks.**	
8.0	**Charitable Funds Committee Risk Assurance Report** BS thanked EM for the short report which was a useful position statement for the Charitable Funds Committee, adding that it would be very helpful to receive a further progress report in relation to the compilation of the Committee's risk register at the October meeting. **Action:** **EM to provide update on progress re Charitable Funds Committee risk register at October Audit Committee meeting.** RB stated that he had received a query about the most appropriate directorate in which the Charitable Fund Committee's risk register should sit. It was agreed that the risk register did not belong to any specific directorate and should sit on its own. **Approval:** **The Audit Committee had adequate assurance regarding the management of risks relating to Charitable Funds.**	**EM**
9.0	**Quality Committee Risk Assurance Report** PD provided a verbal update on the Quality Committee risk management process. She stated that: • Papers had been received addressing all aspects of the Quality Committee ToR, based on the annual workplan; • The workplan was reviewed after each meeting to identify any new or increasing risks;	

		Action
	• All papers contained a briefing about specific risks to enable a view at levels below the BAF; • The regular locality assurance reports also contained an update on the local risk registers; • The risk management report contained updates on process and the general status of corporate and departmental risk registers. PD provided a summary of progress against the BAF risks, highlighting any on-going or new concerns. Items noted included: • Risk 2b – risk on-going relating to software, with short term mitigation in place; • Risk 2b – Report on baseline assessment and plans for roll out of JRCALC guidelines; • Risk 3a – Under-2s conveyance – update on audit and on-going work to ensure full compliance; • Risk 3b – CQC inspection outcome pending – some issues highlighted in initial feedback relating to drug stock checking practices, quality of PDR process and progress in implementing clinical leadership framework; • Risk 3b – HSE review of needle stick injury prevention, follow up and after care – notification of contravention relating to consistency of aftercare; • Risk 5a – Positive assurance on development of programme management and project support; • Risk 5a – Review of programme dashboard and key risks; • Risk 5a – Noted additional CIP challenge sessions led by CEO; • Risk 5b – Positive assurance on EOC incidents; • Risk 5b – Patient falls and staff musculo-skeletal injuries highlighted and actions discussed; • Risk 6a – Review of establishment and recruitment process considered; • Risk 6a – Positive progress noted in supporting information but further work still required to embed fully; • Risk 6b – Intensive activity on recruitment and training related to the workforce plan; • Risk 6b – PDR rate 64% at end of May – continued focus via management teams; • Risk 6b – Positive assurance re sickness rates; • Risk 6b – Positive developments in piloting of values based recruitment; • Risk 7a – No issues highlighted via Significant Events/Lessons Learned paper; • Risk 8a – Noted NHS 111 now fully live and call answer KPI hitting target. Other KPIs remain challenging – service optimisation programme and commissioner discussions on-going.	

		Action
	BS thanked PD for her thorough report and it was agreed that this should be the style for future reports, subject to 'streamlining' developments and decisions.	
10.0	**External Annual Planning Report and Update:** **The Annual Audit Letter** NC presented the final version of the Annual Audit Letter summarising the key matters arising from External Audit work. It was agreed that, in terms of the audit, the letter was self-explanatory and there were no questions. **Approval:** **The Audit Committee noted the report.**	
10.1	**Findings of the 111 Review** NC presented details of the review undertaken on the business case; approach to due diligence; and contractual arrangements that the Trust entered into in relation to the NHS 111 contract RB stated that the changing environment in which the Trust was operating was recognised when the NHS 111 tender was compiled, particularly as the specification was unlike anything the organisation had done before both in terms of scale and commerciality. The reason for requesting the work had been that the Trust knew as it progressed through the tender process that although it was doing a lot right, there must be lessons to be learned prior to entering into a similar situation in the future. BS asked whether the Trust had an in-house framework ready for next substantial exercise. RB confirmed that it did and suggested that the report's action plan should go to F&IC for consideration once it was formally adopted. **Action:** **RB to present 111 Review action plan at F&IC once report formally adopted.** BS asked what steps were required prior to the production of the final version of the report. SP replied that he needed to review and feedback on its recommendations and agreed to provide comments on the report in liaison with colleagues and report back to NC as soon as possible. **Action:** **SP to feedback to Deloitte re report's recommendations as soon as possible.**	**RB** **SP**

		Action
	SP stated that the work on the 111 tender had been intensive and had entailed very detailed Board discussion. The quality of minute taking had been variable at the time so several discussions that had taken place had not been fully captured. NC agreed several crucial items were missing from the minutes, so it was difficult to capture the full audit trail of how decisions were taken. SP stated that the minutes of Board and Committee meetings were now very thorough so discussions, options considered and explicit reasons for decisions were captured. MW agreed that the Board was now much better documented than when she first joined but timescale pressures, etc often meant that things were done outside of formal Board meetings and it was this information that still needed to be captured. SP stated that a key development would be the recruitment of a Commercial Director. EM stated that another area of improvement was that some elements of due diligence which were now in place had not been in place then. **Approval:** **The Audit Committee noted the review.**	
10.2	**Updated Quality Accounts Report** BS stated that the Audit Committee had seen the draft Quality Accounts report at its June meeting when Andy Lane had talked the Committee through it in great depth, adding that the Trust knew in terms of content that there were things that would need to be added in the 2013/14 Report. He invited comments from the Committee. SP stated that his comments were included in the report. The issue around incident reporting related to YAS's use of the Prism system which was not fit for purpose as it did not allow details to be changed, including the grading of incidents, following production of the initial report. There were therefore often discrepancies because information was held in different places. Datix, the new system for incident reporting, had much better functionality and the administrative staff were aware of the need to make changes. In addition, the National Reporting and Learning System (NRLS) updates could now be done electronically with automatic uploading of incidents to occur from August 2013. BS asked whether it was intended to ask Deloitte to carry out a follow up piece of work later in the year. SP replied that he would welcome this and would discuss further with Deloitte.	

		Action
	Action: **SP to discuss scope of follow up piece of work with Deloitte and report back at next meeting.** EM noted that page 12 should say 2013/14 and not 2012/13. BS stated his opinion that the "dry run" exercise had delivered a high level of assurance; pointed out things the Trust knew it would need to include in the next set of Quality Accounts; and had given some additional assurance and focus on improvements that were required to ensure that the Trust could fully comply in relation to patient safety, etc in the 2013/14 Quality Account. PD stated that the Quality Committee should be able to give added assurance. She acknowledged that Datix had been introduced but added that the Serious Incident report was also considered by the NEDs at every meeting of the Quality Committee with timings, exceptions, etc being challenged. SP stated that the audit did not highlight any shortcomings in YAS's management of incidents; their comments all related to systems and how information was fed into the NRLS. BS thanked NC for her helpful update. **Approval:** **The Audit Committee noted the report.**	**SP**
10.3	**Review Effectiveness of External Audit** RB stated that he would schedule the Annual Audit "wash up" session to cover off a number of issues ahead of the next Audit Committee meeting He stated that technical capability in the EA team and the way in which IA and EA worked together to avoid duplication would be covered in the meeting and reported back at the October Audit Committee meeting. **Action:** **RB to report back on Annual Audit "wash up" meeting at October meeting.**	**RB**
11.0	**Internal Audit and Counter Fraud Plan 2013/14** BS stated that the NEDs had met with BJ, SF and RB on 10 July against a backdrop of discussion and actions to take a fresh look at the Trust's approach to IA. The draft IA plan, which had been considered by TEG and the Audit Committee, had subsequently been reconsidered.	

		Action
	BS stated that the meeting had provided a useful deep dive and insight into: ▪ the process by which all the elements that needed auditing had been analysed and considered; ▪ counter fraud and the increasing liaison between IA and counter fraud; and ▪ Audit Committee requirements in relation to sight of the plan, progress against it, individual audit briefs before work was agreed and a view on how the Committee wanted to receive reports on IA progress. He invited comments from the other NEDs. PD stated that she now had a much more comprehensive feel about IA and how it fitted into the bigger picture. EM stated that she had found the meeting very useful and the change of approach to the methodology used behind it was a comfort to her. MW stated that the feedback gave her much more confidence that the organisation was considering the highest priority items. BS stated that, although the Audit Committee respected the scrutiny that TEG had already applied to the plan, it was his belief that the Committee through RB should ask the Executive Directors to look again at the time allocations specifically in relation to EOC and A&E, which continued to look on the light side and days might need to be shifted into those areas. BS recognised the fact that there was a certain amount of catch up in the 2013/14 plan but noted that the number of days in the plan would need to be regularly reviewed in relation to what work potentially needed to be done versus what was affordable. BJ confirmed that, whilst a number of areas were listed under operations, other pieces of work would also cut across into operational areas. **Action:** **RB/TEG to reconsider the IA Plan in relation to the re-allocation of days**. PD stated that the Clinical Leadership Framework was a key issue in terms of quality going forward. The Trust was still actively recruiting so a discreet specified piece of work which looked at what had been achieved and how it had been delivered might be a something that TEG needed to look at.	**RB**

		Action
	Action: **SP/TEG to consider a specific piece of IA work around the implementation of the Clinical Leadership Framework.** BS stated that the NEDs and he needed to pool their requirements in relation to information and reporting requirements from IA ahead of the new style of IA reporting to the Audit Committee going live for the next Audit Committee meeting. In the current audit year he would also like to see IA assurance in relation to all of the BAF risks, the controls identified and the completeness of action gaps. It was agreed that BS would speak to BJ outside of the meeting in relation to the above. **Action:** **BS to liaise with BJ re IA assurance in relation to BAF risks, etc.** BJ stated that there were currently a lot of other elements such as the CQC work in the area of medicine management that cut into and overlapped with the IA and EA work. BS requested that further details be included on pages 29 and 30 of the IA and CF plans report to demonstrate the completeness of the inter-link between BAF content and the IA plan. BJ replied that the IA process had expanded and they were trying to ensure that the plan was proportionate but it was a moving target and it was essential that a pragmatic approach was taken. Changes would be reflected in the progress reports at Audit Committee and TEG meetings. BS stated his belief that this was a good basis on which the organisation could move forward. **Approval:** **The Audit Committee noted the Internal Audit and Counter Fraud Plans for 2013/14 and the necessity for on-going review of these documents.**	**SP** **BS/BJ**
11.1	**Internal Audit Progress Report** BJ stated that seven audit reports had been included the report and provided a progress update of the work undertaken against internal Audit plans. All of the work in the 2012/13 Plan was now complete and the Report Summaries and Action Plans from the remaining seven reports were presented as part of that day's update. BJ confirmed that two reviews from the 2013/14 Plan were complete: • Quality Accounts, which did not require the production of a separate report, as the results were used in support of the	

		Action
	external audit quality accounts review; • ECS Continuous testing, which had been issued in draft and a final report would be presented to the next Audit Committee. She further stated that an additional eight pieces of work were in progress and would be reported to the Audit Committee in due course. These were: • Corporate Governance Compliance • Governance Structures - Assurance Mapping • Recruitment - Recruitment Checks, Interview Process, Induction, etc • Non-Pay Expenditure • Procurement - Tendering & Quotations • Fleet - Vehicle Workshops Repair & Maintenance • ACQIs - Monitoring & Achievement (incl. response times) • PTS - Logistics / Contract & Performance Management / Income & Cost Monitoring Audit Committee BJ stated that the outstanding 2012/13 reviews now completed were: • Clinical Record Management • Management of Contracts & SLAs • Year-End Assurance • Performance Management • Accounts Payable • Asset Register • Medical Device Management **Clinical Record Management** BJ stated that, based on the work undertaken, significant assurance could be provided that adequate arrangements had been established. However, several areas had been identified where arrangements could be further improved, details of which were included in the Progress Report. A discussion took place about the fact that the Clinical Record Management report had been around in draft for some considerable time. **Action:** **BJ to review management of deadlines given for comment on draft IA reports.** BJ stated that IA had been aware of the work pressures that YAS staff were under and had therefore, at times, been too generous with the deadlines provided for feedback. It was agreed that a streamlined process was required to enable IA reports to pass through the system in a timely way.	**BJ**

		Action
	BS asked what the Executive Management team could do to achieve a faster turnaround of reports. RB replied that general action would be taken to improve the processes and he would pursue the matter with TEG and SMG colleagues. **Action:** **RB to discuss processes for improving timeliness of responses to IA draft reports with TEG and SMG colleagues.** PD stated that patient facing issues should be considered at Clinical Governance Group level with comments to be provided by the Medical Director. She further stated that it would be a professional accountability issue if timely and accurate information was not provided. MW stressed that ownership of the work needed to be clarified as part of its scope, so it would be clear who would sign off the report. It was agreed that BJ should update the commentary, as a further piece of follow up work was due to commence shortly. **Action:** **BJ to update Clinical Record Management report commentary.** **Management of Contracts and SLAs** BJ stated that the audit had been able to provide significant assurance that the process in place was effective. The relatively minor issues identified had been discussed with management and remedial action agreed, details of which were included in the Progress Report. BS stated his opinion that this was a straightforward report with only minor issues such as contracts being signed but not dated, a discussion about which had recently taken place. EM stated that, in the private sector, it would be unacceptable to have a contract without a date of signature. Due diligence should mean that this type of error should be picked up on automatically. RB replied that improvements to the system would mean that contracts without a date would now be bounced back. SP stated that, in relation to the Information Governance actions, changes to the external environment had created some difficulty with flows of contractual information containing patient identifiable information. However, following lengthy discussions with a number of different bodies, he was now reasonably confident that the Trust was compliant in this complicated area.	**RB** **BJ**

		Action
	Year-End Assurance BJ stated that significant assurance could be provided as a result of the IA review that the Board Assurance Framework (BAF) met the overall requirements of the Department of Health, etc. SP confirmed that the BAF was constantly being reviewed/improved as part of its on-going development. He further stated that recommendation one which referred to the duplication of risks in the BAF and the Corporate Risk Register was being actioned as part of the introduction of the Datix system. There would shortly be no need for separate departmental risk registers, as all organisational risks would be included in a single risk register. **Performance Management** BJ confirmed that significant assurance could be provided that adequate performance management arrangements were now in place. However, improvements were still needed to the mapping of information and inclusion of unnecessary details in some areas of the Trust's Integrated Performance Report (IPR). BS confirmed that assurance regarding the process for the production of IPRs was an outstanding action at Trust Board and expressed concern that nothing in the report appeared specifically to provide reassurance, confirming earlier verbal assurances. BJ replied that it had been agreed that the work was not solely a review of the IPR although this would form part of the overall review. There had been a demonstration of how the data contained in the IPR was created and processed and the mapping of the information in the IPR to individual processes was commented on. RB reported that the process of producing the IPR was still subject to on-going change and improvement. MW stated that there appeared to be a process change control question, which was a slightly wider issue than that of the IPR and she did not believe that the piece of work provided that level of assurance. BS requested that both executive management and IA provide further assurance regarding the robustness of the IPR production process to the next AC meeting. **Action:** **RB/BJ to provide assurance regarding the reliability of the IPR production process at October meeting.**	**RB/BJ**

		Action
	Accounts Payable BJ stated that this audit was able to provide limited assurance that the control and processes in place were effective. All issues raised had been discussed with relevant personnel and agreement reached to implement the recommendations was documented in the report. BS stated it was not acceptable to have unapproved standing data sitting on the accounts payable ledger and asked whether the Trust needed to carry out a retrospective review to ensure that there was nothing inappropriate on the ledger. It was agreed that RB would investigate this matter. **Action:** **RB to investigate the possible issue of unapproved standing data sitting on the accounts payable ledger and to report back at the next meeting.** BJ stated her belief that YAS's staff needed an awareness of counter fraud basics, including fraud risks associated with accounts payable such as the possibility of inappropriate charges being made by suppliers, etc, adding that there could be a potential overlap with the National Fraud Initiative work. BS asked whether it would be possible accelerate the September 2013 follow up work. It was agreed that BJ would discuss the possibility of this with RB and report back to the next meeting. **Action:** **BJ to discuss with RB and report back on possibility of bringing forward Accounts Payable follow up work at October meeting.** **Asset Register** BJ stated that, following the review of the YAS Asset Register, limited assurance could be provided that adequate and effective procedures were in place. Several action points, details of which could be found in the report, were identified to support and strengthen the arrangements currently in place. BS requested details of the backdrop to this piece of work. RB stated that it had taken place because the last audit had also flagged issues. However, new procedures, etc were currently being developed and the audit had been carried out half way through this process. EM stated that, although she had concerns about the Estates Strategy, she took comfort from the work that was currently in hand and looked forward to an update in due course.	**RB** **BJ**

		Action
	Medical Device Management BJ stated that, based on the IA work undertaken, limited assurance could be provided that adequate procedures and controls were in place, although it was noted that progress had been made in improving control since the previous audit of this area. BS expressed his concern as this was a patient-facing area. It was extremely worrying that around 1200 medical devices could not be found, especially as there was no hint as to how existing systems would be improved to prevent things going missing in the future. PD stated that that this was also an area of concern to her, as devices outside their 28-day window for servicing would not be as reliable as they should be. RB stated that the team was currently in a fire-fighting position and was likely to remain so until all the current vacancies had been filled. He further stated that lessons learned were being factored in for going forward. For example, there were a large number of incidents of equipment moving between vehicles of which both Fleet and locality directors needed to keep an accurate record. PD queried how this was able to happen, as checks of vehicles were undertaken, adding that RB was correct to push the issue back to the locality directors. MW requested information about the total value of the missing devices. SP replied that the Trust had gone through a complicated process of cross-checking various records and a total value should shortly be available. He further stated that a lot of the “missing” equipment was actually equipment that had been disposed of that had not been recorded on the system. A new system had been introduced with additional checks so he had more confidence going forward that this would no longer happen. RB confirmed that the vast majority of the 1200 pieces of kit had been replaced and needed either archiving or disposing of. A physical check of vehicles now took place every six weeks so that the Trust knew exactly where all its equipment was. It was agreed that the follow up piece of work scheduled for September should be accelerated so that a progress report could be provided at the October meeting.	

		Action
	It was further agreed that a progress assurance report which showed that the key issues had been addressed and processes improved to prevent a recurrence of the problem should be provided by locality directors for the consideration at the October meeting. **Actions:** **Follow up work scheduled for September to be accelerated and a progress report provided at October meeting.** **A progress assurance report showing key issues had been addressed and processes improved to prevent recurrence of the problem should be provided by locality directors for consideration at October meeting.** BS stated his belief that the Summary Status Report of all Follow-Up work at the end of the Internal Audit Progress Report needed further development to make it an easily accessible and readable summary of all completed work. BJ stated that the table presented fresh results rather than historic results, adding that IA was still waiting for some information. **Action:** **BJ to liaise with RB/BS re format and contents of Summary Status Report of all Follow-Up work.** **Approval:** **The Audit Committee accepted the results of Internal Audit and Counter Fraud activity and follow up activity since the previous meeting.**	**BJ** **RB** **BJ**
11.2	**Counter Fraud Progress Report** BS asked whether, as SF had provided a verbal update at the IA NED workshop the previous week, the Committee was happy to accept the report. PD stated that if ambulance services were going to move to a single uniform and a more general ambulance logo, it would be more difficult to find the source of any member of staff who tried to sell uniform on line and asked whether it would be appropriate for the Executive Directors to give this further thought. **Action:** **RB to raise the potential issue of tracing members of staff trying to see uniform on line if ambulance services moved to a single uniform with TEG colleagues to report back at next meeting.** **Approval:** **The Audit Committee accepted the results of Counter Fraud activity since the previous meeting; noted the status of the 2013/14 plan; and noted current regional and national counter fraud developments.**	**RB**

		Action
11.3	**Review Effectiveness of Internal Audit** BS stated that the paper submitted by BJ had been a useful summary paper. BJ reiterated her suggestion that the Trust's management redouble their efforts to respond to all agreed audit recommendations in a timely manner. BS thanked BJ for a thorough report which overlaid previous discussions and views expressed by the NEDs in relation to the effectiveness and coverage of IA both now and in the future. It was a source of significant assurance to the Audit Committee. **Approval:** **The Audit Committee considered and accepted the sources of assurance to underpin their assessment of the performance and effectiveness of internal audit and would continue to receive, as appropriate, performance and effectiveness updates as part of internal audit progress reporting throughout the year.**	
12.0	**Compliance with Audit Recommendations** RB provided an internal monitoring update on the status of outstanding Audit and Counter Fraud recommendations. BS stated that, in terms of another aspect of streamlining, some closer integration of IA and YAS reporting of progress regarding compliance with audit recommendations would be helpful. RB confirmed that BJ and he had agreed a new system of monitoring and reporting going forward. PD stated that many IA recommendations were on-going and asked why there were so many gaps in the 'date started' box. As a result of this it would be impossible to know how reasonable an exception or delay was. **Action:** **RB to review clarity of form to see what can be done to improve it with sign off delays to be reported by exception.** MW stated that some of the text did not seem to support the fact that actions were complete and asked who signed them off as completed. RB replied that it would usually be the lead Director PD agreed with MW that there needed to be a stated conclusion by the lead director. **Action:** **RB to discuss improvements to clarity of sign off statements with TEG colleagues to report back to next meeting.**	**RB** **RB**

		Action
	AA confirmed that this would follow the same process as that followed by the Board of Directors. **Approval:** **The Audit Committee noted and accepted the report.**	
13.0	**Review Annual Audit Committee Report** BS presented the draft Annual Audit Committee Report, which had historically been produced in December/January but which he had, as promised, brought forward in line with other Annual Reports. BS invited comments on the draft report. There were no comments so BS would amend the formatting and numbering problems prior to the report going forward to the September Board meeting. **Action:** **BS to amend formatting and numbering issues in draft report to go forward to September Board meeting.** **Approval:** **The Audit Committee approved the report.**	**BS**
14.0	**<u>Standing Financial Instructions & Standing Orders</u>** **SFI Waivers and Contract Award Activity over £100,000** RB confirmed that there was only one contract and no single tender waivers to report. The Committee noted the details of the contract. **Approval:** **The Audit Committee accepted the report.**	
14.1	**Review of Suspension of Standing Orders** AA confirmed that there had been no suspension of Standing Orders since the last Audit Committee meeting.	
14.2	**Review of Standing Finance Instructions and Standing Orders** RB provided an update on changes to Standing Orders (SOs), the Scheme of Delegation and the Standing Financial Instructions (SFIs). BS stated that he had noticed that in reviewing the changes there was still inconsistency between the SO decisions and duties and the Audit Committee Terms of Reference (ToR) that had been authorised and accepted in January 2013. He asked RB to recheck the entries to ensure full consistency between the SOs and the Committees' ToRs.	

		Action
	Action: **RB to check the revised SOs against the F&I, Quality and Audit Committees' ToRs for consistency.** **Approval:** **The Audit Committee postponed its acceptance of the revised Standing Orders and Standing Financial Instructions pending further checks.**	**RB**
15.0	**Losses and Special Payments** RB presented a paper for approval by the Audit Committee of the Losses and Special Payments made for the first quarter of 2013/14. EM asked whether the amount of negligence claims was typical. SP replied that this information was covered in the Claims Report at Quality Committee. He further stated that the increase was mainly due to muscular skeletal injuries and "blue bag" issues. PD asked what the "other" listed in 4b under losses covered. SP replied it was contaminated fuel once it reached a certain age. RB stated that, as the report followed a prescribed national format, there was no room for local variations. MW stated that comparison data from previous periods of time would be useful to show how well the Trust was doing. **Approval:** **The Audit Committee approved the Schedule of Losses and Special Payments for Quarter 1 2013/14.**	
16.0	**Raising Concerns at Work Update** BS stated that the Audit Committee had a duty to periodically review and appraise the YAS 'whistleblowing' procedures and also to consider at each meeting whether any 'concerns at work' notifications had been received since the last meeting. It had been confirmed to BAS that morning by the Interim Executive Director of Workforce & Strategy that none had been received via any of the approved means. SP stated that from time to time CQC received anonymous concerns from YAS staff which they would then raise with the Trust and request feedback. He confirmed that a process was in place for responding to feedback requests when they were received.	
17.0	**Review of Members' Expenses** BS stated that a process was in place whereby processed expenses within the system were reconciled to the approved expense claims with the end result being assurance that the expenses were correct.	

		Action
	MW stated that she did not think that her expenses were correct as she thought that there should be something in them which related to conferences and training. PD replied that training, etc seemed to come under a group expense which was passed on to the Chairman. RB stated that where YAS paid for a course directly this would not be on the expense records as it was not expense for which individual Directors were reimbursed. **Action:** **RB to re-circulate 2012 expenses paper for information.** **Approval:** **The Audit Committee noted and accepted the report.**	**RB**
17.1	**Review of Register of Members' Interests** BS stated it had been agreed that, on a quarterly basis, all NEDs and Executive Directors would email AA to confirm that there were no changes to their interests or to make amendments to the system. AA stated that the register presented that day, which was up-to-date as of 8 July 2013, contained a couple of changes and apologised that the report stated financial year 2012/13 rather than 2013/14. The changes were: • Deputy Chairman had taken off the entries relating to her being a governor of two schools; • Page 8, Interim Executive Director of Workforce and Strategy, Nick Cook had been added. The Directors who had left the organisation would remain on the register for the remainder of the financial year and AA would update the register to include the dates of their resignation. AA further stated that new Interim Director of Operations, Michael Fox-Davies, would be added to the next iteration of the report. **Approval:** **The Audit Committee accepted the record, at Appendix A, as a true representation of the interests declared up to 8 July 2013.**	
18.0	**Review of Meeting Actions and Quality Review of Papers** BS apologised for the late meeting papers, explaining that the it had been due to the proximity of meetings and the general heavy on-going workload within the Trust. There were no further comments.	

		Action
	BS thanked everyone for their attendance and their contributions in the lead up to and during the course of the meeting. He asked the NEDs to stay behind for a private discussion relating to special payments. The meeting closed at 1240 hours.	
19.0	**Date and Time of Next Meeting** Thursday 17 October, 1000–1300 hours, Kirkstall & Fountains, Springhill 2, Wakefield, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**