

**North East Lincolnshire CCG**

Attachment 05

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| **Report to:** | NEL CCG Governing Body |
| **Presented by:** | Cathy Kennedy |
| **Date of Meeting:** | 13 March 2014 |
| **Subject:** | Integrated Governance and Audit Annual Report |
| **Status:** | [x]  OPEN [ ]  CLOSED |
| **Agenda Section:** | [ ]  STRATEGY [ ]  COMMISSIONING [ ] OPERATIONAL ISSUES |

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| **OBJECT OF REPORT** |  |
| The CCG Constitution requires that an annual report is produced by the Integrated Governance and Assurance committee for consideration by the Governing Body. Previous discussions of such annual reports have highlighted that they should include outcome measures of the effectiveness of the committee, which are included in the enclosed report. These outcomes require the committee to consider and report on its work up to the calendar year end.The CCG became a statutory body at 1st April 2013 and therefore the committee has only been in place, undertaking its full role, since that point in time. It was previously operating in shadow form but with limited responsibilities as there was a formal audit committee operating separately as part of the Cluster Board arrangements.Therefore the attached report relates to the activities of the committee from 1st April 2013 to December 2013. The draft format comprises three sections:Compliance with best practice checklist (Appendix A)Outcome based effectiveness measures (Appendix B) Delivery of Terms of Reference (Appendix C) The enclosed report demonstrates a positive picture of the work of the committee so far, in all three areas. The report is brought to members to inform their view of the effective governance arrangements of the organisation, and specifically to assist members in ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance  |

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| **STRATEGY** |  |
| The effectiveness of the committee is a key feature of the organisation assurance framework, which underpins the delivery of the strategic priorities of the organisation. |

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| **IMPLICATIONS** |  |
| None identified |

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| **RECOMMENDATIONS** Members are recommended toconsider whether the report provides adequate assurance that that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance  |
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|  |  | **Yes/No** | **Comments** |
| --- | --- | --- | --- |
|  | Does the document take account of and meet the requirements of the following: |  |  |
| i) | Mental Capacity Act |  |  |
| ii) | CCG Equality Impact Assessment |  |  |
| iii) | Human Rights Act 1998 |  |  |
| iv) | Health and Safety at Work Act 1974 |  |  |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 |  |  |
| iv) | Does the report have regard of the principles and values of the NHS Constitution?[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613) |  |  |

**APPENDIX A**

**AUDIT COMMITTEE HANDBOOK SELF-ASSESSMENT CHECKLIST**

# Status key

1 = must do 2 = should do 3 = could do

| STATUS | **ISSUE** | **YES** | **NO** | **N/A** | **COMMENTS/ACTION** |
| --- | --- | --- | --- | --- | --- |
| COMPOSITION, ESTABLISHMENT AND DUTIES |
| **1** | Does the Audit Committee have written terms of reference that adequately define the Committee’s role in accordance with Department of Health guidance? | √ |  |  |  |
| **1** | Have the terms of reference been adopted by the Board? | √ |  |  |  |
| **1** | Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation? | √ |  |  |  |
| **1** | Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently? | √ |  |  |  |
| **2** | Are changes to the Committee’s current and future workload discussed and approved at Board level? | √ |  |  | Through the annual reporting process |
| **1** | Are Committee members independent of the management team? | √ |  |  |  |
| **1** | Does the Committee report regularly to the Board? | √ |  |  | Minutes and annual report |
| **1** | Has the Chair of the Committee a prior understanding, or received training, on finance and internal control or other relevant expertise? | √ |  |  |  |
| **1** | Are new members provided with appropriate induction? | √ |  |  | Briefing from CFO and/or auditors |
| **1** | Does the Board ensure that members have sufficient knowledge of the organisation’s business to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters? | √ |  |  |  |
| **1** | Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board? | √ |  |  |  |
| **1** | Does the Committee assess its own effectiveness periodically? | √ |  |  | As part of the annual reporting process  |
| MEETINGS |
| **1** | Has the Committee established a plan of matters to be dealt with across the year? | √ |  |  |  |
| **1** | Does the Committee meet sufficiently frequently to deal with planned matters and is enough time allowed for questions and discussion? | √ |  |  |  |
| **1** | Does the Committee’s calendar meet the Board’s requirements and financial and governance calendar? | √ |  |  |  |
| **2** | Are Committee papers distributed in sufficient time for members to give them due consideration? | √ |  |  |  |
| **2** | Are Committee meetings scheduled prior to important decisions being made? | √ |  |  |  |
| **2** | Is the timing of Committee meetings discussed with all the parties involved? | √ |  |  |  |
| ***COMPLIANCE WITH THE LAW AND REGULATIONS GOVERNING THE NHS*** |
| **1** | Does the Committee review assurance and regulatory compliance reporting processes? | √ |  |  |  |
| **3** | Has the Committee formally assessed whether there is a need for the support of a ‘Trust Secretary’ role or its equivalent? |  | √ |  | The board considered this when approving the management structures and organisation constitution |
| **2** | Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues? | √ |  |  |  |
| INTERNAL CONTROL AND RISK MANAGEMENT |
| **1** | Has the Committee formally considered how it integrates with other committees that are reviewing risk – for example, risk management and clinical governance? | √ |  |  | Outcome of consideration is reflected within Terms of Reference |
| **1** | Has the Committee formally considered how its work integrates with wider performance management and standards compliance? | √ |  |  |  |
| **1** | Has the Committee reviewed the robustness and effectiveness of the content of the organisation’s Assurance Framework? | √ |  |  |  |
| **1** | Has the Committee reviewed the robustness and content of the draft Annual Governance Statement on Internal Control before it is presented to the Board? | √ |  |  |  |
| **2** | Has the Committee reviewed whether the reports it receives are timely and have the right format and content to enable it to discharge its internal control and risk management responsibilities? | √ |  |  |  |
| **1** | Has the Committee reviewed the robustness of the data behind reports and assurances received by itself and the Board? | √ |  |  |  |
| **1** | Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation’s responsibilities? | √ |  |  |  |
| **1** | Is the Committee’s role in reviewing and recommending to the Board the annual report and accounts clearly defined? | √ |  |  |  |
| **1** | Does the Committee consider the External Auditor’s report to those charged with governance including proposed adjustments to the accounts? | √ |  |  |  |
| **1** | Does the Committee review management’s letter of representation? | √ |  |  |  |
| **1** | Is there clarity over the timing and content of the assurance statements received by the Committee from the Head of Internal Audit? | √ |  |  |  |
| ***INTERNAL AUDIT*** |
| **1** | Is there a formal ‘charter’ or terms of reference, defining internal audit’s objectives, responsibilities and reporting lines? | √ |  |  | Service Level Agreement and annual audit plan |
| **1** | Are the terms of reference approved by the Committee and regularly reviewed? | √ |  |  |  |
| **2** | Are the key principles of the terms of reference set out in the Constitution? | √ |  |  |  |
| **1** | Does the Committee review and approve the internal audit plan at the beginning of the financial year? | √ |  |  |  |
| **1** | Does the Committee approve any material changes to the plan? | √ |  |  |  |
| **2** | Are audit plans derived from clear processes based on risk assessment with clear links to the Assurance Framework? | √ |  |  |  |
| **1** | Does the Audit Committee receive periodic reports from the Head of Internal Audit? | √ |  |  |  |
| **1** | Do these reports inform the Audit Committee about progress or delays in completing the audit plan?  | √ |  |  |  |
| **3** | Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation? | √ |  |  |  |
| **2** | Does the Committee effectively monitor the implementation of management actions arising from audit reports? | √ |  |  |  |
| **1** | Does the Head of Internal Audit have a direct line of reporting to the Committee and its Chair? | √ |  |  |  |
| **2** | Is internal audit free of any scope restrictions and, if not, what are they and who establishes them? | √ |  |  |  |
| **2** | Is internal audit free from any operating responsibilities or conflicts of interest that could impair its objectivity? | √ |  |  |  |
| **2** | Has the Committee determined the appropriate level of detail it wishes to receive from internal audit? | √ |  |  |  |
| **1** | Does the Committee hold periodic private discussions with the Head of Internal Audit? | √ |  |  | Chair holds private discussions prior to each meeting |
| **2** | Does the Committee review the effectiveness of internal audit and the adequacy of staffing and resources within internal audit? | √ |  |  | Through the annual internal audit report  |
| **2** | Has the Committee evaluated whether internal audit complies with the *NHS Internal Audit Standards* ? | √ |  |  | As above |
| **3** | Has the Committee agreed a range of internal audit performance measures to be reported on a routine basis? | √ |  |  |  |
| **1** | Does the Committee receive and review the Head of Internal Audit’s annual report and opinion?  | √ |  |  |  |
| **2** | Is there appropriate cooperation with the external auditors? | √ |  |  |  |
| **2** | Are there any quality assurance procedures to confirm whether the work of the internal auditors is properly planned, completed, supervised and reviewed? | √ |  |  |  |
| ***EXTERNAL AUDIT*** |
| **1** | Do the external auditors present their audit plans and strategy to the Committee for approval? | √ |  |  |  |
| **2** | Has the Committee satisfied itself that work not relating to the financial statements is adequate and appropriate? |  |  | √ | Cluster committee responsibility for 2012/13 accounts |
| **2** | Does the Committee receive and monitor actions taken in respect of prior years’ reviews? | √ |  |  |  |
| **1** | Does the Committee review the External Auditor's annual audit letter? | √ |  |  |  |
| **1** | Does the Committee review the external auditors’ Use of Resources conclusion? | √ |  |  |  |
| **1** | Does the Committee hold periodic private discussions with the external auditors? | √ |  |  | Chair holds private discussions prior to each meeting |
| **2** | Does the Committee assess the performance of external audit? | √ |  |  |  |
| **3** | Does the Committee require assurance from external audit about the policies for ensuring independence and compliance with staff rotation requirements? |  |  | √ |  |
| **3** | Does the Committee review the nature and value of non-audit work carried out by the external auditors? | √ |  |  | In considering the annual audit plan |
| ***CLINICAL AUDIT*** |
| **1** | Is the Committee clear about where clinical audit assurances are received and monitored? | √ |  |  | Clinical Quality subcommittee |
| **2** | If it is the Audit Committee that receives and monitors clinical audit assurances does it:-Review the clinical audit plan at the beginning of each year?-Confirm that clinical audit plans are derived from clear processes based on risk assessment with clear links to the Assurance Framework?-Receive periodic reports from the person responsible for clinical audit?-Effectively monitor the implementation of management actions arising from clinical audit reports?-Ensure that the person responsible for clinical audit has a direct line of access to the Committee and its Chair?-Hold periodic private discussions with the person responsible for clinical audit?-Review the effectiveness of clinical audit and the adequacy of staffing and resources available for clinical audit?-Evaluate clinical audit against the Healthcare Quality Improvement Partnership’s publication *Clinical Audit: A Simple guide for NHS Boards?*-Confirm that there are quality assurance procedures in place to confirm whether the work of clinical auditors is properly planned, completed, supervised and reviewed?-Confirm that there are terms of reference for clinical audit that define its objectives, responsibilities and reporting lines?-Review clinical audit’s terms of reference regularly? |  |  | √ |  |
| ***COUNTER FRAUD*** |
| **1** | Does the Committee review and approve the counter fraud work plan at the beginning of the financial year? | √ |  |  |  |
| **1** | Does the Committee satisfy itself that the work plan adequately covers each of the seven generic areas defined in NHS counter fraud policy? | √ |  |  |  |
| **1** | Does the Committee approve any material changes to the plan? | √ |  |  |  |
| **2** | Are counter fraud plans derived from clear processes based on risk assessment? | √ |  |  |  |
| **1** | Does the Audit Committee receive periodic reports from the Local Counter Fraud Specialist? | √ |  |  |  |
| **2** | Does the Committee effectively monitor the implementation of management actions arising from counter fraud reports? | √ |  |  |  |
| **1** | Does the Local Counter Fraud Specialist have a right of direct access to the Committee and its Chair? | √ |  |  |  |
| **1** | Does the Committee review the effectiveness of the local counter fraud service and the adequacy of its staffing and resources? | √ |  |  |  |
| **1** | Does the Committee receive and review the Local Counter Fraud Specialist’s annual report of counter fraud activity and any external assessment?  | √ |  |  |  |
| **1** | Does the Committee receive and discuss reports arising from quality inspections by NHS Protect? |  |  | √ |  |
| ***ANNUAL ACCOUNTS AND DISCLOSURE STATEMENTS*** |
| **1** | Is the Committee's role in the approval of the annual accounts clearly defined? | √ |  |  |  |
| **2** | Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit? | √ |  |  |  |
| **1** | Does the Committee specifically review:* Changes in accounting policies?
* Changes in accounting practice due to changes in accounting standards?
* Changes in estimation techniques?
* Significant judgements made?
 | √ |  |  |  |
| **3** | Does the Committee review the draft accounts before the start of the audit? | √ |  |  |  |
| **1** | Does the Committee ensure it receives explanations as to the reasons for any unadjusted errors in the accounts found by the external auditors? | √ |  |  |  |
| **1** | Does the Committee receive and review a draft of the organisation’s Annual Governance Statement? | √ |  |  |  |
| **2** | Does the Committee receive and review the evidence required to demonstrate fitness to register with the Care Quality Commission?  |  |  | √ |  |
| **2** | Does the Committee receive and review a draft of the organisation’s annual report? | √ |  |  |  |
| ***OTHER ISSUES*** |
| **3** | Has the Committee considered the costs that it incurs: and are the costs appropriate to the perceived risks and the benefits? | √ |  |  | In annual report process |
| **2** | Has the Committee reviewed its performance in the year for consistency with its:* Terms of reference?
* Programme for the year?
 | √ |  |  | As above |
| **3** | Does the annual report and accounts of the CCG include a description of the Committee's establishment and activities? |  |  | √ | Not due until summer 2014 |

**APPENDIX B**

**OUTCOME BASED EFFECTIVENESS MEASURES**

The following effectiveness measures have been assessed for the year ending December 2013:-

**Internal Control**

o Head of Internal audit statement gives positive assurance.

*Achieved for 2012/13*

o 100% of internal and external audit reports and recommendations are reviewed by the committee, with follow up to ensure timely and effective resolution.

*Achieved. Reporting of progress against recommendations is undertaken at each meeting.*

o 95% of audit report action plans are implemented by the due date.

*Data not yet available for a full year, but reporting shows good performance to date*

o Weak/limited assurance reports are followed up within 6 months and achieve improved assurance rating.

*As above*

o 100% of Financial Policy waivers and hospitality/sponsorship register entries are considered.

*Achieved for financial policy waivers. Hospitality/sponsorship register requires further work during the year.*

o Governance and Quality representatives attend each meeting to ensure significant issues are brought to the committees attention.

*Achieved*

o Audit Chair meets independently with auditors at least 4 times a year and ensures all matters raised are dealt with.

*Achieved- standing item at each meeting.*

o The committee will require attendance of relevant Directors to gain assurance on mitigation plans wherever significant (adverse) variances against annual budgets arise.

*N/A to date, but would be actioned ‘as and when’ required.*

**Internal and External Audit**

o Risk based IA plans are agreed prior to start of year, and fully delivered within 14 months.

*Achieved - as evidenced in internal audit annual report. Progress against plan is rigorously monitored at each meeting. A board risk assessment workshop was undertaken in December 2012 to inform future year audit and counter fraud plans, and will be refreshed in December 2013.*

o External audit confirm they are content with the scope and content of IA work where it supports the final accounts process.

*Achieved – initial proposed2013/14 NHS audit scope was increased following advice from internal audit and benchmarking review- evidenced in committee minute s.*

o The committee ensures effective communication and co-ordination between internal and external audit to prevent duplication of effort, resulting in maximum efficienc y and effectiveness in the use of these resources.

*Achieved – plans are shared and scope of relevant individual reviews are discussed to minimise duplication and overlap.*

o Annual IA report demonstrates effectiveness, quality and timeliness of the service.

*N/A - first IA annual report for the CCG is due in spring 2014.*

o Annual External Audit Management Letter does not highlight any concerns with the effectiveness of the committee or delivery of its key responsibilities. *N/A – first Letter is due in autumn 2014.*

**Final Accounts**

o Members are able to offer positive assurance to the Board on the draft and final submissions informed by their scrutiny of the timetable, process and content of the accounts.

*N/A – first CCG accounts due June 2014.*

o External audit governance report has no significant (adverse) comments that members have no prior knowledge or understanding of.

*N/A – governance report due autumn 2014*

o The accounts enable achievement of Value for Money assessment

 *N/A – as above.*

**Assessment**

o The committee oversees the internal processes and liaison with NY&H CSU to ensure that the organisation is able to demonstrate (at least) Level 2 achievement against Information Governance Toolkit.

*Level 2 achieved for CCG in shadow form. Progress is being actively managed by the committee for 2013/14.*

**Assurance**

o The corporate lead for Board Assurance attends the committee at least once per annum to ensure the committee is aware of its responsibilities within the assurance framework. Delivery is demonstrated through the board assurance report(s).

*Achieved – attends each meeting*

o The Audit chair raises issues with the wider board or non executives at relevant forums, as and when appropriate to ensure wider corporate understanding and assurance on key issues.

*Achieved.*

o The committee considers the relative ethical health of the organisation through:

ensuring an updated Speaking Out (Whistleblowing) policy is in place and that staff are aware of it e.g. through reviewing policy communication and utilisation,

periodic internal audit reviews of ethic health issues, including awareness and compliance with the NHS Code of Conduct

The committee ensures that action is agreed and implemented where appropriate.

*Partly achieved: Policy is in place. Review of utilization to be undertaken after 12 months. Ethical health audit to be incorporated in 2014/15 audit plan.*

o The committee reviews reports from the Governance lead of all instances of unlawful acts that arise within the organisation, and ensures that actions are agreed and implemented to minimise future opportunities

*Standing agenda item – no instances reported.*

Note: this is in addition to ensuring robust internal controls processes are in place and audited.

**Value for Money**

o The committee will receive progress reports on the development of the CCG Medium Term Financial Plan and associated savings programmes, ensuring that the plans meet the needs of the organisation and therefore support delivery of the strategic plan.

*Achieved – minimum biannual agenda item.*

**Best Practice**

o Members review the operation of the committee against the available best practice checklists/guidance at least annually and take action as required. *Achieved as evidenced in this annual report.*

**Counter Fraud**

o Risk based plan is approved prior to start of year and fully delivered within 13 months.

*Plan in place, with progress being monitored at each meeting.*

o External assessment achieves a minimum requirements set for CCGs.

*N/A – first assessment due spring 2014*

**Reporting**

o The annual report to the Governing Body includes an assessment of delivery against effectiveness measures, best practice and delivery of terms of reference as a minimum.

*Achieved through this report.*

o The committee contributes to the review of financial reporting format and content at least annually, ensuring it meets best practice and other relevant guidance.

*Achieved - through review by the shadow committee. Next review to be undertaken in March 2014*

o The Audit chair and Chief Financial Officer meet with the CCG Chair at least once a year to discuss audit committee effectiveness, and agreed actions are reported to the committee and evidenced through subsequent agendas/papers.

 *To be arranged in February 2014*

**INTEGRATED GOVERNANCE AND AUDIT COMMITTEE**

**APPENDIX C**

**NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP**

**TERMS OF REFERENCE**

**1 Constitution**

 The CCG constitution requires the Governing Body to establish a committee to be known as the Integrated Governance and Audit Committee (the Committee). The Committee is a non-executive committee and has no executive powers other than those specifically delegated in these Terms of Reference.

**2 Membership**

The Committee membership shall be:

* Lay member with responsibility for finance and governance (Chair)
* Not less than two other members of the Partnership Board, at least one of whom shall be a lay member

In addition there shall be provision for an additional member of the committee, who shall be a senior individual (such as a GP partner) drawn from within the CCG practice membership.

The chairman of the CCGGoverning Body shall not be a member of the Committee. The Committee membership shall not include any executive officers of the organisation.

The Quorum shall be two members.

**3 Attendance**

The Deputy Chief Executive, Deputy Chief Financial Officer, Workforce manager, sub group chairs and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Chair shall meet privately with External and Internal Auditors.

The Accountable Officer and other senior officers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that senior officer.

**4 Frequency**

 Meetings shall be held not less than three times a year.

**5 Authority**

The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Governing body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

**6 Duties**

 The duties of the Committee are as follows:

**6.1 Governance, Risk Management and Internal Control**

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives.

In particular, the Committee will review the adequacy and effectiveness of:

1. All risk and control related disclosure statements (in particular those required to support the annual accounts and Annual Report), together with any accompanying Head of Internal Audit statements, external audit opinions or other appropriate independent assurances, prior to endorsement by the Board.

*n/a – first reports due in summer 2014*

1. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

*Achieved (with exception if disclosure statement which are not yet due) as evidenced in meeting agenda’s and minutes*

1. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

*Policies are in place and the committee is overseeing the process of key policy review during 2013/14*

1. The policies and procedures for all work related to fraud and corruption as set out in Standards on Fraud, Bribery and Corruption and as required by NHS Protect.

*Achieved as demonstrated in committee agenda’s and minutes*

1. Assurance of CCG governance arrangements and compliance with legal and statutory requirements

*Achieved as demonstrated in committee agenda’s and minutes*

In carrying out this work the Committee will primarily utilise the work of Internal Audit and other assurance functions, but not be limited to these audit functions. It will also seek reports and assurances from Officers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee’s use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

**6.2 Internal Audit**

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards (PSIAS) and provides appropriate independent assurance to the Committee, Accountable Officer and Governing Body.

This will be achieved by:

(a) Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

*Achieved as demonstrated in committee agenda’s and minutes*

1. Review and approval of the Internal Audit strategies, operational plans and more detailed programmes of work, ensuring that this is consistent with the audit needs of the organisations as identified in the Assurance Frameworks.

*Achieved as demonstrated in committee agenda’s and minutes.*

(c) Consideration of the major findings of internal audit work (and management’s response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

 *Achieved as demonstrated in committee agenda’s and minutes*

1. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisations.

*Achieved as demonstrated in committee agenda’s and minutes. The committee approved an increase of resource from the original 2013/14 CCG budget*

1. Annual review of the effectiveness of internal audit.

*Will be reviewed in the IA annual report due in spring 2014*

**6.3 External Audit**

The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management’s responses to their work. This will be achieved by:

1. Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission’s rules permit.

*There are discussions with the Audit chair before each meeting. Fuller review will be undertaken after annual accounts completion in 2014*

1. Discussion and agreement with the External Auditor, before the audits commence, of the nature and scope of the audits as set out in the Annual Plans, and ensure coordination, as appropriate, with other External Auditors in the local health economy.

*Achieved as demonstrated in committee agenda’s and minutes*

1. Discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCGs and associated impact on the audit fees.

*Achieved as demonstrated in committee agenda’s and minutes*

1. Review and receive all external audit reports, including the reports to those charged with governance, agreement of the annual audit letters and any work undertaken outside the annual audit plans, together with the appropriateness of management responses.

*Achieved as demonstrated in committee agenda’s and minutes – but noting limited reporting to date*

**6.4 Workforce**

The Committee shall be responsible for assuring the appropriate workforce related governance, policy, planning and management arrangements are in place and operating effectively.

*Achieved as demonstrated in committee agenda’s and minutes – workforce reports are a standing item*

**6.5 Quality and Clinical Governance**

The Committee shall be responsible for assuring the appropriate quality and clinical governance arrangements are in place and operating effectively, including (but not limited to) planning, policy, and management arrangements.

*Achieved as demonstrated in committee agenda’s and minutes – clinical quality sub committee established with reporting to each IG&A committee meeting*

**6.6 Counter Fraud**

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

*Achieved as demonstrated in committee agenda’s and minutes*

**6.6 Management**

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control in the organisation.

This shall include receiving a report in all instances where financial policies are proposed to be, or have been, waived.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

*Achieved as demonstrated in committee agenda’s and minutes*

**6.7 Other Assurance Functions**

The Committee shall be responsible for ensuring that it operates in compliance with the latest NHS Audit Handbook guidance.

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (eg, Healthcare Commission, NHS Litigation Authority etc), professional bodies with responsibility for the performance of staff or functions (eg, Royal Colleges, accreditation bodies etc).

In addition, the Committee will review the work of other groups within the organisation, whose work can provide relevant assurance to the Committee’s own scope of work.

*Achieved as demonstrated in committee agenda’s and minutes. Handbook compliance is included in this committee annual report (Appendix A). IG&A review the Terms of Reference of all Partnership Board sub committees to assure overall governance and assurance arrangements.*

**7 Management**

The Committee shall request and review reports and positive assurances from Officers on the overall arrangements for governance, risk management, workforce and internal control.

They may also request specific reports from individual functions within the organisation as may be appropriate to the overall arrangements.

*Achieved as demonstrated in committee agenda’s and minutes*

**8 Financial Reporting**

The Committee shall review and approve the Annual Report and Financial Statements on behalf of the Governing Body.

*N/A – first accounts due June 2014*

The Committee will also ensure that the systems for financial reporting to the Partnership board and Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the board.

*Achieved as demonstrated in committee agenda’s and minutes*

**9 Reporting**

The minutes of the Committee meetings shall be formally recorded and submitted to the Partnership board. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure, or require executive action.

*Achieved as demonstrated in committee agenda’s and minutes*

The Committee shall report annually to the Governing Body on the exercise of the Committees functions and responsibilities.

 *Achieved as demonstrated in committee agenda’s and minutes*

**Freedom of Information Act 2000**

The minutes and papers of this Committee are, in the main, classed as public documents, except where matters, usually due to draft work in progress, issues of confidentiality or commercial sensitivity, are specifically deemed to be unsuitable for publication.

**10 SUB GROUPS**

The committee shall establish sub groups to support delivery of its functions and responsibilities as and when it deems appropriate. Standing groups shall be:

* Financial assurance – chair: Deputy Chief Financial Officer
* Quality and Clinical Governance – chair: Clinical lead
* Others as determined by the Committee

**11 Other Matters**

The Committee shall be supported administratively by the CCG executive administration team.

The terms of reference shall be reviewed annually.

**Version 4 Dated 7 June 2013**