NHS
The Christie
NHS Foundation Trust

Audit Committee Annual Report
April 2017 – March 2018

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1. Introduction

The purpose of this report is to formally report to the Board of Directors on the work of the Audit Committee during the period 1st April 2017 to 31st March 2018 and to set out how it has met its terms of reference and priorities.

2. Committee membership and meetings

The committee was chaired throughout the year by Neil Large, non-executive director, who has the required financial expertise to enable him to express informed views about financial management. The other members of the committee are Kathryn Riddle and Robert Ainsworth.

The committee is also attended by the executive director of finance & business development, the chief nurse & executive director of quality, appointed representatives from the finance department and representatives of the external audit, internal audit and counter fraud service providers. Other directors and other officers can also be invited to attend, particularly when the committee is discussing an issue that is the responsibility of that director or officer.

There were 5 meetings held during 2017/18: 27th April, 24th May, 27th July, 26th October 2017 and 22nd February 2018. There was also a joint meeting with the quality assurance committee to discuss the external audit review of the financial statements, the external audit review of the quality accounts and to approve the annual governance statement and annual report and financial statements 2016/17.

3. Audit committee members: table of attendance

Name	Audit committee (out of 5 possible meetings)	Joint audit & quality committee (out of 1 meeting)
Neil Large (Chair)	5	1
Kathryn Riddle	2	1
Robert Ainsworth	5	1

4. Assurance arrangements

The committee has shared responsibility with the quality assurance committee to provide assurance to the board of directors that The Christie is properly governed and well managed across the full range of its activities.

In broad terms the audit committee is responsible for all matters relating to corporate, financial & investment governance and risk management whilst the quality assurance committee is responsible for clinical & research governance and risk management.

The main responsibilities of the audit committee are set out in the committee's terms of reference.

5. Terms of Reference

The audit committee reviewed its terms of reference (ToR) at its meeting on 27th April 2017. With some minor changes to wording and an update to the section on fraud to reflect new standards for providers, the ToR were approved.

6. Annual committee effectiveness review

Each year the committee undertakes a self-assessment of its effectiveness; the results of the review were extremely positive and showed an improvement on the previous year.

7. Governance, risk management and internal control process

The audit committee followed the annual reporting cycle 2017/2018, approved at its 27th October 2016 meeting, to schedule its work throughout the year and it uses a rolling programme and action log to track committee actions.

The priorities for 2017/18, and the detailed work programme, were based on the corporate objectives, assurance framework, corporate risk register and discussion with executive directors.

The Committee uses an audit recommendation tracking report to receive updates and monitors progress on actions/recommendations for all internal audit reports including those allocated to the quality assurance committee. Outstanding actions are reviewed at each meeting and senior managers are asked to attend to explain to the committee the reasons for any significant delay. At the committee's request high risk recommendations are reported to the Risk & Quality Governance Committee to ensure a link to the relevant divisional risk register.

The committee received a report from the internal auditor at each of its committee meetings which summarised the audit reports issued since the previous meeting. The committee received a full report on any internal audits assigned a 'limited' audit opinion with the responsible manager required to attend the next meeting to present their plans to address the audit recommendations. In addition all limited assurance audits are followed up by an un-notified audit.

The committee also received an executive director of finance & business development report at each of its meetings which provided an update on regular and scheduled business in accordance with the annual reporting cycle and other matters of financial governance interest.

The Christie Pharmacy Ltd

On 11th December 2017 the contract for pharmacy dispensing services at The Christie transferred from Alcura (Boots) Limited to The Christie Pharmacy Limited, a wholly owned subsidiary with The Christie as its sole shareholder. The pharmacy board is made up of the Chair (Robert Ainsworth, Non-Executive Director), Chief Operating Officer (Robert Duncombe, Director of Pharmacy), and Director of Finance (James Thomson, Deputy Director of Finance). All relevant regulatory and governance structures are in place and the audit committee will receive twice yearly updates to allow for assurance regarding final accounts production (July) and internal audit planning (February). As Robert Ainsworth is a member of the audit committee there is a requirement for him to declare an interest at each meeting where The Christie Pharmacy is discussed.

Board Assurance Framework

The Board Assurance Framework (BAF) focuses on the key risks against achievement of the corporate objectives. The BAF is a 'live' document which is continuously reviewed and updated and is owned by the company secretary.

The Audit Committee has reviewed the BAF to ensure that there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, as well as any that are newly arising. This is to ensure that there are no major omissions.

The audit committee reviewed the BAF at each of its meetings and has assured itself that the process undertaken to populate the BAF is appropriate in that the necessary directors and managers have been involved and take responsibility for their entries and that there are no major omissions from the list of controls.

The work of the Audit Committee is not to manage the process of populating the Assurance Framework or getting involved in the operational development of risk management processes, either at an overall level or individual risks. These are operational issues that the committee has satisfied itself are being carried out appropriately by line management.

The committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the board of directors' to understand the appropriate management of those risks. The committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the committee's attention) that have not been adequately resolved.

8. NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers of NHS-funded care. Their role is to offer support to providers to ensure they give patients consistently safe, high quality and compassionate care within local health systems that are financially sustainable.

On 1st October 2016 a Single Oversight Framework, designed to help NHS providers attain and maintain Care Quality Commission (CQC) ratings of 'good' or 'outstanding', was launched and replaced the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority's 'Accountability Framework'.

The single oversight framework helps to identify an NHS provider's potential support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Individual trusts are segmented according to the level of support they require. There are 4 segments:

Segment	Description
1	**Providers with maximum autonomy** − no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** − the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Our current performance is rated as 1.

9. Achievement of the identified priorities

The priorities for 2017/18 were reviewed and allocated between the audit and quality assurance committees. The priorities are set out below:

- Combined financial systems
- Agency cap
- Capital business cases
- Charitable Funds
- Information Governance Toolkit
- IT Programme & Project Management
- Contract monitoring – chemotherapy drugs
- Waiting lists initiative
- Payroll / Human Resources
- Consultant job planning
- Emergency Preparedness

10. Internal audit

Internal audit is a cornerstone of good governance. Boards need timely and relevant assurance and look to internal audit to support that objective. Our internal auditor, Mersey Internal Audit Agency (MIAA), produces a plan of audits to be undertaken during the year. These are reviewed by the audit committee; additional audits can be added to the plan during the year at the request of the audit committee.

It was reported at the audit committee meeting on 22nd February 2018 that the internal audit contract, which had been awarded in 2014 on a 3 year (+1 +1) basis and extended for the first +1 year in 2017, would end in July 2018. It was agreed to extend the contract for the final +1 year after which a tender process will be undertaken.

11. Assurance activity

Detailed reports were received during the year across the full range of trust systems.

The internal audit plan 2017/18 was based on a risk assessment approach centred on discussions with senior staff and non-executive directors and was linked to the organisation's assurance framework. The internal audit plan was structured to meet the NHS internal audit requirements and provide the Director of Audit's Opinion which subsequently contributes to the board's completion of the annual governance statement.

The following internal audit reports were issued and reviewed by the Audit Committee during the year:

Audit	Assurance	Date received	Recommendations
Reports issued:			
Duty of Candour	Significant	27th April 2017	1 medium & 1 low
Quality Spot Check (Ward 11)	Significant	27th April 2017	2 medium & 2 low
Quality Spot Check (Radiology)	Significant	27th April 2017	2 medium & 1 low
Payroll HR / ESR	Significant	27th April 2017	3 medium & 1 low
Information Governance Toolkit	Significant	27th April 2017	No recommendations
Financial Ledger Upgrade Support	High	27th April 2017	1 low
Quality Metrics (CODE)	Significant	27th July 2017	2 medium & 1 low
Key financial systems	High	27th July 2017	1 low

Audit	Assurance	Date received	Recommendations
Agency Cap	Limited	26th October 2017	5 high, 4 medium & 2 low
Contract Monitoring	Significant	26th October 2017	1 medium & 3 low
Cancer Waiting Times	Significant	26th October 2017	7 low
Emergency Preparedness	Significant	26th October 2017	4 medium & 3 low
Quality Spot Check (Ward 10)	Significant	22nd February 2018	4 medium & 4 low
Quality Spot Check (Radiotherapy)	Significant	22nd February 2018	1 high, 2 medium & 5 low
Key Financial Systems	High	22nd February 2018	2 low
Theatre utilisation	Limited	26th April 2018	3 high, 5 medium & 2 low
Mortality Framework	Significant	26th April 2018	1 medium & 1 low
ESR/Payroll	Significant	26th April 2018	3 medium & 1 low
Information governance toolkit	Significant	26th April 2018	n/a
Assurance framework opinion	NHS requirements met	26th April 2018	n/a

The committee received 2 'limited' assurance reports during 2017/18:

- Agency Cap - the director of workforce (DoW) attended the 26th October 2017 audit committee meeting to update on progress in regard to implementation of the agreed agency cap actions. The DoW reported that a task and finish group has been established to lead on this project, a robust checklist has been developed and is now in place and there is a key lead for each area responsible for managing agency booking requests. A master spreadsheet has been developed to ensure a comprehensive recording system for all agency staff is in place and this also captures all of the key requirements of NHSI reporting and NHS Employment Regulations.

  The DoW gave a further update to the 22nd February 2018 meeting and confirmed all the recommended actions have been completed, a centralised recording system of agency use has been developed which meets trust and NHSI requirements and procedures and relevant checklists are now in place to ensure all pre-employment checks are carried out and appropriately signed off. The booking procedure system will be audited on a quarterly basis.

- Theatre utilisation – the assistant chief operating officer/nurse manager attended the 26th April 2018 audit committee meeting to update the committee on actions being taken to address the concerns raised in the report. The internal auditors confirmed that all the recommendation had been identified by the division and plans are in place to improve theatre capacity and utilisation. A standard operating procedure is also being developed for the Theatreman system. The outcome of the theatre utilisation audit will also be reported to the Quality Assurance Committee at its meeting on 28th June 2018. Progress will be monitored through the audit tracking report and MIAA will undertake a follow-up audit during 2019/20.

The Director of internal audit opinion was received at the 28th April 2018 meeting and the overall assurance opinion provided for the year ended 31st March 2018 was significant.

The following pieces of work are 'work in progress' and will be reported to the audit committee on completion.

- Pressure Ulcers
- Charitable Funds
- GDPR readiness

12. Approvals

During the year the audit committee approved changes to the Standing Financial Instructions and Scheme of Delegation. They also approved the following policies / procedures:

- PCI Cardholder Data Procedure
- Cash Handling, Chip and Pin and Contactless Card Procedures for Cashiers

13. Local Anti-Fraud Specialist

The Local Anti-Fraud Specialist service has continued to enhance the Trust's overall anti-fraud arrangements through the conduct of a range of agreed activities (the anti-fraud work plan was received and approved at 27th April 2017 audit committee meeting). A reporting dashboard shows progress against the plan. A significant amount of time has been given to deterring fraud and creating an anti-fraud culture within the organisation.

Consistent with our long term approach of zero tolerance, all suspected frauds identified during the year have been fully investigated and appropriate action taken.

The Trust ensures that all work related to fraud, bribery and corruption during the year is completed in accordance with requirements set out within the NHS Standards Contract and as required by the NHS Counter Fraud Authority's Standards for Providers.

14. Annual governance statement

The draft annual governance statement was considered on 28th April 2018 and was judged consistent with the audit committee's view on the organisation's system of internal control.

The final version will be approved by the joint audit and quality assurance committees before being submitted to the Board of Directors for approval on 24th May 2018.

15. External audit

An external audit is an examination of the annual financial statements of a foundation trust in accordance with specific rules by someone who is independent of the foundation trust. The external auditor performs the audit by examining and testing the information prepared by the foundation trust to support the figures and information it includes in its financial statements.

The effectiveness of the external audit process is assessed through regular reports to the audit committee as well as regular contact with the senior finance team.

The audit committee is responsible for evaluating the performance of the external auditors each year and supports the council of governors to determine and deliver the process for appointing the external auditor. Following an external audit tender process the council of governors approved the appointment of Grant Thornton as the trust's new external auditors from September 2017 for a period of 3 years.

16. Review of annual financial statements 2016/17 and 2017/18

The annual financial statements for 2016/17 and 2017/18 were prepared in accordance with IFRS.

The external auditors provided their annual governance opinion (ISA 260) in relation to the 2017/18 year at its 24th May 2018 meeting. Assurances have been received from the executive director of finance and business development that matters identified in the report will be addressed during 2018/19.

In line with NHS Improvement's timetable for the submission of audited annual accounts a joint audit/quality assurance committee meeting was held on 24th May 2018 to approve the accounts. The external auditors completed full and thorough audits of the exchequer accounts for 2017/18 resulting in an unqualified opinion.

The Christie Charity
The external auditors undertook a full and thorough audit of the charitable fund accounts for 2016/17. The unaudited charitable fund accounts were reviewed by the Charitable Funds Committee, and the audited accounts approved, on 22nd September 2017.

The Christie Trading Company
The Christie Charity trading company was originally set up to manage sponsorship money and any associated tax liabilities. The administration of the trading company is costly, time consuming and requires a separate audit process. The Christie charity has no plans to increase its trading activity so administering any future trade could be managed through the normal accounts process. The company is not commercially viable so it was agreed at the 22nd September 2017 meeting of the Charitable Funds committee that the trading company should close with effect from 31st December 2017. The final set of accounts will be received by the Charitable Funds committee at its meeting on 13th July 2018.

17. Priorities for 2018/19

The following priorities are identified for 2018/19

- Assurance Framework Opinion & Risk Management Arrangements
- Key financial systems, reporting & integrity
- Data protection and security toolkit
- Cyber Security
- Compliance with targets – chemotherapy data flows
- Quality spot checks
- ESR/HR payroll controls
- Cost improvement programme (CIP)
- Portfolio board effectiveness and Transformation Delivery
- Christie Pharmacy governance arrangements
- IPU contract management
- Chemotherapy /Radiotherapy scheduling
- Quality accounts
- WHO checklist
- Inpatient flow

Neil Large
Chair of the Audit Committee
1st April 2018