Audit Committee Annual Report 2020-21

1. Title of Committee: Audit Committee

2. Name and role of person submitting this report:

Louise Brereton, Board Secretary

3. Dates covered by this report:

01/04/20-31/03/2021

4. Number of times the Audit Committee met during this period:

The Audit Committee was routinely scheduled to meet on a quarterly basis and otherwise as the Chair deemed necessary. During the reporting period, it met on five occasions (including an extraordinary meeting in July 2020). Members also held a workshop in May 2021 primarily to review the suite of Committee Annual reports for the reporting period ending 31.3.21 and to finalise its own Annual Report.

Attendance at meetings is detailed within the table below:

Members of the Audit Committee	29.6.20	28.7.20	17.9.20	17.12.20	18.3.21
Medwyn Hughes	P	P	P	P	P
Jacqueline Hughes	P	P	P	P	P
Eifion Jones	P	P	P	P	P
Lyn Meadows	P	P	P	P	P
Formally In attendance (as per Terms of Reference)					
Board Secretary/Acting Board Secretary	P	P	P	P	P
Executive/Acting Director of Finance	P	P	P	P	P

Deputy Chief Executive/Executive Director of Nursing and Midwifery	P	P	X	X	P
Head of Internal Audit	P	P	P	P	P
Representative of Auditor General (External Audit)	P	P	P	P	P
Local Counter Fraud Specialist	X	X	P	P	P
Head/individual responsible for Clinical Audit	X	X	X	X*	X

Key:

P - Present

P* **-** Present for part meeting

A - Apologies submitted

X - Not present

◆ Not a member of the Audit Committee at this time.

* Members Considered the Clinical Audit Plan at the December meeting noting that it had received substantial prior scrutiny by Independent Members as well as approval from the Quality, Safety & Experience Committee. Hence, the decision was made not to ask the Senior Associate Medical Director to attend the meeting.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Audit Committee is designed to provide:

The Audit Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

> 3.1.1 comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on:
>
> - the organisation's ability to achieve its objectives;
> - compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;
> - the reliability, integrity, safety and security of the information collected and used by the organisation;
> - the efficiency, effectiveness and economic use of resources; and

- the extent to which the organisation safeguards and protects all its assets, including its people.

3.1.2 to ensure the provision of effective governance by reviewing;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the effectiveness of the Board's Committees
- the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;
- the, Annual Audit Report and Structured Assessment
- financial conformance and the Schedule of Losses and Compensation;
- the planned activity and results of both internal and external audit, clinical audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

During the period that this Annual Report covers, the Audit Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which normally meets quarterly (albeit it has met less frequently during this year in view of the pandemic). The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework. However, during the year a fundamental review of the Governance Structures has been undertaken by the Interim Director of Governance. This work is being finalised at the point of producing this Annual Report.

The Audit Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there

were no breaches of this nature in terms of either individual papers or the whole agenda not being available seven days before each meeting.

6. Overall *RAG status against Audit Committee's annual objectives / plan: AMBER

The summary below reflects the Audit Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	**Assur-ance Status (RAG) ***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*	**Committee assessment of the quality of the Assurance provided (***please provide in narrative format)*
Comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on: ▪ the organisation's ability to achieve its objectives; ▪ compliance with relevant regulatory requirements,		Board adopted Welsh Government quarterly planning requirements. Revised Risk Management Strategy and Policy adopted in year with updates provided in terms of progress of implementation. Governance review underway in year.	Quality of assurance provided considered to be of an acceptable standard

standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others; ▪ the reliability, integrity, safety and security of the information collected and used by the organisation; ▪ the efficiency, effectiveness and economic use of resources; and ▪ the extent to which the organisation safeguards and protects all its assets, including its people.			
To ensure the provision of effective governance by reviewing; ▪ the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);			Quality of assurance provided considered to be of an acceptable standard. Regular review during the year with presentation of 'Maintaining Good Governance' Reports highlighting fundamental changes to the governance arrangements
▪ the effectiveness of the Board's Committees.		Noting the impact of Covid with a number of the Board's Committees stood down during the year and the establishment of the Cabinet	Governance review undertaken in year and due to conclude in Quarter 1 of 2021-22.
▪ the accounting policies, the accounts, and the annual report			Quality of assurance provided

of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;			considered to be of an acceptable standard
▪ the Annual Audit Report and Structured Assessment		Recommendations monitored as part of audit tracker. Amber status given as not all recommendations have been implemented by the due date.	Quality of assurances provided considered to be of an acceptable standard. Narrative within tracker has improved during the year, despite the impact of Covid with more positive engagement from Leads. Review of certain recommendations also undertaken in year to ensure continued relevance. However Members have expressed concern that recommendations once implemented require timely sign off by the Executive Lead
▪ financial conformance and the Schedule of Losses and Compensation;			Quality of assurance provided considered to be of an acceptable standard

▪ the planned activity and results of both internal and external audit, clinical audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);		Recommendations from both internal and external audits are monitored as part of the Audit Tracker. However, not all recommendations have been implemented by the due date. All External Audit recommendations relating to Counter Fraud have been implemented (as logged on Team Central and approved by the Executive Director of Finance). Any recommendations identified from Fraud Investigations are reported to the Audit Committee via the progress report.	Overall the quality of assurance provided considered to be of an acceptable standard. Any recommendations made by Counter Fraud are implemented and reported to the Committee. However improvements with regard to clinical audit reporting are expected within 2021-22 with an appointment to the Clinical Effectiveness post expected to be made in early Summer 2021.
▪ the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;		Management responses to internal and external audit recommendations continue to be monitored as part of the audit tracker. Amber status given as not all recommendations are implemented by the due date. Improvement in the timeliness of Management Responses is an area for improvement, whilst acknowledging the continuing impact of Covid 19.	Quality of assurances provided considered to be of an acceptable standard. Narrative within tracker has improved during the year, despite the impact of Covid with more positive engagement from Leads. Review of certain recommendations also undertaken in year to ensure continued relevance, however there have been systemic issues with lengthy delays in terms of sign off of

			some management reports.
▪ proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);			Quality of assurance provided considered to be of an acceptable standard
▪ anti-fraud policies, whistle-blowing processes and arrangements for special investigations;			Quality of assurance provided considered to be of an acceptable standard
▪ any particular matter or issue upon which the Board or the Accountable Officer may seek advice.			Quality of assurance provided considered to be of an acceptable standard

Key:

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Audit Committee during this reporting period:

- Committee Breach Log Report
- Risk Management Strategy/Policy
- Schedule of Financial Claims
- Internal Audit, Internal Audit Opinion and 2020-21 Plan and regular progress reports
- Final Internal Audit Report – Deprivation of Liberty Safeguards
- Wales Audit Office, Review of Audited Accounts and Financial Statement, Auditor General and Audit Wales Director letters on COVID-19 impact
- Wales Audit Office, Findings from the Auditor General's Sustainable Development Principle Examinations (Wales First "Future Generations Report")
- Executive Director Briefing on 2019-20 Financial Statements
- Annual Accounts 2019-20
- Remuneration Annual Report 2020
- Annual Governance Statement (AGS)
- Audit Committee Annual Report, Terms of Reference and Cycle of Business
- Quality, Safety & Experience Committee Annual Report, Terms of Reference and Cycle of Business
- Counter Fraud Annual Report 2019/20
- Financial Governance During COVID-19 Report

- In Committee items from previous meeting reported in public
- Re-Setting Governance Arrangements
- BCUHB Annual Report and Annual Quality Statement update
- Auditor General Report: Refurbishment of Ysbyty Glan Clwyd (YGC)
- Chair's Assurance Report: Risk Management Group
- Annual Review of Gifts & Hospitality and Declarations of Interest Register
- Internal Audit Report: Roster Management
- Internal Audit Report: Decontamination
- Internal Audit Report: Salary Overpayments
- Audit Wales Programme Update
- Audit Wales: National Counter-Fraud Report
- Audit Wales: BCUHB Local Counter-Fraud Report
- Primary Care Dental Assurance Report
- End of year Reporting: Committee Annual Reports
- Financial Conformance Report
- Board Assurance Framework and Corporate Risk Register.
- Internal Audit Limited Assurance Report: Delivery of Savings - Ysbyty Glan Clwyd Hospital.
- Internal Audit Limited Assurance Report: NHS Wales Staff Survey.
- Internal Audit Limited Assurance Report: Recruitment - Medical and Dental Staff.
- Internal Audit Limited Assurance Report: Quality Impact Assessment.
- Audit Wales Annual Audit Report
- Audit Wales: BCUHB Structured Assessment
- Audit Wales: Review of Continuing Healthcare Management Arrangements
- Audit Wales: Welsh Community Care Information System
- Financial Governance during Covid-19 Update Report
- Charitable Funds Annual Report and Accounts
- Ablett Redevelopment Report
- Performance & Accountability Framework
- Clinical Audit Plan
- KPMG Field Hospitals Report and Field Hospital Consequential Losses
- Counter Fraud Progress Report
- Update on Internal/External Audit Recommendations
- Internal Audit Progress Report and Internal Audit Plan 2021/22.
- Internal Audit Limited Assurance Report: Business Continuity - Informatics
- Internal Audit Limited Assurance Report: MH&LD Governance Arrangements
- Audit Wales Audit Plan 2021
- Audit Wales, Doing it Differently, Doing it Right. All Wales Report on Governance in the NHS during the Pandemic
- BCUHB response to Well Being of Future Generations report including the Implementing the Well Being of Future Generations Act - BCUHB, Management Response and letter from the Future Generations Commissioner to the BCUHB Interim Chief Executive
- Legislation Assurance Framework
- Post Payment Verification Progress Report Consequential Losses

Full details of the issues considered and discussed by the Audit Committee are documented within the agenda and minutes which are available on the Health

Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Audit Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
29.6.20	• COVID-19 continued to represent a significant risk to both the Health Board's financial position and ability to progress business as usual. • Members approved the Risk Management Strategy/Policy though remained concerned as to the ability to successfully implement and whether the target dates were achievable. Members agreed that this would be the subject of further discussion at the impending Risk Management Workshop. • Members noted that, due to the COVID-19 pandemic and auditor's ability to conduct site visits, there was a risk that it may not be possible to fully implement the Internal Audit Plan. • The All-Wales report on the Well-being of Future Generations highlighted that significant challenges still existed and would not be easy to resolve. • The Health Board's financial duties to balance income with expenditure over a three-year rolling period and to prepare a rolling three-year integrated medium term plan had not been met. • Members noted that there had been an Independent Member vacancy since December 2019 which increased pressure on the remaining nine Independent Members. • COVID-19 had impacted the progress made against recommendations in the Audit Tracker.
28.7.20	• Whilst the Auditor General Report: Refurbishment of YGC did contain positive points noted by Members, the report notes that the Outline and Full Business Cases were insufficiently prepared, with underdeveloped design and cost plans. Furthermore, the report highlights discrepancies identified in the reporting of information. Ineffective project governance allowed the Project Board, the Board of the Health Board and the Welsh Government to be misled about the project's overall affordability and its financial performance against its capital budget. Members noted that the report was due to be published on 8th September in advance of it being considered by the Public Accounts Committee.
17.9.20	The Committee:

	• were concerned to note a failure of the Risk Management Group to be quorate at the meeting held on the 27th July 2020. A new Chair has now been appointed (Acting Executive Medical Director). • noted that full implementation of the revised Risk Management Strategy will be dependent on the organisation's ability to confirm the Health Board's objectives. This was being progressed as part of the Board Development programme. • noted, as part of the discussion on the Schedule of Financial Claims, that there had been an increase in complaints due to COVID-19. It was anticipated that there may also be an increase in claims due to the same. • noted a reduction in compliance and the number of declarations of interest submitted during the previous financial year. The Committee asked the Board Secretary to follow up and in particular with regard to submissions from Estates & Facilities. • Were concerned that a Management Response remained outstanding for the Internal Audit Quality Impact Assessment review. Concerns were further raised as to the Health Board's internal escalation procedure. The Acting Board Secretary agreed to review the arrangements. • noted that recommendations emanating from the limited assurance reports (Roster Management, Decontamination and Salary Overpayments) and the Audit Wales report (Effectiveness of Counter-fraud arrangements) would be monitored by the Team Central tracker. Including the 'priority considerations for the future' from the **Governance Arrangements during COVID review.**
17.12.20	• Noted that the Risk Management Group was not quorate again and queried why the last meeting had been Chaired by the Executive Director of Workforce and Organisational Development. Members were advised that had been as a result of a number of Acting arrangements and that this would be raised with the Executive team and that the Deputy Chief Executive / Executive Director of Nursing & Midwifery would resume the Risk Management Group Chair in January 2021. • Were concerned to note that a risk (risk ID 3739 currently scored at 8) had been raised that the Risk Management Strategy and Policy may not be timely and robustly implemented. This was due to the number of high-level risks being underestimated. The Risk Management team continue to progress reviews and quality checks. • Noted that the Health Board had still not completed the identification of corporate objectives, only priorities.

	Members noted that objectives had been set for quarter three and four. • Noted the EU Exit risk on the Board Assurance Framework. Members received an update on the work and oversight taking place and were advised that Welsh Government would be advising on reporting requirements shortly. • noted that recommendations emanating from the limited assurance reports (Delivery of Savings - Ysbyty Glan Clwyd Hospital, NHS Wales Staff Survey, Recruitment - Medical and Dental Staff and Quality Impact Assessment) and the Audit Wales report (Structured Assessment, Continuing Healthcare Management Arrangements) would be monitored by the Team Central tracker. • Noted that a number of Internal Audit deferrals had been necessary due to the demands placed upon operational teams as the Health Board managed a second wave of the pandemic. However, Members were advised that any further deferments or reviews taken off the Internal Audit Plan would impact on the Head of Internal Audit's ability to deliver a full assurance opinion. • Noted an increase in single tender waivers and agreed that a review of Purchase Orders by supplier should be undertaken to establish whether further investigation was necessary. • Noted an increase in the volume and value of salary overpayments. Members agreed that further information be brought back to the Audit Committee to establish the proportion that related to staff that had left the Health Board. •
18.3.21	• Noted that Internal Audit's ability to deliver the plan depended on the audit team's ability to go out and test, which may be inhibited by pandemic restrictions. • Discussed further issues associated with the Internal Audit Limited Assurance Report: MH&LD Governance Arrangements. Namely, whether the implementation of the Together 4 Mental Health (T4MH) Strategy remained fit for purpose for the people of North Wales. Secondly, concerns around the Psychological Therapies Service in terms of outward reporting and leadership. Members were advised that an internal advertisement for an Acting Head of Psychological Therapies Service post had been placed, whilst work continued with the national and local team to pull together a substantive job description before proceeding to external advert. Applications for the post had been received and were being progressed. • Received the Dental Assurance report and noted that due to minimal patient charge revenue, there was a significant

	overspend risk to the service budget. The service was working closely with finance colleagues to actively manage the situation and the matter was fully addressed via other financial reports within the organisation. • Were concerned to note an increase in single tender waivers. Members were advised that this was associated with the speed in which the Health Board needed to procure, either services or construction during the pandemic. Members noted that single tender waivers were a concern prior to the pandemic. The Executive Director of Finance agreed to raise the issue at an all Wales level and provide a further assurance report for the Committee. • Noted that there were some recommendations on the Audit Tracker Tool requiring Executive sign off. In order for the Committee to manage its business and time effectively, it was important that items marked as implemented, were reviewed and actioned by the relevant Executive prior to submission. This would be addressed by the Office of the Board Secretary.

9. Review of Effectiveness

At a workshop of the Audit Committee held on the 25th May 2021 members reviewed each of the Committee and Advisory Groups' annual reports for 2020-21 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them.

On the whole the Audit Committee felt that the work of the Boards Committees had been very effective during the year particularly when taking into account the pressures that had been placed on Board members as a result of the pandemic as a result of additional meetings e.g. the establishment of the Cabinet, and also acknowledging that the Board had been operating with an Independent Member vacancy for more than twelve months.

The following specific commentary was made in relation to the Committee reports:-

Committee Annual Report	**Commentary**
Quality, Safety and Experience	Suggestion for next year to complete self-assessment akin to Audit (which could be facilitated by Internal Audit) Further consideration to be given to the role of Internal Audit to support the transfer of learning across the organisation.
Digital and Information Governance	Red RAG rating actions to be fully reflected in new business cycle (based on new distribution of responsibilities given disbanding of the Committee in the light of the governance review)

Strategy, Partnerships and Population Health	Red RAG rating actions (partnership working) to be fully reflected in new business cycles
Mental Health Act	Objective as listed in TOR relating to 'receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure' and also 'receive the results of clinical audits and any other reviews relating to the use of the MH Act and oversee the implementation of recommendations'. Option to flex this years' internal audit plan if felt appropriate.

General commentary on the overall suite of reports

- Consistency of completion to be improved in future iterations
- Review template for next year, in particular last column of RAG rating table which could be used to describe what the Committee intends to do in terms of actions going forward.
- Consideration to be given to the overall alignment in terms of Committee performance, progress and assessment at a future meeting of the Targeted Intervention Steering Group.

In line with a good governance regime Audit Committee Members took part in a self-assessment questionnaire reviewing effectiveness, facilitated by Internal Audit during April 2021. The results of this questionnaire were shared with members at the 25 May workshop and are attached as Appendix 2. As a result of the finding Members agreed to review the self-assessment questionnaire for next year and to consider enhanced induction arrangements for Audit Committee Members with open invitation to all Board Members to attend.

10. Focus for the year ahead:

The primary focus of the Audit Committee over the next twelve months will be on monitoring the effectiveness of the revised Risk Management Strategy and Board Assurance Framework arrangements adopted in year. In addition, the Governance Review currently underway at the time of finalising this report is likely to require changes to Committee Terms of Reference, which will need to be approved by the Committee prior to recommending these to the Board. The Committee will continue to track both internal and external audit recommendations. The Committee will towards the end of the financial year consider the findings of the Internal Audit review of effectiveness of the new arrangements post the governance review. A

review of the dental assurance reporting arrangement is also to be undertaken in year. Clinical Audit reporting arrangements are expected to improve over the next twelve months with an appointment due to be made to the Clinical Effectiveness post. It is expected that this will result in the Clinical Audit Plan being presented in a timely fashion for sign off by the Committee at its March 2022 meeting with a progress update being presented to the September 2022 meeting.

The Audit Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 3 (noting as outlined above that both the Committee's Terms of Reference and cycle of business going forward will reflect the output of the Governance Review once concluded).