

E- Meeting of the Audit Committee

minutes

Minutes of the Audit Committee Meeting held on Tuesday 9th July 2024

Committee Members:	John Doyle Margaret Carney Claudette Elliot Nick Brooks	Non-Executive Director (Interim Chair) Non-Executive Director Non-Executive Director Non-Executive Director
Committee Attendees:	James Thomson Ben Vinter James Bradley Kate Warriner Nigel Woodcock Connor Joel-Welsh Jing Ma Ying Li Gary Baines Karen McArdle Archie Samuels Katie Tootill Jennifer Ohlsson	Chief Finance Officer Director of Risk and Corporate Governance. Deputy Chief Finance Officer Chief Digital and Information Officer Senior Audit Manager, MIAA Senior Audit Manager, MIAA Head of Financial Services PSA Senior Manager, Grant Thornton Regional Assurance Director Anti-Fraud Specialist Research & Audit Effectiveness Manager Chief Procurement Officer, Senior Executive Assistant (Minutes)
Apologies:	Bob Burgoyne	Non-Executive Director

1. Apologies for Absence

Apologies noted as above.

2. Declarations of Interest

All meeting participants were asked to declare any interests in respect of items listed on the agenda. All participants confirmed that they had no interests to declare beyond those that may already be known and on Trust registers.

3.1 Minutes of the previous meeting held on 12th March 2024

The minutes of the e-meeting held on 12th March were accepted and recorded as a true record providing Karen McArdle is included on the attendance list.

3.2 Minutes of the previous meeting held on 25th June 2024

The minutes of the e-meeting held on 25th June were accepted and recorded as a true record.

4. Action Log

The action log was reviewed and updated as follows:

Action 1: On agenda for discussion.

Action 2: On agenda for discussion.

5. Governance and Risk

5.1 Annual Review of Governance Manual

An overview was provided of the annual review of the governance manual. Mersey Internal Audit Agency has supported the Trust in the annual review of the Corporate Governance Manual (CGM) in order to provide assurance that it is comprehensive and consistent with best practice.

Comments and questions were welcomed and CFO noted clarification of the Chair of the Audit Committee needs to be reflected.

Clarification was also sought on the credit card limit increase from £50k to £100k. CFO confirmed that this was due to an increase in the number of Certificate of Sponsorship (CoS) payment requests by HR and the only way these can be paid for is via credit card.

The scheme of delegation changes were noted and a query raised on whether the ToRs need to be changed following this. It was confirmed that updated ToRs will follow.

The Audit Committee considered the proposed updates and made a recommendation to the Board of Directors to approve the updates and adopt the revised Corporate Governance Manual

5.2 Risk Management KPIs

An overview was provided of the risk management KPI report, and it was noted that the Trust is compliant with risk reporting requirements as set out in the risk management policy for risks.

The Trust has 479 active risks and regular review of risks is in line with policy expectations. 72% of incidents have been closed within 28 days. The number open over 28 days is 78 with 10 closed over 28 days. Live reports are available on InPhase showing the breakdown by division and area for incidents open over 21 and 28 days.

The Audit Committee are asked to note the content the report and be assured the Trust has systems and processes in place for the identification, management and escalation of risks with actions being taken to increase compliance in some areas.

The Audit Committee are also asked to note the KPI position with regard to incidents over 28 days.

The improvement in the KPIs was noted. The 28-day target was also raised and a recent review that was undertaken and whether this can be checked up on.

5.3 Review Operating policies

It was noted that this is a standing item and there is nothing to review at present.

5.4 Review Clinical Audit Plan and 6-monthly progress reports

Archie Samuels, Clinical Audit and Effectiveness Manager, attended to present an overview of the clinical audit plan and 6-monthly progress report.

The concerted efforts in submitting and complying with CQUINs datasets and quality schedules for 2023-24 have set a strong foundation for future initiatives. The transition to more frequent NICOR data submissions promises enhanced data quality and timely insights, while local project support has stimulated academic and practical advancements.

The challenges identified in ACHD NICOR data quality and LOCSSIP checklist compliance have been met with strategic plans and process improvements, ensuring better outcomes moving forward. The introduction of an information analyst has significantly bolstered the clinical audit department, fostering innovation and efficiency through advanced data visualization and extraction techniques.

Continual development of the team's skills and the implementation of robust data collection processes underscore a commitment to excellence in healthcare data quality. These efforts collectively enhance the ability to monitor, report, and improve clinical practices, ultimately contributing to superior patient care and outcomes.

Comments and questions were welcomed and it was noted that it is assumed that the data quality is 100%, so it is worrying that this isn't. A query was raised on whether the next report will provide assurance that the

data quality has improved. It was confirmed that NICCOR is mandating quarterly data, which will hopefully improve the data quality. There has also been a change in staffing, which should see an improvement.

The audit evaluations were noted and bringing this into standard practice and integrating the outcomes. It was confirmed that the outcomes of the local audits are currently reported to divisional board, however more work could be done to disseminate the learning and the outcomes to the wider organisation.

5.5 Review losses and special payments

Audit Committee colleagues were asked to note the losses and special payments paper. For the period 1st March 2024 to 31st May 2024 there was no loss in excess of £10,000.

For the period 1st March 2024 to 31st May 2024 there have been no special payments in excess of £10,000.

The activity management of debt was noted. It was confirmed that the Finance Team meet with the SBS Debt Team on a monthly basis. The team also meet with BUPA in relation to the aged debt.

A query was raised on whether there is there anything that can be done prior to taking a private patient. CFO confirmed that there has been a large volume increase in private patients.

5.6 Review single supplier tender waivers

CFO provided an overview of the single supplier tender waiver report. A total of five tender waivers were submitted in Q1. The total value of tender waivers raised was £4,314,143.88.

A total of six quotation waivers were submitted in Q1 24/25. The total collective value of the six quotation waivers was £199,657.72 (including VAT).

Comments and questions were welcomed and A query was raised on what is done to proactively reduce the need for tender waivers and how does the system work. CFO suggested bringing back a paper on the tender issue process. It was agreed that more narrative would be helpful to ensure that due process is being followed.

A further query was raised on whether there has ever been a time when a retrospective waiver has not been approved. CFO confirmed that there has not.

5.7 Review of Register of External Visits

The Audit Committee is asked to review the Register of External Visits and confirm that the governance arrangements to deal with the findings and recommendations following external visits and inspections are robust.

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A question was raised on how the Trust know there are visits. It was confirmed that a call goes out each month and it would be unlikely that an external visit would happen without management involvement.

The Audit Committee were asked to note the register from February 2024 to date.

5.8 Regulatory Action Plans

There were no regulatory action plans to note at this meeting.

5.9 Cyber Security Update

An overview was provided of the cyber security update. The threat landscape is continuing to evolve, however as detailed above the Trust control environment is being developed to meet these challenges.

An overview was also provided on recent cyber incidents. Synnovis are a 3rd party Pathology provider which delivers laboratory services to NHS Trusts. In June 2024, they were subject to a Cyber-attack which resulted them losing 400GB of data. The incident is still ongoing and has predominantly impacted NHS providers in the south of England, who regularly utilise their services.

Liverpool Clinical Laboratories, who provide Laboratory services to LHCH, partner with Synnovis for a small number of specialist tests. However, current understanding from the National Team is that there is no impact to data from Laboratory Information System and therefore no current known risk to patient data from LHCH. The Trust will continue to work closely with the National and Regional Teams, ensuring a coordinated approach and response.

Good performance was noted. The BAF score was also noted, and a query raised on whether there is a standardisation of scoring. It was confirmed that this is all about board risk appetite and there is no local or national standardisation. It was added that the ICB do capture cyber risk.

5.10 Data Quality Assurance Report

An overview was provided of the data quality assurance report. The Trust is viewed favourably when reviewing metrics from external submissions CDS and SUS. MIAA completed a data quality audit around the accuracy of Corporate Reporting in July 2023 and all recommendations had been put in place to provide assurance by November 2023. The final report was released in April 2024 which provided an overall assurance opinion of High.

The Audit Committee noted the content of the report.

5.11 Health Procurement Liverpool

Katie Tootill, Chief Procurement Officer, attended Audit Committee to present an update on Health Procurement Liverpool.

In October 2023 a three year procurement strategy was devised and an updated was provided on how this strategy is progressing. The strategy

was developed in consultation with clinical and business colleagues across all partner organisations and reflects the principles and ambitions identified within the HPL business case and partnership agreement. The strategy considers the regional and direction of travel for NHS procurement. The strategy also complements each of the partnership organisations' overarching Trust strategies.

The HPL strategy covers 13 core objectives, each one with a clear action plan on how these objectives will be delivered over the three years. The 13 core objectives have performance metrics to all of them to be tracked and progress to be monitored. The KPIs can be monitored as a collective or at individual Trust level.

An update was also provided on CIP delivery and performance. 253 projects were delivered against a plan of 195. A positive variance of 58 schemes across the alliance. 61 projects were delivered against a plan of 47 for LHCH. A positive variance of 14 schemes.

Comments and questions were welcomed and it was noted that the positive performance is a testament to the team and the leadership.

It was noted that efficiencies and improvement is a real area of focus and a query was raised on whether LHCH are missing anything or is there anything further that can be done. It was confirmed that the key area is having the clinical engagement and support. The mechanisms put in place have worked really well.

A query was raised on whether there are joint contracts across the ICB. It was confirmed that HPL are closely connected to the C&M Procurement workstream and opportunities are shared where possible.

Potential cost increases were also raised and whether there is any intelligence to be shared. It was noted that the inflationary strategy is 'resist, negotiate, explore'. Impact statements are produced and the majority of these are currently coming from NHS supply chain and these are being pushed back into the system. In conclusion the cost increases are challenged and there are mechanisms in place to do this.

6. Internal Audit

6.1 MIAA Management Arrangements

An overview was provided of the proposed MIAA management arrangements. The current MIAA Engagement Manager (Nigel Woodcock), has reduced his working days from 01/04/2024 and additionally has been in the role for a number of years and it is good practice in line with the Public Sector Internal Audit Standards to rotate Engagement Manager periodically.

Following an internal review of portfolios and review by the Assurance Director, it is proposed that Conor Joel-Welsh will become the new Engagement Manager for the Trust.

It is proposed that Nigel Woodcock will close any remaining 2023/2024 assignments with Conor Joel-Welsh taking responsibility for the 2024/2025 plan onwards. A full internal handover will take place to ensure a seamless transition between Engagement Managers.

The Trust will, as a statutory body, continue to have its own standalone Internal Audit Plan and Head of Internal Audit Opinion.

Audit Committee approved the proposed changes and thanked Nigel Woodcock for all the hard work for LHCH audit committee.

6.2 Progress report on delivery of plan

An overview was provided of the progress report, which covers the period since the meeting in March 2024. Reviews that have been finalised are the 2023/24 Strategic Oversight Framework Reporting, 2023/24 Quality Spot Checks, 2023/24 Duty of Candour, 2023/24 WHO Checklist and Waiting List Management.

Audit Committee approval will be requested for any amendments to the original plan and highlighted separately to facilitate the monitoring process. There have been no changes to the 2024-2025 audit plan at this stage.

Comments and questions were welcomed and a query was raised on whether Audit Committee will receive a report on the waiting list management audit. It was confirmed that previously a summary would be provided by the relevant Executive Lead at the appropriate assurance committee. DR&CG added that the COO will present an update to Board of Directors on Safer Waiting List Management.

6.3 Follow-up report

Audit Committee colleagues were asked to note the follow up report. It was noted that there are two recommendations that are awaiting a response, one of these have now been received. Overall there were 23 recommendations, 16 of which have been implemented.

There were no further comments or questions.

6.4 Anti-Fraud Annual report

Audit Committee colleagues were asked to note the anti-fraud annual report. The key risks identified, were conflicts of interest, cyber-enabled fraud (including bank mandate, false invoice and phishing frauds) and also pre-employment checks. With regards to pre-employment checks the AFS carried out a local proactive review specifically reviewing pre-employment checks for agency workers and a bank mandate questionnaire was completed by the Trust with no issues identified.

Progress against the 23/24 plan activities was discussed with the Chief Finance Officer in regular update meetings. The Anti-Fraud Specialist (AFS) undertook periodic update meetings with a variety of key stakeholders across the Trust, throughout the year.

In June, the Anti-Fraud Specialist (AFS) submitted the annual Government Counter Fraud Standard Return for the Trust. This was approved by the Audit Committee Chair and Chief Finance Officer. The Trust reported 'Green' ratings for each of the 12 components which make up the standard.

A number of activities were conducted during the year to raise awareness, including International Fraud Awareness Week. All new starters continue to complete the fraud, bribery and corruption awareness e-learning module as part of induction.

Comments and questions were welcomed and CFO raised a query on whether investigations have been recorded on the national database. It was confirmed that as these were classed as enquiries, they would not need to be recorded.

6.5 Anti-Fraud progress report

Audit committee were asked to note the anti-fraud progress report and there were no further comments or questions

6.6 Annual review of internal audit provision

Chair noted that the NEDs have reported MIAA made a positive contribution and are very responsive. It was noted that the clarity of reports very good.

7. External Audit

7.1 External audit update report

A verbal update was provided on the external update report. There were no significant issues to report.

7.2 Annual review of performance of external auditor

Chair noted the NEDs have reported a professional approach and good feedback to the Board of Directors. One query was raised was whether the Trust need to see more of the external auditor. CFO confirmed a very smooth process with the external auditors.

7.3 Trust Explanation of Audit Finding

An overview was provided of the audit findings report, which explains the details of the audit adjustment of £1.3m cash adjustment recorded for 2023/24 and the key learning points and actions taken by the Trust's finance department.

Financial Services team will take the actions to ensure the accuracy of bank reconciliation and the integrity of financial statements.

It was noted that it is good for Audit Committee to know that there is progress being made.

8. Review of Audit Committee Work plan – 2024/25

Colleagues were asked to note the audit committee workplan and this was approved by the committee.

10. ASG Issues

It was noted that this is a standing item for an opportunity for any Q&A

11. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting.

All committee members confirmed that the meeting had been conducted effectively and useful documentation had been received and discussions had taken place.

12. Date and Time of Next Meeting:

Tuesday 8th October 2024, 08.30am – 10.30am, MS teams