Agenda Item Number: 2.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Audit & Risk Committee held on the 23 June 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Patsy Roseblade	Independent Member (Chair)
Jayne Sadgrove	Health Board Vice Chair
Carolyn Donoghue	Independent Member

In Attendance:

Sara Utley	Audit Wales
Paul Dalton	NWSSP – Internal Audit & Assurance
Emma Samways	NWSSP – Internal Audit & Assurance
Eifion Jones	NWSSP – Internal Audit & Assurance (In part)
Sally May	Executive Director of Finance
Georgina Galletly	Director of Corporate Governance
Owen James	Head of Corporate Finance
Gethin Hughes	Chief Operating Officer (In part)
Matthew Evans	Head of Local Counter Fraud
Emma Walters	Corporate Governance Manager (Committee Secretariat)

1.0.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

P Roseblade, Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted. Members **noted** that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members **noted** that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

The Committee Chair advised that at the end of the meeting, she would be seeking Members views as to how we have done in the meeting.

1.2 Apologies for Absence

Apologies for absence have been received from:

- Ian Wells, Independent Member,
- Hywel Daniel, Executive Director for People;
- Cally Hamblyn, Assistant Director of Governance and Risk;
- Dave Thomas, Audit Wales;
- Mark Jones, Audit Wales.

1.3 Declarations of Interest

No declarations of interest were received prior to the meeting.

2.0.0 CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 Unconfirmed Minutes of the Meeting held on the 28 April 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.2 Unconfirmed In Committee Minutes of the Meeting held on the 18 May 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.3 Unconfirmed Public Minutes of the Meeting held on the 18 May 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.2 FOR NOTING

2.2.1 Audit & Risk Committee Annual Cycle of Business

Resolution: The report was **NOTED.**

2.2.2 Audit & Risk Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED**.

3.0.0 MAIN AGENDA

3.1 GOVERNANCE

3.1.1 Audit & Risk Committee Action Log

G Galletly presented Members with the action log.

G Hughes provided Members with an update in relation to JAG Accreditation and advised that a recent JAG accreditation inspection had been undertaken on the Princess of Wales site. Members noted that there was one remaining action that needed to be completed in relation to the HSDU Unit and noted that JAG had given the Health Board and extension of six months in order for the Health Board to progress the Business Case for the Central Decontamination Unit at Princess of Wales Hospital. G Hughes advised that if JAG were assured on the position after six months then it was expected that JAG accreditation would be reinstated at the Princess of Wales site. Members noted that steps were being taken to prepare Royal Glamorgan Hospital and Prince Charles Hospital for their JAG

Accreditation inspections and noted that it was expected that accreditation would be limited at both hospitals at present, particularly at Prince Charles Hospital given the ground and first floor works that were being undertaken. G Hughes agreed to confirm when the six months extension was due to expire.

The Chair welcomed the review that had been undertaken on the process for leavers and noted the work that had been referred to in the Local Counter Fraud report in relation to potential overpayments to temporary staff during the pandemic.

Resolution: The Action Log was **NOTED**.

Action: Confirmation to be provided outside the meeting in relation to when the six month extension given by JAG was due to expire.

The Chair advised that the order of the agenda had changed slightly and advised that the Internal Audit Follow Up Review into the Patient Pathway Appointment Management Process would be discussed at this point in the meeting to allow for G Hughes to take part in the discussion.

5.3.5 Internal Audit Follow Up Review - Patient Pathway Appointment Management Process

P Dalton presented the report which was a follow up review following the initial review undertaken in October 2019. Members noted that a limited assurance rating was being given.

J Sadgrove expressed her disappointment at receiving a Limited Assurance Follow Up review and also expressed her disappointment at the management response which she felt lacked detail. J Sadgrove sought assurance that the position was actually going to change and that actions were going to be taken to address the position.

G Hughes advised that the disappointment expressed by J Sadgrove was fair and advised that he had found that waiting list management processes within the Health Board were not as robust and were not being managed at the levels expected compared to what he had experienced in other organisations. Members noted that waiting list management was an area of focus for the Planned Care Recovery process and noted that a piece of work would need to be undertaken to address administrative systems and standardise processes across the organisation. G Hughes agreed that the management response needed to be strengthened which would be addressed by the Planned Care Recovery Programme.

G Hughes advised that work was being undertaken with Clinicians to ensure outcome codings were clear and that the correct forms were being used at the end of each clinic. G Hughes advised that he would be working closely with the Director of Digital to address some of the issues and added that an Access Policy was in the process of being developed which sets out the standards and rules

for managing waiting lists to ensure consistency was in place across the Health Board. Members noted that this was a significant change management programme which would take time to address.

J Sadgrove extended her thanks to G Hughes for the helpful and encouraging update and highlighted that, flowing through the reports being presented to this particular meeting, there appeared to be some resistance in relation to standardisation being in place across the organisation. J Sadgrove added that she felt concerned as to whether it would be possible to move the organisation into a culture of ensuring standardisation was in place across the board which was a potential risk moving forward. G Hughes confirmed that there were legacy issues with variance in place within the Cwm Taf Morgannwg footprint in addition to the former Cwm Taf footprint and advised that it would be important to introduce the Access Policy outlining the rules and standards that needed to be followed across the organisation. Members noted that the changes being made to the Management Structure would help to address some of this as there would be one person managerially responsible for Planned Care across the organisation. G Hughes advised that consideration would also need to be given to service reconfiguration and consolidation of services which should also help to address some of the behaviours being experienced.

In response to a question raised by C Donoghue as to whether a realistic timescale had been set to achieve the actions given the significant cultural change that would need to be undertaken, G Hughes advised that the priority action would be the development of the Access Policy which would hopefully be in place by the end of the summer. Members noted that work would then need to be undertaken during Quarter 3 to embed the policy and it was then hoped that by the end of Quarter 4 the position would have improved enough to move away from a Limited Assurance rating. G Hughes advised that the cultural piece of work that would need to be undertaken with Clinicians was likely to take longer to address.

In response to concerns raised by the Chair in relation to the potential clinical risk in relation to patient records not being updated, G Hughes advised that there would always be a level of clinical risk for patients on waiting lists and agreed that the issues regarding standardisation of processes would need to be addressed as quickly as possible. Members noted that the patients who were at greater risk would be identified through manual processes and noted that the issues mainly related to capacity not being planned in the most effective way.

J Sadgrove advised that given that some of the aspects being discussed in relation to this report was patient harm, it would be helpful if the Quality & Safety Committee could be provided with regular updates on this matter via the Chief Operating Officers report. G Hughes agreed to provide regular updates to the Quality & Safety Committee.

Resolution: The report was NOTED.

Action: Regular updates to be included in the Chief Operating Officers report to Quality & Safety Committee on the work being undertaken to address the issues highlighted within the report.

4.0.0 SUSTAINING OUR FUTURE

4.1 Local Counter Fraud Report

M Evans presented Members the report.

J Sadgrove welcomed the comprehensive report and advised that she was pleased to see cases being closed relatively quickly. J Sadgrove made reference to the benchmarking data which indicated that there was some reluctance from staff to engage with in house training and sought clarity as to whether work was being undertaken with the communications team to consider whether there were alternative ways of raising awareness amongst staff. M Evans confirmed that there was recognition that staff were reluctant to engage in the programme and added the team were disappointed with the level of engagement. Members noted that consideration was being given to all available methods in relation to reaching out to staff with face to face information sessions being planned for the summer which would lead into Counter Fraud Awareness week. In response to a question raised by J Sadgrove as to whether there was any help that the Executive Team could provide in relation to raising awareness, M Evans confirmed that he would welcomed support from Executive colleagues in relation to awareness raising regarding specific issues, for example overpayment of salary issues. Members noted that case studies would also help to raise awareness amongst staff.

In response to a question raised by C Donoghue regarding the case relating to the theft of petty cash and the reasons as to why it was so complex, M Evans advised that the number of suspects involved and the nature of the offences made this case to be complex and added that the fraud had been ongoing over a number of years across a number of public sector organisations. Members noted that only one of the suspects had been an employee of the Health Board.

In response to a question raised by the Chair as to why the number of recoveries during 2021 had been greater than the number of referrals, M Evans advised that recoveries varied on a case by case basis and depended on the nature of each individual fraud. M Evans advised that he would be happy to undertake a detailed review of the position if required.

Resolution: The report was **NOTED.**

4.2 Loss & Special Payments Report

S May presented Members with the report.

Members noted that in relation to the outstanding Learning From Events reports, a contingent liability disclosure had been included in the annual accounts

regarding this matter and noted that work was being undertaken to mitigate the impact of reports not being submitted at speed. G Galletly confirmed that an action plan was in place and advised that progress was being made in this area which would create an opportunity for the risks to be reduced.

Members noted that there was an increase of £1.1m in the Welsh Risk Pool sharing agreement which had been included in the financial plan for 2022/2023.

Resolution: The report was **NOTED**.

4.3 Procurements and Scheme of Delegation Report

S May presented Members with the report.

The Chair made reference to the Andrew Scott Ltd Single Tender Action Waiver for £1m and sought clarity as to how much the original contract was for. S May advised that she would provide a response to Committee members outside the meeting regarding this.

The Chair sought clarity as to whether this was linked to the Internal Audit Report received on Facilities Governance which had identified issues with procurement processes not being followed. S May confirmed that this matter was disconnected from the Facilities report and advised that this related to the Estates Directorate and related to the rapid work undertaken last year to ensure Covid Capital funding was spent alongside a range of other pressures which meant that the preparation and full scoping of the project was not as advanced. S May advised that she would provide a fuller explanation to the Chair outside the meeting.

Resolution: The report was **NOTED**.

Action: Confirmation to be provided outside the meeting regarding the cost of the original contract for Andrew Scott Ltd.

Action: Explanation to be provided to the Committee Chair outside the meeting regarding the reasons behind procurement processes not being followed in relation to the Andrew Scott Ltd contract.

5.0.0 IMPROVING CARE

5.1 Audit Recommendations Tracker

G Galletly presented the report.

The Chair welcomed the evolving format of the report which she found to be really helpful and advised that it helped focus the mind on the most urgent long standing actions. The Chair sought clarity from Members as to whether they felt distracted by the level of detail contained within the previous updates column. G Galletly advised that the updates provided for the most recent period were

being included in the penultimate column and advised that if Members felt that the amount of information contained within the final column was distracting then this could be removed whilst still being retained on file. The Chair suggested that maybe Members could reflect on the position and share any comments outside the meeting.

J Sadgrove advised that whilst she recognised that efforts that had been made by G Galletly and her team in seeking updates, there were still a number of recommendations where no updates had been provided. J Sadgrove advised that the Committee needed to be assured that progress was being made against the recommendations or whether recommendations had been superceded. J Sadgrove suggested that it may be helpful to hold a separate session with Executive colleagues regarding the recommendations which had remained outstanding for a long period of time and would help focus the minds of the Executive Team. G Galletly supported this suggestion and advised that it may be timely to hold this session given the significant changes in personnel.

P Dalton advised that the way in which some of the older recommendations had been set out had been helpful to management and added that work had been undertaken over the last 6-8 months to ensure recommendations were more granular and manageable. P Dalton advised that as soon as some of the earlier recommendations had been closed this would make the audit tracker more manageable and easier to read.

The Chair made reference to the Bridgend Transfer of IT, recommendation 03, and advised that it appeared that this was being proposed for closure as a result of the resignation of the Head of Information Governance. The Chair added that she was not quite sure why the resignation would have prompted the closure of this recommendation given that at the time the audit had taken place the Head of Information Governance was in place. G Galletly advised that the recommendation had not been closed as a result of the resignation. Members noted that Information Governance resourcing had been identified as a risk on the risk register for some time and resourcing of the function had been difficult given the lack of additional funding. G Galletly advised that consideration was now being given to potential resource opportunities that may be created by the Operating Model realignment and added that interim arrangements were being put into place until the Head of Information Governance role was recruited into. The Chair advised that it was a management decision in relation to the closure of the recommendation which the Committee could support and added that the follow up audit would determine whether it was appropriate to close the recommendation down.

Resolution: The report was **NOTED**.

Action: Committee members to reflect as to whether they felt the level of detail contained within the final column of the tracker was helpful or distracting.

Action: Consideration to be given to holding a separate workshop with Executive Directors to discuss the older recommendations contained within the Tracker.

5.3 IMPROVING CARE

5.3.1 Internal Audit Progress Report

P Dalton presented the report.

J Sadgrove made reference to the table contained within Appendix A and advised that she could see that there were some draft reports that had been issued which had not made it onto today's agenda and sought clarity as to whether this was as a result of management responses not being received. P Dalton confirmed that management responses had not yet been received for these reviews.

J Sadgrove highlighted that previous Internal Audit Progress reports had included information in relation to performance and compliance against the receipt of management responses which had not been included in this report. P Dalton advised that was a result of a timing issue and added this information would be included in future iterations of the report. Members noted that performance figures for 2021/2022 in relation to completion of management responses had been included in the Internal Audit Annual Report. P Dalton advised that he felt optimistic that as we move into the new year management responses would be submitted in good time.

The Chair advised that the timeliness of management responses being submitted was highly important as late submission impacted on the time available to Internal Audit to digest the management response prior to it being presented to the Committee and asked if a reminder could be given to Executive colleagues regarding the timeliness of providing management responses. G Galletly advised that she had previously discussed this with P Dalton and advised that her team frequently had to chase management responses with matters being escalated to her if no response received. G Galletly advised that she was happy to further discuss this at the Executive Leadership Team to advise that focus was now being placed on this by Audit & Risk Committee Members.

Resolution: The report was **NOTED**.

Action: Further discussion to be held with the Executive Team in relation to timeliness of management responses to Internal Audit Reviews.

5.3.2 Internal Audit Review – Facilities Governance

E Samways presented the report which had been included as an additional review in the 2021/2022 plan following a request received from the Director of Finance. Members noted that the review had been allocated a Limited Assurance rating.

S May advised that whilst the Covid pandemic may have been one issue, the Facilities Team had persistently not followed procurement processes when

placing orders and added that their lack of understanding of the process had been a real issue. Members noted that whilst some progress had been made there was still a considerable amount of work that needed to be undertaken to ensure the team were correctly following processes.

J Sadgrove extended her thanks to S May for requesting for this audit to be undertaken and added that it was clear that there was significant risk in this area regarding absence of controls and cultural approaches which did not involve the following of any process. J Sadgrove welcomed the timeliness of the management actions, most of which were completed, and advised that she recognised that there was further work to do in this area. S May advised that the precision of the actions identified would help to track progress in this area.

The Chair advised that she felt encouraged by the enthusiasm of the management responses that had been provided which seemed to differ from the comments that had been made by S May. S May advised that whilst the action plan was a good plan, the Team had been persistently mis-interpretating the rules with a great deal of learning left to undertake.

In response to a question raised by the Chair as to when a follow up review would be undertaken, P Dalton advised that this would normally be undertaken during 2023 and added that he would be happy to work with the Health Board to determine the best time to undertake the follow up review.

S May advised that the Health Board should not be directing its audits to the areas where it was thought the best results would be achieved and added that the Health Board needed to use Internal Audit as a management tool to help identify the areas where further learning was required.

Resolution: The report was **NOTED**.

5.3.3 Internal Audit Review – Welsh Risk Pool

E Samways presented the report which had been allocated an overall rating of Reasonable Assurance. Members noted that there was a limited aspect of the report which related to the completion of the LFER documents within the timeframes.

G Galletly acknowledged the report and advised that a discussion would be held at the next Leadership Forum on the launch of the new Incident Management Framework which would help to contribute to better performance in relation to the completion of LFER's.

Resolution: The report was **NOTED**.

5.3.4 Internal Audit Follow Up Review – Medical & Dental Rostering

P Dalton presented the report which was a follow up to the initial review undertaken in 2019/2020. Members noted that the assurance rating had moved from Limited to a Reasonable Assurance rating.

P Dalton made Members aware that the Management Response indicated that no further action would be taken on the roll out of the Health Roster system within Anaesthetics and the Emergency Department which would continue to create inconsistencies across different services within the organisation. J Sadgrove expressed her concern regarding this and advised that the Board needed to be assured that resource was being utilised effectively and was being deployed in the best possible way and added that it had been felt that the Health Roster system would help to address this. J Sadgrove added that there didn't seem to be a plan in place to control and manage rostering moving forwards if this system was not going to be utilised.

S May advised that she was aware that Anaesthetics had wished to maintain the spreadsheet system they were currently using as there were issues with calculations within the Health Roster system which needed to be resolved before the Team felt comfortable in moving across to the system. Members noted that medical productivity, rostering and job planning were a key component of the Value and Effectiveness workstream.

The Chair advised that she also felt concerned regarding the management response which did not indicate that there were issues with the health roster system and queried whether this needed to be referred to another Committee for consideration. P Dalton advised that the management response regarding this review had been submitted quite late and added that the Internal Audit Team had requested more detail regarding the partially implemented recommendations. Following discussion, it was agreed that the review would need to be presented to the next meeting together with a strengthened management response for further scrutiny.

Resolution: The report was **NOTED**.

Action: Report to be presented back to next meeting with strengthened management response.

5.3.6 Internal Audit Review – Financial Systems

E Samways presented the report which had been allocated a reasonable assurance rating. S May advised that the review identified that further work needed to be undertaken to strengthen procurement and requisition processes and added that there was a need to remind staff of their responsibilities as budget holders.

The Chair welcomed the extensive management responses that had been provided and recognised that processes had continued to remain relaxed following the pandemic.

Resolution: The report was **NOTED**.

5.3.7 Internal Audit Review – Waste Management

E Jones presented the report which had been allocated a reasonable assurance rating, with substantial assurance given to three areas within the report.

The Chair welcomed the report which she had found to be highly encouraging.

Resolution: The report was **NOTED**.

5.3.8 Internal Audit Review – PCH Redevelopment: Technical Compliance

E Jones presented the report which had been allocated a reasonable assurance rating.

The Chair welcomed the report which she had found to be very positive.

Resolution: The report was **NOTED**.

5.3.9 Internal Audit Review – PCH Redevelopment: Quality Assurance Arrangements

E Jones presented the report which had been allocated a Substantial assurance rating.

The Chair extended her thanks to the Team for the work being undertaken in this area.

Resolution: The report was **NOTED**.

5.2 Organisational Risk Register

G Galletly presented the report.

The Chair advised that given the report had already been presented to Board, it felt odd that the Committee were being asked to approve a report retrospectively. The Chair also commented that the emerging risks were the same risks that had been presented to Audit & Risk Committee in April and the comments made in red also remained the same as the last report. G Galletly advised that the Team had been short staffed which had highlighted the need to bolster the resource to support the risk process as part of the realisation of the opportunities that would fall out of the Operating Model. G Galletly advised that the Team do try to ensure that the report being presented was as timely as possible.

Resolution: The report was NOTED.

5.4 AUDIT WALES

5.4.1 Audit Wales Audit & Risk Committee Update

S Utley presented the report and advised that Audit Wales would shortly be commencing their Structured Assessment for this year. Members noted that the management response for the review into Health & Social Care Partnerships had now been completed and noted that the report would be presented to the next meeting.

Resolution: The report was **NOTED**.

6.0.0 ANY OTHER BUSINESS

There was no other business to report.

A discussion was held in relation to how Committee members felt the meeting went today. The following responses were provided:

- Members agreed that presenters of reports had focussed on the key issues which had resulted in the agenda being managed in the time allocated and agreed that time had been spent on the most concerning areas;
- It was felt that the Committee had considered its values during the meeting and that strategic focus had been maintained;
- It was felt that there were some areas where sufficient assurance had not been provided to the committee which had resulted in Members seeking further assurance;
- It was felt that whilst the Committee did understand their risks to some degree, the Chair advised that she was unsure what the most important risks were for the Board. G Galletly advised that the Board Assurance Framework should hopefully provide an oversight to the Board of the key principal risks.

7.0.0 DATE AND TIME OF NEXT MEETING

The next meeting would take place at 3:00pm on Monday 22 August 2022.

8.0.0 CLOSE