CD&T Clinical Board Governance and Financial Arrangements

Final Internal Audit Report 2026/27

Cardiff & Vale University Health Board



Reasonable Assurance

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Executive Summary

Purpose

Our review of the processes in relation to Clinical Diagnostics and Therapeutics (CD&T) Clinical Board Governance and Financial Arrangements was completed in line with the 2026/27 Internal Audit Plan for Cardiff & Vale University Health Board ('the Health Board').

Governance structures and their applications are fundamental to ensuring the success of the Health Board in delivering its statutory obligations.

Good corporate governance plays a vital role in underpinning the integrity and efficiency of the Health Board and the wider community in which it operates. Robust properly developed and embedded governance structures are fundamental to ensuring the achievement of the Health Board's strategic objectives and in delivering its statutory, regulatory and legal requirements.

Each Clinical Board is led by a director and is required to have effective governance arrangements in place for the services they are accountable for, in order to provide assurance to the Board and its Committees on the quality and effectiveness of the services provided to its users, coupled with ensuring the aims and objectives set by the Board are delivered. Clinical Boards have delegated responsibility to manage their financial budgets, with support from designated Finance Business Partners.

CD&T Clinical Board has seven directorates covering Pharmacy and Medicines Management, Radiology and Medical Physics / Clinical Engineering, Therapeutics and Toxicology, Therapies, Medical Illustration, Outpatients / Patient Administration and Laboratory Medicine. These provide a wide range of diagnostic and therapeutic procedures on a local, national and UK-wide basis.

Overview

We have concluded **reasonable** assurance on this area. The matters requiring management attention are:

- There was an absence of a Terms of Reference for one Directorate governance group and some ToR required updating or finalising.
- Several meetings did not achieve the required quorum requirements set out in the ToR, and there was limited assurance that key members consistently attended meetings as required. In addition, meeting minutes were not always available for all meetings held, reducing the ability to demonstrate effective oversight, challenge and accountability.
- The Clinical Board has been unable to identify and deliver sufficient savings to meet the target set by the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	An appropriate governance structure is in place within the Clinical Board including all required groups, aligned to the Health Board's committee structures and directed by Terms of Reference (ToR)	1	**Reasonable**
2	Adequate governance arrangements are in place with meetings being conducted in line with TOR and notes or minutes being maintained that provide a record of the key discussions and decisions made during the meetings	2	**Reasonable**
3	The Clinical Board works collaboratively with their Finance Business Partners to manage their financial budgets, and the financial position is presented and discussed at appropriate meetings and actions are taken to address identified issues	-	**Substantial**

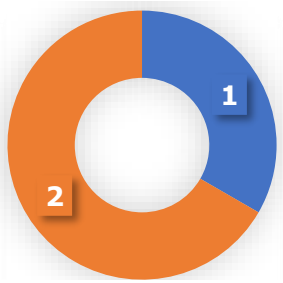
4	Appropriate savings plans are developed as part of the Clinical Board's Quality Improvement & Efficiency Plan (QIEP) and implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level, and risks to achievement of savings targets are identified	3	**Limited**

Management Actions

1
High Priority

2
Medium Priority

Themes



- Finance Management & Control
- Governance

Risk Types

Financial Loss

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: An appropriate governance structure is in place within the Clinical Board including all required groups, aligned to the Health Board's committee structures and directed by Terms of Reference (ToR)	**Reasonable**

Overview / Summary of Observations

The Clinical Board provides oversight across multiple directorates, each of which maintains local governance arrangements that feed into the wider Clinical Board structure.

The governance framework is supported by formal committees and groups, including the Clinical Board Formal Board and Combined Board, Senior Management Team, Quality, Safety and Experience (QSE) Subcommittee, Regulatory Compliance Group (RCG), Health and Safety Group, Directorate Performance Review Meetings and the Partnership Forum. These groups provide oversight of quality, safety, performance, regulatory compliance and operational risks. Clear escalation and reporting routes are in place, with directorate governance arrangements reporting through to the Clinical Board Formal and Combined Board and QSE Subcommittee to the Health Board Quality Committee. Health and safety matters are also reported through wider organisational governance structures.

The majority of Clinical Board and Directorate governance groups have Terms of Reference (ToR) in place, with detailed membership, attendance requirements and arrangements for representation clearly documented. However, some groups do not have ToR or have ToR that are out of date or require review.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Terms of Reference documentation** We reviewed key Clinical Board and Directorate governance meetings identified through discussions with Clinical Board senior management. Copies of the Terms of Reference (ToR) were obtained to assess whether they were current, clearly defined each group's purpose and objectives, and demonstrated alignment with the strategic aims of the Directorates, Clinical Board and Health Board. We noted that a few groups had no ToR or they were out of date including: • The Clinical Board Quality, Safety and Experience (QSE) Sub Committee and Regulatory Compliance Group (RCG) ToR were still recorded as draft documents. • The Blood Transfusion Laboratory Quality Group ToR were dated April 2024. • There was no ToR for the Outpatients Patients Admin Directorate Group.	Outdated, draft, or absent Terms of Reference may result in unclear governance arrangements, accountability gaps, and inconsistent decision-making. **Medium Priority**	**Agreed Action:** We will review all Clinical Board and Directorate governance groups to ensure current, approved Terms of Reference are in place. **Expected Evidence of Implementation:** Directorates to confirm in writing that ToRs are in place. **Officer:** Director of Operations **Target Implementation Date:** 31/12/2026

	Theme: Governance	Control Operation	

Objective 2: Adequate governance arrangements are in place with meetings being conducted in line with TOR and notes or minutes being maintained that provide a record of the key discussions and decisions made during the meetings	**Reasonable**

Overview / Summary of Observations

We found that governance arrangements are generally well established, with formal governance groups operating under approved Terms of Reference (ToRs), regular meeting schedules, documented reporting lines and evidence of action tracking and escalation processes. Clinical Board Formal Board and Combined Board, Quality, QSE Subcommittee and RCG meetings were supported by agendas, minutes and action logs, providing evidence of oversight and follow-up of key issues.

Governance oversight was weakened by incomplete meeting records, inconsistent achievement of quorum requirements, and variable attendance across key committees and groups. Missing minutes and limited documentation reduced assurance that governance processes were operating effectively, while several meetings were not quorate. Attendance levels were inconsistent, with low participation from some key leadership and specialist roles, limiting effective oversight, challenge, and decision-making.

Overall, governance arrangements are operating effectively in many areas; however, improvements are required to strengthen compliance with meeting schedules and improve attendance and representation.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Compliance with ToR requirements and documenting of meetings** We requested the Clinical Board and Directorate Groups meeting minutes for the period June 2025 to May 2026 and review of those provided identified the following: **Formal Board and Combined Board** • The Executive Board Representative is a member of the group but has not attended any of the Formal Board meetings. • The February 2026 meeting of the Combined Board was not quorate, although attendance overall was high. The ToR states that from 11 members 50% would make up quoracy. • It was identified that attendance levels for some members was below 50% which included the Clinical Board Lead Staff Representative (33%); Finance Business Partner (33%); Lead Nurse (33%). **Quality Safety and Experience Subcommittee** • The Clinical Board Director did not attend any of the meetings.	Meetings proceeding without the required quorum could result in decisions being made without sufficient authority or representation.	**Agreed Action:** We will introduce standard arrangements for agendas, minutes, action logs, attendance and quorum recording. Non-quorate meetings and any decisions requiring subsequent ratification will be clearly documented. Attendance and compliance will be reviewed bi-annually, with recurring concerns escalated to the relevant chair or manager.

- We identified that attendance levels for some members were below 50% which included the Clinical Board Director of Operations (36%); Deputy Clinical Board Director of Operations (45%); Directorate Managers/Heads of Service (varied between 9% and 45%) and Directorate Quality Managers / Clinical Governance Leads (varied between 9% and 36%).

Regulatory Compliance Group

- Quoracy requirements were not met at meetings held between June to October 2025, February 2026 and March 2026. Attendance at the March 2026 meeting was limited to six members, falling below the quorum requirement of seven members as specified in the ToR.
- We identified that attendance levels for some members were below 50% which included the Deputy Director of Operations (30%), Quality Manager Haematology (40%) and Principal Pharmacist Quality Control & Qualified Person, St Marys Pharmaceutical Unit (10%).
- Agendas were not produced for this group.

Health and Safety Group

- We reviewed the meetings and it was identified that the Deputy Fire safety manager did not attend any meetings; the senior fire safety adviser attendance was 29%; Staff side representative and Directorate Representatives were on average 29% attendance for all meetings held.
- Agendas were not produced for this group.

Medical Biochemistry & Immunology Management Group

- Quoracy was difficult to validate as ToR states that "core members strive to attend" it does not provide a definitive quoracy level.
- There were 17 members noted on ToR, however, only nine members attended the meetings of which the Quality Manager only attended 33% of the meetings.

Medical Biochemistry & Immunology Quality Group

- The Laboratory Director only attended 40% of meetings and Laboratory Quality Officer did not attend any meetings.

Outpatients Patients Admin Directorate and Blood Transfusion Quality Meeting Data Review

Expected Evidence of Implementation:

	• Limited minutes were available for these Groups. For the Outpatient patient Admin Directorate, minutes were only available for March 2025, while for the Blood Transfusion Quality Meeting Data Review, minutes were only available for May 2026.		Standard templates created for Directorate use, complete meeting records, a non-quorate meeting and ratification log, and quarterly compliance reports.
	Theme: Governance	**Medium Priority** Control Operation	**Officer:** Director of Nursing and Multidisciplinary Teams **Target Implementation Date:** 31/12/2026

Objective 3: The Clinical Boards work collaboratively with their Finance Business Partners to manage their financial budgets, and the financial position is presented and discussed at appropriate meetings and actions are taken to address identified issues	**Substantial**

Overview / Summary of Observations

Monthly finance reports are prepared and presented to budget holders and governance forums, with financial performance reviewed regularly at the Formal Board, Combined Formal Board, Directorate Performance Review and Executive Turnaround meetings. The Senior Finance Business Partner is a regular attendee at these forums, providing ongoing support, challenge and scrutiny of financial performance.

The Clinical Board Formal Board minutes demonstrated regular consideration of the Health Board's financial position, Clinical Board control totals, savings requirements, workforce affordability, financial recovery plans and forecast budget pressures. Directorate Performance Review meetings provided further operational-level scrutiny, including review of budget variances, pay and non-pay expenditure, vacancies, recruitment proposals, affordability assessments, cost pressures and savings opportunities.

Evidence demonstrated that emerging financial issues were identified, discussed and challenged appropriately. Actions arising from discussions were clearly recorded and monitored through established governance processes.

Overall, there is evidence of effective budget management, regular engagement with the Finance Business Partner, and timely discussion and escalation of financial risks and issues.

Objective 4: Appropriate savings plans are developed as part of the Clinical Board's Quality Improvement & Efficiency Plan (QIEP) and implementation of agreed savings plans are monitored, reported and acted upon at Clinical Board level, and risks to achievement of savings targets are identified.	**Limited**

Overview / Summary of Observations

The Clinical Board has established arrangements to develop, monitor and report savings plans as part of its 2026/27 Quality Improvement & Efficiency Plan (QIEP). Savings targets and delivery plans were reviewed through the Formal and Combined Formal Board meetings, with responsibility for delivering the £4.916m savings target delegated across directorates. A centrally maintained savings tracker is used to record, monitor and report savings schemes, including scheme ownership, forecast delivery and RAG ratings. Savings performance is routinely scrutinised through Formal Clinical Board meetings, Directorate Performance Reviews, finance meetings and Executive Turnaround meetings, with identified delivery issues and recovery actions subject to challenge and escalation.

There is evidence that risks to achieving savings targets are actively monitored. The savings tracker, turnaround arrangements and executive oversight processes provide visibility of delivery confidence, emerging risks, dependencies and barriers to implementation. Savings gaps are routinely reported and discussed, with directorates required to identify additional opportunities and recovery actions where targets are at risk. Enhanced monitoring arrangements including Turn Around meetings with the Executive Director of Finance have also been introduced during 2026/27 in response to the scale of the financial challenge.

As detailed above, the Clinical Board has a 2026/27 savings target of £4.916m. Current forecasts indicate that cash releasing savings rated Green and Amber will deliver £2.459m, resulting in an anticipated shortfall of £2.456m (50%) against the target. While total identified schemes amount to £2.770m, this includes £311k of Red-rated schemes, highlighting a significant level of delivery risk.

The cash releasing savings are forecast to achieve £1.783m against the recurrent target of £4.916m, leaving a larger projected gap of £3.133m (64%).

Collectively, these issues highlight a significant risk to the Board's ability to achieve its savings objectives and demonstrate the need to identify, develop and implement further sustainable savings and income generation opportunities.

Key Findings		Risk & Impact	Agreed Management Action
3	**Savings** Whilst governance and monitoring arrangements are well established, sufficient savings plans had not been identified to achieve the full savings target at the time of review. As of 30 June 2026, the Clinical Board had identified £2.459m of Green and Amber-rated schemes against a target of £4.916m, leaving a shortfall of approximately £2.456m. Management confirmed there was no clear line of sight to achieving the full target, despite a few emerging opportunities. Consequently, while savings delivery is being actively monitored and risks are clearly identified, assurance over achievement of the full savings target remains limited.	Failure to identify and approve sufficient savings schemes to meet the Clinical Board's QIEP savings target may result in non-delivery of planned financial savings, increased financial pressures, and reduced assurance over the achievement of financial recovery objectives.	**Agreed Action:** The Board will continue to develop further recurrent savings schemes to address the remaining QIEP gap. Each scheme will have a named lead, quantified benefit, milestones, financial validation and appropriate impact assessment. Delivery will be monitored weekly, with recovery actions or replacement schemes agreed where delivery is at risk.
			Expected Evidence of Implementation: Minutes from Turnaround Meetings
		High Priority	**Officer:** Director of Operations
	Theme: Finance Management & Control	Control Design	**Target Implementation Date:** Immediate

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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