Audit & Assurance Committee Meeting

Tue 06 February 2024, 09:00 - 11:05

Microsoft Teams

Agenda

09:00 - 09:10
10 min

1. Preliminaries

1.1. Welcome & Introductions

Rhian Thomas

1.2. Apologies for Absence

Rhian Thomas

1.3. Declarations of Interest

Rhian Thomas

1.4. Minutes of the Committee meeting held: 07.11.2023

Rhian Thomas

1.4 Draft Public Audit Minutes 07.11.2023.pdf (11 pages)

1.5. Actions following meeting held: 07.11.2023

Rhian Thomas

1.5 Audit Public Action Log.pdf (2 pages)

1.6. Any Other Urgent Business

Rhian Thomas

09:10 - 10:40
90 min

2. Items for Review & Assurance

45 minutes

2.1. Internal Audit Progress Report including:

Ian Virgil

- *Mental Health Clinical Board Governance Arrangements*
- *Capital Systems*
- *Infection, Prevention & Control*
- *Technical Continuity*
- *Estates Condition*
- *Health Roster System*
- *Alcohol Standards*
- *Shaping Our Future Wellbeing – Future Hospital Programme*

2.1 A&A Progress Report February 24 cover.pdf (3 pages)
2.1a CV AC A&A Progress Report February 24.pdf (22 pages)
2.1b Cover Report Internal Audit Reports for Information.pdf (2 pages)

2.1c MH CB Governance Final Report.pdf (16 pages)
2.1d Capital Systems Management Final Internal Audit Report.pdf (18 pages)
2.1e IPC Draft Internal Audit Final Report.pdf (19 pages)
2.1f Technical continuity final IA Report.pdf (20 pages)
2.1g Estates Condition - Final Audit Report (002).pdf (29 pages)
2.1h Implementation of Health Roster System final report.pdf (30 pages)
2.1i Alcohol Standards Final Audit Report 1.pdf (19 pages)
2.1j SOFH Governance Review Final Report.pdf (14 pages)

2.2. Audit Wales Update to include:

20 minutes *Wales Audit*

- *Structured Assessment 2023*

2.2 CVUHB Audit Committee Update (February 2024).pdf (14 pages)
2.2a Structured Assessment 2023 Report (FINAL).pdf (44 pages)

2.3. Review of the Risk Management System verbal update

Matt Phillips

5 minutes

2.4. Procurement Compliance Report / Single Tender Actions

Catherine Phillips

10 minutes

2.4 Procurement Audit Committee Board Report.pdf (8 pages)

2.5. BREAK – 10 minutes

10:40 - 10:50
10 min

3. Items for Approval/Ratification

3.1. Audit Wales Annual Report

Wales Audit

5 minutes

3.1 CVUHB Annual Audit Report 2023 (FINAL).pdf (24 pages)

3.2. Review of Workforce planning Arrangements

Wales Audit

5 minutes

3.2 CVUHB Workforce Planning.pdf (34 pages)

10:50 - 11:05
15 min

4. Items for Noting & Information

4.1. Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report

Matt Phillips

5 minutes

4.2. Counter Fraud Progress Update

Catherine Phillips / Gareth Lavington

4.2 COUNTER FRAUD PROGRESS PUBLIC COVER SHEET.pdf (2 pages)
4.2a COUNTER FRAUD PROGRESS REPORT PUBLIC.pdf (9 pages)

4.3. Thematic Engagement Exercise – Good Practice

Catherine Phillips / Gareth Lavington

4.3 Good Practice _ PUBLIC _ COVER SHEET.pdf (6 pages)
4.3a GoodPracticeCardiff v1.0 (1).pdf (8 pages)

11:05 - 11:05
0 min

5. Agenda for Private Audit and Assurance Committee

i. *Counter Fraud Progress Update (Confidential – ongoing investigations*
ii. *Health Board Salaries Overpayment Update*

11:05 - 11:05
0 min

6. Any Other Business

11:05 - 11:05
0 min

7. Review & Final Closure

7.1. Items to deferred to the Board / Committees

7.2. Date and Time of the next Committee meeting:

Tuesday 2nd April 2024 at 9am via MS Teams

11:05 - 11:05
0 min

8. Declaration

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

Minutes of the Public Audit & Assurance Committee Meeting
Held On 7 November 2023 at 9:00am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair (CC)
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Rhian Thomas	RT	Independent Member for Capital and Estates (IM-CE)
In Attendance:		
Rachel Gidman	RG	Executive Director of People and Culture
Mark Jones	MJ	Audit Manager – Audit Wales
Lucy Jugessur	WW	Interim Deputy Head of Internal Audit (IDHIA)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist (LLCFS)
Robert Mahoney	RM	Deputy Director of Finance
Sion O'Keefe	SK	Directorate Manager – CD&T
Urvisha Perez	UP	Audit Lead - Audit Wales
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Ian Virgil	IV	Head of Internal Audit (HIA)
James Webb	JW	Head of Information Governance
Adam Wright	AW	Head of Operational Planning
Observers:		
Keisha Megji	KM	Management Graduate Trainee
Glynis Mulford	GM	Risk & Regulation Officer
Aimee Osborne	AO	Financial Management Graduate Trainee
Frankie Thomas	FT	Head of Corporate Governance
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Ceri Phillips	CP	UHB Vice Chair
David Thomas	DT	Director of Digital & Health Intelligence

Item No	Agenda Item	Action
AAC 23/11/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 23/11/002	**Apologies for Absence** Apologies for absence were received. **The Committee resolved that:** a) Apologies were noted.	
AAC 23/11/003	**Declarations of Interest** **The Committee resolved that:**	

	a) No Declarations of Interest were noted.	
AAC 23/11/004	**Minutes of the Meeting Held on 5th September 2023** The Minutes of the Meeting Held on the 5th September 2023 were received. **The Committee resolved that:** a) The draft minutes of the meetings held on 5th September 2023, were held to be a true and accurate record of the meeting.	
AAC 23/11/005	**Action Log – Following Meeting held on 5th September 2023** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 23/11/006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
AAC 23/11/007	**Internal Audit Progress Report** The Internal Audit Progress Report was received. The Head of Internal Audit (HIA) reminded the Committee that the report outlined the work undertaken by the Audit & Assurance Service in accordance with its annual plan and set out the program of work for the year ahead. He added that the 6 assignments noted in the table of the report, which included: • Estates Assurance – Estate Condition • Shaping Our Future Wellbeing – Future Hospitals Programme • Implementation of Health Roster System • Mental Health Clinical Board Governance • Mortality Reviews • Alcohol Standards Had been planned to be reported to the November Audit Committee but had not met the deadline. It was noted that the Estates Assurance and Shaping Our Future Wellbeing – Future Hospitals Programme reports were more complex and required further discussion with management to ensure that both sides were happy with the reports and the outcomes before being finalised. The HIA advised the Committee that 8 assignments had been finalised since the previous meeting of the Committee and were highlighted in the report along with the allocated assurance ratings which included: • Refresh of the Health Board's Strategy – Substantial Assurance • Urgent and Emergency Care – Welsh Government Six Goals Programme – Substantial Assurance	

- PARIS System – Reasonable Assurance
- Follow-up: Chemocare IT System – Reasonable Assurance
- Surgery Clinical Board - Consultant Job Plans – Limited Assurance
- Pentyrch Surgery Development – Site Evaluation Process – Advisory
- Leadership and Management Training and Development – Advisory
- Quality, Safety & Experience Governance – Advisory

The Committee was advised of the overall progress on the delivery of the 2023/24 Internal Audit Plan which included:

- 8 audits from the 2023/24 plan had been finalised and 5 others had reached the draft report stage.
- 7 audits were currently a work in progress with a further 8 at the planning stage.

The HIA noted that of the 36 audits within the plan, there were only the 8 yet to be started which provided good assurance to the Committee.

He added that the appendix A received by the Committee included details of the 3 audits from the 2022/23 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2022/23 and noted that the outcomes from those audits would feed into the 2023/24 Opinion.

It was noted that appendix C received by the Committee showed the current level of performance against the Audit & Assurance Key Performance Indicators (KPIs).

The Interim Deputy Head of Internal Audit (IDHIA) and HIA summarised the final audit reports which included:

- The Refresh of the Health Board's Strategy and noted the assurance rating of Substantial.

The Independent Member – Capital & Estates (IMCE) asked what recommendations could be made based upon the findings from Internal Audit around the stakeholder engagement on the Health Board's Strategy.

The IDHIA responded that at the time of writing the report, Welsh Government (WG) had released a document that stated the level of engagement required and noted that the document was very well produced.

- Urgent and Emergency Care – Welsh Government Six Goals Programme and noted the assurance rating of Substantial.

- PARIS System and noted the assurance rating of Reasonable.

- Follow-up: Chemocare IT System and noted the assurance rating of Reasonable.

- Surgery CB - Consultant Job Plans and noted the assurance rating of Limited.

The HIA advised the Committee that the significant matters which required management attention included but were not limited to:

- Not all job plans were on the allocate e-job planning system.
- All job plans were out of date or not agreed and fully signed off
- No evidence to confirm additional approval of job plans with over 12 sessions per week.
- Personal outcomes were not being recorded.

The Executive Director of People & Culture advised the Committee that all job planning had a two signature sign off and noted that the Executive team were asking for trajectories at the Executive reviews with each clinical board.

- Leadership and Management Training and Development – It was noted that it was an advisory review to support management, rather than an assurance report, therefore no assurance rating was offered.

- Quality, Safety & Experience Governance - It was noted that it was an advisory review to support management, rather than an assurance report, therefore no assurance rating was offered.

The Head of Operational Planning (HOP) joined the meeting to provide further information on the Limited Assurance received on the Surgery CB - Consultant Job Plans.

The HOP advised the Committee that the team had identified issues within job planning across a number of areas and had focused on two of the biggest surgical specialties in the surgical clinical board:

- General surgery
- Trauma

It was noted that those 2 areas covered around 58 consultants.

It was noted that the findings from Internal Audit had been received and accepted by the clinical Board and that there was no dispute into the accuracy of the report.

The HOP added that a lot of the general surgery actions had been completed and that outstanding actions had a completion date set for November and December 2023 and so assurance could be provided that actions would be completed.

It was noted that the Trauma speciality was not quite as ahead as General Surgery and that an update had been provided the week prior to the meeting which had highlighted that all of the consultants who were missing from the job planning had been added onto the allocation of job plans.

The HIA thanked the HOP for the summary and noted he would liaise with him to bring back a report to the Committee in April 2024.

The Committee resolved that:

a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report were considered.

AAC 23/11/008	**CD&T Clinical Board Medical Records Tracking Update** The CD&T Clinical Board Medical Records Tracking Update was received. The Directorate Manager for CD&T (DMCDT) advised the Committee that in January 2023, the Internal Audit Report on Medical Records Tracking was finalised and it concluded that there was 'Limited Assurance' with regards the effectiveness of the mechanisms for tracking medical records; within and external to the Health Records department. He added that the audit outlined seven recommendations and significant progress had been undertaken against those with two 'High' priority recommendations completed and two 'High' priorities in progress. It was noted that the report also outlined two 'Medium' priorities, both of which were in progress and one 'Low' priority which was also in progress. The DMCDT outlined and provided assurance on each of the priorities which included: • Recommendation R1/ 7: The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) which required review. • Recommendation R3/ 7: Management should consider viable options to address the issues identified through our observations of security and storage arrangements of Health Records. • Recommendation R5/7: Management should ensure staff were reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location. • Recommendation R2/7: In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there was a line of sight to the accountable executive of the policy and procedure. • Recommendation R4/7: Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that could be escalated for resolution. • Recommendation R6/7: Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on the findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between University Hospital Llandough (UHL) and University Hospital of Wales (UHW), and random spot checks on locations. • Recommendation R7/7: Following the implementation of recommendations 1 and 2 within the report, consideration should be given by management and the relevant governance forums of how the known barriers to digitisation could be addressed, if the Health Board aspired to digitise Health Records.	

	The CC thanked the Clinical Board for all of the hard work being undertaken to achieve the recommendations outlined and noted that seeing the progress as well as the digitalisation of records was a good thing for patients. The HIA added his thanks and noted the comprehensive update provided which would help to inform Internal Audits follow up report. **The Committee resolved that:** a) The contents of the report and progress made against recommendations were noted.	
AAC 23/11/009	**Updated Policies Plan** The Updated Policies Plan was received. The Director of Corporate Governance (DCG) advised the Committee that the update followed an internal audit report received in May 2023 and provided updates on the actions being taken which included: • A dedicated Policy lead within the Corporate Governance Team • Baselining the entire catalogue of policies in the Health Board to identify which policies were out of date and who owned the policies. It was noted that policy owners would be contacted to provide an update. • Identification of the benefits of using the Audit Management and Tracking platform (AMaT) that was currently used by a number of Clinical Boards for Audits, Inspections and Projects. The DCG advised the Committee that Internal Audit would review the policies plan in quarter 4 (Q4), by which time the remaining policy owners and authors would have been identified and the works to transfer each policy to AMaT in progress, allowing for full demonstration of the increased controls, transparency, access and ownership. The CC asked if Q4 was an appropriate timescale. The DCG responded that he welcomed the timescale but noted that there were over 500 policies that needed attention and so the help of Internal Audit would be of benefit. The HIA added that he was comfortable with the approach identified and would liaise with the DCG to ensure actions were taken. **The Committee resolved that:** a) The update and the intended Course of action was noted.	
AAC 23/11/010	**Audit Wales Update** The Audit Wales Update was received. The Audit Lead - Audit Wales (ALAW) advised the Committee that Exhibit 2 received by the Committee summarised the status of Audit Wales' current and planned performance audit work.	

	She added that she would take the report as read and highlighted key points which included: • The draft report for the review of workforce planning arrangements had been issued and later in November 2023, the draft Primary Care follow up review report would be issued for clearance through the Health Board. • The Structured Assessment for the Health Board was being finalised and would be received by the Committee at its February meeting. The ALAW advised the Committee that the original plan had been to provide a deep dive on digital arrangements on the structured assessments but noted that due to the financial challenges across NHS Wales, a piece of work would be undertaken which would focus on approaches being taken by Health Bodies to achieve cost improvements and financial sustainability. • NHS workforce data briefing. It was noted the briefing highlighted the workforce challenges faced by the NHS in Wales and brought together a range of metrics and comparisons with other nations as well. The ALAW noted that it would be beneficial for the People & Culture Committee to receive the briefing. The EDPC responded that the briefing would be taken to the People & Culture Committee as well as the Senior Leadership Board. The ALAW concluded that the report would be received by the Committee at its February 2024 meeting. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 23/11/011	**Internal Audit Recommendation Tracker Report, Audit Wales Recommendation Tracking Report and Regulatory Compliance Tracking Report** The Internal Audit Recommendation Tracker Report, Audit Wales Recommendation Tracking Report and Regulatory Compliance Tracking Report were received. The DCG advised the Committee that he would take the 3 reports together and would take them as read by the Committee. He added that the overarching point was that alongside the update he had provided around policies earlier in the meeting, there would be a restructuring of the Corporate Governance Team with the intention that each tracker received by the Committee would be split between 3 Corporate Governance Officers. He added that each of the reports provided specific attention and representation of ongoing discussions. The DCG advised the Committee that he attended all Committee of the Board meetings and that another layer of assurance he could provide was that the discussions happening at those meetings were taking place.	

	The HIA responded that it was a sensible approach to split the responsibility for the trackers across the Corporate Governance Team. He added that from within the trackers received, he had been able to identify older audits which were felt to still be appropriate. The DCG added that as an outstanding action, all audits from 2019/2020 would be looked at and ongoing action taken. The CC noted that he was assured that at each meeting, good progress was being made. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in July 2023 was noted and assurance provided c) The progress which had been made in relation to the completion of Audit Wales recommendations was noted and assurance provided. d) The continuing development of the Audit Wales Recommendation Tracker was noted e) The updates shared were reviewed and assurance was taken from the continuing development and review of the Legislative and Regulatory Compliance Tracker.	
AAC 23/11/012	**Procurement Compliance Report – Chair's Action Review** The Procurement Compliance Report – Chair's Action Review was received. The EDF advised the Committee that a lot of Chairs Actions were received and an improvement project was requested to see how improvements could be made because the finance team were having to ask some very senior people to make decisions of high value at short notice. She added that the improvement piece of work had been in train for about 6 to 12 months now and that there was still quite a high volume of Chairs Actions being received, but noted that any contract over £1,000,000 would need that standard of approval. The EDF concluded that a Chairs Actions review would be received by the Committee every 6 months. The CC asked how many of the Chairs Actions requests had been received by the Board. The EDF responded that she would include that data on future analysis reports. **The Committee resolved that:** a) The contents of the Report was noted.	
AAC 23/11/013	**Procurement Compliance Report / Single Tender Actions**	

	The Procurement Compliance Report / Single Tender Actions were received. The Deputy Director of Finance (DDF) advised the Committee that he would take the report as read and noted that the Single Tender Actions (STAs) were coming down and comparators had been referenced within the paper received by the Committee. **The Committee resolved that:** a) The contents of the Report were noted and approved/agreed.	
AAC 23/11/014	**Annual Clinical Audit Plan** The Annual Clinical Audit Plan was received. The Executive Medical Director (EMD) advised the Committee that she would take the paper as read. She added that the assurance provided from the audit team was strengthening all the time and that the report gave an overview of audit plans going forward. It was noted that whilst it was recognised that there was a significant amount of clinical audit underway across the Health Board, the oversight and governance of that audit was lacking and the activity was not always focused on quality and patient safety priorities. The EMD advised the Committee that a Clinical Effectiveness Committee had been strengthened to support improved membership and engagement from Clinical Boards where audits were reviewed. She added that Clinical Boards attend the Clinical Effectiveness Committee as a priority and noted that anything major would be escalated to the Quality, Safety & Experience Committee. The Committee was advised that the introduction of the Audit Management and Tracking (AMaT) system was a big step taken to provide assurance against audits. **The Committee resolved that:** a) The assurance provided by the development of the clinical audit policy and strategy as well as the audit underway and planned for 2023/24 was noted.	
AAC 23/11/015	**Counter Fraud Progress Report - Review the effectiveness of Counter Fraud Specialist.** The Counter Fraud Progress Report - Review the effectiveness of Counter Fraud Specialist was received. The Lead Local Counter Fraud Specialist (LLCFS) advised the Board that he would take the report as read and noted that the report seeked to provide assurance to members of the Audit Committee that the Counter Fraud work being undertaken was satisfactory, robust and compliant with NHS Counter Fraud Authority requirements.	

	He added that fraud work had started in relation to 5 areas which included: • Progress made against the Annual Counter Fraud Plan • Promotional /Educational Activity • Summary of Investigations • Prevention activity • National Fraud Initiative work It was noted that the work should be completed by February 2024. The CC asked if there was sufficient staff to complete investigations. The LLCFS responded that there was but noted that it was sometimes difficult to prioritise well within the team. **The Committee resolved that:** a) The report was noted.	
AAC 23/11/016	**Internal Audit Reports for information** The Internal Audit Reports for information were received and included: • Refresh of the Health Board's Strategy - (Substantial Assurance) • Urgent and Emergency Care – Welsh Government Six Goals Programme – (Substantial Assurance) • PARIS System – (Reasonable Assurance) • Follow-up: Chemocare IT System – (Reasonable Assurance) • Surgery CB - Consultant Job Plans – (Limited Assurance) • Leadership and Management Training and Development (Advisory) • Quality, Safety and Experience Governance (Advisory) **The Committee resolved that:** a) The final Internal Audit reports were considered and noted.	
AAC 23/11/017	**Review of Draft Charitable Funds Annual Report and Accounts** The Review of Draft Charitable Funds Annual Report and Accounts were received. The DDF advised the Committee that he would take the report as read and noted that the timetable for the Charity accounts was different form the main set of Health Board accounts. He added that they accounts had been completed an sent to Audit Wales **The Committee resolved that:** a) The reported financial performance contained within the Draft Annual Accounts was noted. b) The response of the audit enquiries to management and those charged with governance was noted. c) The Draft Annual Accounts were supported and endorsed.	

AAC 23/11/018	**Agenda for Private Audit and Assurance Committee** *i. Audit of Accounts Report Addendum – Recommendations (Confidential Discussion)* *ii. Pentyrch Advisory Internal Audit Report (Confidential Discussion)* *iii. Cyber Security Update (verbal)* *iv. Counter Fraud Progress Update (Confidential – ongoing investigations* *v. Overpayments of Salary (Confidential Discussion)* *vi. Procurement Improvement Plan Update*	
AAC 23/11/019	**Any Other Business** No Other Business was discussed.	
AAC 23/11/020	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
AAC 23/11/021	**Date and time of next committee meeting** Tuesday 6th February at 9am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
7 November 2023
(Updated for the meeting being held 6 February 2024)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions					
AAC 23/11/010	Audit Wales Update	The Structured Assessment, Workforce Planning Report and Primary Care Follow Up Report to be received by the Committee at its next meeting	Audit Wales	**06.02.2024**	**COMPLETED** *On February 6th Agenda (item 2.2)*
AAC 23/11/011	Internal Audit Recommendation Tracker Report	All recommendations from 2019/20 to be looked at and details to explain actions being taken to close those off where appropriate to be received by the Committee.	Matt Phillips	**06.02.2024**	**COMPLETED** *On agenda for April meeting. Verbal update to be given.*
AAC 23/11/014	Procurement Compliance Report – Chair's Action Review	An update on improvements around the progress and structure of how Chairs Actions are processed to be received by the Committee in 6 months' time.	Catherine Phillips / Claire Salisbury	**07.05.2024**	**COMPLETED** *On Forward Plan for May's meeting.*
AAC 4/7/23/014	Updated Policies Plan	Update on the Plan be brought to the Committee.	Matt Phillips	**07.11.2023**	**COMPLETED** *Committee updated on 07.11.2023 via agenda item 2.3*
AAC 5/9/23/014	Counter Fraud Progress Report	To provide information on how many salary overpayments have come through to the Counter Fraud team.	Gareth Lavington	**07.11.2023**	**COMPLETED** *Committee updated on 07.11.2023 via agenda item 2.12*
AAC 7/2/23/007	Internal Audit Progress Report	Follow up audit report in relation to the Medical Records Tracking (CD&T Clinical Board) to be brought to Committee at a later date.	Internal Audit	**07.11.2023**	**COMPLETED** *Committee updated on 07.11.2023 via agenda item 2.2 from Sion O'Keefe*

AAC 4/7/23/007	Follow up Audits	To build in-between projects to ensure that they have followed all the right governance.	Ian Virgil	**07.11.2023**	**COMPLETED** *Committee updated on 07.11.2023*
Actions in Progress					
AAC 23/11/009	Policies Plan	An update on the policies plan to be provided to the Committee at the next meeting following assistance from Internal Audit	Matt Phillips	**06.02.2024**	**Update to be given in February 2024**
Actions referred to Board / Committees					
AAC 23/11/010	Audit Wales Update	The People & Culture (P&C) Committee to receive the NHS Workforce Data Briefing at their next available meeting	Rachel Gidman	**23.01.2024**	**COMPLETED** *P&C Committee updated on 23.01.2024*

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	2.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	06/02/24	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report

Background and current situation:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University Health Board.

The work undertaken by the Audit & Assurance Service is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Audit & Assurance Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the engagement process established with the Health Board.

The 2023/24 plan was formally approved by the Audit Committee at its April 23 meeting.

The progress report provides the Audit & Assurance Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including commentary as to progress with the delivery of assignments.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The progress report highlights the conclusions and assurance ratings for audits finalised in the current period.

The following reports have been finalised since the November 23 meeting:

- Mental Health Clinical Board Governance Arrangements (Reasonable Assurance)
- Capital Systems (Reasonable Assurance)
- Infection Prevention & Control (Reasonable Assurance)
- Technical Continuity (Reasonable Assurance)
- Estates Condition (Limited Assurance)
- Health Roster System (Limited Assurance)
- Alcohol Standards (Limited Assurance)
- Shaping Our Future Wellbeing – Future Hospitals Programme (Advisory)

The progress report also includes details of proposed adjustments to the 2023/24 plan.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report.
- **Approve** the proposed adjustments to the 2023/24 plan.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	X	Integration	x	Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.
Safety: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes an audit that provides assurance around controls and processes relating to patient safety.
Financial: ~~Yes~~/No
Workforce: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes audits that provide assurance around controls and processes relating to workforce.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
The progress report provides an update on the delivery of the Internal Audit plan for 2023/24, which includes audits that provide assurance around reputational risks.
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No

Decarbonisation: ~~Yes~~/No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee February 2024

NWSSP Audit and Assurance Services

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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5.Changes to the 2023/24 Internal Audit Plan *5*
6.Development of the 2025/26 Internal Audit Plan *6*
7.Final Report Summaries *7*

Appendix A Assignment Status Schedule
Appendix B Report Response Times
Appendix C Key Performance Indicators
Appendix D Assurance Ratings

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2023/24 Internal Audit plan.

The report includes details of the progress made to date against individual assignments along with details regarding the delivery of the plan and any required updates.

The plan for 2023/24 was agreed by the Audit & Assurance Committee in April 2023 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

The assignments noted in the table below are those which had been planned to be reported to the November Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
UHL Endoscopy Development	Draft Report	Reasonable	Delay in receiving management responses and Executive sign-off of draft report.
Patient Safety Incident Management	Draft Report	Reasonable	Additional fieldwork required prior to issue of draft report.
Financial Management within Clinical Boards	Work in Progress		Delay in progressing fieldwork due to other priorities on Internal Audit resources.
PCIC CB Governance	Work in Progress		Delay in progressing fieldwork due to other priorities on Internal Audit resources.
Mortality Reviews	Work in Progress		Delay in agreeing scope and meeting management to progress fieldwork.

3. Outcomes from Completed Audit Reviews

Eight assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

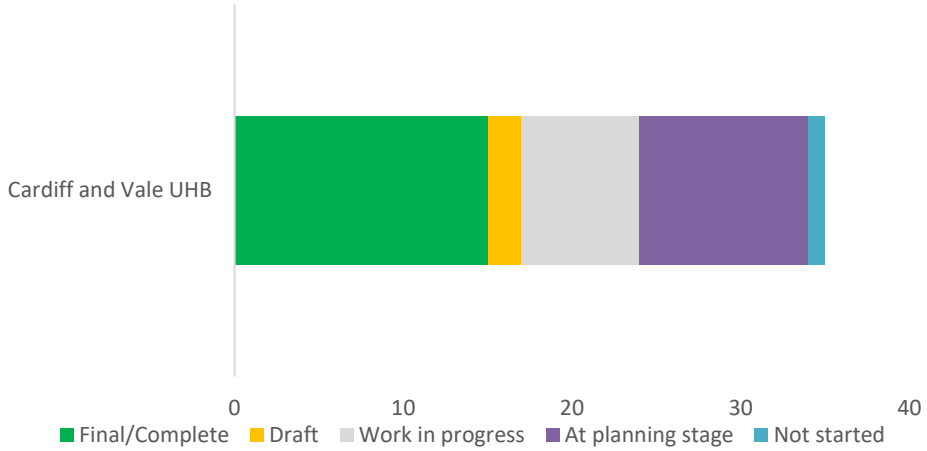
The Executive Summaries from seven of the final reports are provided in Section six. The full reports are included separately within the Audit Committee agenda for information.

The final report for the advisory audit of the Pentyrch Surgery Development – Site Evaluation Process is included within the private committee papers due to the sensitive nature of the subject matter.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Mental Health Clinical Board Governance Arrangements	Reasonable	
Capital Systems		
Infection Prevention & Control		
Technical Continuity		
Estates Condition	Limited	
HealthRoster System		
Alcohol Standards		
Shaping Our Future Wellbeing – Future Hospitals Programme	Advisory	

4. Delivery of the 2023/24 Internal Audit Plan

There are a total of 35 reviews within the 2023/24 Internal Audit Plan, (including the changes highlighted below), and overall progress at this stage of the year is summarised below.



The graph above illustrates that fifteen audits from the 2023/24 plan have been finalised so far this year and two others have reached the draft report stage.

In addition, there are seven audits that are currently work in progress with a further ten at the planning stage.

Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A.

Appendix A also includes details of the three audits from the 2022/23 plan that had not been sufficiently progressed to be included within the Head of Internal Audit

Opinion for 2022/23. The outcomes from these audits will feed into the 2023/24 Opinion.

Appendix B highlights the times for responding to Internal Audit reports.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators (KPI).

5. Changes to the 23/23 Internal Audit Plan

The following audit has been proposed as an addition to the plan:

- Eye Care Digitisation Process – Following the transfer of the National Digital Eye Care Programme to DHCW, the audit was agreed by the Executive Director of Finance to review the current status of the contractual commitment entered into by the Health Board to deliver the Eye Care Digitisation Programme.

The following audits have also been identified for deferral / removal from the plan:

- Business Continuity Planning – Proposed for deferral to the 24/25 plan due to the sickness absence of the lead manager. Deferral has been agreed with the Executive Director of Strategic Planning; and
- Shaping Our Future Hospitals Programme, 23/24 audit – Proposed for removal from the plan as the Programme is not currently progressing. Removal has been agreed with the Executive Director of Strategic Planning.

6. Development of the 24/25 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors during January and February to discuss potential areas for inclusion within the 2023/24 Internal Audit Plan.

An initial draft plan will be submitted to a meeting of the Senior Leadership Board during February / March for review. An updated draft will then be presented to the April Audit & Assurance Committee for formal approval.

7. Final Report Summaries

7.1 Mental Health Clinical Board Governance Arrangements

Purpose

The audit reviewed the structure and governance arrangements within the Clinical Board noting escalation processes and updates to Health Board Committees.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Terms of reference were not in place or are out of date for some of the groups/ committees within the Clinical Board.
- The meetings being held were not always in compliance with the terms of reference.
- The actions from meetings could not always be identified and therefore may not be addressed.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	An appropriate governance structure is in place.	Substantial
2	Terms of References (TOR) are in place for all groups within the Clinical Board.	Limited
3	Meetings are conducted in line with the requirements of the Terms of Reference	Reasonable
4	Adequate meeting notes or minutes are maintained.	Reasonable
5	Key issues are effectively escalated.	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Terms of reference are not in place or out of date	2	Design	High
2	Compliance with terms of reference	3	Operation	Medium
3	Meeting records	4	Operation	Medium

7.2 Capital Systems

Purpose

This audit formed a part of the 2023/24 Internal Audit Plan and has sought to evaluate the ongoing progression and delivery of the Action Plan designed to remedy compliance issues identified by the Director of Corporate Governance and submitted to the Board in August 2021. The action plan largely targeted issues associated with the procurement, governance and financial monitoring arrangements of capital schemes and expenditure at the University Health Board.

The prior audit report was issued in January 2023 with a Reasonable assurance rating.

Overview

The audit noted that project information was generally well organised and readily available for review.

Some of the weaknesses identified at the previous audit had been addressed through use of Docusign software e.g. formal documentation of key approvals.

Improved reporting was observed at the sampled projects including to the Capital Management Group (CMG) – with improved executive attendance at the same.

The matters identified for management consideration were:

- Chair's actions and contractual documentation were not consistently completed to include e.g. name of signatory, date etc.
- The Project Issues Form was not consistently utilised to document compliance with Delegated Limits.

Accordingly, **reasonable** assurance has been determined.

Report Opinion

	Trend
Reasonable  Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2022/23

Assurance summary[1]

Objectives		Assurance
1	Follow Up	Reasonable
2	Capital Approvals	Substantial
3	Change Management	Substantial
4	Contractual Arrangements	Reasonable
5	Delegated Limits	Reasonable
6	Monitoring and Reporting	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Failure to print and date signatures	4	Operation	Medium
2	Lack of continuity in naming conventions	6	Operation	Low
3	Lack of status reporting at project level	6	Operation	Low
4	Inconsistent utilisation of the Project Issues Form to demonstrate compliance with delegated limits.	5	Operation	Medium

7.3 Infection Prevention & Control

Purpose

The overall objective of the report is to provide assurance that there are effective infection prevention and control processes and procedures in place to prevent the spread of infection.

Overview

We have provided reasonable assurance. The matters requiring management attention include:

- IPC policies and procedures are not readily available to Health Board staff and some were out of date;
- The IPC Group Terms of Reference was out of date;
- The IPC Annual Programme is in need of refreshing and there was no evidence that the 2023/24 IPC Annual Programme had been approved or published; and
- The IPC Group was not reporting to the Q,S&E Committee in line with their Terms of Reference.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	⇔ 2019/20

Assurance summary[1]

Objectives		Assurance
1	Policies and Procedures	Reasonable
2	IPC Structure	Substantial
3	IPC Framework	Reasonable
4	Awareness & Training	Substantial
5	Incident Reporting & Monitoring	Substantial
6	Internal Reporting	Reasonable
7	External Reporting	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IPC Policies and Procedures	1	Operation	Medium
3	IPC Group Terms of Reference	3	Operation	Medium
4	IPC Annual Programme	3	Operation	High
5	IPC Group Reporting	6	Operation	Medium

7.4 Technical Continuity

Purpose

The overall objective of the audit was to provide the Health Board with assurance that there is appropriate provision of technical continuity and fault domain awareness to ensure that the Health Board can maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.

Overview

We have issued reasonable assurance on this area.

Hardware is securely hosted and there is extensive use of virtualisation to enable resilience. There have been recent improvements to the provision of services with upgrades to the virtual environment and the backup process, with work ongoing to provide alternative sites to enable disaster recovery. However, there is currently no geographical resilience and the disaster recovery plan is incomplete, with no order of restoration of services.

The matters requiring management attention include:

- Ensuring the risk relating to geographical resilience is appropriately recorded;
- Ensuring all hosted services are fully documented, with a formal agreement and acknowledgement of resilience position;
- Updating the Disaster Recovery Plan; and
- Enabling record of learning within the incident management process.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Resilience Design	Limited
2	Testing of Resilience	Reasonable
3	Disaster Recovery Planning	Limited
4	Back Ups	Substantial
5	Continual Improvement	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Civica Service Report	1	Operation	Medium
2	Dormant Accounts	3	Operation	Medium
3	Leavers Report	3	Operation	Medium
6	System Back-ups	7	Operation	High

7.5 Estates Condition

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the UHB confirmed a total backlog maintenance requirement of £152m – although the capital investment requirement to clear the backlog maintenance is likely to be materially higher.

The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Key to understanding the challenge is the quality of the baseline data. This is acknowledged within the UHB's Board Assurance Framework (BAF) noting that the UHB's current estates condition baseline data was developed from a 2017 condition survey which had been updated annually by desktop review. A tendering exercise was currently being progressed to survey the estate and to establish an updated baseline. Experience of other NHS organisations suggests that this update is likely to result in an increase in the reported data. It has been recommended that the executive lead approve the proposed approach.

In the short to medium term, the UHB uses a combination of all Wales capital funding, targeted Estates Facilities Advisory Board (EFAB) funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas as follows, e.g.:

- All-Wales capital funding was secured for the UHL Engineering Infrastructure scheme (£5.5m). Further business cases have been submitted to Welsh Government for approval.
- The UHB successfully secured EFAB funding of £6.035m across 2023/24 & 2024/25 to tackle high/significant backlog maintenance priorities.
- Across NHS Wales, due to pre-commitments and other pressures on the discretionary capital funding, the allocation for backlog maintenance had historically been insufficient to effectively manage the position – with £500k earmarked at the UHB specifically for backlog maintenance in

Report Classification

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary

Assurance objectives		Assurance
1	Governance	Reasonable
2	Baseline Information	Reasonable
3	Estates Strategy	Limited
4	Funding Strategy	Limited
5	Monitoring & Reporting	Reasonable
6	Risk Management	Limited

The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Assurance Objective	Priority
1	Estates surveys are required to inform an updated backlog maintenance baseline position.	*2*	Medium
2	The UHBs estates strategy requires reviewing in several areas including performance indicators.	3	Medium
3	Increased corporate assurance/reporting is required surrounding the Estates Strategy and Capital Plan.	4	High

2022/23 (over and above UHB contributions to EFAB funding). Available resources were targeted at priorities based on existing risk assessments.

- Whilst revenue resources were targeted at the priority planned and reactive maintenance areas, the UHB had the lowest 'Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)'. In response, an internal review was being initiated to better understand the existing and required skill mix within the maintenance team – to inform potential future recruitment and funding requirements.

Noting the above, there were arrangements in place to focus the limited available resources on progressively addressing the high priority areas within the UHBs estate.

In the longer-term, the UHBs 10-year programme highlights an indicative funding requirement of circa £3.3 billion for the estate to address the backlog maintenance risks and meet the future healthcare needs of the population. Noting the scale of the investment required, there is a significant risk to the UHB that this strategy is not affordable. It has been recommended that the Board continue to receive regular updates on the delivery of the estate strategy and 10-year capital programme, particularly any risks/impact resulting from delay/non delivery.

A corresponding revised long-term strategy is required for maintenance, as continued investment at historic levels is likely to result in the UHB estates being in a further deteriorating position requiring increased levels of capital investment.

Whilst operational risks were well documented, reported and escalated, the Board should seek further assurance that the identified actions within the Board Assurance Framework are effective – noting their impact to date.

Whilst the UHB had been focussing the available resource to high priority estate risks, an overall **limited assurance** has been determined, recognising that it may not be possible to manage all identified risks within available funding. This assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Further matters arising concerning the areas for refinement and further development have also been noted (see **Appendix A**).

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. The centrally commissioned surveys have identified only isolated instances of RAAC requiring urgent attention - at the time of reporting, the surveys identified no areas requiring urgent action within the UHB estate.

4	A review of the estate workforce, coupled with the development of a clear long term financial model for the revenue support in the estate is required.	4	High
5	Monitoring and reporting the performance of backlog maintenance position should be clearly established.	5	Medium
6	Actions within the Board Assurance Framework to reduce the risk associated with the capital assets should be reviewed.	6	High

7.6 HealthRoster System

Purpose

The overall objective of the audit was to review the usage of the HealthRoster system within the Health Board.

Overview

We have issued limited assurance on this area. The review identified several significant matters which require management attention and include:

- Rosters are not being created, approved, and published in a timely manner.
- A number of staff were either not meeting their contracted hours or had worked more than their contracted hours.
- Shifts worked by staff are not always verified adequately within the system.
- Safecare census patient data is not always updated.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Roster production, approval and publishing in accordance with timescales	Limited
2	Staff are utilising auto rostering to generate their rosters	Reasonable
3	Annual leave is appropriately managed to ensure headroom allocation is complied with	Reasonable
4	Staff balances are managed adequately to ensure staff are working their contracted hours	Limited
5	Rosters are produced in accordance with funded nurse establishment levels	Limited
6	Management are verifying worked rosters in a timely manner	Limited
7	Management are undertaking the Safecare census twice daily	Limited
8	Rosters ensure staff are complying with the Working Time Directive	Substantial
9	Regular monitoring of the roll out and usage of the HealthRoster system is being undertaken	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Rostering process is not timely	1&5	Operation	High
3	HealthRoster system segregation of duties	1	Operation	Medium
4	Auto-roster functionality uptake	2&5	Operation	Medium
7	Incorrect working hour balances	4&5	Operation	High
8	Roster verification and finalisation	6	Operation	High
9	Safecare census missing patient data	7	Operation	High

7.7 Alcohol Standards

Purpose

Review the processes in place within the Health Board in relation to compliance with NICE guidelines around alcohol use.

Overview

We have issued limited assurance on this area. The review identified several significant matters which require management attention and include:

- There is a lack of health board guidance in relation to the Alcohol Standards, providing details on identifying, preventing and diagnosing patients.
- There is a lack of resource within the team to meet with the demand across the Health Board.
- Screening for alcohol consumption is not being formally undertaken.
- There is no documented formal referral process in place.
- There is no central record maintained of staff that have received training on alcohol screening for patients.
- Documentation informing patients about the screening process and reducing alcohol consumption was not available within the Health Board.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	The Health Board complies with NICE guidance.	Limited
2	Screening for alcohol consumption.	Limited
3	Results from screening are being recorded.	Limited
4	Training is provided to staff.	Limited
5	Documentation information patients about the screening process.	Limited
6	There is an intervention pathway.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Lack of Health Board guidance	1	Operation	High
2	No operational screening tool in place	2	Operation	High
3	Resource within the team	2	Operation	High
4	Referral Process	3	Operation	High
5	Training Records	4	Operation	High
6	Documentation for patients	5	Operation	High
7	Intervention Pathway	6	Operation	Medium

7.8 Shaping Our Future Wellbeing – Future Hospitals Programme

Purpose

The University Health Board (UHB) has received positive feedback from Welsh Government on their Shaping Our Future Wellbeing – Future Hospitals Programme, Programme Business Case (PBC). Aligned to this, Welsh Government were commissioning a review of the clinical model outlined within the PBC.

At the time of our review, the UHB was in the process of establishing arrangements to develop a Strategic Outline Case (SOC). This stage was being progressed at risk, noting Welsh Government endorsement of the PBC or confirmation of SOC funding had not yet been received (pending conclusion of the clinical review).

This review was advisory in nature and provides proactive advice on the proposed governance arrangements to see the Programme through the activities outlined above to the next key juncture.

Scope

The scope of the review was agreed as follows:

- **Governance Structure**: To assess the adequacy of the proposed structure, including supportive working groups, to achieve the overall objectives of the current phase of the programme. The review also considered the integration of the Programme within existing committee structures of the University Health Board.
- **Procedural Requirements**: To consider the adequacy of the existing procedural framework and alignment with both the University Health Board and national requirements.
- **Resource requirements**: To assess whether the resourcing requirements have been identified for each activity at this stage of the programme. Where required, external support is identified where there is insufficient capacity or capability internally.
- **Monitoring & Reporting**: A review of the proposed arrangements to monitor the activities of both internal and external advisers.
- **Other:** Any other issues identified at the project affecting project delivery.

As this was an advisory review, in line with Public Sector Internal Audit Standards, it does not proffer an overall opinion. However, a basic aim was to provide proactive advice, identify good practice and relevant systems weaknesses for management consideration and, where appropriate, provide direction to existing guidance.

Conclusion:

The review observed many positive arrangements, such as clear ownership / leadership, a dedicated sub-committee of the Board (currently stood down) and standardised governance procedures to provide clarity and consistency. A comprehensive "Gathering Intelligence" exercise has been undertaken on other new hospital programmes across the UK, including understanding of lessons learnt and best practice. This will inform the development of the Shaping Our Future Hospitals (SOFH) Programme in terms of next steps, individual projects, workstream activity and decision-making processes.

However, at the time of review the UHB had not received formal approval to the PBC, or approval of funding to develop the SOC, with the outcome of the WG commissioned clinical review also awaited. The UHB was therefore progressing at risk in the continuation of Programme governance arrangements and in the development of SOC plans. It is recommended that further investment of resources (time/effort/financial) should be limited pending the outcome of the clinical review, the receipt of WG funding for the SOC development and confirming the future of the project. Following the outcome of the clinical review and receipt of appropriate approvals to proceed to the next stage, the implementation of the procurement programme would require a considered, phased implementation process and associated resource plan.

Recommendations have been outlined for management consideration at **Appendix A.**

Management advise that, following conclusion of the review, Welsh Government had invited the UHB to the Infrastructure Investment Board (IIB) to consider the way forward for the project. The recommendations made below can be considered once this has taken place and the UHB has a clearer understanding of the potential way forward.

ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2022/23 Plan							
Surgery CB - Consultant Job Plans		COO			Final Report	Limited	November
Shaping Our Future Wellbeing – Future Hospitals Programme		*Finance*			*Final Report*	*Advisory*	*February*
Medical Staff Additional Sessions		Medical			Planning (Final brief issued)		April
2023/24 Plan							
Recommendation Tracking	6	Corporate Governance	Q1		Final Report	Substantial	September
Leadership and Management Training and Development (Advisory)	10	People & Culture	Q1		Final Report	Advisory	November
Refresh of the Health Board's Strategy	18	Strategic Planning	Q1		Final Report	Substantial	November
Quality, Safety &Experience Governance (Advisory)	28	Nursing / Medical	Q1		Final Report	Advisory	November
ChemoCare IT System Follow-up	36	Digital & Health Intelligence	Q1		Final Report	Reasonable	November
Paris System	12	Digital & Health Intelligence	Q2		Final Report	Reasonable	November
Urgent and Emergency Care – Welsh Government Six Goals Programme	22	COO	Q2		Final Report	Substantial	November
Pentyrch Surgery Development – Site Evaluation Process	37	Chief Executive	Q2		Final Report	Advisory	November

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Estates Assurance – Estate Condition	4	Finance	Q1		Final Report	Limited	February
Mental Health Clinical Board Governance Arrangements	24	COO	Q1		Final Report	Reasonable	February
Capital Systems	3	Finance	Q2		Final Report	Reasonable	February
Technical Continuity	13	Digital & Health Intelligence	Q2		Final Report	Reasonable	February
Alcohol Standards	21	Public Health	Q2		Final Report	Limited	February
HealthRoster System	9	People & Culture	Q2/3		Final Report	Limited	February
Infection Prevention & Control	30	Nursing	Q3		Final Report	Reasonable	February
Patient Safety Incident Management	29	Nursing	Q2		Draft Report	Reasonable	April
Financial Management within Clinical Boards	2	Finance	Q2		Work in Progress		April
PCIC CB Governance	25	COO	Q2		Work in Progress		April
Mortality Reviews	33	Medical	Q2		Work in Progress		April
Core Financial Systems	1	Finance	Q2/3		Work in Progress		April
Information Governance	14	Digital & Health Intelligence	Q3		Work in Progress		April
Temporary Staffing Costs	7	People & Culture / Finance	Q3		Work in Progress		April
Cyber Security Follow-up	15	Digital & Health Intelligence	Q3		Planning (Final brief issued)		April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
IMTP Development Process	16	Strategic Planning	Q3		Planning (Final brief issued)		April
Cancer Services	23	COO	Q3		Work in Progress		April
Medical Records Tracking (CD&T) Follow-up	27	COO	Q3		Planning (Final brief issued)		April
Risk Management / Board Assurance Framework	5	Corporate Governance	Q4		Planning (Final brief issued)		May
Implementation of People & Culture Plan	8	People & Culture	Q4		Planning (Draft brief issued)		May
Performance Reporting	11	Digital & Health Intelligence	Q4		Planning (Draft brief issued)		May
Decarbonisation	19	Strategic Planning	Q4		Planning (Final brief issued)		May
Maternity Care – Ockenden Review	31	Nursing	Q4		Planning		May
Management of Health Board Policies Follow-up	35	Nursing	Q4		Planning (Final brief issued)		May
Eye Care Digitisation Programme	38	Finance	Q4		Planning (Final brief issued)		May
Development of Integrated Audit Plans:							
• *UHL - Endoscopy Unit Development*	*34*	*Strategic Planning*	*Q2*		*Draft Report*	*Reasonable*	*April*
• *UHW – Vascular Hybrid Theatre & MTC Theatre*	*37*	*Strategic Planning*	*TBC*				*TBC*

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reviews removed from the plan							
ISO Accreditation within ALAC	32	Therapies	~~Q1~~	Q2	The external accreditation review has been completed with a positive outcome, so no value in completing our planned audit. Removal agreed with the Director of Therapies and Health Science. Agreed by September AC.		
Medicine CB – Acute Model / Same Day Emergency Care	26	COO	Q3		The COO requested deferral to Q1 of the 24/25 plan to allow further time for the developments to be embedded. Agreed by September AC.		
Business Continuity Planning	17	Strategic Planning	Q3		Proposed for deferral to the 24/25 plan due to the sickness absence of the lead manager. Deferral has been agreed with the Executive Director of Strategic Planning. To be agreed by February AC.		
Shaping Our Future Hospitals Programme	20	Strategic Planning	Q4		Proposed for removal from the plan as the Programme is not currently progressing. Removal has been agreed with the Executive Director of Strategic Planning. To be agreed by February AC.		

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Recommendation Tracking	Substantial	Final	25/07/23	15/08/23	11/08/23	11/08/23	G
Pentyrch Surgery Development – Site Evaluation Process	Advisory	Final	08/09/23	29/09/23	21/09/23	21/09/23	G
Leadership and Management Training and Development	Advisory	Final	21/09/23	12/10/23	02/10/23	03/10/23	G
Refresh of the Health Board's Strategy	Limited	Final	29/09/23	20/10/23	06/10/23	09/10/23	G
PARIS System	Reasonable	Final	28/09/23	19/10/23	02/10/23	09/10/23	G
Quality, Safety & Experience Governance	Advisory	Final	17/08/23	8/09/23	12/10/23	13/10/23	R
Urgent and Emergency Care – Welsh Government Six Goals Programme	Substantial	Final	12/10/23	22/11/23	19/10/23	19/10/23	G
Follow-up: Chemocare IT System	Reasonable	Final	26/09/23	17/10/23	23/10/23	24/10/23	R
Capital Systems	Reasonable	Final	21/09/23	06/10/23	06/10/23	25/10/23	G
HealthRoster System	Limited	Final	12/10/23	02/11/23	16/11/23	16/11/23	R
Mental Health Clinical Board Governance Arrangements	Reasonable	Final	02/11/23	23/11/23	21/11/23	28/11/23	G
Alcohol Standards	Limited	Final	15/11/23	01/12/23	22/12/23	21/12/23	G
Infection Prevention & Control	Reasonable	Final	02/01/24	23/01/24	22/01/24	22/01/24	G
Technical Continuity	Reasonable	Final	12/12/23	05/01/24	24/01/24	24/01/24	R
Estates Assurance – Estate Condition	Limited	Final	11/09/23	02/10/23	24/01/24	24/01/24	R

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	April 2023	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2023/24	A	85% 17 from 20	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	88% 15 from 17	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	67% 10 from 15	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	94% 16 from 15	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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.

Office details:

Audit and Assurance Services
1st Floor, Woodland House
Maes y Coed Road
Cardiff
CF14 4HH.

Contact details
Ian Virgill (Head of Internal Audit) - ian.virgil@wales.nhs.uk

Report Title:	**Internal Audit Reports for Information**				Agenda Item no.	2.1b	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	06/02/24	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report

Background and current situation:

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Cardiff and Vale University Health Board.

The work undertaken by Internal Audit is in accordance with its annual plan, which is prepared following a detailed planning process, including consultation with the Executive Directors, and is subject to Audit Committee approval. The plan sets out the program of work for the year ahead as well as describing how we deliver that work in accordance with professional standards and the engagement process established with the UHB.

As individual audit reviews are completed, the final reports are submitted to the Committee for assurance and information.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The following audit reports have been finalised since the last meeting of the Committee:

- Mental Health Clinical Board Governance Arrangements (Reasonable Assurance)
- Capital Systems (Reasonable Assurance)
- Infection Prevention & Control (Reasonable Assurance)
- Technical Continuity (Reasonable Assurance)
- Estates Condition (Limited Assurance)
- Health Roster System (Limited Assurance)
- Alcohol Standards (Limited Assurance)
- Shaping Our Future Wellbeing – Future Hospitals Programme (Advisory)

Recommendation:

The Audit & Assurance Committee are requested to:

• **Consider and note** the final Internal Audit reports.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
The finalised audit reports provide assurance around a number highlighted risks and also identify areas requiring improvement.
Safety: Yes/~~No~~
One of the finalised audits provides assurance around quality and safety risks.
Financial: ~~Yes~~/No
Workforce: Yes/~~No~~
A number of the finalised audits provide assurance around workforce risks.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
A number of the finalised audits provide assurance around reputational risks.
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
29/01/2024 17:21:57

Mental Health Clinical Board Governance Arrangements

Final Internal Audit Report

November 2023

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Review reference:	CVU 2223-24
Report status:	Final Report
Fieldwork commencement:	3 July 2023
Fieldwork completion:	27 October 2023
Debrief meeting:	27 October 2023
Draft report issued:	2 November 2023
Management response received:	21 November 2023
Final report issued:	28 November 2023
Auditors:	Ian Virgill Head of Internal Audit Lucy Jugessur Acting Deputy Head of Internal Audit Jayne Gibbon Audit Manager
Executive sign-off:	Paul Bostock Chief Operating Officer
Distribution:	Daniel Crossland Director of Operations Mental Health Clinical Board Julian Willett Manager Primary Care Mark Doherty Director of Nursing Mental Health Clinical Board Neil Jones Clinical Board Director Mental Health Clinical Board
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The audit reviewed the structure and governance arrangements within the Clinical Board noting escalation processes and updates to Health Board Committees.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Terms of reference were not in place or are out of date for some of the groups/ committees within the Clinical Board.
- The meetings being held were not always in compliance with the terms of reference.
- The actions from meetings could not always be identified and therefore may not be addressed.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	An appropriate governance structure is in place.	Substantial
2	Terms of References (TOR) are in place for all groups within the Clinical Board.	Limited
3	Meetings are conducted in line with the requirements of the Terms of Reference	Reasonable
4	Adequate meeting notes or minutes are maintained.	Reasonable
5	Key issues are effectively escalated.	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Terms of reference are not in place or out of date	2	Design	High
2	Compliance with terms of reference	3	Operation	Medium
3	Meeting records	4	Operation	Medium

1. Introduction

1.1 The audit of the Mental Health Clinical Board Governance Arrangements was undertaken and completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

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

1.3 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.

1.4 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.

1.5 The Mental Health Clinical Board is split into Psychology & Psychological Therapies, Mental Health for Adult Services and Mental Health Services for Older People (MHSOP) and covers community and in-patient settings. The Senior Leadership Team within the Mental Health Clinical Board has been formed quite recently.

1.6 The associated risks for the audit are:

- Objectives may not be delivered if governance arrangements are not effectively identifying and escalating concerns and if arrangements are not properly discharged;
- Areas of poor performance are not identified and addressed; and
- A lack of clear, consistent direction accountability and leadership with governance arrangements are not properly discharged.

1.7 The Executive Lead for this audit is the Chief Operating Officer.

2. Detailed Audit Findings

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.

2.1 The current governance structure in place within the Mental Health Clinical Board reflects some of the Health Board Committee meeting structure such as:

- Mental Health Clinical Board (MHCB) – Directorate Management Teams feed into the Board. The MHCB feeds into the Health Board Senior Leadership Team;

- Clinical Board Quality & Safety Committee (CBQ&S)– The Directorate Quality and Safety Groups feed into the CBQ&S which reports into the Health's Board Quality, Safety and Experience Committee;
- Clinical Board Health & Safety - The Directorate Health and Safety Groups feed into the Clinical Board Health and Safety which reports into the Health's Board People and Culture Committee. However, previously reported into the Health Board's Health and Safety Committee;
- Mental Health Clinical Board Performance Review – There are also Directorate performance reviews held within the Clinical Board; and
- Mental Health Legislation and Mental Capacity Act Committee – This Committee is the overall Health Board Committee.

2.2 As well as the above, there is a Mental Health Senior Team and Senior Team Core Group. These are weekly meetings to discuss operational issues to note any feedback from Health Board meetings that need to be communicated to the wider Health Board and also to discuss performance issues. Membership will vary dependent on the subjects that are going to be discussed.

Conclusion:

2.3 The current governance structure within the Clinical Board is appropriate and reflects the Health Board Committee structure where applicable and with many of the meetings being replicated within the Clinical Board. We have provided Substantial Assurance for this objective.

Objective 2: Terms of References (TOR) are in place for all groups within the Clinical Board and they are up to date, with the purpose of the group clearly defined including links to strategic aims and functions of the Clinical Board.

2.4 We selected a sample of 20 groups that take place within the Clinical Board and the Directorates to ascertain if terms of reference are in place for said groups. From discussions that took place it was determined that terms of reference would only be required for 12 of the groups. However, we were only provided with terms of reference for seven of those groups. **(Matter Arising one – High Priority)**

2.5 Our review of the terms of reference in place for the seven groups identified issues such as quoracy requirements, identification of Chair and Vice Chair and terms of references being out of date. **(Matter Arising one – High Priority)**

2.6 Our review did note that, for the terms of reference we reviewed the purpose of the group was clearly defined and where applicable the strategic aims and functions of the Clinical Board were noted.

Conclusion:

2.7 Our testing found that terms of reference were not in place for all groups/ committees within the Clinical Board. Furthermore, where terms of reference were

in place some were out of date and in some cases required enhancing. We have provided Limited Assurance for this objective.

Objective 3: Meetings are conducted in line with the requirements stated within the TOR including regularity, attendees, quoracy and coverage of the stated areas of responsibility.

2.8 We undertook testing on the seven Clinical Board meetings where terms of reference were in place to confirm that the meetings were in compliance with the terms of reference. The following observations were noted:

- For one of the seven meetings the frequency of the meetings differed to that stated in the terms of reference;
- One of the meetings for one group was not quorate. In addition, we were unable to confirm for another two groups if the meetings were quorate as quoracy arrangements are not detailed in the terms of reference;
- We were unable to determine if the business discussed was appropriate and in line with the terms of reference for one of the seven meetings, as there were no formal agendas in place;
- The Clinical Board's three Directorates were not always represented for two of the groups reviewed; and
- The notes of the meeting for one group only recorded details of staff that have given apologies with no record of attendees.

(Matter Arising two – Medium Priority)

2.9 For two of the seven meetings reviewed, our testing confirmed that the meetings that took place were in compliance with the terms of reference.

2.10 Our review of the agendas provided noted that the agenda items / business was as set out within the terms of reference.

Conclusion:

2.11 Our testing of meetings against their terms of reference identified a number of issues concerning quoracy, frequency and attendance. We have provided Reasonable Assurance for this objective.

Objective 4: Adequate meeting notes or minutes are maintained that provide a record of the key discussions and decisions made during the meetings.

2.12 From the sample of Clinical Board meetings reviewed, we were able to evidence that the meeting records for seven of the meetings were of a high quality.

2.13 For these seven meetings we were also able to evidence that actions were clearly highlighted, and records of the actions were maintained. We were also able to confirm that where actions were identified updates were provided at subsequent meetings.

2.14 For the nine remaining meetings where meeting records were in place the following observations were noted:

- Actions and key leads were not clearly identified in the minutes for four of the nine meetings;
- The minutes of the meetings did not align with the meeting agendas for two of the nine meetings; and
- There were no action logs in place, or they required enhancing for five of the nine meetings.

(Matter Arising three – Medium Priority)

Conclusion:

2.15 Improvements are required in the recording of actions identified for the minutes and notes in place for a number of the meetings reviewed. We have therefore provided Reasonable Assurance for this objective.

Objective 5: Groups within the Clinical Board are adequately feeding up to the Health Board's Committees and the Board to ensure key issues are effectively escalated.

2.16 For the Clinical Board meetings that reported into the Health Board meetings we were able to confirm that Clinical Board staff attend where appropriate.

2.17 We noted that updates are provided to Health Board meetings on an exception basis, and we were able to evidence examples of this with Clinical Board updates having been provided at the Health Board's Senior Leadership Team, Health & Safety Committee and the People and Culture Committee.

2.18 We also noted that copies of the Clinical Board's Quality & Safety Committee minutes are submitted to the Health Board's Quality, Safety and Experience Committee for information. However, we did note that there is an issue in the timeliness of these minutes being submitted. **(Matter Arising four – Low Priority)**

2.19 The Clinical Board have monthly performance reviews with Health Board Senior Management that are chaired by the Chief Operating Officer. There is a standard pack of slides that the Clinical Board are required to complete ahead of the meeting for discussion. A record is maintained of all actions agreed, and this is reviewed at the next meeting to ascertain whether the Clinical Board have taken them forward.

Conclusion:

2.20 Our review found that the Clinical Board was represented at Health Board meetings when required and that updates to an appropriate forum are provided on an exception basis. A minor issue was identified in the timeliness of the submission of the Clinical Board's Quality & Safety meeting minutes to the Health Board's Committee. We have provided Substantial Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Terms of reference are not in place or out of date (Design)	**Impact**
We reviewed a sample of 20 groups that take place within the Mental Health Clinical Board to ensure that terms of reference were in place. It was noted that terms of reference were not required for eight of our sample. For the remaining 12 meetings the following observations were noted: • For five of the 12 meetings no terms of reference were provided when requested: (Mental Health Clinical Board Health & Safety; MHSOP Directorate Quality & Safety; Psychology & Psychological Therapies Directorate Quality & Safety; Psychology & Psychological Therapies Directorate Management Team and Adult Mental Health Directorate Health & Safety). We were advised that they were not in place for one group but for the remaining four it is unclear if they are not in place or are in place but could not be located. • The terms of reference provided for six groups were out of date or had no review date: (Mental Health Clinical Board Meeting; Mental Health Clinical Board Quality & Safety Committee; Adult Mental Health Directorate Quality & Safety; Adult Mental Health Directorate Management Team; MHSOP Directorate Management Team and Primary Care Mental Health Service Provider Group). • The terms of reference for the Digital Steering Group were still identified as draft but we were informed that they had been reviewed and approved by the Group. • The terms of reference for the Digital Steering Group and the Primary Care Mental Health Service Provider Group did not stipulate quoracy requirements. • The terms of reference for the Directorate Management Team meetings for Adult Mental Health and MHSOP did not stipulate accountability details. • The terms of reference for the Clinical Board Quality & Safety Committee and Adult Mental Health Directorate Quality & Safety Group did not identify which posts are Chair and Vice Chair. • The terms of reference for the Adult Mental Health Directorate Management Team meeting did not identify which post is Vice Chair. Saunders,Nathan 29/01/2024 17:21:57	Potential risk of: • A lack of clear, consistent direction, accountability and leadership with governance arrangements not properly discharged.

Recommendations			Priority
1.1	Clinical Board Management should ensure that there are terms of reference in place for all groups and committees and that they are up to date. Management should ensure where terms of reference are in place that as a minimum they detail the purpose of the meeting, accountability arrangements, membership to include identifying Chair and Vice Chair, quoracy, meeting frequency and review arrangements.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The identified meetings above will require either a review and completion of TORs or a renewal of TORs. These are being addressed and Directorate teams are taking this opportunity to review quoracy, frequency, attendance and purpose.	7th November 2023	Dan Crossland Director of Operations, Mark Doherty Director of Nursing

Matter Arising 2: Compliance with terms of reference (Operation)	**Impact**
We reviewed the agendas and minutes/ notes of the meetings against the terms of reference for the seven Clinical Board meetings that had terms of reference in place. The following observations were noted: • Primary Care Mental Health Service Provider Group – The attendance at meetings is appropriate but as the terms of reference do not state quoracy requirements we were unable to confirm if the meetings reviewed were quorate. We also noted that some members had not attended any of the meetings we reviewed. To note the last meeting was held in March 2023 and the Group is currently 'on hold' due to embarking on a communication piece of work. • Digital Steering Group – The Adult Mental Health Directorate was not represented at two of the three meetings reviewed and the MHSOP Directorate was not represented at one meeting. We were also unable to determine if the meetings were quorate as the terms of reference did not detail quoracy requirements. • Mental Health Clinical Board meeting – Meetings were held in March, June and September but we were only able to review the one meeting in March and we noted that the meeting was not quorate as there was no Independent Member present. It was also noted that two of the three Directorates were not represented. We also noted that the frequency of meetings was not in accordance with the terms of reference. • Adult Mental Health Directorate Quality & Safety meeting – We were unable to determine if the meetings were quorate as neither the minutes nor the terms of reference detailed which posts were Chair or Vice Chair. We also noted that not all staff identified as members attended the meetings. • MHSOP Directorate Management Team meeting – We noted that the frequency (bi-weekly) differed to that stated in the terms of reference (monthly). The notes of the meeting only recorded apologies and so we were unable to determine if the attendance was appropriate or that the meetings were quorate.	Potential risk of: • Objectives may not be delivered if governance arrangements are not effectively identifying and escalating concerns and if arrangements are not properly discharged.

Recommendations		**Priority**
2.1	Management should ensure that meetings are held in accordance with the frequency detailed within their terms of reference.	**Medium**

	Chairs / Vice Chairs of all meetings should also remind all members of their responsibility to attend required meetings or send a representative when they are unable to attend. Management should also ensure that all records of meetings identify all attendees and in the capacity that they are attending.	

Agreed Management Action		Target Date	Responsible Officer
2.1	Representatives for the meetings listed above will need to be reviewed. Quoracy and chairship will be agreed. Reviews of frequency of the above meetings will be reviewed and completed.	31/12/23	Dan Crossland Director of Operations

Matter Arising 3: Meeting records (Operation)	**Impact**
From our sample of 20 meetings that take place within the Mental Health Clinical Board we undertook a review of the records of 16 of the meetings to ensure that the records were appropriate and that key actions were identified, and progress noted. (With regards to the four meetings not reviewed, two of the meetings are not applicable as the business had been merged with another meeting and the remaining two are Senior Management meetings groups that are informal and held on a weekly basis to discuss operational matters). Our testing on the records for the 16 meetings found a number of issues with nine of the meetings as follows: • For four of the meetings, whilst the minutes / notes of the meetings were of a high quality we noted that the records did not clearly identify actions or the key leads. The meetings were Mental Health Clinical Board; Mental Health Clinical Board Quality & Safety Committee; Digital Steering Group and Psychology & Psychological Therapies Directorate Performance. • It was noted for two of the meetings that the minutes/ notes of the meeting did not align with the meeting agendas. The meetings being the Mental Health Clinical Board Quality & Safety Committee and the Digital Steering Group. • For three of the meetings, whilst actions were identified in the minutes there was no action log in place and therefore it was difficult to evidence that progress on actions were followed up and reported. The meetings were Mental Health Clinical Board Health & Safety, Adult Mental Health Directorate Management Team and Adult Mental Health Quality & Safety. • For one of the meetings, Psychology & Psychological Therapies Directorate Management Team, whilst there is an action log in place updates on actions are recorded via a RAG system with no actual narrative on progress made. • For one of the meetings, Psychology & Psychological Therapies Directorate Quality & Safety, an action log was created after each meeting. However, we were unable to evidence any follow up of those actions at subsequent meetings. Saunders,Nathan 29/01/2024 17:21:57	Potential risk of: • Areas of poor performance are not identified and addressed.

Recommendations		Priority
3.1	Management should ensure the following: • The minutes / notes of meetings should clearly record actions identified and the title/name of person taking the lead. • The minutes / notes of the meetings should clearly align with the meeting agendas. Management should also consider recommending to the meeting chairs that where actions are identified that they are recorded on a meeting action log which should be reviewed at each meeting and clearly record the progress on the actions recorded.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Communication to all meeting chairs that the above actions are implemented.	31/12/23	Dan Crossland Director of Operations

Matter Arising 4: Updates to Health Board's Quality, Safety & Experience Committee (Operation)			**Impact**
In accordance with the terms of reference of the Health Board's Quality, Safety & Experience Committee copies of all minutes of the Clinical Boards' Quality & Safety Committee meetings are to be submitted for information. Our review of the minutes for a number of meetings of the Health Board's Quality, Safety & Experience Committee found that whilst copies of the Mental Health Clinical Board's Quality & Safety Committee meetings were submitted, they were not always on a timely basis. It was also noted that the minutes of the Clinical Board's Quality & Safety Committee held on the 16th February 2023 was submitted to both the May 2023 and July 2023 meetings of the Health Board's Quality, Safety & Experience Committee.			Potential risk of: • Failure to comply with Terms of Reference
Recommendations			**Priority**
4.1	Management should ensure that once the minutes of each Mental Health Clinical Board Quality & Safety Committee meeting have been formally approved, they should be sent to the Secretariat for the Health Board's Quality, Safety & Experience Committee for noting at the next scheduled meeting.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	To be implemented by Chair of the MHCB QSE meeting	31/12/23	Mark Doherty Director of Nursing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Capital Systems
Internal Audit Report

October 2023

Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

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Fieldwork commencement:	20th July 2023
Fieldwork completion:	9th September 2023
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Draft report meeting:	27th September 2023
Management response received:	6th September 2023
Final report issued:	25th October 2023
Auditors:	NWSSP Audit & Assurance – Specialist Services Unit
Executive sign-off:	Catherine Phillips, Executive Director of Finance
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities (Project Director) Matt Phillips, Director of Corporate Governance Stephen Gardiner, Head of Capital Planning Claire Salisbury, Head of Procurement
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

This audit formed a part of the 2023/24 Internal Audit Plan and has sought to evaluate the ongoing progression and delivery of the Action Plan designed to remedy compliance issues identified by the Director of Corporate Governance and submitted to the Board in August 2021. The action plan largely targeted issues associated with the procurement, governance and financial monitoring arrangements of capital schemes and expenditure at the University Health Board.

The prior audit report was issued in January 2023 with a Reasonable assurance rating.

Overview

The audit noted that project information was generally well organised and readily available for review.

Some of the weaknesses identified at the previous audit had been addressed through use of Docusign software e.g. formal documentation of key approvals.

Improved reporting was observed at the sampled projects including to the Capital Management Group (CMG) – with improved executive attendance at the same.

The matters identified for management consideration were:

- Chair's actions and contractual documentation were not consistently completed to include e.g. name of signatory, date etc.
- The Project Issues Form was not consistently utilised to document compliance with Delegated Limits.

Accordingly, **reasonable** assurance has been determined.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2022/23

Assurance summary[1]

Objectives		Assurance
1	Follow Up	Reasonable
2	Capital Approvals	Substantial
3	Change Management	Substantial
4	Contractual Arrangements	Reasonable
5	Delegated Limits	Reasonable
6	Monitoring and Reporting	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Failure to print and date signatures	4	Operation	Medium
2	Lack of continuity in naming conventions	6	Operation	Low
3	Lack of status reporting at project level	6	Operation	Low
4	Inconsistent utilisation of the Project Issues Form to demonstrate compliance with delegated limits.	5	Operation	Medium

1. Introduction

1.1 This audit formed a part of the 2023/24 Integrated Audit Plan and has sought to evaluate the ongoing progression and delivery of the Action plan designed to remedy compliance issues identified by the Director of Corporate Governance and submitted to the Board in August 2021. The action plan largely targeted issues associated with the procurement, governance and financial monitoring arrangements applied at capital schemes and associated expenditure at the University Health Board.

1.2 The audit sampling focused on 5 capital schemes:

Table 1

Capital Scheme	Notes	Funding Route	Value
Ward A4 (General Medicine) Refurb	Referred to at CMG as 'Polytrauma Ward'	Discretionary Capital Fund	£564k
Ward C5 (Functional Rehab and Medical Evaluation) Refurb	Referred to at CMG as 'Cardiothoracic Ward'	Discretionary Capital Fund - SBAR	£1,067k
UHL CT Scanner Replacement	Cost was for CT Scanner Room preparation cost; equipment was funded separately	Discretionary Capital Fund	£770k
UHW EU (Emergency Unit) Refurb	Spend referred to in component parts at CMG (AV, Waiting room & hub)	Approved and funded by Welsh Government	£98k
Adult Fracture Clinic		Discretionary Capital Fund	£1,136k

1.3 The potential risks considered at this review included:

- Previously agreed management actions may not have been implemented, meaning identified control weaknesses may not be addressed,
- Non-compliance with the Standing Orders, Standing Financial Instructions and National Procurement Regulations,
- Non-compliance with established framework / contractual arrangements,
- Inappropriate planning and approval processes resulting in a lack of adequate control,
- Poor project governance and management arrangements put the achievement of project objectives at risk.

2. Detailed Audit Findings

Follow-Up: An assessment of progress against the agreed management actions from the prior audit report.

2.1. The status of previously agreed management actions from the prior Capital Systems Management Audit Report (issued January 2023) can be summarised as follows:

Original Priority Rating	Number of Recommendations	Implemented	Partially implemented / Ongoing	Outstanding
High	1	1	-	-
Medium	8	5	2	1
Low	2	2	-	-
Total	**11**	**8**	**2**	**1**

2.2. Further details of the specific outstanding actions can be found at **Appendix B**.

2.3. Noting good progress to address previously agreed recommendations a **Reasonable** assurance rating has been determined.

Capital Approvals: To obtain assurance on the adequacy of the UHB Capital approval processes in conjunction with the Standing Orders and Standing Financial Instructions and the Capital Procedure Manual.

2.4. The review of the procurement and governance arrangements, by the Director of Corporate Governance, focused on the approval of capital schemes, noted three main stages which should be undertaken and signed off by the Board prior to capital works commencing:

- Approval of capital schemes or business cases to progress, by the Board, up to £1m. Contracts over £1m required Welsh Government approval. *"It is noted that business cases for capital schemes, greater than £1m, will be presented to Board for approval and this is outside of delegated limits; however, it is noted that at submission stage, there is no commitment to provide / receive funding therefore acceptable".* This objective focuses on this element of Capital Approvals.
- Appropriate procurement exercises to be undertaken in line with procurement legislation and regulations and the UHB's SFI's to ensure value for money and transparency. See Contractual Arrangements Objective findings.

2.5. Approval of the award of a contract and signed by the relevant authority once the procurement exercise has been undertaken. The values are <£500k (Chief Executive or Management Executive) and >£500k (Board or Chair's Action). See Contractual Arrangements Objective findings.

2.6. Appropriate WG and UHB approvals were evidenced prior to the progression of all of the projects examined. Accordingly, a **Substantial** assurance rating was determined for this objective.

Change Management: To obtain assurance on the adequacy and appropriateness of the change control processes applied to capital projects including additional approvals and virement arrangements.

2.7. Section 2.3.1 of the Procedure Manual for Managing Capital Projects states :

> *'any changes proposed by the User Group Lead, after the brief has been frozen, will need to be strictly controlled via the Health Board Project Issues Form (internally) and subsequently with the contractor using the NEC3 Compensation Event process. As such, all requests must be costed and any programme/quality implications assessed before the Project Manager seeks approval of the Assistant Director, Capital Planning, Estates & Operational Services to proceed via the Project Issues Form process'.*

2.8. A populated change register was evidenced at all of the projects examined, which accorded with the data (description and costing information) provided at respective change control forms.

2.9. Despite a mix of NEC Project Manager's Instructions and the internal "Project Issue Forms" being applied across the sampled projects (see **Delegated Limits** below), the information recorded relating to change control was largely clear to the user, accurate, and had been appropriately signed, reflecting entries made on the change control registers.

2.10. Accordingly, **Substantial** assurance rating has been determined in respect of the change management arrangements being applied at the projects examined.

Contractual Arrangements: To obtain assurance on the content of the agreed contract/ framework arrangements and compliance at the relevant stage of the capital project.

2.11. Four of the five sampled projects reviewed obtained contractors via the 'Mini Competition of Internal Buildings Framework' (CAV-OJEU-PROJECT42311), each receiving 2 returns from 4 invitations to tender. In all four instances, the same 2 contractors provided the returns.

2.12. The UHW Emergency Unit contract was tendered under the same framework as above but utilised the emergency works element. This is awarded to framework contractors on a rotating basis capable of working within the delimitations of trauma units and other high dependency areas of hospitals.

2.13. None of the sampled projects were subject to single tender action, and in all cases, procurement reports were signed in accordance with the relevant scheme of delegation.

2.14. A requisition request was evidenced for all five schemes examined and signed in accordance with the UHB's scheme of delegation. However, at the Ward A4S refurbishment proforma, the 'budget' and 'committed to date' fields had not been populated albeit the summary total figure was completed and reconciled to other procurement documents (**MA 1**).

2.15. Formal approval was observed for all five projects. Three were reliant upon a Chair's Action to support either the spending limit or urgency of the procurement.

2.16. It was noted that for the Adult Fracture Clinic (£1.136m), the Request for Approval stated 'Yes' in agreement to the statement 'The Chair is asked to take urgent action in respect of contract approval' however states 'Not applicable' in respect of the following two statements:

- 'Expenditure Exceeds £500k (Ministerial Noting)' and
- 'Expenditure Exceeds £1m (Ministerial Approval)'.

2.17. The Director of Corporate Governance had signed to confirm that they "have reviewed the information contained within the request and that it accords with the process for approval of such expenditure", however no Chair's Action or Board Approval was evidenced (noting the value of the contract at >£1m) (**MA 1**).

2.18. All of the schemes sampled were progressed in accordance with the Corporate Governance guidance i.e., "only *once a contract has been signed can a requisition be placed on the system for processing of contractual payments"*. It was noted that the contract (signed as a deed) for the Adult Fracture Clinic was signed without dating, or printing of name, and without stating the position of the person signing. Further the date on the deed (17/11/22) was redacted with it being replaced with a year only. However, this was not consistent with that observed at the other contracts (**MA 1**).

2.19. The absence of the name of signatory and dating on some Chair Action's and Contracts led to some ambiguity. It was noted that the Action Plan recommendation to implement Docusign for procurement documents has been actioned, resulting in a reduced timescale for the completion of contract documentation.

2.20. Noting the above, **Reasonable** assurance has been determined in respect of the contractual arrangements applied at the projects reviewed.

Delegated Limits: A review of the appropriateness of delegated authority limits.

2.21. The Health Board has developed an internal Project Issue Forms (PIF) to operate alongside contractual change forms, to document internal approvals. A total of 45 changes were sampled across the 5 projects.

2.22. The UHB's PIF process details the expected project delegation arrangements to be applied for any in-project changes i.e.:

- Project Manager £0-£25k

- Director of Capital, Estates & Facilities £25k-£75k
- Director of Planning £75k-£125k
- Chief Executive £125k-£500k
- Chair Above £500k

2.23. PIFs were only observed at one of the projects sampled (representing 23 of the 45 changes). Project Manager's Instructions (in accordance with NEC contract requirements) were observed in lieu of the PIFs, but these did not require Director of Capital, Estates & Facilities approval.

2.24. Accordingly, there were 22 changes where an internal approval (PIF) was not documented. Of those, six changes were observed to be in excess of the Project Manager's delegated limits. It was noted that three of the four schemes were delivered within the approved budget (i.e. project contingencies were not fully utilised, the UHW Emergency Unit Refurb project was delivered £14.6k over the approved budget. Nonetheless, the PIF process should apply to all projects do demonstrate compliance with internal delegated limits (**MA 4**).

2.25. No changes were observed in excess of the delegated limit of the Director of Capital, Estates & Facilities of £75k.

2.26. In reflection of the transparent and entire completion of the PMI forms and the net position of the changes across the projects being in accordance with delegated limits, a **Reasonable** assurance rating has been determined.

Monitoring and Reporting: A review of the adequacy of arrangements in place to monitor performance (including cost position) and report to an appropriate forum to ensure the capital project is delivered within control parameters.

2.27. To address previous concerns, an enhanced Monthly Project Progress Report had been implemented for use by the project managers from February 2022.

2.28. It was noted that only 1 project sampled (Adult Fracture Clinic) had applied the enhanced Monthly Project Progress Report.

2.29. The other 4 sampled projects documented "on the floor" discussion and action points in the form of minutes from twice monthly meetings. These meetings were largely well attended, with minutes primarily devoted to recording clear action points, stating action ownership and target dates for completion, as well as critical dependencies. Subsequent meetings had brought forward actions and noted completion and issues.

2.30. Matrix reporting was also observed which included a number of project metrics, including financials, change control, issues, and discussed at a Matrix Reporting meetings at a Project level on a monthly basis. The Matrix Report is included within the Capital Management Group (CMG) papers and is reviewed at the CMG meeting monthly.

2.31. A consistent reporting approach should be agreed noting the introduction of both "Matrix Reporting and the enhanced Monthly Progress Reports, t (**MA 3**).

2.32. Concern was previously raised relating to poor Executive Level attendance at Capital Management Group Meetings. Testing of CMG meeting dates noted attendance by the Executive Director of Finance, Executive Director of Planning (Chair), and Director of Capital, Estate and Facilities at all of the meetings subsequent to the last audit report.

2.33. In conclusion, a **Reasonable** assurance rating has been determined for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Failure to print and date signatures (Operation)	**Impact**
It was noted that the contract (signed as a deed) for the Adult Fracture Clinic was signed without dating, or printing of name, and without stating the position of the person signing; there is concern that this could lead to ambiguity in ratifying to the scheme of delegation. Further, the date on the deed was crossed out with it being replaced with a year only. The project office stated that this was because the deed was signed on more than one date and this is correct legal protocol, and that legally the overarching date of reference on the contract is the start date. This was not consistently observed at the other projects sampled. Similarly, whilst the date of the corresponding Chair's action could possibly be determinable from minutes, the formal record did not have dates shown for the Chair and CEO signatures but did for the other two members who had signed.	Potential risk of: • Ambiguity over liability, and responsibility within documents, and in documented actions and decisions. • Failure to identify poor process due to inability to establish timelines. • Difficulty in ratifying approval in line with scheme of delegation.

Recommendations		**Priority**
1.1	Project officers should ensure that returned contracts and Chair's action are signed, initialled, and dated consistently.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.	31/10/2023	Head of Capital Planning

Matter Arising 2: Lack of continuity in naming conventions (Operation)	**Impact**
Ward A4 Refurbishment, CT Scanner Building Preparation, and Adult Fracture Clinic were included in the Annual Capital Plan paper and appendix listings of schemes included under the Discretionary Capital Plan; however, they were referred to using different terms. Within Matrix Reporting, Capital Management Group Reporting and Fortnightly project level meeting minutes, the names of the sample schemes were referred to using different terms; making it more difficult to track and challenge progress and confirm approvals, potentially creating confusion or failure to mitigate risk.	Potential risk of: • Failure to properly address/ mitigate risk through misidentification of projects.

Recommendations		**Priority**
2.1	Standardised reference numbers and descriptive titles should be used for schemes across all reporting, forms, applications, and minutes. It was noted that the Procurement reference number was used in the Procurement Report and often the Request for Approval form, but thereafter, any consistency was often lost.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Standardised reference numbers and descriptive titles will be used for schemes across all reporting, forms, applications, and minutes.	31/10/2023	Head of Capital Planning

Matter Arising 3: Status reporting at project level (Operation)	**Impact**
The development of Matrix Reporting has to an extent fulfilled the recommendation for 'Highlight' reporting to be developed, however the nature of Matrix reporting being monthly, does not meet the intention of a 'Highlight' report which was intended to be fortnightly. The not dissimilar Monthly Project Progress Report which was only produced for 1 of the sampled projects, was also produced on a monthly basis. The improved attendance at Capital Management Group meetings, with a two-week separation from Matrix Reporting meeting dates, does mitigate the lack of fortnightly reporting, as does the pragmatic approach taken to minute taking and action logging of the fortnightly Progress Meetings. However, further consideration should be given to the consistency of reporting at projects.	Potential risk of: • Despite the two-week separation between Matrix and Capital Management Group meetings, and the fortnightly frequency of Project Review Meetings, 'on the floor' issues and risks may not be drawn to Board level attention for up to a month.

Recommendations		**Priority**
3.1	The preferred method of reporting should be consistently completed on a pre-determined frequency.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed. Standardised reporting arrangements are being implemented, which will be consistently applied across all UHB projects.	31/10/2023	Head of Capital Planning

Matter Arising 4: Inconsistent Reporting of Change (Operation)	**Impact**
A sample of 45 changes at the projects noted that changes were documented in one of two formats: Project Manager Instructions (PMI's) or Projects Issues Form's (PIF's). PIF's (provided for the Adult Fracture Clinic sample) provide for approval signatures, and all were signed appropriately. PMI's (as used by the remaining sample) do not provide for an approval beyond the level of Project Manager; however, they clearly state additions and omissions. From the sample there were seven changes that exceeded the delegated limits of the respective Project Managers (£25k) but all were less than £75k delegated limit of the Director of Capital, Estates & Facilities. The PIF proforma should be applied at all projects.	Potential risk of: • Cost saving opportunities could be missed, and funding used on unrelated and unapproved spend without adequate scrutiny. • Inconsistent change reporting across projects resulting in inability to compare performance. • Difficulty in ratifying approval in line with scheme of delegation.

Recommendations		**Priority**
4.1	Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed – the Health Board have already commenced transitioning to this approach.	All newly arising change requests – from 30/09/2023	Head of Capital Planning

Appendix B: Status of previously agreed recommendations (January 2023)

Capital Systems Management				Previously providing	
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
1.1	Completion of agreed actions	3 - Consideration be given to expanding the remit of Finance Committee to monitor expenditure of major capital schemes	Outstanding - Obtain Finance Committee Minutes	Assistant Director of Finance 31.10.23	**Medium**
1.2	Completion of agreed actions	CEF5 - Review the capital procedures manual that was produced to provide guidance to the major capital and discretionary capital teams on key stages of project development including procurement and standing financial instructions to ensure it aligns to the current requirements.	In progress - Currently being reviewed to simplify format and update.	Head of Capital Planning 31.12.23	**Medium**
1.3	Completion of agreed actions	CEF10 - Provide the appointed Executive Lead for each capital scheme >£200k with an assurance report to include the financial position of the scheme, any changes design or client, procurement reports and contract status.	Complete - See Capital Approvals Objective.	N/A	**Medium**
1.4	Completion of agreed actions	CEF13 - Review contract documents currently used by CEF for capital works and services to ensure that we reflect any specific requirements from the Health Board.	In progress - Currently being revised by legal team to incorporate NEC4 Updates.	Head of Capital Planning 30.11.23	**Medium**
2.1	Change Management and Delegated Limits	The consistent application of management processes across the CEF teams at all major capital	Complete - see Change Management Objective for	N/A	**Medium**

Capital Systems Management				Previously providing 	
		projects (irrespective of the UHB team managing the schemes).	details of implementation of Docusign for the PIF process.		
2.2	Change Management and Delegated Limits	Changes should be approved in accordance with the approved scheme of delegation.	Complete - see Change Management Objective.	N/A	**High**
2.3	Change Management and Delegated Limits	Management may wish to consider the implementation of a revised scheme of delegation for capital schemes funded by Welsh Government.	Complete - Director of Capital, Estates & Facilities previously had delegated limit for stage payments >£25k, revised by Board to >£75k 24/11/2022.	N/A	**Medium**
3.1	Contract Approval	Contracts should be in place prior to the commencement of capital schemes.	Complete - See Contractual Arrangements Objective.	N/A	**Low**
4.1	Monitoring and Reporting	The required monthly highlight reporting should be applied at all capital projects.	Complete - See Monitoring and Reporting Objective.	N/A	**Medium**
4.2	Monitoring and Reporting	Nominated project Lead Executives should be advised in writing of their responsibilities to the project, as required by the Action Plan.	Complete - See Capital Approvals Objective.	N/A	**Low**
4.3	Monitoring and Reporting	Capital, Estates & Facilities should develop supporting procedures to ensure the Lead Executives receive relevant and timely assurance to facilitate their responsibilities.	Complete - See Monitoring and Reporting Objective.	N/A	**Medium**

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that the project achieves its key delivery objectives and that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Infection Prevention & Control
Final Internal Audit Report

January 2024

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Executive sign-off:	Jason Roberts, Executive Nurse Director
Distribution:	Yvonne Hyde, Head of Nursing for IPC
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the report is to provide assurance that there are effective infection prevention and control processes and procedures in place to prevent the spread of infection.

Overview

We have provided reasonable assurance. The matters requiring management attention include:

- IPC policies and procedures are not readily available to Health Board staff and some were out of date;
- The IPC Group Terms of Reference was out of date;
- The IPC Annual Programme is in need of refreshing and there was no evidence that the 2023/24 IPC Annual Programme had been approved or published; and
- The IPC Group was not reporting to the Q,S&E Committee in line with their Terms of Reference.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved	⇔ 2019/20

Assurance summary[1]

Objectives		Assurance
1	Policies and Procedures	Reasonable
2	IPC Structure	Substantial
3	IPC Framework	Reasonable
4	Awareness & Training	Substantial
5	Incident Reporting & Monitoring	Substantial
6	Internal Reporting	Reasonable
7	External Reporting	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IPC Policies and Procedures	1	Operation	Medium
3	IPC Group Terms of Reference	3	Operation	Medium
4	IPC Annual Programme	3	Operation	High
5	IPC Group Reporting	6	Operation	Medium

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1. Introduction

1.1 Our audit review of Infection Prevention and Control was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Infection Prevention and Control (IPC) is fundamental in ensuring the provision of a safe environment for staff and service users. The Covid-19 pandemic has emphasised the need for healthcare organisations to have coordinated, collaborative, agile and robust IPC processes and structures in place to ensure an effective and timely IPC response.

1.3 Healthcare Associated Infection (HCAI) refers to an infection that occurs because of contact with the healthcare system. A consistent approach and effective leadership within the Health Board is required to prevent HCAI within Health Board services.

1.4 The Health Board's central IPC Team provides advice and support to all Health Board services, particularly clinical and front facing staff. IPC is however the responsibility of all Health Board staff, with Clinical Boards responsible for ensuring effective IPC management within their operational services.

1.5 Infection Control is reported as part of the Integrated Performance Report including a performance summary on the reduction expectation for infections.[1]

1.6 The Executive Nurse Director was the lead Executive for this review.

Audit Risks

1.7 The risks associated with the review were as follows:

- The Health Board fails to prevent the spread of infection; and
- Non-compliance with infection control requirements / and or legislation.

2. Detailed Audit Findings

Objective 1: The Health Board has appropriate, up to date infection prevention and control policies and procedures in place which provide clear direction and align with Welsh Government requirements and relevant legislation.

2.1 We were informed by the Head of Nursing for IPC that there are a range of IPC policies and procedures in place, and these are reviewed and updated by the Infection, Prevention and Control Group.

2.2 These were reviewed and whilst most were up to date, three were overdue for review and a number had not been updated with their last review date. In addition, none of the policies and procedures are currently available to Health Board staff via Sharepoint **(see Matter Arising 1 - Medium Priority)**.

[1] cavuhb.nhs.wales/files/board-and-committees/board-2023-24/2023-07-27-public-board-papers-v3-pdf/ pg 148

2.3 The Welsh Government provides IPC guidance through Public Health Wales, for example through the issue of alerts and guidance in response to specific threats and outbreaks, and the issue of Welsh Health Circulars (WHCs). The UK has a 5 year strategy to combat antimicrobial resistance through the reduced use of antibiotics, and the Welsh Government issues a WHC annually setting out the goals for Wales for each year. The circular for 2023/24 includes 9 goals, and the Health Board's progress against these is reported to the IPC Group via the Antimicrobial Sub-Group.

Conclusion:

2.4 Although there was a range of appropriate infection prevention and control policies and procedures in place, these were not readily available to Health Board staff, and not all were up to date. We have provided **Reasonable Assurance** for this objective.

Objective 2: The Health Board has an effective infection prevention and control structure in place with operational and Executive responsibilities clearly outlined.

2.5 The current IPC structure, as informed by the Head of Nursing for IPC, has a Head of Nursing for IPC who reports into the Executive Nurse Director, a Senior Nurse for IPC which is currently vacant, 5.7 FTE Clinical Nurse Specialists in IP & C and four FTE Associate Clinical Nurse Specialists in IP & C. The Head of Nursing for IP & C also has a PA. In addition to the above there are four Public Health Wales staff attached to the unit: two Consultant Microbiologists (Infection Control Doctors), one Infection Control Scientist and an Epidemiologist.

2.6 Copies of the Job Description / Person Specification for each level within the structure outlined above were obtained and reviewed to ensure they were up to date and clearly outlined roles and responsibilities within the unit. Whilst the roles and responsibilities for each post were clearly documented within the Job Descriptions reviewed, not all were up to date and appropriately signed off **(see Matter Arising 2 - Low Priority).**

Conclusion:

2.7 There is an effective IPC structure in place within the Health Board. Although there were detailed job descriptions and person specifications in place for all roles within the IPC team, some were not dated / signed off and may be overdue for review. We have provided **Substantial Assurance** for this objective.

Objective 3: An appropriate infection control framework and / or plan is produced and effectively communicated and implemented across the Health Board.

2.8 The work of the IPC team is overseen by the Infection Prevention Control (IPC) Group which is chaired by the Executive Nurse Director. As well as the IPC Group there are currently four sub-groups in place that report into the IPC Group. These

are the Decontamination Group, the Water Safety Group, the Ventilation Safety Group and the Antimicrobial Group.

2.9 There is also a documented All Wales Framework for the Management and Reduction of Antimicrobial Resistance which the IPC team are responsible for implementing.

2.10 The IPC Group Terms of Reference (ToR) state that they should be reviewed annually, but the document is dated 9th September 2010. Our review of the ToR identified that a number of areas require updating (**see Matter Arising 3 - Medium Priority**).

2.11 The Head of Nursing for IPC prepares an annual Infection Prevention Control Programme. This sets out the IPC team's aims and objectives for the year and includes targets and also specifies a range of IPC audits to be carried out during 2023/24.

2.12 It can be seen from the annual IPC Programme that the IPC team is aligned with the Health Board's Clinical Board structure, and each Clinical Board has an assigned IPC Nurse Specialist. Updates from each Clinical Board are provided to the IPC group at each of their quarterly meetings, and this is a standing agenda item. This helps ensure that the infection control framework is effectively communicated and implemented across the Health Board.

2.13 However, our review of the Annual IPC Programme for 2023/24 identified a number of issues. Some of the activities included in the programme are no longer relevant, and there are no targets for the number of audits to be carried out in clinical areas. There has also been no Clinical Board input to the programme. The document provided to us was undated, had no document control page and contained several unresolved comments and some highlighted text. The file name also suggests the document was still in draft **(see Matter Arising 4 - High Priority)**.

2.14 The minutes of the IPC Group meetings held in March, April and September 2023 were reviewed but there was also no evidence that the 2023/24 programme had been reviewed and approved by the Group. Consequently, we were unable to determine the status of the document and if it had been approved or was still in draft **(see Matter Arising 4 - High Priority)**.

2.15 All IPC audits carried out are now recorded on the Tendable system, and this enables reports to be prepared showing all IPC team audit activity, as well as the audits undertaken by wards / departments.

2.16 The latest Tendable audit report was prepared in September 2023. This shows that a reasonable number of 475 audits had been carried out by the team between April and August 2023, and these were in line with the annual IPC Programme. The types of audit carried out include BBE, Bed and Mattress, Commode, Invasive Devices, MRSA, Catheters, Hand Hygiene, Linen, Equipment, Theatres Environment and CRO. The report shows the results of audits, and infections by

type and location. These include smaller hospitals such as Barry and St Davids as well as University Hospital Wales (UHW) and University Hospital Llandough (UHL).

2.17 Review of the minutes of the IPC Group confirmed that the Tendable IPC audit report had been presented to the last three meetings of the IPC Group.

Conclusion:

2.18 The work of the IPC team is overseen by the IPC Group. Whilst an infection prevention control programme is drawn up annually, the programme for 2023/24 appears to be still in draft and is no longer fit for purpose. There is a specialist IPC Nurse assigned to each Clinical Board, and updates are provided to the IPC Group quarterly on the progress of the annual IPC Programme. However, the IPC Group terms of reference is out of date. We have provided **Reasonable Assurance** for this objective.

Objective 4: There is awareness of infection prevention and control guidance and staff have undertaken appropriate training.

2.19 It was confirmed in discussions with the Head of Nursing for IPC that IPC training is carried out face to face by the IPC team for all Health Board staff. Classroom training is undertaken at Llanishen and workplace training is also provided to groups of staff.

2.20 IPC induction training is part of staff mandatory training and must be completed by all staff through completion of the All-Wales e-learning module. The ESR system records all induction training carried out.

2.21 We were informed that mandatory training compliance rates for the IPC module by Clinical Board are reported to the IPC Group. However, no updates were noted in the IPC Group minutes for March, June and September 2023. Following the audit, we have been advised that the compliance rates for the IPC module will be reported going forward to the IPC Group. Clinical Board compliance rates for December 2023 ranged from 77.63% to 91.74%, with an average for the Health Board of 83.99%.

2.22 Records of classroom training and on-site training sessions delivered to date for the current year were provided. This shows that between the beginning of April 2023 and the end of September 2023 a total of 63 training sessions had been delivered to 723 staff. These figures are reported to the IPC Group through the IPC Position report.

2.23 As detailed in the IPC Position reports, members of the IPC team are proactive in raising awareness of IPC and attend various Health Board meetings, for example the Covid 19 Outpatient Parenteral Antibiotic Therapy (OPAT) meetings with Clinical Board representatives, weekly hospital operation / weekend planning meetings, Clinical Board / Directorate Quality & Safety and IP & C meetings.

2.24 IPC Nurses also attend All Wales and regional meetings and work closely with Capital & Estates departments during the design and construction of all new builds and the refurbishment of clinical areas.

2.25 The IP&C Doctors provide education sessions to Junior doctors, medical students and Allied Health Professionals

Conclusion:

2.26 Induction and classroom training is provided to Health Board staff by the IPC Team who also raise awareness of IPC issues through attendance at various Health Board meetings and All Wales and regional meetings. We have provided **Substantial Assurance** for this objective.

Objective 5: Robust incident reporting and monitoring processes are in place across the Health Board to allow for accurate and timely identification and recording of all infection control related incidents to ensure appropriate actions are taken and lessons are learned.

2.27 Internally, all infection related incidents should be reported on Datix. These are monitored by the IPC team who will contact the affected areas to offer advice, guidance and assistance as required. Incident reports should then be completed by the affected area that includes a root cause analysis (RCA).

2.28 A sample of incident reports was reviewed, and testing undertaken to ensure the incident had been reported via Datix, the incident had been adequately recorded and an RCA had been completed. Although the documentation provided was inconsistent in format, the information was the same in each case and consisted of a detailed report of the outbreak and a root cause analysis with lessons learned.

2.29 Healthcare Associated Infections (HCAI) such as C.Diff, MRSA and E.Coli arise as a direct result of healthcare interventions or from contact within healthcare settings. All cases of HCAI's are recorded on the ICNET system which is a Public Health Wales system and used by them to monitor cases on an All-Wales basis.

2.30 The system is used by the IPC team to monitor cases within the Health Board. Reports are run monthly and presented to the IPC Group. These show the number of cases for each disease for the Health Board as a whole and within each Clinical Board. The reports also include comparative data for the previous two years.

2.31 Externally, outbreak reports are provided weekly by Public Health Wales to warn of potential threats. These give details of new outbreaks in Wales such as Chicken Pox, Covid, Norovirus etc. and the number of outbreaks and cases by area and Health Board.

Conclusion:

2.32 Infection related incidents are recorded on the Datix system by the affected areas who complete an incident report with root cause analysis and lessons learned. These are monitored by the IPC team who provide advice and assistance as

required. Healthcare Associated Infections are monitored through the ICNET system and reported to the IPC Group. Outbreak reports are received daily from Public Health Wales and are used to identify any potential infection threats. We have provided **Substantial Assurance** for this objective.

Objective 6: There is regular reporting on IPC performance, and reports are submitted to appropriate management and Board level Groups for information and action.

2.33 As noted previously, IPC performance is reported to the Infection Prevention Group (IPG). The minutes of the last three IPC Group meetings held in March, June and September 2023 were reviewed. The meetings reviewed were well attended and quorate, and the minutes were sufficiently detailed with action points arising. However, we note that not all Clinical Boards were represented at every meeting. There was no Children and Women representative at 1/3 meetings and no Mental Health or PCIC representatives at 2/3 meetings.

2.34 The Head of Nursing for Infection, Prevention & Control produces a position report that is presented to each meeting of the IPC Group. This contains a range of information including the current staffing levels within the department, an update on meetings attended by IPC staff, policies and procedures, incident / outbreak management updates and training delivered.

2.35 Other regular reports to the IPC Group include Incident / Outbreak Reports from UHW and UHL, the HCAI Performance Report, Clinical Board Reports, audit activity via Tendable system reports and reports from sub-groups, for example the Decontamination Group and Antimicrobial Group. Any new Welsh Government guidance is also shared at the meetings.

2.36 Elements of IPC performance are included in the organisation's Integrated Performance Report that is presented to each meeting of the Board.

2.37 Whilst the Integrated Performance Report is presented to the Board, the IPC Group is directly accountable to the Quality, Safety & Experience Committee (QSE Committee). A Health Board wide Quality Indicators report has been presented to each meeting of the QSE Committee from July 2023, and this includes a section on IPC. However, the only data reported is the prevailing HCAI infection rates.

2.38 In line with the IPC Groups Terms of Reference, the group should report to the QSE Committee formally, regularly and on a timely basis on the Group's activities. Reporting should include verbal updates and the submission of the Group's minutes and written reports of progress against the annual programme throughout the year. However, review of the minutes of the QSE Committee minutes for the period 7th March 2023 to the 25th October 2023 did not identify any reports from the IPC Group **(see Matter Arising 5 - Medium Priority).**

Conclusion:

2.39 There was evidence of regular reporting on IPC performance to the Infection Prevention Control Group. However, there were inconsistencies in the format and content of the position report presented to the IPC Group and there was no evidence of reporting to the QSE Committee for the period reviewed, as required by the IPC Groups Terms of Reference. We have provided **Reasonable Assurance** for this objective.

Objective 7: The Health Board complies with all reporting requirements relating to reportable diseases and infections.

2.40 There is a requirement to report all incidents / outbreaks of infection through the Patient Safety Team. All Health Board incidents and HCIA's are recorded on the ICNET system which PHW has full access to.

2.41 Public Health Wales will regularly report any serious infection incidents or outbreaks to Welsh Government, and they collate all the information on Covid and other infectious diseases such as C'Diff, MRSA etc. from all the Welsh Health Bodies and will then report to Welsh Government on an All-Wales basis.

Conclusion:

2.42 There are no statutory or specific reporting requirements for the Health Board in relation to infections and diseases. Public Health Wales have overall 'Strategic' responsibility for Public Health, and they collate all the information on Covid and other infectious diseases such as C'Diff, MRSA etc. from all the Welsh Health Bodies and then report to Welsh Government on an All-Wales basis. We have provided **Substantial Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policies and Procedures (Operation)	**Impact**
The Health Board has a range of IPC policies and procedures in place. However, the following issues were noted from a review of the documents provided to us: • CJD - Dated August 2020 and due for review on the 1st August 2023 therefore it is out of date. • C'Diff - Appears to have been reviewed in 2021 with next review due December 2024 but this is not reflected in the document header or the summary of reviews on page 2. • Blood Borne Viruses - Reviewed and updated March 2023 but Summary of reviews on page 2 not updated. • Ectoparastic Infections - Appears to have been reviewed in March 2023 with next review due March 2026 but this is not reflected in the document header or the summary of reviews on page 2. • Hand Hygiene - Appears to have been reviewed in June 2021 with next review due June 2024 but this is not reflected in the document header or the summary of reviews on page 2. • Infectious Incidents - Updated September 2021 and due for review September 2024. The document header and summary of reviews on page 3 have not been updated to reflect this. • MRSA - Updated in December 2021 and due for review December 2024. The document header and summary of reviews on page 3 have not been updated to reflect this. • Varicella Zoster - Updated March 2023 and due for review March 2026. The document header and summary of reviews on page 2 have not been updated to reflect this. • Viral Gastroenteritis - Updated December 2021 and due for review December 2024. Date of next review incorrect on page 1 and subsequent headers, and summary of reviews on page 3 needs updating. We note from a review of the IPC Group minutes dated 2nd March 2023 that two policies were due for review and updating, namely TB and needle stick injury, neither of which were included in the policies provided to us. The updated policies were also not presented to the IPC Group meetings held in June and September 2023, so are still in need of review. In addition, none of the IPC policies and procedures are available to Health Board staff on Sharepoint. Saunders,Nathan 29/01/2024 17:21:57	The Health Board fails to prevent the spread of infection.

Recommendations		Priority
1.1	The IPC policies and procedures that have passed their review dates should be reviewed and updated as a matter of urgency. Review dates should be accurately recorded on the reviewed documents. A log of all IPC policies and procedures should be maintained that records the review dates. All IPC policies and procedures should be posted on Sharepoint as soon as is practicably possible.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	The 3 procedures that have passed the review date are currently under review and drafts will be circulated to the members of the IPCG for review	End of February 2024	Head of Nursing for IP&C
	All complete policies and procedures will be reviewed and updated to the correct Health Board format. This will be complete by the March 2024 meeting of the IP&C Group	March 2024	Head of Nursing for IP&C
	Once updated to the correct format they will be updated to Sharepoint and out of date procedures will be removed	March/April 2024	Head of Nursing for IP&C

Matter Arising 2: Roles and Responsibilities (Operation)	**Impact**
Copies of the Job Description / Person Specification for each level within the IPC team structure were obtained and reviewed to ensure they were up to date and clearly outlined roles and responsibilities at each level within the unit. Whilst the roles and responsibilities for each post were clearly documented within the Job Descriptions reviewed, the following issues were identified: • The Job Description for the Head of Nursing IPC was prepared in March 2021 by the Executive Nurse Director but is marked as Draft so it is unclear if the Job Description / Person Specification has been approved. • The Person Specification for the Senior Nurse post is not signed off or dated, although the Job Description had been reviewed and signed off by the Head of Nursing IPC in June 2023. • The Job Description for the Band 7 Clinical Nurse Specialist role is undated but states the post is accountable to the 'Lead Doctor IPC', a role that no longer exists. It also makes reference to the 'Trust', and states that the Job Description should be subject to regular review, but the evidence suggests it has not been reviewed / updated for some time. • Although the Band 6 Associate Clinical Nurse Specialist Job Description / Person Specification was in an up-to-date format, it had also not been dated and signed off. • The base for the Band 4 PA was stated as Capital Quarter, and the document had a Public Health Wales logo. It had been reviewed and updated in 2021 but makes no reference to IPC.	The Health Board fails to prevent the spread of infection.

Recommendations		**Priority**
2.1	Management should ensure that each role within the IPC unit has an up to date and approved Job Description and Person Specification.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The Job description/Person specification was approved, the document will be shared with audit team	End of February 2024	Head of Nursing for IP&C

Matter Arising 3: IPC Group terms of Reference (Operation)			**Impact**
The work of the IPC team is overseen by the Infection Prevention Control Group which is chaired by the Executive Nurse Director. The IPC Group Terms of Reference (ToR) states that the ToR should be reviewed annually, but the document is dated 9th September 2010 and still marked as 'Final Draft for consideration'. Our review of the ToR identified that a number of areas require updating. For example the Group is directly accountable to the Quality Safety and Experience Committee. The document also makes reference to strategic documents dated 2004 and 2007.			The Health Board fails to prevent the spread of infection.
Recommendations			**Priority**
3.1	The IPC Group Terms of Reference should be reviewed annually.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The IPC Group Terms of Reference will be reviewed and taken to the IPC Cell at the beginning of February for discussion. The document will be taken to the March IPC Group meeting for comment and ratification	March 2024	Executive Director of Nursing and Head of Nursing for IP&C

Matter Arising 4: IPC Annual Programme (Operation)	**Impact**
The Head of Nursing for IPC prepares an annual Infection Prevention Control Programme. This sets out the IPC team's aims and objectives for the year and includes targets and also specifies a range of IPC audits to be carried out during the year. However, our review of the Annual IPC Programme for 2023/24 identified a number of issues. Although the range of pro-active audits to be carried out was specified, there was no target set for the number of audits of each type that should be completed in the year. Furthermore, there was no Clinical Board input to the plan, and Clinical Boards have not produced their own IPC plans. Some of the activities included in the plan are no longer relevant, for example the requirement for audit results to be fed back to teams and for Ward Sisters to produce action plans within 3 weeks. In addition, the document provided to us was undated, had no document control page and contained several unresolved comments and some highlighted text. The file name also suggests the document was still in draft. The minutes of the IPC Group meetings held in March, April and September 2023 were reviewed but there was no evidence that the 2023/24 programme had been reviewed and approved by the Group. Consequently, we were unable to determine the status of the document and if it had been approved or was still in draft.	The Health Board fails to prevent the spread of infection.

Recommendations		**Priority**
4.1	The format and content of the IPC Annual Programme should be reviewed and updated. This should include setting of targets for the number of pro-active audits to be carried out in clinical areas. The Head of Nursing for IPC should also seek Clinical Board input when compiling the IPC Annual Programme and should request each Clinical Board to prepare their own IPC annual plans. The annual IPC Programme should be completed and submitted to the IPC Group for approval every year prior to the start of the year.	**High**

Agreed Management Action		Target Date	Responsible Officer
4.1	The IPC Annual Programme for 2024/25 will be reviewed and format updated by the Head of Nursing IP&C and the IP&C team. It will be shared with Clinical Board Directors of Nursing for agreement	June 2024	Head of Nursing IP&C
	Clinical Boards will develop their plans for 2024 and present to the IP&C group	September 2024	Clinical Board Directors of Nursing

Matter Arising 5: IPC Group Reporting (Operation)			**Impact**
The IPC Group is directly accountable to the Quality, Safety and Experience Committee in line with their Terms of Reference, and should report to the Committee formally, regularly and on a timely basis on the Group's activities. Reporting should include verbal updates and the submission of the Group's minutes and written reports of progress against the annual programme throughout the year. However, review of the minutes of the QSE Committee minutes for the period 7th March 2023 to the 25th October 2023 did not identify any reports from the IPC Group. It is acknowledged that a Quality Indicators report has been submitted to the QSE since July 2023, but this only reports on prevailing HCAI infection rates.			The Health Board fails to prevent the spread of infection.
Recommendations			**Priority**
5.1	The IPC Group should report to the Quality, Safety and Experience Committee in line with their Terms of Reference. This should include submission of the Group's minutes and written reports of progress against the annual plan. Alternatively, the Group's Terms of Reference should be amended to reflect their reporting preferences.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	The minutes of the IPC Group meetings will be submitted to the Quality, Safety and Experience Committee	February 2024	Executive Director of Nursing

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Technical Continuity
Final Internal Audit Report

January 2024

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Cardiff and Vale University Health Board

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Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Nigel Lewis, Assistant Director of IT Russel Kent, Head of Digital Operations
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the audit was to provide the Health Board with assurance that there is appropriate provision of technical continuity and fault domain awareness to ensure that the Health Board can maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.

Overview

We have issued reasonable assurance on this area.

Hardware is securely hosted and there is extensive use of virtualisation to enable resilience. There have been recent improvements to the provision of services with upgrades to the virtual environment and the backup process, with work ongoing to provide alternative sites to enable disaster recovery. However, there is currently no geographical resilience and the disaster recovery plan is incomplete, with no order of restoration of services.

The matters requiring management attention include:

- Ensuring the risk relating to geographical resilience is appropriately recorded;
- Ensuring all hosted services are fully documented, with a formal agreement and acknowledgement of resilience position;
- Updating the Disaster Recovery Plan; and
- Enabling record of learning within the incident management process.

Other recommendations / advisory points are contained within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Resilience Design	Limited
2	Testing of Resilience	Reasonable
3	Disaster Recovery Planning	Limited
4	Back Ups	Substantial
5	Continual Improvement	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Risk Recording	1	Operation	Medium
3	Record of Hosted Services	1	Operation	Medium
5	DR Plan	3	Operation	High
7	Incident Learning	5	Operation	Medium

1. Introduction

1.1 Our review of technical continuity was completed in line with the 2023/24 Internal Audit Plan for Cardiff and Value UHB (the 'Health Board'). The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

1.2 In an environment where technology outages impact an organisation's ability to operate and customers require services to be 'always on', near-instantaneous recovery is often required with minimal data loss. The environment is made up of inter-related layers, each with its own risks and resilience requirements:

- Infrastructure – the foundation layer consists of components such as power, network connectivity, physical security and environment controls, and data centres providing the hosting environment.
- Environment – the infrastructure supports the environment and is the storage and compute functions of the systems (cloud, physical or virtual servers).
- Platform – the environment supports the platform which is the operating systems, databases, and the management of storage and compute resources that host the applications.
- Applications – the software tools which allow the organisation to perform its business and operational processes.

1.3 The risks considered during this review were as follows:

- Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm;
- Loss of key processing or networking services;
- Legal and regulatory breaches; and
- Reputational damage and/or financial loss.

1.4 The relevant lead director for the review is the Director of Digital and Health Intelligence.

2. Detailed Audit Findings

Objective 1: Resilience is designed into the delivery of the technical infrastructure, the design has been enacted appropriately and applications ensure the designed resilience is utilised.

2.1 The Health Board digital services are provided from one main site, the Services Accommodation Centre (SAC). We note that this has changed over time, with services having moved into the SAC from the old IT room (held within the main building of UHW), with this room now only used for third party systems. There is also a room within Cardiff Royal Infirmary (CRI) which is used to store backups and for the Oracle Financials system.

2.2 As all the health board systems are held within a single site, there is currently a lack of geographical resilience in place. Should the SAC be lost, then the Health Board runs the risk of losing all its digital functionality, and as the Health Board hosts systems that are used across Wales, the impact would be felt nationally. This is compounded by the lack of any available DR hardware to be able to restore the current production environment back up on to. Currently there is no risk contained within the Digital risk register that defines this. **Matter Arising 1**

2.3 There is work ongoing to improve the geographic resilience, with the development of two additional datacentres underway, these are within University Hospital Llandough (UHL) and Woodland House. The intent is to use the UHL site to host services based on site and to use Woodland House as a disaster recovery (DR) site.

2.4 All sites have appropriate environmental protections in place, with air conditioning, dual power suppliers and uninterruptible power supply (UPS) with generator support with these being provided and managed by the Estates department.

2.5 The main datacentre rooms within the SAC, UHL and Woodland House have dual power supplies and room based supply UPS. The UPS is provided under a contract which ensures regular servicing and testing and was replaced 4 years ago as a like for like replacement.

2.6 The contents of the data centre are documented, so the Digital Directorate ('Digital') are clear about what is being hosted within the datacentres and where items are within the rooms. However, the Estates department are unaware of any changes to the contents of the rooms, and as such the UPS runtime and fault tolerance is not known. **Matter Arising 2**

2.7 Cooling is also provided under a contract and we note that air conditioning is provided to all rooms. And all rooms have fire detection in place with the main sites having gas based suppression in place.

2.8 There is extensive use of virtualisation software, using VMware version 7.03 and higher, with an intent to move all onto version 8, which increases resilience. We note that there have been recent improvements in the use of virtualisation with the purchase of improved licencing. This has enabled a consolidation from approximately 70 hosts to 30, and better use of resilience enhancing features such as high availability and distributed resource scheduling.

2.9 Some functionality within VMware is not currently in use. Fault tolerance is not in use and site recovery manager (SRM) is not used as all equipment is in the same site and reliance placed on the Veeam backup solution to cover the required functionality. We note that there is an intent to review this once the new sites are established, as SRM allows for automated recover which would speed the DR process up.

2.10 Improvements have also been made to the storage in use, with storage fabric in place, enabling shared storage for hosts within the rooms, with the rooms interconnected to enable backup. We noted a stated intent to move towards a

supercluster with backup over the fabric once Woodland House is operational in order to provide DR for key servers.

2.11 As previously noted there is limited geographical resilience at present, with services provided from the SAC from within two pods. Work is ongoing to improve this, both across the Health Board and within the SAC. The stated intent is to have clusters spread across the pods within SAC, and a DR site. This would move the key fault domain down a level to a pod from the current position of the SAC.

2.12 The Digital Directorate have limited control into the design and establishment of departmental systems, although the Directorate provides the hosting for servers and as part of that has put in place a process for agreeing the hosting and backup arrangements (HBA). As such the resilience for individual services varies across the Health Board.

2.13 The Digital Directorate hold a list of all systems hosted within the SAC, and this records information on resilience. However, not all services have an agreed HBA and there is no explicit consideration of recovery time objective or recovery point objective (RTO/RPO) within HBAs or within the Directorate record of services. **Matter Arising 3**

2.14 We also note the existent of legacy applications that run on older operating systems

2.15 The autonomy of the Service Groups has meant that although applications use virtualisation, they are treated separately, with many being single servers and there is limited use of load balancing. We also note that some services use physical servers. As noted above there is currently limited geographic resilience in place which also impacts on resilience, and this is exacerbated by the hosting of some systems that are used on a national basis. **Matter Arising 4**

Conclusion:

2.16 Hardware is hosted in secure locations with good environmental controls and resilient power provision and there is extensive use of virtualisation. The provision of digital services has been recently improved, with an upgrade to the virtual environment and storage and the development of alternative sites which would better enable resilience and disaster recovery. However, at present there is no geographical resilience for digital services, which include some that are used across Wales. We also note that applications do not always maximise the use of the available resilience potential, not all have an agreed hosting arrangement in place and no explicit agreement of RTO/RPO. Accordingly, we have provided Limited Assurance over this objective, with geographical resilience being the key limiting factor.

Objective 2: Resilience is subject to testing at both infrastructure and application level to ensure that processes are operating as anticipated.

2.17 As all services are currently hosted within the single building, there is no testing of DR failover to alternate sites. We note that work to establish alternate sites is

ongoing, and once complete the DR / failover process should be tested to ensure that it operates as anticipated.

2.18 There is testing of generator power supplies, and as part of the maintenance contracts for UPS and cooling, these are tested by the relevant suppliers.

2.19 There has recently been a formal project to test the power resilience, including back up supplies and generator at the UHW site. We note that this was a full test which included National Grid shutting down power to the site. Digital were heavily involved in the planning of this test, and we note that the outcome was positive and provides assurance for power resilience.

2.20 As applications are provided from a single site and are largely managed by Service Groups there is no regular testing of the resilience available to applications. Although we do note that there is a periodic requirement for some services to be recovered.

Conclusion:

2.21 There is testing of the cooling provision, and of the power supplies, with a periodic requirement for the recovery of services. As there is currently no alternative site provision there is no capacity for failover, however we note that once the DR sites are operational there is a stated intent to test this. Accordingly, we have provided Reasonable Assurance over this objective.

Objective 3: An effective and tested recovery plan which meets the business requirements should be in place.

2.22 There are restore instructions in place that set out how to restore virtual servers and how to restore data from the backups. As part of the development of the new backup process, the lead shared information about the set up and how to enact restores.

2.23 There is an IT Disaster Recovery Plan in place. This was last updated in 2019, with information relating to backups being out of date, however we note work is currently ongoing to update it. The DR plan considers the main types of failure such as IT, power, communications and covers the network infrastructure, together with PMS.

2.24 The DR plan contains a list of applications hosted by IT, however there is no categorisation of these, no consideration of RTO/RPO and no order of restoration of services. As noted above not all services have a completed HBA, and so have not completed an impact assessment which would enable a fully prioritised restoration order. **Matter Arising 5**

2.25 The current DR plan does not fully set out or signpost to the processes to follow in order to restore services in the event of varying degrees of failure such as:

- Failure of site> provision of failover instructions, restore priorities;
- Failure of rack >provision of failover and restore instructions;
- Failover of VM > restore and restore from backup; and
- Failure of system – VM restore / backup restore.

2.26 We also note that the individual applications do not have DR plans, with reliance being placed on both IT and suppliers to restore provision, and discussions with leads indicated limited awareness of RTO. **Matter Arising 5**

2.27 As noted previously, the architecture is changing, and this will better enable DR planning. Woodland House is due to be the DR site for key servers, with storage provided for approximately half of the virtual machines (VMs) there, with the rest in UHL. However as there has been no full categorisation of services there has been no prioritisation over what should go to Woodland House. We also note that although the virtual environment has been / is being improved, there has been no licencing of SRM which would enable the automation of DR and site recovery.

Conclusion:

2.28 Although there are restore instructions in place and there is a continuity / disaster recovery document in place, this is out of date, and there is no full set of instructions for recovery from varying levels of incident. There is no up to date prioritised list of services that sets out a restore order, and not all applications have DR plans. The site provision is being improved and we note that the DR plan is currently under review. Accordingly, we have provided Limited Assurance over this objective.

Objective 4: Back ups are taken appropriately, are tested and protected from unauthorised access and change to enable resilience.

2.29 As part of the deployment process within IT for new virtual machines there is a requirement for formal notification to be passed to the backup team in order to ensure that all VMs are included within the backup regimen.

2.30 The processes for backing up data have been improved recently with investment obtained which has enabled the Health Board to standardise the backup processes onto Veeam, with 2Pb storage. We note that once Woodland House is complete the intent is to send the backups to UHL and Woodland house to enable offsite storage.

2.31 Backups are also run to tape for long term storage as part of the previous NetBackup process, however this is being phased out as all backups move onto Veeam.

2.32 We note the existence of legacy applications running on out of date operating systems within the Health Board. As Veeam does not fully support any out of support Microsoft operating systems, the defined RTO/RPO for these systems may not be achievable, with the Veeam process working on a best endeavour basis for these.

2.33 Testing of backups by restore in order to confirm the validity of the data is an ad-hoc process and not subject to formal requirements. Restores are done on request from services and there has been a recent whole server test restore. We also note that as part of the improvements, all backup jobs have been checked within the last 12 months. These provide some confidence that the backup process is

operating appropriately, however the lack of a formal testing requirement may mean some aspects or areas are missed in the future.

2.34 The move on to Veeam provides an opportunity to enable testing of data integrity as part of the backup process. This functionality is not currently in use due to the lack of a DR site, however we note a stated intent to include this functionality in the future. **Matter Arising 6**

2.35 There is no health board policy or procedure that sets out the backup policy and process or restore instructions. As part of the establishment of the new process the lead provided learning sessions, and the Veeam documentation is available and comprehensive. The Veeam documentation provides sufficient guidance to operate the process, however there is limited information available for non-core staff and no definition of health board policy. **Matter Arising 6**

Conclusion:

2.36 There is a good process for backing up services, and this has been recently improved, with improvements continuing. The provision of alternative sites will enable further improvements such as automated testing of backup validity. Accordingly, we have provided Substantial Assurance over this objective.

Objective 5: There is a continual process of review and assessment, including post-incident reviews to identify the root causes of disruptions.

2.37 There is a process for monitoring the status of core infrastructure (network, servers, firewalls), using Solar Winds. There are dashboards set up within Solar Winds which show an immediate picture of the state of the infrastructure and an alerts process in place.

2.38 Alerts are provided once the defined trigger points have been met which send emails to the relevant team, and to the on-call phone if outside normal working hours. The thresholds for alerts have been amended to avoid being overloaded with alerts that cannot be dealt with, and we note that this process is being continually worked on.

2.39 Any failures within the infrastructure are dealt with using a service management approach, with incidents recorded and subject to investigation and resolution. This activity is recorded within the new Ivanti service desk management system and as part of our work we reviewed the handling of failures and confirmed that all were resolved appropriately on a timely basis.

2.40 The Ivanti service desk also includes a Knowledge Base and Learning section. This is searchable and provides FAQs and issue resolution records which enables staff to identify quick resolutions to some issues.

2.41 We note that Ivanti is being continually developed, however currently it is missing key fields which would enable the continuous improvement in the estate. There is no place to record the full details of a root cause analysis, with the "cause" field being very high level, and no formal process for identifying and recording learning and improvement points. Without these in place the health board will be subject

to repeated, avoidable incidents. We also note that there are currently no formal procedures or guides for dealing with incidents. **Matter Arising 7**

Conclusion:

2.42 There is a process for monitoring the infrastructure which provides alerts when issues occur that impact on digital service delivery. When failures occur, they are recorded and subject to timely resolution. We have noted that incident investigation does not full enable learning and improvements to be documented. Accordingly, we have provided Reasonable Assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Risk Recording (Operation)			**Impact**
As all the health board systems are held within a single site, there is currently a lack of geographical resilience in place. Should the SAC be lost, then the health board runs the risk of losing all its digital functionality, and as the health board hosts systems that are used across Wales, the impact would be felt nationally. Currently there is no risk contained within the Digital risk register that defines this.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
1.1	The risk relating to geographical resilience and the impact on All Wales services should be appropriately included within the risk register.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Added to the Digital Risk Register (Confirmation required it is already in the Server Team Risk Register).	Q1/24	Head of Information Governance & Cyber Security Server & Infrastructure Manager

Matter Arising 2: Fault Tolerance (Operation)			**Impact**
The contents of the data centre are documented, so Digital are clear about what is being hosted within the datacentres and where items are within the rooms. However, Estates are unaware of any changes to the contents of the rooms, and as such the UPS runtime and fault tolerance is not known.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
2.1	The contents of the datacentre rooms should be recorded, with inclusion of cooling and power requirements, and this information should be shared with the Estates department and kept up to date in order to ensure that there is appropriate fault tolerance for cooling and power.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	CEF are responsible for the power and cooling in the Datacentre rooms. Power tests have been completed in 2023 with frequent scheduled tests planned for 2024 onwards	Completed Q1/24	n/a

Matter Arising 3: Record of Hosted Services (Operation)			**Impact**
The Digital Directorate hold a list of all systems hosted within the SAC, and this records information on resilience. However, not all services have an agreed HBA and there is no explicit consideration of RTO/RPO within HBAs or within the Directorate record of services.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
3.1	The record of hosted services should be updated to include consideration of RTO/RPO, and all services required to complete the HBA which includes an assessment of impact.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Migration of existing RBAC spreadsheet to Online dynamic forms for all servers and applications.	Q2/24	Server & Infrastructure Manager

Matter Arising 4: Resilience Position (Operation)			**Impact**
The autonomy of the Service Groups has meant that although applications use virtualisation, they are treated separately, with many being single servers and there is limited use of load balancing. We also note that some services use physical servers. As noted above there is currently limited geographic resilience in place which also impacts on resilience, and this is exacerbated by the hosting of some systems that are used on a national basis.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
4.1	As part of the move to the new architecture, consideration should be given to providing more holistic management of hosted applications to maximise the resilience position, with Digital providing greater input into design. Services on physical servers should be moved into the virtual environment.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Work with the Clinical Boards, Services and Departments to migrate their servers to new OS, Hardware and introduce HA and Fault Tolerance.	Q4/24	Server & Infrastructure Manager

Matter Arising 5: DR Plan (Operation)	**Impact**
The DR plan contains a list of applications hosted by IT, however there is no categorisation of these, no consideration of RTO/RPO and no order of restoration of services. As noted above not all services have a completed HBA, and so have not completed an impact assessment which would enable a fully prioritised restoration order. The current DR plan does not fully set out or signpost to the processes to follow in order to restore services in the event of varying degrees of failure such as: • Failure of site> provision of failover instructions, restore priorities; • Failure of rack >provision of failover and restore instructions; • Failover of VM > restore and restore from backup; and • Failure of system – VM restore / backup restore. We also note that the individual applications do not have DR plans, with reliance being place on both IT and suppliers to restore provision, and discussions with leads indicated limited awareness of RTO.	Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.

Recommendations		**Priority**
5.1	The DR plan should be updated to include: • Procedures or signposting to procedures for varying failure types • Updating for the new architecture • Prioritised order of restoration, which is agreed with services • Explicit consideration of RTO/RPO	**High**
5.2	Services should be requested to provide DR plans that synchronise with the Digital Directorate. As part of this the RTO/RPP provided by digital should be agreed.	**High**

Agreed Management Action		Target Date	Responsible Officer
5.1	As part of the NIS 2 Directive there is an expectation that all "Critical" systems have resilience. Often this is overlooked due to cost and lack of technical information provided at the point of implementation. A task to go through all the systems and confirm resilience, RPO and RTO abilities has started and will continue for the foreseeable future.	Q4/24	Head of Information Governance & Cyber Security Server & Infrastructure Manager

Matter Arising 6: Backup Documentation (Operation)			**Impact**
There is no Health Board policy or procedure that sets out the backup policy and process or restore instructions. Although the Veeam documentation provides sufficient guidance to operate the process there is limited information available for non core staff and no definition of Health Board policy. The move on to Veeam provides an opportunity to enable testing of data integrity as part of the backup process. This functionality is not currently in use due to the lack of a DR site, however we note a stated intent to include this functionality in the future.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
6.1	A formal documentation of the Health Board backup policy should be developed, that signposts to the detailed instructions. Once the DR site is established, the use of SureBackup and/or Veeam Health Check should be enacted.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Update and communicate new backup, restore and DR documentation when DR sites are available later in 2024.	Q3/24	Server & Infrastructure Manager

Matter Arising 7: (Operation)			**Impact**
Currently Ivanti is missing key fields which would enable the continuous improvement in the estate. There is no place to record the full details of a root cause analysis, with the "cause" field being very high level, and no process for identifying and recording learning and improvement points. Without these in place the Health Board will be subject to repeated, avoidable incidents. We also note that there are currently no formal procedures or guides for dealing with incidents.			Potential risk of: • Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
Recommendations			**Priority**
7.1a 7.1b	Ivanti should be further developed to include fields for recording of the detail of a root cause analysis and for improvement actions. A formal procedure or guide for incident handling should be developed.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Confirm or create method for capturing root cause analysis within Ivanti Service Desk. Provide updated documentation for Incident Management.	Q3/24	Support Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Saunders,Nathan
29/01/2024 17:21:57

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Estates Condition
Final Internal Audit Report

January 2024

Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the UHB confirmed a total backlog maintenance requirement of £152m – although the capital investment requirement to clear the backlog maintenance is likely to be materially higher.

The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

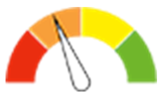
Overview

Key to understanding the challenge is the quality of the baseline data. This is acknowledged within the UHB's Board Assurance Framework (BAF) noting that the UHB's current estates condition baseline data was developed from a 2017 condition survey which had been updated annually by desktop review. A tendering exercise was currently being progressed to survey the estate and to establish an updated baseline. Experience of other NHS organisations suggests that this update is likely to result in an increase in the reported data. It has been recommended that the executive lead approve the proposed approach.

In the short to medium term, the UHB uses a combination of all Wales capital funding, targeted Estates Facilities Advisory Board (EFAB) funding, planned/ reactive maintenance, and discretionary funding to address identified high-priority areas as follows, e.g.:

- All-Wales capital funding was secured for the UHL Engineering Infrastructure scheme (£5.5m). Further business cases have been submitted to Welsh Government for approval.

Report Classification



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary

	Assurance objectives	Assurance
1	Governance	Reasonable
2	Baseline Information	Reasonable
3	Estates Strategy	Limited
4	Funding Strategy	Limited
5	Monitoring & Reporting	Reasonable
6	Risk Management	Limited

The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Priority
1	Estates surveys are required to inform an updated backlog maintenance baseline position.	*2*	Medium
2	The UHBs estates strategy requires reviewing in several areas including performance indicators.	3	Medium
3	Increased corporate assurance/reporting is required surrounding	4	High

- The UHB successfully secured EFAB funding of £6.035m across 2023/24 & 2024/25 to tackle high/significant backlog maintenance priorities.
- Across NHS Wales, due to pre-commitments and other pressures on the discretionary capital funding, the allocation for backlog maintenance had historically been insufficient to effectively manage the position – with £500k earmarked at the UHB specifically for backlog maintenance in 2022/23 (over and above UHB contributions to EFAB funding). Available resources were targeted at priorities based on existing risk assessments.
- Whilst revenue resources were targeted at the priority planned and reactive maintenance areas, the UHB had the lowest 'Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)'. In response, an internal review was being initiated to better understand the existing and required skill mix within the maintenance team – to inform potential future recruitment and funding requirements.

Noting the above, there were arrangements in place to focus the limited available resources on progressively addressing the high priority areas within the UHBs estate.

In the longer-term, the UHBs 10-year programme highlights an indicative funding requirement of circa £3.3 billion for the estate to address the backlog maintenance risks and meet the future healthcare needs of the population. Noting the scale of the investment required, there is a significant risk to the UHB that this strategy is not affordable. It has been recommended that the Board continue to receive regular updates on the delivery of the estate strategy and 10-year capital programme, particularly any risks/impact resulting from delay/non delivery.

A corresponding revised long-term strategy is required for maintenance, as continued investment at historic levels is likely to result in the UHB estates being in a further deteriorating position requiring increased levels of capital investment.

Whilst operational risks were well documented, reported and escalated, the Board should seek further assurance that the identified actions within the Board Assurance Framework are effective – noting their impact to date.

Whilst the UHB had been focussing the available resource to high priority estate risks, an overall **limited assurance** has been determined, recognising that it may not be possible to manage all identified risks within available funding. This

	the Estates Strategy and Capital Plan.		
4	A review of the estate workforce, coupled with the development of a clear long term financial model for the revenue support in the estate is required.	4	High
5	Monitoring and reporting the performance of backlog maintenance position should be clearly established.	5	Medium
6	Actions within the Board Assurance Framework to reduce the risk associated with the capital assets should be reviewed.	6	High

assurance opinion is in line with that determined across NHS Wales, given the common challenges faced by each organisation.

Further matters arising concerning the areas for refinement and further development have also been noted (see **Appendix A**).

Whilst not a specific focus of this review, the recently nationally reported Reinforced Autoclaved Aerated Concrete (RAAC) issues have further increased the risk profile of the NHS Wales estate. The centrally commissioned surveys have identified only isolated instances of RAAC requiring urgent attention - at the time of reporting, the surveys identified no areas requiring urgent action within the UHB estate.

1. Introduction

1.1 The audit forms a part of the 2023/24 Internal Audit Plan agreed with Cardiff and Vale University Health Board *('The UHB').*

1.2 The effective and efficient management of the NHS Wales estate is essential for the delivery of quality health care services.

1.3 The audit was undertaken to evaluate the processes and procedures put in place by the UHB to support the management, condition, and performance of the estate.

1.4 The potential risks considered in the review were as follows:

- The Board may be unaware and/ or may not be adequately informed to effectively assess and manage the risks associated with backlog maintenance (particularly statutory requirements).
- Appropriate funding may not be in place.
- The status and value of backlog maintenance may not be adequately defined, and the probability and impact may not be fully understood.
- Information may not be interrogated to ensure focus is prioritised on the key risks.
- Performance in addressing identified priorities may not be monitored, potentially impacting organisational objectives.

1.5 The Estates and Facilities Performance Management System (EFPMS) enables the UHB to submit its annual declaration on key data to Welsh Government. The UHB reported position over the last three years, against NHS Wales averages, was as follows:

Table 1

Measure	2019/20	2020/21	2021/22
UHB cost to eradicate High Risk Backlog maintenance (£)	32,841,799	30,280,767	32,033,876
UHB cost to eradicate Significant Risk Backlog Maintenance (£)	94,070,620	80,902,510	85,487,856
UHB Total Backlog Maintenance Cost (£)	125,542,116	127,473,900	151,836,322
NHS Wales average: Total Backlog Maintenance Cost (£)	97,320,207	97,385,329	113,007,158
UHB Risk Adjusted Backlog Maintenance Cost (£)	77,288,908	100,110,784	101,262,019

UHB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	14.32	14.08	16.22
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

1.6 EFPMS data for 2022/23 had not been submitted at the time of the current audit.

1.7 Additional estate performance data across NHS Wales is presented at **Appendix B,** taken from the NHS Estate Dashboard Report for 2021/22 (published by NWSSP: Specialist Estates Services).

1.8 Our audit work was reliant on the above information. We have not sought to provide assurance over the accuracy of supplied information; however, we have commented within the body of this report on the consistency in approach with other NHS Wales Organisations

2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Governance: *Assurance that robust governance arrangements were applied to ensure the organisation stays abreast of matters and associated risks relating to the estates condition.*

2.2 An Independent Member with responsibility for capital and estates was appointed to the Board in February 2020 which highlights the Board's commitment to capital and estates provision and scrutiny.

2.3 Governance arrangements were in place with escalation processes to a corporate level noted. The executive lead for the estate was the Executive Director of Finance who chaired the Capital Management Group, which was the main operational forum for receiving capital and estates reports.

2.4 Board assurance had been informed via the inclusion of estate condition risks at the Corporate Risk Register (see ***risk management*** section) and discussions surrounding this at Board and subcommittee level. We have made several recommendations throughout this report aimed at strengthening the level of assurance received by the Board in respect of the significant estate condition risks faced by the UHB (see **MA3, MA6**).

2.5 It was recognised that the UHB has well established governance and reporting arrangements in place for its major capital investment projects via associated Project Boards and where appropriate to respective committees. However, during

the interim period of the Estate Strategy (2018 -2022), regular progress reporting to the Board of the delivery of its Estate Strategy objectives (and associated delivery risks) was limited.

2.6 Whilst no issues were identified with the specific governance arrangements in place, sound decision making is predicated upon the quality of management information provided. Accordingly, noting the absence of regular Estate Strategy progress updates to the Board and associated issues in subsequent sections of this report, **reasonable assurance** has been determined in respect of the governance arrangements applied.

Baseline Information: *To obtain assurance that the UHB had detailed records on the condition of the estate based on a combination of robust condition surveys and risk assessments. The information was managed and retained within robust management systems that were subject to regular review.*

2.7 The key guidance in relation to assessing backlog maintenance: *'A risk-based methodology for establishing and managing backlog'* (updated March 2013), describes the steps involved in establishing and managing backlog maintenance, as follows:

2.8 In respect of the detailed condition survey, the guidance recommends that:

> *"NHS organisations carry out a detailed survey of their assets on a five-yearly basis."*[1].

2.9 Detailed estate condition surveys were undertaken on the UHB estate between 2017-2018 (with Rookwood being an outlier having been undertaken pre-2015). At the time of reporting the UHB were proposing a tendering exercise (during 2023/24) for an external survey of the estate condition, with the expectation of reporting late 2023/24 or early 2024/25. However, at the time of reporting, the 'fee submission for the provision of specialist estates services' had been prepared and was awaiting issue. Noting the proposed approach slightly varies to the guidance provided at Estatecode e.g., the exclusion of the Environmental Management' facet, it has been recommended that the executive lead approval should be sought to the approach being adopted (including any benefits/limitations/additions/omissions). (**MA1**).

2.10 Where other NHS Wales Health Bodies had commissioned recent external costed surveys, the backlog maintenance figures had significantly increased. This presents the potential for other Health Bodies (including CVUHB) to be underestimating the cost implications of backlog maintenance. This is acknowledged within the UHB's Board Assurance Framework (BAF) that 'Full condition surveys of all buildings have not been carried out, so it is not possible to fully understand the condition of the estate'.

2.11 Once the UHB has established an accurate baseline, it is important this is kept up to date to enable effective monitoring, reporting and investment planning. The guidance recommends that:

> *"You should update the findings of your detailed survey on an annual basis. This will inform your investment planning process and ensure your assets are safe and fit for purpose."*

2.12 Ongoing statutory compliance surveys were undertaken on a routine basis; budgeted within the discretionary capital programme and performance monitored and reported to the UHB's Capital Management Group.

2.13 Management highlighted that an annual meeting also takes place to update results for the EFPMS submission.

2.14 Given the UHB had identified the need for updating the estates condition surveys, **reasonable assurance** has been determined in relation to baseline information, noting there is a potentially negative impact on current estimates.

Estates Strategy: *To obtain assurance that a tailored estates strategy was in place including linkage to major investment, estates condition, statutory compliance, decarbonisation requirements, service needs etc. The strategy also reflected emerging risks.*

2.15 Welsh Health Building Note 00-08 2018 'Estatecode' highlights that:

> *"Once a comprehensive analysis of the condition and performance of the existing estate has been completed, the organisation will have the baseline data used when developing an estate strategy.*
>
> *An estate strategy should represent the vision for the future of the organisation's estate…in order to deliver and satisfy the current and perceived business plans, the expected operational service requirements, aligned with objectives of contributors to health and social care delivery.*
>
> *The estate strategy should be reviewed annually using EFPMS data and the information from the five-facet survey. The clinical strategy should be the driver of the estate."*

2.16 The UHB's Annual Plan makes multiple references to the estate and contained a specific section on the estate strategy.

2.17 The UHB's Estates Strategy 2018-2028 determined the strategic direction for the estate. As above, the UHB had identified the need for a review of this strategy as part of the BAF. However, enhancements have been suggested aimed at ensuring that the strategy aligns with current guidance e.g., Estatecode 2018, Developing and Estate Strategy 2018 (**MA2**).

2.18 The February 2023 Board development session received an update on delivering the estates strategy with an overall RED risk assessment (using a RAG rating) recognising the progress at the time of reporting. However, the backlog maintenance position highlights an increasing negative trend (see **table 1**).

2.19 In addition to the above, the UHB produced a prioritised 10-year capital programme reflecting the capital requirement to achieve the estate strategy. Whilst several projects had progressed (e.g., UHL Engineering Infrastructure) other targeted projects had been delayed.

2.20 Recognising the update (February 2023), the Board or nominated committee should continue to receive regular updates on the delivery of the estate strategy and 10-year capital programme, particularly any risks/impact resulting from delay/non delivery (**MA3**)

2.21 It was concluded that the UHB had identified the need for updating the estates strategy, however, further work was required to ensure the vision remained achievable. Accordingly, **limited assurance** has been determined in relation to the estate's strategy.

Funding strategy: *Assurance that there is a co-ordinated approach to the targeting of All-Wales, Estates Funding Advisory Board (EFAB) and Discretionary funding to implement the estates strategy.*

2.22 There has been historical under-investment across Wales in this area, resulting in a deterioration of the NHS estate condition. The cost of the UHB's backlog maintenance was estimated as £151,836,322 in 2021/22 (see table 1 section 1.5).

2.23 The UHB submitted a 10-year capital plan to Welsh Government that identified an indicative capital funding requirement of circa £3.3 billion. Corresponding funding at this level had not been secured and no assurances had been received that funding would be made available. There remained therefore a material risk that the Estates Strategy and capital plan was unaffordable, particularly recognising the current financial climate and considering total funding requirements across Wales (**MA3**).

2.24 Alternative funding streams had been made available to the UHB, such as the Welsh Government administered Estates and Facilities Advisory Board funding (EFAB - relating to works to address fire safety, infrastructure, and decarbonisation).

- For 2021/22 schemes totalling £3.2m were completed.
- For 2023/24 & 2024/25 funding of £6.035m was awarded.

2.25 The EFAB funding had been prioritised by the UHB (based on existing risk assessments) to tackle high/significant backlog maintenance areas. However, due to the availability of monies and the timeframe that monies had to be spent, not all high priority projects were included within the bidding process.

2.26 Annual discretionary capital funding was also targeted at risk assessed priorities. However, slippage in the delivery (and funding) of major capital schemes and other service priorities had led to increasing pre-commitments being required from the discretionary programme, reducing the available funding for backlog maintenance works.

2.27 The Estates and Facilities Performance Management System (EFPMS) categorises the 'Total Building & Engineering Maintenance Cost per Occupied Floor Area' over the last two years" i.e.

Table 2

Measure	2019/20	2020/21	2021/22
UHB Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	14.32	14.08	16.22
NHS Wales average: Total Building & Engineering Maintenance Cost per Occupied Floor Area (£/m²)	23.86	27.43	28.77

Subject to the accuracy of the above data, this measure indicates that the UHB is significantly below the All-Wales averages and the lowest within NHS Wales. Local and national resource constraints were also evident through our conversations with management. At the time of review, the UHB was planning an exercise during 2023/24 to review their workforce, and plan for future needs of the service (**MA4**).

2.28 It was concluded therefore that the UHB had utilised a range of funding options for their estate investment. However, whilst acknowledging the historical underinvestment and the material gap in approved levels of investment, **limited assurance** has been determined in relation to the funding strategy.

Monitoring and reporting: *To gain assurance that appropriate management information was presented with regularity on key issues, including the estate condition and progress to implement the estates / funding strategy. Monitoring and reporting included an assessment of the success of the combined strategies in improving estates condition (and reducing risk exposure), and confirmation that expenditure of funding was in line with agreed conditions.*

2.29 The most recent report detailing the overall backlog maintenance position was presented to the February 2023 Board development session. This detailed the backlog maintenance position and trends since 2017/18, together with an update of the capital schemes within the estate strategy. The report was consistent with the position reported within the EFPMS.

2.30 Management had recently implemented (July 2023) reporting to the Health and Safety Committee on the progress to address identified estate risks this includes priorities funded through discretionary capital, EFAB monies and all Wales capital funded projects.

2.31 Whilst reporting was established for risk management purposes, the resulting impact of the total backlog maintenance position has not been routinely reported e.g., inflationary adjustments, reductions due to direct/indirect investment, benchmarking information, newly discovered backlog maintenance. The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position (**MA5**).

2.32 Statutory compliance surveys were monitored and reported on a regular basis (monthly) at the Capital Management Group Meetings (chaired by the Executive Director of Finance (DOF) and included other executive membership).

2.33 EFAB schemes were also monitored and reported to the Capital Management Group via the discretionary capital manager, who oversaw the EFAB investment programme. Issues /risks were highlighted to this forum in the first instance. At the time of the audit fieldwork (May/June 2023) the 2023/24 EFAB programme was in the early stages of progression and no significant issues were noted.

2.34 It is concluded therefore that the UHB had established appropriate monitoring and reporting arrangements, however, further focus on the overall estate condition and backlog maintenance position was required. Accordingly, **reasonable assurance** has been determined in relation to monitoring and reporting.

Risk management: *Assurance that risks were appropriately logged and escalated through the corporate risk reporting arrangements. The risk exposure of the UHB in relation to estates condition is clearly reported.*

2.35 Capital and estates risks are generally identified, assessed, and escalated in accordance with the UHB wide approach to risk management. The Director of Capital and Estates utilised this assessment to focus existing resource and target specific capital priorities.

2.36 At an operational level, within Capital and Estates there were multiple risk registers for different elements within the services. Monthly meetings took place for consolidation and escalation were appropriate.

2.37 Performance in terms of undertaking and updating operational risk registers was monitored via regular reporting to the Capital Management Group, chaired by the Executive Director of Finance.

2.38 The UHB's corporate risk register was regularly reported to the Board, including high-level summaries of key risks, which were assessed and escalated by the Clinical Board and Corporate Divisions. The corporate risk register contained multiple risks relating to the Capital Assets.

2.39 The BAF was developed based upon the UHB's approved risk appetite for these key risk areas. One of the key risks identified was associated with the UHB's capital assets (Estates, IT Infrastructure, Medical Devices) i.e.:

"There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective, and prudent health care for the patients of Cardiff and Vale UHB. The condition of facilities within our main hospitals are impacting on our ability to continue to provide the full range of services and provide the new treatments WHSSC would like to commission from us. This is because of insufficient funding and resource to bring the estate up to the required condition in a timely way."

2.40 A high-level action plan was in place for the above. However, noting the effectiveness of these actions to reduce the risk to date, the continued deterioration of the estate condition in the same period, aligned with increasing pressures on availability capital resource, the above should be reviewed to provide assurance to the Board that the actions are progressively achieving the desired risk mitigation. (**MA6**). Accordingly, **limited assurance** had been determined in relation to risk management.

Appendix A: Management Action Plan

Matter Arising 1: Baseline Information - Surveys (Operation)	**Impact**
Estatecode guidance (WHBN 00-08 2018) outlines that responsibility for the UHBs estate rests with the Chief Executive, however, this is likely to be delegated. The Director of Finance had been delegated this responsibility within the UHB. Estatecode further suggest the use of a 5-facet survey – subsequently this has been extended to include quality aspects i.e., a 6-facet survey. It is recommended within the NHS Wales Risk Based Methodology for Establishing and Managing Backlog (as amended in March 2013) that NHS organisations carry out a detailed survey of their assets on a five-yearly basis. Most of the detailed surveys on the UHB's estate were undertaken between 2017-2018 as reported within the 2021/22 EFPMS returns; with Rookwood being an outlier having been undertaken pre-2015. Ongoing surveys within the UHW estate were evident, such as a structural engineering review of existing buildings and a high-level visual inspection of mechanical and electrical systems within the main clinical block at UHW, both reported in 2022. At the time of reporting, the UHB were proposing a tendering exercise (during 2023/24) for an external estates condition survey of the full estate, with the expectation of reporting late 2023/24 or early 2024/25. At the time of reporting, the 'fee submission for the provision of specialist estates services' had been prepared and was awaiting issue. This document covered key aspects of the 6 facet survey i.e. • Physical Condition • Statutory Compliance/Health and Safety • Statutory Fire	Potential risk of: • The UHB may not fully understand the estate condition.

- Functional Suitability
- Occupancy and Space Utilisation

In addition to the above, good practice was noted in the inclusion of the to 'Produce a 10-year programme of prioritised expenditure based on survey and risk assessment findings to reduce/eradicate backlog maintenance and bring risks down to a suitable level'.

However, the 'Quality' & 'Environmental Management' facets (as suggested within the Estatecode) were not included within the proposed scope of the survey. Noting the responsibility of the key executives outlined above, it would be prudent to seek approval to the approach, outlining any benefits/limitations to the approach being applied, key omissions, additions etc.

Recommendations		Priority
1.1	The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken.	**Low**
1.2	Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed.	29 February 2024	Executive Director of Finance.

1.2	Agreed. Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025. EFPMS will continue to be updated, until after the condition survey update, using informed data.	31 July 2025	Director of Capital, Estates and Facilities.

Matter Arising 2: Estate Strategy (Operation)	**Impact**
WHBN 00-08 2018 Estatecode outlines that the estate strategy should represent the vision for the future estate to deliver and satisfy the current/anticipated business plans and operational services. The UHB's estates strategy for 2018-2028 determined the strategic direction for the estate. The estate strategy was due for a refresh; noting the same, the following were recommended for inclusion: 1. Increased focus on shorter term activities for the reduction of 'high' and 'significant' estate backlog maintenance risks. 2. Setting targets for the reduction in 'high' and 'significant' estates backlog maintenance risks as a 'high' level of backlog maintenance is an indicator of a significant under investment over time. 3. Measures the UHB would put in place to ensure refurbished buildings are maintained in the future; thus, ensuring that any future backlog maintenance can be managed appropriately. 4. Inclusion of other available sources of finance to fund projects should be considered e.g., disposals of assets, working with third parties etc. 5. Reference to the current level of space utilisation within the current sites and if opportunities exist for efficiencies.	Potential risk of: • The Estates Strategy may not effectively prioritise the highest risk backlog maintenance requirements, risking the ability to secure funding.

Recommendations		**Priority**
2	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

2	Agreed in principle. The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	Initial review 31 March 2024. Final Review 30 September 2025 (completion of condition survey information).	Director of Capital, Estates and Facilities.

Matter Arising 3: Funding Strategy – Capital Investment (Design)	**Impact**
As part of the UHBs Estates Strategy (2018-2028), there were several schemes categorised under the following heading "*a significant backlog investment required to maintain and timely replace core infrastructure to maintain existing service provision*". In addition to the above, the UHB produced a prioritised 10-year capital programme (March 2022) reflecting the above which also identified a recurring funding requirement of £14.5m per annum for '*Essential works to address infrastructure safety and compliance requirements'* at UHW. The Estates Strategy included the major development schemes which had either recently been completed or were being progressed through to development via the formal business case process. The UHB has sought WG agreement for capital investment to address key infrastructure issues e.g., UHL Engineering Infrastructure (£5.5m), UHW Tertiary Tower Electrical Infrastructure Resilience Upgrade (£2.3m), UHW Lift Refurbishment Programme (£10m), UHW Hybrid and Major Trauma Theatres (£40m). Furthermore, the UHB had been targeting backlog maintenance through other funding streams such as EFAB funding: • For 2021/22 schemes were completed totalling £3.2m. • For 2023/24 & 2024/25 Welsh Government awarded funding of £6.035m. It was recognised that the UHB has well established governance and reporting arrangements in place for its major capital investment projects via associated Project Boards and where appropriate to respective committees. However, during the interim period of the Estate Strategy (2018 -2022), regular progress reporting to the Board of the delivery of its Estate Strategy objectives (and associated delivery risks) was limited. However, good practice was observed in that a comprehensive midterm progress update was provided to the February 2023 Board development session. This afforded an overall RED delivery status (using a RAG rating) against the delivery of the Estate Strategy objectives.	Potential risk of: • The Estates Strategy and 10-year capital programme may be unaffordable, meaning identified estates condition risks will not be addressed.

Noting the UHB's ambitious vision, regular reporting of progress should be provided to the Board (or nominated Committee) outlining progress in delivering the vision and how resulting risks are being mitigated/managed (particularly those elements critical to business continuity). Whilst there were multiple funding sources available, the backlog maintenance position highlights an increasing negative trend (see **table 1**). Accordingly, there remains a significant risk that the Estates Strategy and capital plan is unaffordable, in the current financial climate and in consideration of similar funding needs across Wales.			
Recommendations			**Priority**
3	Recognising the limited progress reporting to the Board on the delivery of its Estates Strategy objectives for the period 2018-2022 and the recent (February 2023 – Board development session) red status reported against the mid-point delivery of the Estate Strategy objectives; the Board or nominated committee should receive regular updates on the delivery of the Estate Strategy and 10-year capital programme (particularly any risks/impact resulting from delay/non delivery).		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Agreed in principle. The Board is updated in many areas in relation to the requirements of the estate and the funding implications thereof. The Board will be further informed of the continuing shortfall in availability of funding and the need to address on-going financial implications of the estate at regular intervals. A programme of update reports will be agreed to be included in the future Board agendas.	31 March 2024	Executive Director of Finance.

Matter Arising 4: Funding Strategy – Revenue Investment (Design)	**Impact**
WHBN 00-08 2018 Estatecode highlights the importance of life cycle investment planning as key to managing the performance of the estate. **Table 1** of this report presents the UHB and All-Wales comparators for maintenance expenditure on the estate: with the UHB spending significantly below the All-Wales average in 2021/22 (based on reported EFPMS data). When this was correlated against an increasing estates backlog maintenance position (also within **Table 1**), it indicated that the UHB is unlikely to see significant progress in reducing the backlog maintenance in the short to medium term. Also, any new or refurbished estate is likely to deteriorate in the future without a change in the level of investment. An inadequate internal maintenance resource can contribute to an increasing backlog maintenance position i.e., reduced ability to address reactive and planned maintenance. It was evident through our conversations that local and national workforce issues present the UHB with challenges surrounding recruiting and retaining skilled labour to enable effective estates service provision. It was highlighted at the presentation to the Board at its development session that resourcing remained a key 'Risk and Concern'. At the time of reporting, the Capital and Estates team were planning on undertaking an exercise during 2023/24 to review their workforce, and plan for future needs of the services; this would include numbers of staff, skill mix etc. However, at the time of reporting this had yet to materially progress.	Potential risk of: • The UHB may not invest sufficient resources in maintaining the estate. • The Estate condition may not improve.

Recommendations		**Priority**
4	A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity. Following this, a clear financial model for the revenue support needed to manage the estate should be developed.	**High**

Agreed Management Action		Target Date	Responsible Officer
4	Agreed in principle. 12 months data has been collated and reports are being run to establish the various levels of staffing required.	31 March 2024	Director of Capital, Estates and Facilities.

Matter Arising 5: Monitoring and Reporting - Assurance (Design)	**Impact**
The most recent reporting of the overall backlog maintenance position was to the Board in February 2023 at their development session. This detailed the backlog maintenance position and trend since 2017/18. Management had recently implemented (July 2023) reporting to the Health and Safety Committee on the progress to address identified estate risks, this includes priorities funded through discretionary capital, EFAB monies and all Wales capital funded projects. Whilst reporting was established for risk management purposes the resulting impact of the total backlog maintenance position has not been routinely reported e.g., inflationary adjustments, reductions due to direct/indirect investment, benchmarking information, newly discovered backlog maintenance.	Potential risk of: • The Board / Committee may not receive timely assurance on the performance of the estates condition.

Recommendations		**Priority**
5	The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	Agreed in principle. The appropriate timing will be agreed with information governance and a report generated in accordance with the recommendation, on an annual basis.	31 March 2024	Director of Capital, Estates and Facilities.

Matter Arising 6 Risk Management - Assurance (Operation)	**Impact**
The UHB has a defined Risk Management and Board Assurance Strategy which provides guidance on the management of strategic and operational risks and the Board Assurance Framework (BAF) within the organisation. This is further supplemented by the UHB risk management procedure which provides an outline of the risk management process, conduct of risk assessment and the purpose and use of risk registers. Good practice is acknowledged in that the capital and estates risks were generally identified, assessed, and escalated in accordance with the UHB wide approach to risk management. The Director of Capital and Estates utilised this assessment to focus existing resource and target specific capital priorities. Where estate risks could not be managed/mitigated within the department to a tolerable level, these risks were escalated through the existing risk management framework. Multiple entries were provided at the corporate risk register associated with capital assets (Estates, IT Infrastructure, Medical Devices). Capital asset risks were also raised via Clinical Boards which were also provided at the corporate risk register. The UHB BAF provides information on the controls and assurances in place to manage and/mitigate the significant risks which would impact upon the delivery of the UHB Strategic Objectives and identify any further actions which may be required. Capital asset risks were consolidated at the BAF; the associated risk first recorded in November 2018. Based on the Board Assurance Strategy the risk was considered 'Extreme', with an associated score of 25. The residual risk, recognising the internal controls, was assessed as 20 (Extreme). The UHB target risk score for the above is 10 (High) based on: • A review and refresh of the estate strategy. • The continued prioritisation of the discretionary capital budget to target small priority schemes.	Potential risk of: • Board may not be assured that risk were appropriately managed.

• The continued progression of major capital schemes aligned to the prioritised 10-year Capital Programme. • Continue oversight by the acute infrastructure group of the short – medium term priorities. Noting the effectiveness of these actions to reduce the risk to date, the continued deterioration of the estate condition in the same period, aligned with increasing pressures on availability capital resource, the above should be reviewed to provide assurance to the Board that the actions are progressively achieving the desired risk mitigation.		
Recommendations		**Priority**
6	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	**High**
Agreed Management Action	**Target Date**	**Responsible Officer**

6	Agreed in principle. There is an existing agreed capital investment review that is issued to the Board, via the updates provided by the Capital Management Group, and the investment undertaken and the impact thereof on the current estate. What will be included in the future is the impact of this investment on the overall capital requirements of the estate, including understanding depreciation of the estate in the same period of the investment. This will be provided an annual basis. A programme of these updates will be agreed and formulated for the future Board agenda.	31 March 2024	Executive Director of Finance.

Appendix B: NHS Estate Dashboard Report 2021/22

NHS ESTATE DASHBOARD REPORT 2021/2022

HEALTH BOARD / TRUST ESTATE PERFORMANCE BREAKDOWN 2021/2022

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol
Shared Services Partnership
Specialist Estates Services

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	93	85	98	91
BETSI CADWALADR UNIVERSITY HEALTH BOARD	62	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	78	86	87	66	81
CWM TAF UNIVERSITY HEALTH BOARD	96	89	95	100	97
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	65	91	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	51	47	47	55	97
VELINDRE UNIVERSITY NHS TRUST	65	95	95	88	99
WELSH AMBULANCE SERVICES NHS TRUST	48	90	90	36	99

Below 75% — Energy consumption of 480 kWh/m² or more
Within 75% - 89% range — Energy consumption within 411-479 kWh/m² range
Above 90% — Energy consumption of 410 kWh/m² or less

Energy Performance and Carbon Dioxide (CO_2) Emissions

	Net Energy Consumption (kWh/m²)	CO_2 Emissions* (kg/m²)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	341	70
BETSI CADWALADR UNIVERSITY HEALTH BOARD	460	95
CARDIFF & VALE UNIVERSITY HEALTH BOARD	373	81
CWM TAF UNIVERSITY HEALTH BOARD	419	85
HYWEL DDA UNIVERSITY HEALTH BOARD	485	106
POWYS TEACHING LHB	448	91
SWANSEA BAY UNIVERSITY HEALTH BOARD	407	83
VELINDRE UNIVERSITY NHS TRUST	411	90
WELSH AMBULANCE SERVICES NHS TRUST	246	57

*Target to be agreed

Backlog Maintenance Costs

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	37,754,428	16,518,352	45,488,017	49,807,323	98,296,321
BETSI CADWALADR UNIVERSITY HEALTH BOARD	91,809,773	142,498,091	68,658,155	45,421,260	239,955,528
CARDIFF & VALE UNIVERSITY HEALTH BOARD	32,033,876	85,487,856	28,777,072	5,537,518	101,262,019
CWM TAF UNIVERSITY HEALTH BOARD	31,261,530	31,963,352	22,345,412	1,519,250	64,046,747
HYWEL DDA UNIVERSITY HEALTH BOARD	0	89,509,339	9,432,673	6,802,904	90,679,218
POWYS TEACHING LHB	5,075,437	23,998,187	12,931,568	10,039,954	30,117,985
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,057,000	46,516,759	41,835,883	4,598,390	56,464,069
VELINDRE UNIVERSITY NHS TRUST	139,220	1,894,312	5,002,211	2,719,910	1,875,521
WELSH AMBULANCE SERVICES NHS TRUST	667,486	2,855,208	3,170,304	3,936,411	7,184,233

The complete dataset upon which this report is based is accessible from the NHS Wales Shared Services Partnership - Specialist Estates Services intranet and internet sites

27 in

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

HealthRoster System
Final Internal Audit Report

November 2023

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Executive sign-off:	Rachel Gidman – Executive Director of People and Culture Jason Roberts – Executive Nurse Director
Distribution:	Lianne Morse – Deputy Director of People and Culture Paul Jones – E-Rostering Manager
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the audit was to review the usage of the HealthRoster system within the Health Board.

Overview

We have issued limited assurance on this area. The review identified several significant matters which require management attention and include:

- Rosters are not being created, approved, and published in a timely manner.
- A number of staff were either not meeting their contracted hours or had worked more than their contracted hours.
- Shifts worked by staff are not always verified adequately within the system.
- Safecare census patient data is not always updated.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Roster production, approval and publishing in accordance with timescales	Limited
2	Staff are utilising auto rostering to generate their rosters	Reasonable
3	Annual leave is appropriately managed to ensure headroom allocation is complied with	Reasonable
4	Staff balances are managed adequately to ensure staff are working their contracted hours	Limited
5	Rosters are produced in accordance with funded nurse establishment levels	Limited
6	Management are verifying worked rosters in a timely manner	Limited
7	Management are undertaking the Safecare census twice daily	Limited
8	Rosters ensure staff are complying with the Working Time Directive	Substantial
9	Regular monitoring of the roll out and usage of the HealthRoster system is being undertaken	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
2	Rostering process is not timely	1&5	Operation	High
3	HealthRoster system segregation of duties	1	Operation	Medium
4	Auto-roster functionality uptake	2&5	Operation	Medium
7	Incorrect working hour balances	4&5	Operation	High
8	Roster verification and finalisation	6	Operation	High
9	Safecare census missing patient data	7	Operation	High

1. Introduction

1.1 Our review of the HealthRoster System was completed in line with the 2023/24 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 The rollout of HealthRoster system commenced on 21st February 2022, with the aim of having all Nursing areas rolled out by September 2023. Plans are in place to roll out HealthRoster to other staff groups, for example, Facilities, Pharmacy, Laboratories and Therapies.

1.3 The Health Board have developed a Rostering Framework which is aligned to the Health Board's People and Culture Plan and the national workforce strategy for Health and Social Care. The Framework confirms:

- Benefits of e-rostering on patients and different levels of staff;
- Creating a Good Roster; and
- The plan for rollout.

1.4 In addition to the Rostering Framework, the Health Board have developed a Rostering Procedure and numerous 'how to' guidance documents that set out the core principles to be complied with to facilitate the effective use of rostering via the HealthRoster system and to ensure consistent rostering standards are applied throughout the Health Board.

1.5 The potential audit risks considered as part of this review were as follows:

- Late preparation and agreement of rosters may impact the work life balance of staff;
- Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and
- Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

1.6 The relevant lead for the review is the Executive Director of People and Culture.

2. Detailed Audit Findings

Objective 1: Rosters are produced, signed off and published in advance by appropriate staff and in accordance with timescales set out in the roster timetable.

2.1 The Health Board's Rostering Procedure requires that staff rosters are to be created, authorised and published through the HealthRoster system. Upon review we noted that the procedures which are available to all staff via the Health Board's intranet, are currently still in draft with areas of the document still incomplete. **(Matter Arising one – Low priority)**

2.2 Prior to being set up on the HealthRoster system, all Roster Managers are required to attend workshops and system training sessions delivered by the E-Roster Team. Following the completion of training, staff are also provided with several "how-to" user guides.

2.3 The Rostering Procedure details that the Roster Managers are responsible for creating the rosters and submitting these to the Senior Nursing Managers for final review and approval. Once approved, the rosters are published and are available for staff to view. The HealthRoster system provides a full audit trail capturing the dates and names of staff who have performed each stage of the process.

2.4 The Health Board has published a roster timetable for 2023/24 setting out the key dates for creating, approving, and publishing rosters to staff. The timescales apply to each roster period (4-weeks) of the year and require that approved rosters are published at least six weeks in advance.

2.5 We selected a sample of six units/wards and reviewed the timeliness of the roster process over a period of six months (March to August 2023). Our testing concluded that most rosters had not been produced, approved and published in line with the timescales set by the Health Board. **(Matter Arising two – High Priority)**

2.6 During our testing we noted that several Roster Managers were creating, approving and publishing rosters. This practice does not allow for segregation of duties and does not comply with the Rostering Procedure which states that rosters should be approved and published by Senior Management. **(Matter Arising three – Medium Priority)**

Conclusion:

2.7 The findings from our sample testing indicate that rosters are not being produced, approved and published in advance by appropriate staff and in accordance with timescales set out in the roster timetable. We have provided Limited Assurance for this objective.

Objective 2: Staff are utilising auto rostering to generate their rosters.

2.8 The auto-rostering feature that resides within the HealthRoster system aims to reduce administrative burden on Roster Managers by automatically allocating shifts within the roster. The effectiveness of the auto-roster functionality is dependent on data integrity and on several parameters/rules being set up correctly within the HealthRoster system.

2.9 Roster Managers are responsible for data integrity of the rosters and should regularly review the parameters/rules within HealthRoster to ensure that they reflect their requirements for the rostering process. In the event of data integrity issues and/or parameters/rules being out of date, Roster Managers need to engage with the E-Roster Team to resolve these issues.

2.10 We performed an analysis of the HealthRoster system to determine the utilisation of the auto-rostering functionality within our sampled areas across the period of six months (March – August 2023). The analysis indicates that there is minimal uptake/utilisation of the auto-rostering functionality. **(Matter Arising four – Medium Priority)**

Conclusion:

2.11 Our analysis confirms that whilst Roster Managers are utilising auto-rostering as part of the rostering process, the functionality does not currently work as intended as the rules and parameters within the system are out of date. The E-Roster Team are aware of the issues and recognise that further engagement is required with Roster Managers to update the system and improve the effectiveness of the functionality. We have provided Reasonable Assurance for this objective.

Objective 3: Annual leave is appropriately managed within the wards to ensure that the headroom allocation is complied with.

2.12 The Rostering Procedure states that *"50% of annual leave should be agreed with staff by the end of April each year at the latest. Leave requests will be considered in the light of service needs and should be balanced over the year"*.

2.13 Annual leave is submitted on HealthRoster, which facilitates management of the roster in respect of staff availability. It also facilitates the ability to adhere to the built-in headroom allocation to cover expected absence as determined by Nurse Staffing Act (26.9%). This allows for staff taking annual leave (15-17%), and sickness and study leave within each funded establishment.

2.14 We performed an analysis of the rosters for our sampled units/wards over the past five months (March-August 2023) and can confirm that, on average, annual leave has adhered to the 15-17% set by the Health Board. (See appendix B – Exhibit 1)

2.15 We performed a review of the processed annual leave during the latest roster period (20th August 2023 to 10th September 2023) for sampled areas and noted not all annual leave is being requested through the HealthRoster system. **(Matter Arising Five – Low Priority)**

2.16 Discussions with the Roster Managers and with the E-Roster Manager noted that the annual leave entitlements within the HealthRoster system may not accurately reflect annual leave entitlements within ESR at any given time. **(Matter Arising Six – Low Priority)**

Conclusion:

2.17 Our findings confirm there is appropriate roster management within the wards to ensure that the annual leave headroom allocation is complied with. We noted minor issues relating to the administration of annual leave requests. We have provided Reasonable Assurance for this objective.

Objective 4: Staff balances are being managed adequately to ensure staff are working their contracted hours and are not owing or being owed excessive hours.

2.18 In line with the Rostering Procedure, all rosters reviewed as part of our sample adhered to nurse establishment levels which are clearly set within the HealthRoster system.

2.19 There is an expectation that staff contracted hours should be fully assigned across the 4-week roster period. However, we were informed that there is flexibility on the weekly contracted hours being fully assigned across the rosters.

2.20 We reviewed the arrangements in place for arranging makeup shifts, which account for the 1.5 hours per week that are paid (salaried) but not actually worked and is either worked back as a 6-hour shift per month, or a 12 hour shift every other month.

2.21 Whilst we were able to evidence the monitoring of makeup shifts by Roster Management in all the six areas sampled, we did note a lack of utilisation of the "notes" section within the HealthRoster system to substantiate the need for scheduling make up shifts and providing the required audit trail of agreement by staff/roster managers.

2.22 We reviewed the latest rosters (as of 16th September 2023) for our sampled areas and noted that whilst the majority of staff were meeting their contracted hours of work, there were a number of staff who were either not meeting their contracted hours or had worked more than their contracted hours. **(Matter Arising Seven – High Priority)**

Conclusion:

2.23 Our analysis confirmed that whilst the majority of staff within our sampled areas were meeting their contracted hours. Contracted hour balances for a large proportion of staff (47) were not being managed adequately to ensure that they were working their contracted hours and were not owing or being owed excessive hours. We have provided Limited Assurance for this objective.

Objective 5: Rosters are produced in accordance with funded nurse establishment levels to ensure contracted hours are met before requesting overtime, Bank or Agency.

2.24 In line with Health Board's Rostering Procedure, all rosters reviewed as part of our sample adhered to nurse establishment levels which are clearly set within the HealthRoster system. However, as we noted earlier in the report the roster production, approval and publishing arrangements are not operating in line with the agreed timescales set by the Health Board. **(See Matter Arising two)**

2.25 Discussions with Roster Managers confirmed that there is a general consensus on the benefits of planning and producing rosters early in advance as staff are more prepared; and the need for bank and agency can be factored in, in readiness, especially on wards which have been experiencing high sickness and vacancy rates. We were advised by Roster Managers that shifts are allocated firstly to staff on the ward, then staff wanting to do overtime, then bank staff and finally agency staff.

2.26 The HealthRoster system has a number of features which support Roster Managers when preparing the rosters to ensure the effective utilisation of staff such as ensuring that all staff have worked their contracted hours, flexible working requests, annual leave and overtime has been approved. These features rely on data integrity and several parameters/rules within the system being up to date. Throughout our testing we have identified several data integrity issues which are impacting on the systems functionalities. **(See Matters Arising four, five and seven).**

Conclusion:

2.27 Whilst there are management arrangement systems in place for reviewing and reporting the effectiveness of the rostering process, as with objective 2 and 4, there is scope to improve data integrity and update the rules and parameters of the HealthRoster system so that management can utilise the data analysis features of the system to better inform decision making. We have provided Limited Assurance for this objective.

Objective 6: Management are verifying worked rosters in a timely manner in line with the Rostering Procedure.

2.28 The Rostering Procedure states that Roster Managers are responsible for ensuring that the roster is accurate and reflects the shifts that have been worked by staff. This is important also from a payroll perspective as the shift data is utilised on a monthly basis to calculate staff's pay. We note that all Roster Managers have been provided with the monthly payroll deadlines/cut off dates.

2.29 Whilst discussions with Roster Managers confirmed a consistent understanding of the verification process, discussions with the E-Roster Team noted that shift finalisation is an area for improvement with large numbers of shifts not being finalised by the payroll cut-off date.

2.30 We reviewed the HealthRoster system as at the September 2023 payroll cut off date (22nd September 2023) and noted that there was a significant number of shifts that were still awaiting finalisation by the Roster Managers. **(Matter Arising eight – High Priority)**

Conclusion:

2.31 Our testing indicates that Roster Managers are not always finalising shifts in a timely manner, and this is impacting on the accuracy of the pay run data creating the risk of staff being over/under paid. We have provided Limited Assurance for this objective.

Objective 7: Management are undertaking the Safecare census twice daily to enable senior management to view the actual staffing levels on a ward.

2.32 Safecare is an additional ward management module that forms part of the HealthRoster system and provides a visual presentation of live data entered by operational staff relating to the acuity of patients and planned and deployed nurse staffing levels. The Health Board is still in the process of rolling out the Safecare module to all units/wards with some 75 areas having moved to the module to date.

2.33 The system has the potential to improve the operational decision making across the organisation, clearly highlighting areas which are requiring additional support. Reporting acuity data is a necessity in Safecare and this information will provide accurate data about patient acuity that will support the establishment review process.

2.34 There is no reference to the Safecare census arrangements within the Health Board's Rostering Procedure. **(See Matter Arising one)**

2.35 We performed an analysis of the Safecare data and noted numerous instances where patient data had not been updated onto the system (See Appendix B – Exhibit 3). **(Matter Arising nine – High Priority)**

Conclusion:

2.36 The Health Board has rolled out Safecare, a tool that matches staffing levels to patient acuity. Our analysis of the tool noted that patient acuity data is not always being updated. We have provided Limited Assurance for this objective.

Objective 8: Management are producing rosters that ensure staff are complying with the requirements of the Working Time Directive.

2.37 All new members of staff express their wish to "opt in/out" of the Working Time Directive (WTD) and Roster Managers take this decision into consideration at roster production stage.

2.38 If a member of staff has opted in and decides to opt out of the WTD at a later date, an opt out form is completed and signed by the individual and scanned and a copy provided to Workforce with original forms maintained by Roster Managers within staff's personnel files.

Conclusion:

2.39 We can confirm that for our sampled areas, Roster Managers are producing rosters that ensure staff are complying with the requirements of the Working Time Directive. We have provided Substantial Assurance for this objective.

Objective 9: Regular monitoring of the roll out and usage of the HealthRoster system is being undertaken and the outcomes are reported to appropriate Groups and/or Committees within the Health Board.

2.40 The Health Board's long-term plan, as described within the Rostering Framework, is for e-rostering software to be used for all rosters in all areas. The Framework sets out the benefits of good rostering as well as considerations and top tips for managers and staff. We note that the Framework is aligned to the Health Board's People and Culture Plan and the Adaptable Workforce Policy specifically to the ambition to have workforce systems that drive efficiency, whilst ensuring patient safety, cost and efficiency.

2.41 During the initial rollout phase for the HealthRoster system (July 2022) the Health Board, through the E-Rostering Programme Board, has been monitoring the implementation of the system.

2.42 As part of the rollout, which is currently ongoing, the E-rostering team continues to provide training to Senior Managers and Roster Managers in the use of HealthRoster and improving rostering practices across the organisation.

2.43 Discussions with the E-Roster Manager noted the HealthRoster implementation project continues to move forward and is currently in the data cleansing/analysis phase. Following the analysis, the information will be shared with Senior Nursing Management to initiate discussions/agreement on the rostering Key Performance Indicators to be used going forward.

2.44 A Nurse Staffing/Workforce group which meets monthly and is chaired by the Director of Nursing Strategic Workforce has been set up to review e-rostering process efficiencies, bank/agency staff usage (projection and utilisation), roster headline reports and feedback from Roster Managers.

Conclusion:

2.45 We can confirm that regular monitoring of the roll out and usage of the HealthRoster system is being undertaken and the outcomes are being reported accordingly. We note that the Health Board continues to progress through the phases of the implementation project and is currently focusing on cleansing data held within the HealthRoster system so that this can be utilised to drive rostering key performance indicators going forward. However, the significant issues that have been highlighted within the areas we sampled illustrate that the system is not yet being used consistently and effectively. We have provided Reasonable Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Rostering procedure requires updating (Design)	**Impact**
The Rostering Procedure "UHB 339" was last reviewed and approved in June 2017 and published in December 2018. We note that a review of the procedures began in December 2022 however the procedures are yet to be finalised with several sections, including the following examples, still requiring updating: • Section 2.2.5 – "Working shift request allocations for contracted hours". • Appendix 1 – "Development of an Audit Tool for Key Performance Indicator monitoring". We also noted that there is no explicit guidance/reference within the procedures to the requirements by staff to comply with the SafeCare Census process.	Potential risk of: • Inadequate documentation of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
1.1	The review of the Rostering Procedure UHB 339 should be finalised, approved and the updated procedures should be disseminated to all relevant staff.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	• The e-rostering procedure was considered at the Employment Policy Sub-Group (EPSG) meeting in October. The meeting me membership is trade union representatives and People & Culture Team representatives. The group did not approve the procedure as they felt it needed further review to reflect the culture that we want to create, i.e. flexibility, good work life balance, high engagement and retention. The revised procedure will include the link to the Rostering Principles, Safe Care Guidance and Nurse Staffing Framework, highlighted below. The procedure is being considered by EPSG in December 2023.	31/12/23	Paul Jones, E-Rostering Manager – supported by Rachel Pressley, Head of People Assurance & Experience

	• Nurse rostering principles with SafeCare guidance and Nurse Staffing framework agreed at Directors of Nursing meeting in August 2023 and shared with Clinical Boards, as part of the wider Workforce Sustainability Programme.	30/09/23 (complete)	Carys Fox, Assistant Director, Strategic Nursing
	• Rostering Sharepoint site has been developed and will be further enhanced to include procedure, principles, training documents, etc.	31/12/23	Paul Jones, E-Rostering Manager

Matter Arising 2: Roster process is not timely (Operation)	**Impact**
We selected a sample of six units/wards and reviewed the timeliness of the roster process over a period of six months (March to August 2023). Each roster covers a period of four weeks and we therefore reviewed a total of 42 rosters. Our findings concluded that rosters are not being produced, approved and published in a timely manner when compared to the roster timetable: • 40 (95%) rosters were not produced by Roster Managers in a timely manner; • 24 (57%) rosters were not approved by Senior Management in a timely manner; and • 24 (57%) rosters were not published in a timely manner. A separate analysis of the Health Roster system as at the 12th September 2023, also identified the following issues: • There were four unapproved and unpublished rosters for working periods that had occurred; and • There were ten unapproved and unpublished rosters for working periods that were due to commence on the 17th September 2023.	Potential risk of: • Late preparation and agreement of rosters may impact the work life balance of staff; • Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks.

Recommendations		**Priority**
2.1	Arrangements should be put in place to ensure that rosters are created, approved and published in line with the roster timetable.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The Corporate Nursing Team (working with the e-rostering team) are producing monthly reports for Roster Managers, Senior and Lead Nurses. The reports contain information on rosters that have not been approved or not approved in accordance with the rostering timetable. Recently these reports have been sent to Clinical Board DoN requesting that more focus is placed on the importance of publishing the roster 6 weeks in advance. Compliance will be monitored monthly via the Rostering KPI dashboard.	31/03/24	Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards

Matter Arising 3: HealthRoster system segregation of duties (Operation)	**Impact**
During our testing of the rostering process, we found that 24 rosters, out of a total of 42, had been created, approved and published by the same individual (Roster Manager) within the same day. The Rostering Procedure clearly states that the rosters must be created by Roster Managers and must be reviewed, approved and published by Senior Managers allowing for adequate segregation of duties. As such, the user access levels within the HealthRoster system should be set up in such a way to prevent the Roster Managers from being able to approve and publish the rosters. We discussed the findings with the E-Roster Manager and were informed that in certain circumstances, Roster Managers are provided with the ability to approve and publish the rosters. This may be necessary if the Senior Manager had not yet been trained on the HealthRoster system. Whilst this practice may be reasonable, it should only be a temporary measure. Our findings indicate that the Roster Managers had continued to approve and publish rosters over the entirety of the sampled period (March to August 2023).	Potential risk of: • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
3.1	A review of the HealthRoster system should be undertaken to ensure that the user privileges for Roster Managers and Senior Management are correct and allow for appropriate segregation of duties in line with the Rostering Procedure.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	HealthRoster privileges/permission have been reviewed and updated to ensure the Roster Manager cannot create and approve a roster. The new permissions hierarchy includes: first approver - Roster Manager and second approver - Senior Nurse	31/10/2023 (complete)	Paul Jones, Head of E-Rostering

Matter Arising 4: Auto-rostering functionality uptake (Operation)	**Impact**
The auto-rostering feature that resides within the HealthRoster system aims to reduce administrative burden on Roster Managers by automatically allocating shifts within the roster. We performed an analysis of the data held within the HealthRoster system to evaluate the uptake of the auto-roster functionality. The analysis was performed for the six sampled wards/units over a six-month period from March - August 2023 (42 rosters in total). Our analysis indicates that over the six-month period, each sampled area has utilised the "auto-roster" functionality to roster the following percentage shifts: • Sampled Area 1 – 34%; • Sampled Area 2 – 31%; • Sampled Area 3 – 19%, • Sampled Area 4 – 17%, • Sampled Area 5 – 13%, and • Sampled Area 6 – 2%. We discussed the analysis with the Roster Managers and noted that most felt that the functionality did not work as intended, fell short of expectations, and often increased the requirement for manual adjustments of individual shifts increasing the administrative burden of the rostering process.	Potential risks of: • Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
4.1	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	• The e-rostering team have just undertaken roster reviews with approx. 45 ward areas, this was an in-depth review which took 50 days in total.	31/03/24	Paul Jones, E-Rostering Manager

	The team are working with Roster Managers daily to ensure the rules and parameters they need are built into the HealthRoster system. The aim is to build confidence in the function, change behaviours and increase the number of rosters that are created using the auto-roster functionality. The improvement will be monitored monthly through the KPI dashboard. • The e-rostering Leads (3x band 6) are aligned to CBs to ensure that Roster Managers have the appropriate level of support to use the system to its full potential, including auto rostering.		Roster Managers, Clinical Boards

Matter Arising 5: Annual leave requests (Operation)	**Impact**
We performed an analysis of the processed annual leave during the latest roster period (20th August to 10th September 2023) for our selected sampled areas and noted that for a total of 194 annual leave allocations, only 26 (13%) were requested by staff via the HealthRoster system. For the remaining 168 (87%) annual leave allocations there was no audit trail within the system that detailed the member of staff requesting annual leave. We discussed the findings with the Roster Managers and noted that not all members of staff utilise the HealthRoster system to request annual leave. Verbal agreements are often reached between staff and the Roster Managers on annual leave requests, and these are added onto the roster at creation stage.	Potential risk of: • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
5.1	Staff should be reminded that annual leave requests should be processed within the HealthRoster system to ensure that all requests and approvals are supported by a full audit trail.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	• The e-rostering team as part of the ongoing training and support to Roster Managers are reminding Roster Managers of the importance that their team need to request annual leave through the Healthroster system rather than by other mechanisms. This message is also being reinforced by the Clinical Board, DoN and the Corporate Nursing Team. The number of annual leave requests made through the HealthRoster system will be monitored monthly, if the % does not increase this will be escalated to the DoN and to NPG.	31/03/24	Directors of Nursing, Clinical Boards Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager

Matter Arising 6: Annual leave interface (Operation)	**Impact**
Staff's annual leave entitlements may change from time to time, usually due to changes in circumstances (reduced/increased working hours) and whilst the ESR system is updated, there is no live data feed that implements the annual leave changes into the HealthRoster system. To mitigate this risk, the E-Roster Team perform regular data uploads from ESR into the HealthRoster system to ensure that the annual leave entitlements agree. This is a manual step and relies on continuous engagement between the Roster Managers (who should review balances and notify accordingly) and the E-Roster Team. We note that the Health Board has explored ESR-GO which enables an automatic transfer of information between HealthRoster and ESR however this functionality does not work.	Potential risk of: • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
6.1	Consideration should be given to exploring alternative ways to integrate live data from ESR to HealthRoster system ensuring that annual leave entitlements within the HealthRoster system are correct and up to date.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Whilst there is no direct interface between ESR and HealthRoster currently available (a service request is being submitted) there is an A/L entitlement report available in ESR that we can adapt and be manually uploaded into HealthRoster. The work will involve cross referencing the data between both ESR and HealthRoster, but the end achievement will be to load a monthly file into Healthroster using the manual import file in ESR.	31/01/24	Mike Mullan, Head of People Analytics Paul Jones, E-Rostering Manager

Matter Arising 7: Incorrect working hour balances (Operation)	**Impact**
Roster Managers have the visibility of their staff's working hours directly via the HealthRoster system which calculates the total number of hours worked by staff against their contracted hours. The system will flag staff who are in credit (have worked over their contracted hours) or deficit (have not worked their contracted hours). Roster Managers should plan upcoming rosters and take these balances into account to ensure that they are reducing overtime. An analysis of the HealthRoster system as of the 16th September 2023 noted that there are 47 employees across our sampled areas with a "Net Hours" balance above or below 20 hours (see Appendix B – Exhibit 2). Discussions with Roster Managers noted differing practices across the units/wards within our sampled areas, with some Roster Managers keeping paper-based records of staff's working hour balances.	Potential risk of: • Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
7.1	Arrangements should be put in place to ensure that staff balances are being managed adequately to ensure that staff are working their contracted hours and are not owing or being owed excessive hours.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Embedding an effective rostering culture is one of the UHB's top priority and the system will support drive the efficiency. Corporate Nursing, People & Culture		Directors of Nursing, Clinical Boards

	and Clinical Boards have worked together to reach an agreement on how we will support managers to embed effective rostering principles and achieve this priority:		
	• Monthly e-rostering reports were piloted in October, every DoN has received a report for their Clinical Board, detailing every member of staff who has an owing time balance between 24 and 100 hours. Lead Nurses are validating this data and rostering the outstanding hours as appropriate. Progress will be monitored on a quarterly basis.	31/03/24	Emma Davies, Senior Nurse, Nurse Staffing Levels
	• For time balances owed over 100 hours the E-Rostering Team are undertaking regular reviews of rosters. Any staff member that owes over 100 hours will be discussed and validated with the Roster Manager. Changes will be made in the system to correct the balance and any genuine time balances will be rostered by the Roster Manager.	31/03/24	Paul Jones, E-Rostering Manager
	• A Rostering Dashboard has been created that provides high level data in relation to rostering KPIs. This will be developed into a more intuitive tool once the DataHub has been implemented. The dashboard will help monitor the agreed KPIs and will provide assurance that effective rostering is being embedded into the UHB and efficiencies are being achieved through the HealthRoster system.	31/03/24	Paul Jones, E-Rostering Manager

Matter Arising 8: Roster verification and finalisation (Operation)	**Impact**
Roster verification should be undertaken by the Roster Managers on a regular basis to confirm that shifts have been worked as planned and to account for any changes that have occurred and reflect these within the roster accordingly. Shifts need to be recorded as finalised within the HealthRoster system so that the data can be submitted to payroll. If shifts are not finalised in a timely manner, there is the risk that the pay run data is not accurate and could either omit shifts that have been worked or include shifts that have not been worked resulting in staff being under/overpaid. We note that shifts verified after the deadline may miss that month's pay run and would normally be picked up for payment in the following month. On a monthly basis, the E-Roster Team review the system for unfinalised shifts and chase/remind Roster Managers to finalise these. Roster Managers are shown how to generate these reports as part of their initial training and should be reviewing the system in a timely manner to ensure the data within the rosters is accurate for pay run purposes. A review of the HealthRoster system as at September's payroll cutoff date (22nd September 2023) noted that there were a significant number of shifts that were still awaiting finalisation (253) which related to our sampled areas.	Potential risk of: • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
8.1	Arrangements should be put in place to ensure that Roster Managers are finalising shifts in a timely manner.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
8.1	A monthly report is sent to Roster Managers to inform them how many unverified shifts they have outstanding, any outstanding shifts are escalated to the DoN 3 days and 1 day before the payroll is run. It has been agreed with the Executive Director of Nursing that any shifts that have not been verified in time will not be processed for Payroll, this has been communicated to all Roster Managers. Unverified shifts are no longer a KPI that the Health Board	31/03/24	Paul Jones, Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards

	intends to use. The number of unverified shifts will be closely monitored by the e-rostering team and if it becomes problematic it will be escalated to DoNs, Corporate Nursing team and the EDoN.		

Matter Arising 9: Safecare census missing patient data (Operation)	**Impact**
Units/Wards that are part of the rollout have been provided with electronic tablets for inputting information. We note that the data within the Safecare Tool feeds into the HealthRoster system. Provided that the data inputted into the Safecare tool is accurate and complete, Nurses in charge, Roster Managers and Senior Managers have an instant view of whether actual staffing levels are deemed safe to meet clinical demand, with professional judgement applied to all outputs. We analysed the data stored within the Safecare Tool between the 5th March 2023 to the 10th September 2023 for our sampled areas and noted that in total there was 366 (19%) shifts missing patient data. (See Appendix B – Exhibit 3).	Potential risk of: • Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Recommendations		**Priority**
9.1	Arrangements should be put in place to ensure that there is appropriate and timely oversight of the Safecare tool, and that Senior Management/Roster Managers are ensuring that Nurses in Charge are updating patient acuity data.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
9.1	• SafeCare has been rolled out to approximately 67 ward areas with training taking place in February and March 2023. Staffing meetings have now been introduced and take place twice daily to review staffing levels on SafeCare and to share risk across the whole of the UHB.	31/03/24	Emma Davies, Senior Nurse for Nurse Staffing Act. Directors of Nursing, Clinical Boards

	• The Senior Nurse for the Nurse Staffing Act (Corporate Nursing) works closely with the nursing team to ensure that patient acuity is recorded accurately. We have identified that patient data is not always updated at the start of the night shift, the audit also shows this, there is a plan in place to improve this position. Reports are being generated for Senior and Lead Nurses monthly to show non-compliant areas and regular updates are provided to the Nursing Productivity Group. • A power-bi dashboard has been created and is updated monthly, which contains information relating to SafeCare compliance, nurse staffing level and patient acuity. The dashboard is readily available and provides ward to board overview.		

Exhibit 1 (Annual Leave)

	28th May to the 24th June 2023				25th June to the 22nd July 2023				23rd July to the 19th August 2023				20th August to the 16th September 2023				Average
Unit/Ward	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	**Wk1**	**Wk2**	**Wk3**	**Wk4**	
Sample Area 1	20%	18%	10%	13%	17%	4%	7%	7%	13%	13%	10%	17%	15%	13%	15%	9%	**13%**
Sample Area 2	15%	14%	11%	13%	20%	12%	14%	12%	18%	15%	17%	21%	23%	15%	16%	13%	**15%**
Sample Area 3	14%	15%	19%	8%	12%	8%	9%	16%	13%	13%	22%	20%	18%	20%	18%	0%	**14%**
Sample Area 4	28%	10%	10%	14%	18%	21%	19%	14%	13%	14%	18%	25%	26%	17%	9%	22%	**17%**
Sample Area 5	28%	10%	10%	14%	18%	21%	14%	19%	14%	14%	18%	25%	26%	17%	9%	22%	**17%**
Sample Area 6	19%	15%	18%	7%	3%	19%	8%	10%	12%	17%	23%	24%	17%	21%	12%	17%	**15%**

Note: Cells highlighted in red represent instances where the annual leave for the week was over the 17%.

Exhibit 2 (Contracted hour balances)

Sampled Area	No of staff with a "Net Hours" balance above/below 20 hours
Sample Area 1	6
Sample Area 2	4
Sample Area 3	8
Sample Area 4	17
Sample Area 5	4
Sample Area 6	8
Grand Total	**47**

Exhibit 3 (SafeCare missing patient data)

Sampled Unit/Ward	Shifts missing patient data		Grand Total	% of shifts missing
	Day	Night		
Sample 1	20	127	147	39%
Sample 2	21	121	142	37%
Sample 3	8	24	32	8%
Sample 4	7	18	25	7%
Sample 5	5	15	20	5%
Total	61	305	366	19%

Note: Exhibit 3 data relates to a period spanning 190 days (5th March to the 10th September 2023). As there is a requirement for Nurses in Charge to input the data twice daily (Night/Day shift) each sampled area should have total of input of 380 entries within this period (190 days x 2 shifts).

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
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* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Alcohol Standards
Final Internal Audit Report

January 2024

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Cardiff and Vale University Health Board

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Executive sign-off:	Fiona Kinghorn, Executive Director of Public Health
Distribution:	Sian Griffiths, Consultant in Public Health Lauren Idowu, Principal Health Promotion Specialist Kate Roberts, Senior Health Promotion Practitioner
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

Review the processes in place within the Health Board in relation to compliance with NICE guidelines around alcohol use and relevant NICE guidelines for screening, brief intervention and onward referral or action in departments that represent the main routes through which patients are admitted to/enter Health Board hospital services.

Overview

We have issued limited assurance on this area. The review identified several significant matters which require management attention and include:

- There is a lack of health board guidance in relation to the Alcohol Standards, providing details on identifying, preventing and diagnosing patients.
- There is a lack of resource within the team to meet with the demand across the Health Board.
- Screening for alcohol consumption is not being formally undertaken.
- There is no documented formal referral process in place.
- There is no central record maintained of staff that have received training on alcohol screening for patients.
- Documentation informing patients about the screening process and reducing alcohol consumption was not available within the Health Board.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	The Health Board complies with NICE guidance.	Limited
2	Screening for alcohol consumption.	Limited
3	Results from screening are being recorded.	Limited
4	Training is provided to staff.	Limited
5	Documentation information patients about the screening process.	Limited
6	There is an intervention pathway.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Lack of Health Board guidance	1	Operation	High
2	No operational screening tool in place	2	Operation	High
3	Resource within the team	2	Operation	High
4	Referral Process	3	Operation	High
5	Training Records	4	Operation	High
6	Documentation for patients	5	Operation	High
7	Intervention Pathway	6	Operation	Medium

1. Introduction

1.1 Our audit review of Alcohol Standards was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

There are NICE guidelines in place for alcohol use, and these are:

- PH24 Alcohol-use disorders: prevention[1] - the guidance is on the prevention and early identification of alcohol-use disorders among adults and adolescents; and
- CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high risk drinking) and alcohol dependence[2] - The guideline makes recommendation on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10 to 17 years.

1.2 A Clinical Audit was undertaken within the Health Board in September 2019 to discover 'Are we effectively screening patients for alcohol misuse in the Emergency Department?' The conclusion of the study identified that there was an increase in alcohol screening but there was a need for ongoing training to continue to maximise future screening for alcohol misuse in the Emergency Department.

1.3 The potential audit risks considered as part of this review were as follows:

- Non-compliance with the NICE guidance; and
- Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board.

1.4 The Executive Director of Public Health is the lead Executive for this review.

2. Detailed Audit Findings

Objective 1: The Health Board is able to show that it complies with NICE guidance on Alcohol-use disorders.

2.1 There are recommendations detailed within the NICE guidance (PH24 and CG115) which are specific for the NHS including undertaking screening, brief interventions and extended brief interventions. However, the Health Board does not have their own guidance in place, in line with the NICE guidance. Subsequently, due to the lack of local guidance, there is no recognised pathway for referrals of people who consume a harmful level of alcohol. **(Matter Arising one – High Priority)**

2.2 There is a draft 'Symptom-Triggered Alcohol Detoxification Guideline' in place within the Health Board. The guidance details the process for staff to follow for alcohol detoxification within Health Board inpatient settings.

[1] Overview | Alcohol-use disorders: prevention | Guidance | NICE

[2] Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE

2.3 The Substance Misuse Liaison Team (SMLT) provide quarterly data monitoring reports to the Cardiff and Vale Area Planning Board, as they commission services to provide the end-to-end pathway for substance misuse in Cardiff and Vale of Glamorgan and within this, provide the Health Board with funding for alcohol interventions and treatment. The reports provide data on the number of referrals, assessments and treatments for alcohol and drug users. The Substance Misuse Liaison Nurse advised that there were no comparable reports produced internally within the Health Board. **(see Matter Arising One)**

Conclusion:

2.4 At present the Health Board is not able to demonstrate that they are adhering to NICE guidance as there is no policy / procedure in place detailing the processes to follow. Furthermore, there are no internal reports produced on the number of alcohol users identified within the Health Board and the actions that have been taken to help them. We have provided Limited Assurance for the objective.

Objective 2: Screening for alcohol consumption is being undertaken at all times within specific areas within the Health Board.

2.5 An 'Are we effectively screening patients for alcohol misuse in the Emergency Department?' clinical audit was undertaken within the Health Board prior to covid. The results confirmed that there had been an increase in alcohol screening with the Audit-C screening tool being utilised. However, during covid the Audit-C screening tool was not used, and it has yet to be reintroduced. We were, however, advised that a patient's alcohol consumption may be entered into their notes, but we were unable to verify this. **(Matter Arising Two – High Priority)**

2.6 The SMLT provide a service across the Health Board. However, due to capacity issues they are only able to attend the University Hospital of Llandough (UHL) once a week to see referrals. **(Matter Arising Three – High Priority)**

2.7 The SMLT is currently operating between the hours of 9am and 5pm Monday to Friday across the Health Board. People attending the Emergency Department after these hours are referred to the Substance Misuse service by a staff member leaving a message on the department's answering machine. The referral is received by the department when they return to work on the Monday but, by this time the patient may have been discharged. **(see Matter Arising Three)**

Conclusion:

2.8 There is no alcohol screening tool in place and there is a lack of resource within the SMLT department, despite the increase in demand on the service. This may result in a reoccurring risk that the Health Board is not able to meet the needs of the patients who present with underlying alcohol issues. We have provided Limited Assurance for the objective.

Objective 3: Results and outcomes from screening patients are being recorded appropriately on patient's records and actions are taken as required, including timely referral to, and assessment by the Substance Misuse Liaison Service.

2.9 As detailed in paragraph 2.5 above there is currently no formal screening tool in place within the Health Board. However, the number of units of alcohol a person consumes may be recorded within the patient's notes, but we were unable to evidence this. As part of the audit, we had planned to review the referral process to assess if referrals were actioned in a consistent way and completed in a timely manner, and the time taken for the patient to be seen by the SMLT. However, we were unable to undertake the testing due to the lack of formal process in place and difficulties in differentiating between alcohol and drug referrals. **(Matter Arising Four - High Priority)**

2.10 As detailed above, referrals are made by leaving a message on the SMLT department answering machine. There are no referral documents completed for alcohol users detailing the name of the patient and the reason they need to be referred. **(see Matter Arising Four)**

Conclusion:

2.11 We were unable to substantiate the results and outcomes from screening due to the fact that there is a lack of differentiation between alcohol / drug referrals and there is a lack of processes in place. We have provided Limited Assurance for this objective.

Objective 4: Training is provided to staff on undertaking the alcohol screening for patients.

2.12 We were advised that training on alcohol screening for patients is provided within the Health Board. However, at the time of the review there was no record maintained detailing the training that had been provided, who it had been provided to and when it was undertaken. **(Matter Arising Five – High Priority)**

2.13 We were informed that a Clinical Nurse Specialist has been tasked with identifying a standard training toolkit which will capture information on alcohol screening for all grades of staff, but this is not yet in place.

Conclusion:

2.14 There is no alcohol screening for patients' training record maintained within the Health Board and therefore we were unable to confirm if any staff had received the training. We have provided Limited Assurance for this objective.

Objective 5: Documentation informing patients about the screening process and reducing alcohol consumption is available within the wards and other relevant clinical areas.

2.15 We did not note any documentation about the screening process and reducing alcohol consumption within any of the areas we visited. We were advised by the

Substance Misuse Liaison Nurse that documentation on alcohol consumption was no longer available on wards and the Emergency Department since the covid pandemic. The availability of documentation informing patients about the dangers of harmful drinking was generally acknowledged by the staff members we spoke to as an area where improvement could be made. **(Matter Arising Six – High Priority)**

Conclusion:

2.16 Documentation informing patients about the screening process and reducing alcohol consumption is not currently available within the Health Board. We have provided Limited Assurance for this objective.

Objective 6: There is an intervention pathway in place for individuals who are identified as being at risk when they access Health Board services.

2.17 When a patient has been referred to the Substance Misuse Liaison team with alcohol issues, an assessment is completed, and a treatment pathway determined.

2.18 Although we were informed anecdotally that staff across the Health Board are aware of individuals that may be at risk and the pathways that should be followed. We were unable to identify how these were recorded and monitored due to inadequate processes. **(Matter Arising Seven – Medium Priority)**

Conclusion:

2.19 An intervention pathway is put in place once the patient has been referred to the Substance Misuse Liaison Team. However, there is no evidence to show that those patients who are drinking over the recommended limit but are not referred to the team have any brief interventions or are provided with any information. We have provided Reasonable Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Guidance (Operation)	**Impact**
In June 2021, the First Minister acknowledged that there had been an increase in alcohol specific deaths by stating "more data is needed to confirm and assess this. The reasons for any rise may be complex and will need additional analysis". NICE have issued guidelines in relation to Alcohol specifically "PH24 Alcohol Use disorders: Prevention" and "CG1115 Alcohol - use disorders: Diagnosis, Assessment, and management of harmful drinking and alcohol dependence." Currently, the Health Board is unable to demonstrate that it is treating people in line with the NICE guidance as they have not implemented a Health Board specific alcohol disorder policy or procedure which details the organisations process for identifying people who attend the hospital with alcohol issues and the actions that should be taken. The Substance Misuse Liaison Team (SMLT) produce reports for the Cardiff and Vale Area Planning Board that provide information on the team's staffing levels, the number of referrals completed, and the number of assessments undertaken along with the referral source. The figures are not currently being reported internally within the Health Board.	Potential risk of: • Non-compliance with the NICE guidance

Recommendations		**Priority**
1.1	The Health Board should compile guidance which aligns to the NICE recommendations on detailing the screening process, the brief interventions that will be followed, and who should be targeted and action that should be taken.	**High**
1.2	Given the fact that alcohol related harm is a major health problem, internal reporting within the Health Board should be undertaken to ensure that Senior Managers are aware of the number of patients who are presenting with alcohol issues.	

Agreed Management Action		Target Date	Responsible Officer
1.1	**Funding for fixed term post (to March 2025) for Alcohol Programme Manager secured to support the implementation of management actions.** Guidance for the screening process, the brief interventions to be followed and who should be targeted will be produced and disseminated to relevant staff.	June 2024	Alcohol Programme Manager
1.2	Collation of data from the screening process will be standardised and reported quarterly to the appropriate Senior Managers.	June 2024	Alcohol Programme Manager

Matter Arising 2: Screening tool (Operation)	**Impact**
The NICE guidance states that "NHS professionals should routinely carry out alcohol screening as an integral part of practice". It further states that an appropriate screening tool should be completed when assessing patients. Prior to the covid pandemic, the Audit-C screening tool was implemented within the Emergency Department. However, during covid the screening tool was not used and is still not being utilised. However, we were advised that questions relating to the patient's alcohol consumption are posed and the responses may be entered into their notes. However, this could be difficult to locate as it may not be held in the same place for every patient and the results are not completed on an identifiable form and therefore patients that require assistance might not receive it.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board.

Recommendations		**Priority**
2.1	The Health Board should introduce an appropriate alcohol screening tool, in order to provide a more consistent approach to noting patient information and assisting in identifying people who potentially have an alcohol-use disorder.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Consistent recording mechanism for the chosen screening tool implemented and rolled out to all relevant teams. E.g. Electronic workstation	Sept 2024	Alcohol Programme Manager

Matter Arising 3: Resources in the team (Operation)	**Impact**
The Substance Misuse Liaison Team (SMLT) has recently recruited a new member into the team and there are now four members of staff who cover the whole Health Board, providing a service across University Hospital Wales and UHL for substance misuse. However, due to capacity issues within the team they are only able to attend UHL once a week. At present the team operate a service between Monday – Friday, 9am- 5pm. Therefore, patients presenting outside these hours could be overlooked, which may not be giving a true reflection on the harmful drinking patterns within Cardiff and the Vale. Out of hours referrals are completed by leaving a message on the SMLT answering machine which would be received when they return to work on Monday. Subsequently there are many patients who are referred to the service after working hours who are discharged before being seen. A Substance Misuse Liaison Team performance report that was produced for the audit review by the Substance Misuse Nurse states that for the period 1st January 2023 to 3rd October 2023, 107 patients referred to the SMLT have been discharged without being seen.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board.

Recommendations		**Priority**
3.1	Management should consider completing a resource needs analysis to ensure that the SMLT are meeting the demand, and they are providing an effective service to meet needs of patients who have substance misuse issues.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	SMLT to review where resource within the team is currently being utilised via a resource needs analysis and where there are currently gaps and proposals to address these, either singularly or in partnership with MH Liaison Team.	June 2024	Des Collins/ Neil Jones

Matter Arising 4: Referral Process (Operation)	**Impact**
There is no formal process in place for referring someone to the Substance Misuse Liaison team as all referrals are completed via leaving a message on the answerphone. It was evidenced that forms are not completed detailing the referral and there is no way to differentiate between drug and alcohol referrals at present. Therefore, we were unable to determine: • when the referral was made; • what information was provided; • whether the patient was referred for alcohol or drug misuse; • whether the patient was discharged before being seen; • whether the information was captured within their medical notes and input onto the Paris system; • whether the patient was sent a follow up letter offering further advice; and • whether the patient had been previously identified and if there was a pattern. However, at the time of the review, the SMLT provided us with a referral form that they are hoping to roll out across the Health Board.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board

Recommendations		**Priority**
4.1	Management should implement the referral form as soon as possible in order to provide a consistent approach to the referral process and enable an audit trail of all referrals that have been made.	**High**

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Agreed Management Action		Target Date	Responsible Officer
4.1	Referral processes to be standardised and recorded for all referrals made. To include reason and type of referral, any action taken, further referrals onwards or interventions given. Processes to be simple to follow and easily retrieved and accessible for monitoring and reporting purposes.	June 2024	Alcohol Programme Manager

Matter Arising 5: Training (Design)	Impact
It was identified that there is no formal record maintained of training on alcohol screening for patients. We were advised by the Senior Nurse for Substance Misuse Services that: • The SMLT staff are allocated three days a year to receive training for additional / motivational training in relation to alcohol and stimulants. • General training is provided to staff on identifying individuals who are drinking in a harmful, hazardous or dependant way and where brief interventions would be required. However, we were not provided with any evidence to show who has received the training. • Training is provided every 6 months to junior doctors, and from November 2023 they are hoping to offer this training more widely. However, training is not currently provided to nurses across the Health Board as standard. We requested details on the nature of training that was provided but this was not provided. Individuals with alcohol problems may be in contact with NHS secondary care hospital services such as ante-natal, gastroenterology, maxillofacial surgery and psychiatric services, through out-patient, accident and emergency or in-patient activity. These hospital wards and departments can help to identify and address the needs of individuals with alcohol problems but are not currently trained on alcohol issues. Currently, work is being undertaken to identify a standard training toolkit for all grades of staff as there is currently no central record of training that has been provided on alcohol screening.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board

Recommendations		Priority
5.1	Management should review the current process and consider implementing a central database that includes the records of all appropriate staff across the organisation and detailing the alcohol awareness training undertaken, the date provided and the date for renewal.	**High**

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Agreed Management Action		Target Date	Responsible Officer
5.1	Embed alcohol training within current training schedule for relevant staff and trainees. Ensure training records centralised and kept up to date, including dates for refresher training when required and what areas the staff work in.	Sept 2024	Alcohol Programme Manager

Matter Arising 6: Documentation for patients (Operation)	Impact
We were advised that prior to covid, documentation was available on alcohol misuse and how to receive help, however, these are no longer readily available within the Emergency Department and the wards within the Health Board. Staff confirmed that the availability of documentation relating to alcohol needed to be improved as the numbers of patients with alcohol issues are increasing. This was acknowledged at the time of the review as an area where improvement could be made as since the COVID pandemic the documentation was taken away.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board.

Recommendations		Priority
6.1	Management should consider the current situation and with alcohol levels rising and an increase in alcohol specific deaths there is a need for more leaflets and information to be available for patients at the Emergency Department and across the Health Board. There is also a need to have visible signposts to websites where more advice can be sought relating to the dangers of alcohol and where they can seek further advice or intervention.	**High**

Agreed Management Action		Target Date	Responsible Officer
6.1	Public Health Team to identify or produce resources (leaflets, posters, scratchcards, electronic materials/screens) on alcohol and signposting for patients. Alcohol Programme Manager to identify areas for these materials to be best placed for patients.	Dec 2024	Lauren Idowu (C&V Public Health Team, UHB)

Matter Arising 7: Intervention Pathway (Operation)	Impact
When an individual presents with alcohol issues and is referred to the Substance Misuse Liaison team, an assessment is completed, and a treatment pathway determined. Patients who do not want help with their drinking would be provided with information on CAVDAS - Cardiff and Vale Drug and Alcohol Service by the SMLT. However, since so many patients are discharged before being seen by the SMLT and there is no Alcohol Disorder Policy / Procedure, there is no evidence to show that staff within the ED or across the Health Board would be aware of the brief interventions, pathway or advice that should be provided. Research shows that there is a major link between alcohol and more than 60 medical conditions, so it is important that all staff across the Health Board are aware of other signs to look out for, in order to ensure the patient is receiving the right treatment.	Potential risk of: • Inadequate screening of patients resulting in an increase of patients with alcohol related conditions within the Health Board

Recommendations		Priority
7.1	Management should consider extending the alcohol screening training sessions across the wider Health Board on signs to look out for when a patient is admitted. This would help raise the profile and identify patients who attend the Health Board outside of the Emergency Department who drink in a harmful way and ensure that they are treated in the most appropriate way.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
7.1	Alcohol screening training (electronic) extended across wider Health Board staff. Information on alcohol, it's impact on health and screening and treatment services to be made available and promoted to all staff and departments, waiting rooms etc.	March 2025	Alcohol Programme Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

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NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Shaping Our Future Wellbeing – Future Hospitals Programme

Forward Look Governance Review

Final Report

November 2023

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This advisory report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The University Health Board (UHB) has received positive feedback from Welsh Government on their Shaping Our Future Wellbeing – Future Hospitals Programme, Programme Business Case (PBC). Aligned to this, Welsh Government were commissioning a review of the clinical model outlined within the PBC.

At the time of our review, the UHB was in the process of establishing arrangements to develop a Strategic Outline Case (SOC). This stage was being progressed at risk, noting Welsh Government endorsement of the PBC or confirmation of SOC funding had not yet been received (pending conclusion of the clinical review).

This review was advisory in nature and provides proactive advice on the proposed governance arrangements to see the Programme through the activities outlined above to the next key juncture.

Scope

The scope of the review was agreed as follows:

- **Governance Structure**: To assess the adequacy of the proposed structure, including supportive working groups, to achieve the overall objectives of the current phase of the programme. The review also considered the integration of the Programme within existing committee structures of the University Health Board.
- **Procedural Requirements**: To consider the adequacy of the existing procedural framework and alignment with both the University Health Board and national requirements.
- **Resource requirements**: To assess whether the resourcing requirements have been identified for each activity at this stage of the programme. Where required, external support is identified where there is insufficient capacity or capability internally.
- **Monitoring & Reporting**: A review of the proposed arrangements to monitor the activities of both internal and external advisers.
- **Other:** Any other issues identified at the project affecting project delivery.

As this was an advisory review, in line with Public Sector Internal Audit Standards, it does not proffer an overall opinion. However, a basic aim was to provide proactive advice, identify good practice and relevant systems weaknesses for management consideration and, where appropriate, provide direction to existing guidance.

Conclusion:

The review observed many positive arrangements, such as clear ownership / leadership, a dedicated sub-committee of the Board (currently stood down) and standardised governance procedures to provide clarity and consistency. A comprehensive "Gathering Intelligence" exercise has been undertaken on other new hospital programmes across the UK, including understanding of lessons learnt and best practice. This will inform the development of the Shaping Our Future Hospitals (SOFH) Programme in terms of next steps, individual projects, workstream activity and decision-making processes.

However, at the time of review the UHB had not received formal approval to the PBC, or approval of funding to develop the SOC, with the outcome of the WG commissioned clinical review also awaited. The UHB was therefore progressing at risk in the continuation of Programme governance arrangements and in the development of SOC plans. It is recommended that further investment of resources (time/effort/financial) should be limited pending the outcome of the clinical review, the receipt of WG funding for the SOC development and confirming the future of the project. Following the outcome of the clinical review and receipt of appropriate approvals to proceed to the next stage, the implementation of the procurement programme would require a considered, phased implementation process and associated resource plan.

Recommendations have been outlined for management consideration at **Appendix A.**

Management advise that, following conclusion of the review, Welsh Government had invited the UHB to the Infrastructure Investment Board (IIB) to consider the way forward for the project. The recommendations made below can be considered once this has taken place and the UHB has a clearer understanding of the potential way forward.

Appendix A: Management Action Plan

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
Governance Structure				
1.	Significant time and effort had been invested in the SOFH Programme following submission of the Programme Business Case in early 2021, including continuation of the SOFH Committee (recognising this was stood down in March 2022), Programme Board and Working Group. However, limited progress has been made during this time. The funding bid to develop the SOC (submitted in November 2022) had not yet been approved by Welsh Government, and there were significant wider concerns as to whether there is a viable funding model within NHS Wales to take this Programme forward. The UHB was effectively progressing at risk during this period. The routine continuation of the Programme governance arrangements can also draw focus and time from operational activities, and over time, may risk the loss of engagement / support for the Programme if no progress is evidenced. In this context, the UHB should give careful consideration to whether the current level of governance is proportionate, effective and sustainable.	There should be a review of the level of Programme governance activities required, and the viability of progressing with the aim of developing a SOC, until wider concerns over affordability / funding models have been addressed: to be approved at Board / SOFH Committee level.	Post-attendance at IIB and receipt of feedback from WG.	Agreed. This will be informed by the outcome of the clinical review and attendance at WG IIB. Executives met with WG at the beginning of September to understand likelihood of funding. There is currently no line of sight to funding but have been invited to an IIB in on 13/11/23. Programme Boards and Project Boards have been stood down. The outcome of discussions with WG along with the Nuffield report should drive a review of next steps and Governance (including frequency) and the assistance of the Corporate Governance team will be requested. This said, communication from WG was pointing to

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
				funding before the NHS Wales cost pressures changed messaging to be less certain of funding the SOC. The SRO and PD had been keen to maintain rhythm of governance within C&V and the need for SOFH to be progressed given unsustainable estate condition. The members of the Programme Board attended monthly meetings reliably, however given the prolonged uncertainty, it is agreed the time has come to review. It should be mentioned that the team were not seeking to commence the SOC, rather plan and prepare the ground for the SOC once funding landed.
Noting the potential impact of the above recommendation, the following recommendations are contingent on a decision to maintain some level of governance arrangements going forward, or to be considered if and when governance arrangements are reinstated.				

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
2.	Noting the level of activity to date and focus only on the progression of the Hospital Infrastructure Project SOC within the wider Programme, there may be some inefficiency / duplication within the structure, with the Working Group (now Project Board) and Programme Board receiving similar sets of papers and holding similar discussions. Moving forward, there is scope to review the terms of reference for each group, to ensure appropriate focus on its purpose/role and also how this accommodates external partners e.g. the University, potentially leading to a more refined structure (including linkage with clinical strategy). The process by which stakeholder representation at Project Board is achieved could also be considered e.g. providing linkage and reporting/feedback rather than through attendance of all stakeholders. It is recognised that in the future, as further (constituent) projects are initiated within the Programme, separate Project Boards feeding into the one Programme Board would be considered good practice.	Noting the current wait for funding, it is timely to evaluate terms of reference and governance structures to ensure each forum is appropriately focused.	Post-attendance at IIB and receipt of feedback from WG.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB. The SOC production is considered a project and was being reported into the Programme Board. As the only project, it was the only Project Board. It is acknowledged that it is in the programme's early stages and the only group meeting, the Project Board was also covering more general ground by updating stakeholders on matters.
3.	The SOFH Committee, via membership including Independent Members, provided a level of independent scrutiny and oversight which would be beneficial at a programme of this size and importance. Whilst noting the Committee was stood down in March 2022 due to lack of progress at the Programme, periodic oversight would be useful even during periods of limited activity: to ensure commitment and focus is maintained and challenged where necessary. This oversight could be delivered by an	The above review may include consideration of reinstatement of the SOFH Committee, or utilisation of an existing Committee, to provide periodic scrutiny and oversight of programme activities.	Post-attendance at IIB and receipt of feedback from WG.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB.

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
	existing Committee, until the workload requires the dedicated Committee to be re-introduced.			
4.	A programme-specific Scheme of Delegation would be beneficial as the programme moves forward, ensuring decision-making powers are clearly delegated from Board level to support timely programme decision making, where appropriate.	A Programme / Project-specific Scheme of Delegation should be developed.	Post-attendance at IIB and receipt of feedback from WG.	Agreed.
5.	Whilst recognising full workstream governance arrangements had not yet been confirmed, the governance documents reviewed (including the Project Initiation Document (PID), 'SOFCS & SOFH Management Structure', 'SOC Workstream & Working Groups' document, SOC Readiness Report (February 2023) and SOFH SOC Scope paper to WG, presented an inconsistent picture of the proposed SOC workstream arrangements, and did not align with the arrangements operating at the time of review. The PID (pulling together key guidance/operating requirements within a single document) should provide the central reference point for governance arrangements, and be maintained as a live document as arrangements develop.	The workstream governance structure should be clearly and consistently presented in key governance documents.	Post-attendance at IIB and receipt of feedback from WG.	Agreed. The observation is understandable. The inconsistency reflects work that was in flight when documents were provided for the audit - where the PID hadn't caught up with the sub-documents having been updated.
6.	Working group arrangements for the SOC development were at varying stages of development i.e. some with dedicated teams meeting routinely (e.g. BI Modelling), some being managed within existing departmental structures (e.g. Digital) and some without the proposed governance arrangements yet defined (e.g. Capital & Estates). Terms of reference were only in place for the BI Modelling working group.	Working groups should be clearly defined, with terms of reference in place to identify memberships, governance arrangements etc. These should be distinct from normal UHB operations, to ensure the Programme receives the necessary focus and to support	Post-attendance at IIB and receipt of feedback from WG.	Agreed. Terms of reference were developed for workstreams and presented at the May project board during/post the audit review. Given the expectation of funding, it was prudent to plan the SOC to be efficient

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
		clear monitoring and reporting of performance.		with time so we were relying on existing leaders to spare the time to assist and participate. In the absence of confirmed funding, there has been limited time colleagues have been able to commit alongside the 'day-job.' Receipt of funding would have enabled the recruitment of dedicated resource for SOFH (and SOFCS) work. Our approach did see planning progressing at differential paces and in the future needs either dedicated time from matrixed resources or dedicated resources from the workstreams assigned to the programme. To be considered as part of the governance and resource review recommended in this report.

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
Resource Requirements				
7.	A Project Plan had been developed to map out the activities required to deliver the SOC, over a targeted one-year period. Concerns have been expressed to Audit by some stakeholders that further work is needed around key areas such as development of the clinical model and clear understanding of the current estate infrastructure and utilisation, before work on the SOC can commence. Procurement of external advisers ahead of having a clear internal understanding also risks incurring increased adviser fees and delays to the project timeline. It was also noted that whilst the Project Plan had been mapped out in detail for the Strategic Case, detail remained limited (in terms of activities and committed staff) for the other four cases of the SOC. Whilst there was a high level understanding of the inputs required into these cases, the absence of firm plans does somewhat reduce the confidence in the estimated timeline and resources required to deliver the overall SOC product. To enable delivery of the Plan, a bid for £2m funding has been submitted to WG. Management advised that the bid was significantly reduced to reach a sum that was considered affordable to Welsh Government. In comparing the identified level of resource required to deliver the SOC to that determined by other Health bodies (whilst recognising some differences in the nature and stage of the programmes when compared), a significant variance was noted (both in numbers and categories of staff proposed) - with the	There should be a detailed review of the resources required as the UHB moves through the Programme, from SOC, to OBC and onwards, using an activity-based resource schedule. Resource schedules should be agreed with key departments and individuals to ensure risks and limitations are fully understood. Where funding bids are adjusted downwards, reporting to key forums should be clear as to the gaps this will leave in skills / capacity and the associated risks to programme delivery.	Post-attendance at IIB and receipt of feedback from WG.	Agreed. Our plans did acknowledge the pre-requisites of the Clinical Model and Estate baseline work as early pre-requisites. The approach to understanding the estate condition has changed, with the SOC initially expected to rely on existing data. More recently, with a potential for consideration of a do-minimum option, we recognise there is a need to update this data to accurately reflect current risks. When funding was looking likely to arrive, preparing to procure an external advisor was work that was decided could start. Preparing for this exercise was right at the time and was happening in parallel with planning. This procurement work is now on hold and no tender will or

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
	Cardiff & Vale funding requirement significantly lower than that identified by other Health bodies. Whilst recognising the rationale for the UHB's approach, and that resourcing to date has been to match available funding, the risks associated with this (e.g. being unable to deliver a quality product, undue pressure on existing staff, protracted timeframes, the UHB having to provide 'top-up' funding additional to any Welsh Government allocations etc.), should be carefully considered and reported. The application of activity-based resource plans is suggested – scheduling work against activities/outputs for both internal and external resources, and determining/identifying full resource requirements at key stages of the procurement programme (facilitating gap analysis), in consultation and agreement with key stakeholders. It would also be useful to identify opportunities to stop and reallocate resources at periods of down time. A skills assessment could also be undertaken, to identify what skills are already available within the UHB, and when they would need to be called upon.			can be progressed without a plan being complete and committed to along with a clear line of sight to funding. The point about a low level of resource request is noted and has been a subject of ongoing internal discussions since submission. We will consider our options upon the imminent receipt of a report from the Nuffield Trust on the clinical model described in our PBC. Indications from Nuffield are that resources applied so far to SOFH and SOFCS has been on the low side. The complexity of the transformation has also been mentioned by the Nuffield during their review and await their formal opinion in their report. Given the urgent need to replace our infrastructure, it had been a long-held ambition that a SOC would

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
				be attempted to be produced within 12 months. This is a reasonable ambition given the high-level detail WG were requesting and to avoid the risk of drift. Setting a time bound ambition is common practice. The plan wasn't in a position at the time of the review to be executed as it needed more work. Firm plans being produced prior to execution was the intent. It was our intent to 'outsource' the production of work such as the Economic Case (which is a function of the Strategic Case). With C&V plans more certain, e.g. knowing when a signed off CSP would be available, procuring a partner to help produce content for which we don't have skills could have commenced and they would bid the timeline and the steps. This would have completed the plan.

Ref.	Observations	Recommendation	Suggested Timescale	Responsibility/ Management Response
8.	Whilst the Stakeholder Engagement Approach had been outlined, development of a detailed communications plan was contingent on receipt of the SOC funding to provide the required capacity within the Communications Team. It is recognised that to date, an intentionally minimal approach to communication has been taken, as requested by WG, noting the absence of an agreed approach for the Programme. As the Programme moves forward, consistency in communication with stakeholders will be important, and once clarity has been received as to the direction of the Programme, the Communications Plan should be developed.	The team should move forward with development of a Communications Plan as soon as possible.	Post-attendance at IIB and receipt of feedback from WG.	Agreed.
Monitoring & Reporting				
9.	A Flash report was included in the agenda for each Programme and Project Board meeting. At the time of review, the same content was included in each report (see also observation no. 2 regarding distinction between Project Board and Programme Board activities). The workstream highlight report utilised the same template as Project and Programme flash reports. There is scope to enhance workstream reporting to ensure performance is captured, e.g. via achievement of planned outputs, and risks to wider programme progress.	Governance forums should receive clearly distinguishable highlight / flash reports focusing on the assigned responsibilities of the reporting forum. Workstream highlight reports should be enhanced to clearly present performance information and associated risks.	Post-attendance at IIB and receipt of feedback from WG.	Agreed.

Key Documents Referenced:
Welsh Government - Better Business Cases Better business cases: investment decision-making framework | GOV.WALES
NHS Wales Infrastructure Investment Guidance - NHS Wales infrastructure investment guidance (gov.wales)
HM Treasury - The Green Book The Green Book (publishing.service.gov.uk)
HM Treasury – Checklist for Assessment of Project and Programme Business Cases - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072128/Business_Case_Reviewers_Checklist.pdf
HM Government - Project Delivery - Government Functional Standard (publishing.service.gov.uk)
Infrastructure and Projects Authority - Principles for project success - IPA_Principles_for_Project_Success.pdf (publishing.service.gov.uk)
Infrastructure and Projects Authority - Project Routemap - Handbook_-_FINAL.pdf (publishing.service.gov.uk)

Archwilio Cymru
Audit Wales

Audit and Assurance Committee Update – **Cardiff and Vale University Health Board**

Date issued: January 2024

Document reference: 3461A2023

This document has been prepared for the internal use of Cardiff and Vale University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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About this document

1 This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board.

2 We also provide additional information on:

- Other relevant examinations and studies published by the Auditor General.
- Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Financial audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2022-23 Charitable Funds Accounts	Executive Director of Finance	To provide an audit opinion on the Health Board's Charitable Funds Accounts.	Completed in January 2024 (as scheduled at the time of submitting this paper.)	By Trustee Members on 24 January 2024, with certification on 26 January 2024.

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	We anticipate starting our audit planning in March 2024.	To be covered within the 2024 Audit Plan, which is to be presented at the Committee's next meeting.

5 A summary of our accounts audit work completed in 2023 is provided in the 2023 Annual Audit Report, which is being presented to the Audit and Assurance Committee today.

Performance audit update

6 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic on workforce planning arrangements	Executive Director of People and Culture	This work examined the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It examined how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Completed Final report in today's papers.	February 2024
Structured Assessment 2023 – Core	Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2023 Structured Assessment reviewed: • Board and committee cohesion and effectiveness; • Corporate systems of assurance;	Completed Final report in today's papers.	February 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Corporate planning arrangements; and • Corporate financial planning and management arrangements.		
Examination of the Setting of Well-being Objectives (2023 Local Work)	Executive Director of Strategic Planning and Executive Director of Public Health	This work assessed the extent to which the Health Board has acted in accordance with the sustainable development principle when setting its well-being objectives as part of its arrangements for refreshing the organisation's long-term strategy. This work was incorporated in, and has been reported, through our 2023 Structured Assessment.	Completed Reported as part of structured assessment	February 2024
Review of Unscheduled Care	Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working.	Blog and data tool published in April 2022	

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).	Part 1 – Regional report being drafted. Part 2 – Review due to start in early 2024.	April 2024 To be confirmed
Primary Care Services - Follow-up Review (2022 Local Work)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	Draft report to be issued for clearance in February 2024.	April 2024

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2023 – Deep Dive	Executive Director of Finance	We had previously indicated an intention to undertake deeper dive work to examine digital arrangements. However, given the significantly challenging financial position across NHS Wales, we are now looking at replacing the work on digital with focused work examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Fieldwork underway	To be confirmed
All-Wales thematic review of planned care	Chief Operating Officer	This work will follow on from our 2022 review. The specific focus of this work is to be confirmed.	Planning	To be confirmed
Follow-up of 2019 Clinical Coding follow-up review (2023 Local Work)	Chief Operating Officer	This work will review the Health Board's progress in addressing the recommendations made in our 2019 clinical coding follow-up review.	Planning	To be confirmed

7 A summary of our performance audit work completed in 2023 is provided in the 2023 Annual Audit Report, which is being presented to the Audit and Assurance Committee today.

Other relevant publications

8 Exhibit 3 provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
Corporate Joint Committees – commentary on their progress	**November 2023**
NHS Workforce data briefing	September 2023
NHS Wales Finances Data Tool - up to March 2023	September 2023
Approaches to achieving net zero across the UK	September 2023
'Cracks in the Foundations' – Building Safety in Wales	August 2023

Additional information

9 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
Equality Report 2022-23	November 2023
Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2025 Supporting information for the Estimate for Audit Wales 2024-25	October 2023
Interim Report 2023	October 2023

10 There are no relevant Audit Wales consultations currently underway.

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff, CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Cardiff and Vale University Health Board

Audit year: 2023

Date issued: December 2023

Document reference: 3961A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Cardiff and Vale University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on;

- Board transparency, cohesion, and effectiveness;
- Corporate systems of assurance;
- Corporate approach to planning, and
- Corporate approach to financial management.

We have not reviewed the Health Board's operational arrangements as part of this work.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between June and November 2023. The methods we used to deliver our work are summarised in **Appendix 1**.

5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6 Overall, we found that **the Health Board has maintained effective arrangements to ensure good governance and has adopted a refreshed long-term strategy. Opportunities exist to enhance certain arrangements, to support the delivery of the organisation's refreshed strategic objectives, and address the challenges facing the Health Board.**

Corporate approach to planning

7 We found that **the Health Board has taken positive steps to refresh its long-term vision and strategic / well-being objectives. As with other Health Boards, it has been unable to produce an approvable Integrated Medium-Term Plan (IMTP) and is working to an Integrated Annual Plan instead. Its approach to overseeing the delivery of strategies and plans is maturing, but reports could be strengthened to provide greater assurance to the Board that actions are achieving the intended benefits and outcomes.**

8 The Health Board's arrangements for producing, overseeing, and scrutinising the development of corporate strategies and plans are robust. The Health Board has taken positive steps to refresh its long-term strategy and has adopted a new long-term vision and strategic objectives. However, like other Health Boards in Wales, it has been unable to produce an approvable IMTP for 2023-26 due to its challenging financial position and is working to an Annual Plan for 2023-24 instead.

9 The Health Board's new strategic objectives are also its well-being objectives as required under the Well-being of Future Generations (Wales) Act 2015. Whilst the well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations.

10 Key corporate strategies and plans, such as the long-term strategy and 2023-24 Annual Plan, contain clear strategic objectives and priorities and SMART milestones, targets, and outcomes. The Health Board also has good arrangements in place to enable the Board to oversee and scrutinise the delivery of key corporate strategies and plans. However, opportunities exist to enhance reports to provide greater assurance to the Board on the delivery of intended benefits and outcomes.

Board transparency, effectiveness, and cohesion

11 We found that **the Board and its committees continue to operate effectively, and maintain a good focus on public transparency, good governance, and continuous improvement. Opportunities remain to further enhance public transparency of Board business as well as to review the effectiveness of the new committee structure**.

12 The Board continues to have good arrangements in place to conduct its business transparently, but opportunities remain to improve public accessibility of Board meetings and keep governance related documents on its website up to date. Whilst arrangements continue to support the effective conduct of Board business, the substantial backlog of outdated polices poses a potential risk to breaching regulatory and statutory requirements.

13 The Health Board's new committee structure appears to be bedding down well, but it is too early to comment on its overall effectiveness. Given the launch of the refreshed strategy, there is an opportunity to review the new committee structure, as part of the 2023-24 Board and committee effectiveness review, to ensure it is operating as intended and supporting the delivery of the refreshed strategic objectives. The Board and its committees continue to receive timely, well written papers, and the Health Board is taking steps to further improve their content and quality. The Health Board continues to have a stable and experienced Board. Whilst there are some Independent Member vacancies, the Health Board has taken steps to ensure committees remain quorate whilst recruitment is underway. As in previous years, the Health Board maintains a strong focus on continuous improvement. It also remains committed to hearing from patients and service users, but opportunities exist to make greater use of patient stories at Quality, Safety, and Experience Committee meetings.

Corporate systems of assurance

14 We found that **whilst the Health Board has maintained good corporate systems of assurance, there are opportunities to enhance operational risk management arrangements, performance reporting, and overseeing recommendations tracking.**

15 The Board continues to have good arrangements for overseeing strategic and corporate risks and it has updated its Board Assurance Framework to align risks to the Health Board's refreshed strategic objectives, priorities, and workstreams. However, opportunities remain to improve operational risk management arrangements. The Board maintains good oversight of organisational performance, but we found opportunities to strengthen the improved Integrated Performance Report as well as to review the Performance Management Framework to ensure it supports delivery of the refreshed strategic objectives. The Health Board is taking appropriate steps to ensure compliance with the new duties of quality and candour and is improving its overall approach to overseeing the quality and safety of

services. Whilst the Health Board has strong arrangements for tracking audit and review recommendations, opportunities exist to enhance these arrangements further to support learning and improvement.

Corporate approach to managing financial resources

16 We found that **despite clear processes for financial planning, management and monitoring, the Health Board's financial position for 2023-24 is challenging.**

17 The Health Board did not achieve its financial duties and objectives for 2022-23, and the financial position for 2023-24 remains challenging. The Health Board has a good approach to financial planning, and has set an ambitions savings target with a clear focus on quality improvements and achieving financial sustainability. Arrangements for overseeing and scrutinising financial management and controls have been strengthened. The Health Board continues to have robust arrangements for overseeing and scrutinising financial performance, with clear financial reports which are open about financial challenges and risks.

Recommendations

18 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Well-being Objectives R1 Whilst the Health Board's new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations. The Health Board, therefore, should: a) consider incorporating additional priorities that encompass all aspects of sustainable development, particularly those that relate to the environment; and b) set out how each individual well-being objective aligns to the national well-being objectives and the well-being objectives of it partners.

Recommendations

Accessibility of public Board meetings

R2 In order to enhance public transparency of Board business, the Health Board should improve public access to Board meetings by:

- livestreaming and recording public Board meetings; and
- making the recordings available on the Health Board's website shortly after each meeting.

Public accessibility of governance documents

R3 We found a number of outdated or unavailable governance related documents on the Health Board's website for example Standing Orders and Standing Financial Instructions. The Health Board should review its website, ensuring the latest versions of governance documents and papers are available.

New committee structure effectiveness review

R4 As part of its 2023-24 Board and committee effectiveness review, the Health Board should review the effectiveness of its new committee structure. The review should pay particular attention to whether:

- the committee structure supports sufficient oversight of the refreshed strategic objectives;
- committee terms of reference and workplans adequately cover all aspects of Board business;
- there is merit in instigating a regular meeting for committee chairs;
- there is an appropriate training and development for new committee chairs and new committee members; and
- officers and Members have the capacity and resources to support more frequent committee meetings.

Hearing patient stories

R5 Currently the Quality, Safety, and Experience Committee does not receive patient stories. The committee should start every other meeting with a patient story to usefully set the tone for the remaining meeting and to ensure that members hear about patient experiences and related learning.

Improving performance reporting

Recommendations

R6 The Health Board has improved its Integrated Performance Report (IPR). Whilst we recognise it is a new and evolving report, we have found potential to enhance it by:

- strengthening its links with the Annual Plan Delivery Report to ensure the relationship between some of the delivery milestones and key performance indicators is clearer;
- having a more consistent focus on actions being taken to tackle underperformance in both the IPR and its cover report;
- being clearer about whether the metrics in section two of the IPR are on target or not;
- being consistent in providing reasons why data charts are unavailable in section two of the IPR, instead of leaving the section blank; and
- providing benchmarking data (where available) to show how the Health Board compares to other health bodies.

Enhancing recommendation tracking

R7 The Health Board has good recommendation tracking arrangements but there are opportunities to enhance them further to support learning and improvement. The Health Board should:

a) formally refer recommendations and/or audit and review reports to relevant committees for deeper scrutiny, with the committees reporting back to the Audit and Assurance Committee for assurance, and

b) develop a report for the Audit and Assurance Committee pulling together common themes, issues and learning from the internal, external and regulatory compliance reports.

Detailed report

Corporate approach to planning

19 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

20 We found that **the Health Board has taken positive steps to refresh its long-term vision and strategic / well-being objectives. As with other Health Boards, it has been unable to produce an approvable IMTP and is working to an Integrated Annual Plan instead. Its approach to overseeing the delivery of strategies and plans is maturing, but reports could be strengthened to provide greater assurance to the Board that actions are achieving the intended benefits and outcomes.**

Corporate approach to producing strategies and plans

21 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of;

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

22 We found that **the Health Board's arrangements for producing, overseeing, and scrutinising the development of strategies and corporate plans are robust**. **However, opportunities exist to broaden the coverage of the Health Board's well-being objectives and align them to the national well-being goals as well as the well-being objectives of its partners.**

23 The Health Board has a clear vision which is articulated in its refreshed long-term strategy, Shaping Our Future Well-being (2023-2035). The vision is concise, future-focussed, and places a clear emphasis on delivering high-quality and safe services, collaboration, prevention, and reducing health inequalities to improve outcomes. The vision is underpinned by four new strategic objectives – putting people first; providing outstanding quality; delivering in the right places; and acting for the future. The strategic objectives are also the Health Board's well-being objectives (we discuss this further in **paragraph 27**). The refreshed strategy,

approved by the Board in July 2023, is based on a good understanding of population health needs drawn from a range of sources[1].

24 The Health Board engaged effectively with a wide range of internal and external stakeholders, utilising a range of approaches to support their involvement in shaping all aspects of the strategy. It worked particularly well with community and third sector organisations to engage with 'seldom-heard groups'[2]. An Internal Audit Service review of the Health Board's approach to stakeholder engagement gave a substantial assurance rating.

25 The strategy refresh was overseen by a Steering Group established by the Board, and co-ordinated by a cross-departmental group which ensured appropriate input from Clinical Boards and Corporate Directorates. There were appropriate Board-level arrangements to oversee the development of the strategy and involve Independent Members. The Health Board plans to review and realign its strategic programmes, including the Shaping Our Future Clinical Services Programme, to the refreshed long-term strategy.

26 As with other Health Boards, the Health Board was unable to produce a Welsh Government approved Integrated Medium-Term Plan for 2023-26 due to its planned financial deficit in 2023-24. Instead, it has produced an Annual Integrated Plan for 2023-24, which sets out how it will deliver its key priorities alongside a cost improvement programme to achieve financial balance over the medium-term. The Health Board adopted a bottom-up approach, developing its Annual Integrated Plan through the Clinical Boards and Corporate Departments via the Strategy Development and Delivery Group. The delivery priorities, performance ambitions, and cost improvement programmes were considered by the Senior Leadership Board before they were included in the plan for approval by the Board. The Board and relevant committees were fully involved in the plan development, with Independent Members providing good scrutiny, challenge, and input particularly in relation to the priorities and financial options. The Annual Integrated Plan was approved by the Board on 30 March 2023, and submitted to Welsh Government on 31 March 2023. Elements of the plan were updated following feedback by Welsh Government, with the changes approved by the Board on 25 May 2023 prior to re-submission to Welsh Government on 31 May 2023.

27 As noted in **paragraph 23**, the Health Board's new strategic objectives are also its well-being objectives under the Well-being of Future Generations (Wales) Act 2015. The strategic objectives / well-being objectives were shaped in line with the sustainable development principle. They were developed and agreed by the Board following a detailed analysis of population health needs, opportunities, challenges,

[1] The sources include the well-being assessments completed by the Cardiff Public Services Board and the Vale of Glamorgan Public Services Board, an analysis of opportunities, challenges, risks, and the views of stakeholders.

[2] Under-represented people who use or might use health and social services and who are less likely to be heard by service professionals and decision-makers.

risks, and extensive internal and external stakeholder engagement. The strategic objectives / well-being objectives are cross-cutting, future focussed, and underpinned by the five ways of working. Each strategic objective / well-being objective is accompanied by a clear set of priorities. However, opportunities exist to broaden the priorities under each strategic objective / well-being objective to encompass all aspects of sustainable development. For example, there are no priorities relating to biodiversity or climate adaptation, despite their clear relevance to the Health Board **(Recommendation 1a)**. The long-term strategy appropriately references the seven national well-being goals. However, the Health Board has not clearly shown how its strategic objectives / well-being objectives align to them. Furthermore, it is not clear either how the Health Board's strategic objectives / well-being objectives align to the well-being objectives of its partners **(Recommendation 1b)**.

Corporate approach to overseeing the delivery of strategies and plans

28 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[3] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

29 We found that **the Health Board's key corporate strategies and plans contain clear strategic objectives and priorities and SMART delivery milestones, targets, and outcomes. It has good arrangements in place to enable the Board to oversee and scrutinise the delivery of key corporate strategies and plans. However, reports could be strengthened to provide greater assurance on the delivery of intended benefits and outcomes**.

30 The Health Board's strategic objectives are accompanied by clear strategic priorities. The Health Board has set high-level delivery milestones for each priority which are specific, measurable, achievable, relevant, and timebound. However, they lack a baseline to aid monitoring. The Health Board intends to develop a suite of key indicators to enable the Board to measure and monitor the organisation's progress in delivering its strategic objectives and priorities.

31 The Annual Integrated Plan 2023-24 also contains clear priorities which are aligned to the Health Board's strategic objectives. The plan clearly sets out the Health Board's aim for each priority area, and each aim is outcome focussed. There are clear areas of focus for each priority, accompanied by a detailed set of actions. The

[3] Specific, measurable, achievable, relevant, and time-bound.

Annual Plan also includes the key areas of focus and actions from the Health Board's Infrastructure Plan; Decarbonisation Action Plan; and People and Culture Plan. There is a detailed section outlining how success will be measured, with key delivery milestones and actions broken down by quarter to aid monitoring and reporting (see **Appendix 2 2021 R2a**). The Health Board could enhance these arrangements further by setting out more clearly which Executive Director is responsible for delivery and which committee is responsible for providing oversight.

32 The Health Board's approach to overseeing the delivery of corporate strategies and plans continues to mature. During 2022-23, the quarterly reports presented to Board provided a good overview of the targets that were met during the quarter, the risks and mitigations to delivery, and the targets for the next quarter. The quarter four report also provided a good overview of the key achievements during the year (see **Appendix 2 2021 R2b**).

33 The format for the quarterly report has been refreshed for 2023-24. The report presented to the Board in September 2023 provides a good overview of the status of the quarter one delivery milestones as set out in the Annual Integrated Plan 2023-24. For milestones that haven't been delivered in line with the plan, a clear reason is provided as well as details of what action(s) will be taken to bring the milestone back on track during the next quarter along with an assessment of the organisation's confidence in being able to achieve this. The report is intended to be read alongside the Integrated Performance Report. However, the relationship between some of the delivery milestones and key performance indicators is not clear in all cases. As a result, it is difficult for the Board to assess whether achieving the milestones are delivering the intended benefits and outcomes (we discuss the Integrated Performance Report further in **paragraph 73**. Delivery of the Annual Integrated Plan 2023-24 has been identified as a specific strategic risk[4] in the Board Assurance Framework.

Board transparency, effectiveness, and cohesion

34 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

35 We found that **the Board and its committees continue to operate effectively, and maintain a good focus on public transparency, good governance, and continuous improvement. Opportunities remain to further enhance public transparency of Board business as well as to review the effectiveness of the new committee structure**.

[4] For this risk, the current risk score, controls, and assurances are clearly set out in the Board Assurance Framework, as are the key actions to address gaps in controls and assurance.

Public transparency of Board business

36 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings;
- business and decision-making being conducted transparently;
- meeting minutes being made publicly available in a timely manner.

37 We found that **whilst the Board continues to have good arrangements in place to conduct its business transparently, there are still opportunities for enhancement**.

38 Whilst committee meetings continue to be virtual, livestreamed and recorded, Board meetings are still held only in person. As a result, there are fewer options for the public to attend and observe Board meetings. However, the September 2023 public Board Meeting and Annual General Meeting were held virtually and well publicised on social media. The Health Board reported that more people than usual observed both meetings, showing that there is public interest in Board business when meetings are well publicised and accessible. To enhance public transparency further, the Health Board should routinely livestream public Board meetings and make recordings available via its website **(Recommendation 2)**. Last year, we recommended that Board and committee meeting reminders and links to papers should be posted on social media closer to meeting dates. This recommendation still stands (see **Appendix 2 2022 R3a**).

39 Board and committee papers remain accessible to the public, and continue to be published on the Health Board's website seven days in advance of meetings. Confirmed minutes are uploaded to the Health Board's website separately, so minutes are available to the public before the next Board or committee meeting. However, this practice has been inconsistent since the start of this year **(Recommendation 3)**. Last year, we recommended that the Health Board should ensure the papers for all Advisory Group meetings are published on its website in a timely manner. Overall, this has improved. However, Stakeholder Reference Group[5] papers are still not uploaded in a timely manner. Furthermore, although the Health Professionals Forum is currently under review, previous meeting papers are not available either (see **Appendix 2 2022 R3b**).

40 The Health Board reserves private Board and committee meetings for the most sensitive matters and continues to detail items to be discussed in private on the agendas of public Board and committee meetings. As recommended last year, the Health Board has enhanced arrangements by briefly explaining on public agendas why matters are being discussed in private (see **Appendix 2 2022 R3f**). However,

[5] The Stakeholder Reference Group papers have not been uploaded to the Health Board's website since May 2023.

as yet, it is not making abridged minutes of private Board and committee meetings available publicly (see **Appendix 2 2022 R3c**).

41 Chair's Actions continue to be made in line with Standing Orders and reported at the next public Board meeting. However, a high number of procurement decisions have been made by the Chair[6] rather than the full Board due to unforeseen emergency situations. This was highlighted in a report presented at the April 2023 Audit Committee. By investigating and reporting findings to the Audit Committee, the Health Board has taken a mature approach to review the opportunity to increase transparency of Board decision making.

Arrangements to support the conduct of Board business

42 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

43 We found that **whilst arrangements continue to support the effective conduct of Board business, the substantial backlog of outdated polices poses a potential risk to breaching regulatory and statutory requirements**.

44 The Health Board's Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions continue to be reviewed annually, with good evidence of compliance. The Board approved amendments to these documents in May and November 2023, following scrutiny by the Audit and Assurance Committee. Whilst they are available on the Health Board's website, the versions available are dated May 2022, rather than the most recent versions **(Recommendation 3)**.

45 Declarations of interest remain a standing item on all Board and committee agendas, and we continue to observe compliance. The Health Board uses the electronic staff record to record declarations of interests, gifts, and hospitality[7]. The Audit and Assurance Committee maintains regular oversight of the process and

[6] In 2023, there had been 34 Chair's Actions and only two Board meeting approvals.

[7] Health Board employees are asked to make a single declaration of interest, only altering it if their circumstances change. For gifts, hospitality and sponsorship, staff are required to make declarations as needed.

compliance, receiving the Declarations of Interest, Gifts and Hospitality Tracking Report and full register of interests at most meetings. The register of interest for all staff is published on the Health Board's website. The Health Board also publishes a separate register for Board members on its website. However, it is out-of-date and requires updating to reflect changes to Board membership **(Recommendation 3)**.

46 The Health Board has a substantial backlog of outdated polices. In May 2023, an Internal Audit Service review of the Health Board's management of policy documents gave limited assurance. The Internal Audit Service found that 68% of Health Board policies were either out-of-date or in need of review, which poses a potential risk to breaching regulatory and statutory requirements. To improve policies management, the Health Board is exploring the use of the Audit Management and Tracking (AMaT) platform[8]. It also has a dedicated policy lead within the Corporate Governance Team to lead this improvement work.

Effectiveness of Board and committee meetings

47 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board; and
- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

48 We found that **the new committee structure appears to be bedding down well, but it is too early to comment on its overall effectiveness. The Board continues to receive timely, well written papers and the Health Board is taking positive steps to further improve their content and quality**.

[8] The AMaT system would facilitate clear cataloguing of policies and renewal dates, automatically sending reminders to owner as policy review dates approach. Currently, this is a manual system.

49 Last year, we reported that the Health Board was reviewing its committee structure. Following Board approval in March 2023, the new structure came into effect in April 2023, and is a mixture of new committees and changes to existing arrangements[9]. Whilst the new structure appears to be bedding down well, it is too early to comment on its effectiveness. However, the Health Board should review the effectiveness of the new committee structure as part of the 2023-24 Board and committee effectiveness review **(Recommendation 4)**. The review should pay particular attention to whether there is sufficient:

- oversight of the refreshed strategic objectives and priorities;
- coverage of all aspects of Board business;
- oversight of all strategic risks; and
- officer and member capacity to support more frequent committee meetings.

50 The Board and its committees continue to have up-to-date terms of reference and work programmes, which are reviewed annually[10]. Board and committee Terms of Reference and workplans are available on the Health Board's website and clearly state review and approval dates, as recommended last year (see **Appendix 2 2022 R3d**). Accepting that the new committee structure is still embedding, we observed well chaired committee meetings, which followed agreed processes, ran to time, and had good support from the Corporate Governance Team. Independent Members continue to provide good challenge, which is delivered in a constructive way. Positively, there appears to be a healthy relationship between Executive and Independent Members.

51 Committees continue to appropriately cross-refer matters to other committees and escalate matters to the Board as necessary. Highlight reports by committee chairs remain at the top of Board agendas, thus ensuring any risks highlighted by the chairs are discussed first. Committee chairs do not meet separately; however, all Independent Members meet before each Board meeting and meet informally each month. This provides an opportunity to ask questions, raise awareness of matters, and to cross-refer issues. However, the Health Board might also want to consider establishing a dedicated group for committee chairs to specifically discuss committee business and the best approach for receiving assurance on matters that cut across more than one committee **(Recommendation 4)**.

[9] The Health Board stood down the Strategy and Delivery Committee and Finance Committee, establishing a new People and Culture Committee and Finance and Performance Committee. The Health and Safety Committee is now a sub-committee reporting up to the new People and Culture Committee. The frequency of Quality, Safety, and Experience Committee and Digital and Health Intelligence Committee meeting has increased to monthly and quarterly respectively. Strategic discussions are reserved for the first hour and a half of bi-monthly Board Development Sessions.

[10] In March 2023, the Board approved most committee terms of reference and workplans. The Board approved the terms of reference and workplans for the two new committees in July 2023 to allow time for further refinement.

52 The Health Board continues to produce clear, timely, and well written Board and committee papers, which are accompanied by cover reports that focus on key matters. Since last year, we have seen an increase in the use of data to support narrative reports, which is a positive development. The Health Board is also trying to reduce the volume of papers by making supporting documents available separately. Whilst we see the value of this arrangement, it is not always clear why some documents are considered supporting and others not. For example, the refreshed long-term strategy was a supporting document in the Board papers for the September 2023 meeting, despite it being presented for approval. The Health Board recognises there is room for improvement, and has set up a Task and Finish Group to develop proposals for the Chair to consider. Last year, we highlighted instances of officers speaking to a set of presentation slides which had not been shared in advance. This has improved, with presentations now included within papers or used on the day to present a paper already in the pack, allowing Board members to fully prepare beforehand (see **Appendix 2 2022 R3e**).

Board commitment to hearing from patients/service users and staff

53 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- The Board using a range of suitable approaches to hear from patients/service users and staff.

54 We found that **the Health Board remains committed to hearing from patients and service users**.

55 The Health Board continues to use a range of methods for engaging with and listening to patients and staff. The Board continues to receive a good range of patient and staff stories at the start of each public Board meeting. Positively, the new People and Culture Committee also receives a staff story at the start of each meeting. However, there is an opportunity to replicate this arrangement for the Quality, Safety, and Experience Committee to allow members to routinely hear patient stories **(Recommendation 5)**. Board members have maintained monthly patient safety walkabouts across a range of services. Interviewees were positive about this process, with issues identified during the walkabouts recorded and managed through the Tendable[11] application.

56 In October 2022, the Health Board rolled out CIVICA[12], which enables richer ways to capture and analyse patient views to inform improvement plans. Through its Integrated Performance Report, the Board receives regular updates on the

[11]Tendable is an application used to record, report, and manage health care quality inspections in real time.

[12] CIVICA is a digital system to capture patient experiences.

success of the CIVICA system in terms of increasing patient engagement. The Quality Indicators Report, which is received by the Quality, Safety, and Experience Committee, gives an overview of patient feedback collected through the CIVICA system, which is subsequently reported to the Board through the committee chair's report. The Health Board is also exploring using the system to capture staff views.

Board cohesiveness and commitment to continuous improvement

57 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

58 We found that **there is a stable, skilled, and experienced Board which remains committed to learning, development, and continuous improvement. Whilst there are a number of Independent Member vacancies, positive steps have been taken to ensure committee meetings remain quorate.**

59 The Executive Team has stabilised following several new executive appointments last year. This year, there has been two changes, both of which have been well managed. In February 2023 the Director of Corporate Governance left, with an interim director in post until the new Director of Corporate Governance commenced in August 2023. The new Executive Director of Public Health started in December 2023, following the previous director's retirement during the same month.

60 However, there has been a turnover of Independent Members this year. The Health Board currently holds three vacancies following the departure of the Independent Member (Legal), the Independent Member (Local Government), and the Independent Member (University) in August, October, and November 2023 respectively. The recruitment process for all positions is underway and interim arrangements are in place to ensure all committee meetings remain quorate. Independent Members continue to feel supported by the Chair, who meets with them on a monthly basis, and conducts annual and six-monthly interim appraisals, to discuss objectives and personal development needs.

61 Board member development continues to be well supported through the Health Board's bi-monthly Board Development Sessions, which are 'dynamic' to allow consideration of live and current issues. Aside from strategic discussions, which occupy the first part of each meeting, Board Development Sessions have covered a range of appropriate topics, including the Health Boards's response to the matters arising from the Leanne Letby case, developing a long-term financial plan and three facilitated sessions on Board effectiveness. However, no specific training

or induction was offered to Independent Members following the creation of the new committee structure (see **paragraph 49**). As part of its effectiveness review, the Health Board should reflect on the support available to new committee chairs or committee members **(Recommendation 4)**. This will be particularly important as new Independent Members join the organisation. Positively, Independent Members told us they have appreciated the proactive approach the new Director of Corporate Governance is taking to identifying training and development needs.

62 The Board continues to have good arrangements in place for reviewing its effectiveness. During February and March 2023, prior to the new committee structure taking effect, the Board and committees completed their respective annual effectiveness reviews. This led to a discussion on common themes at the April 2023 Board Development Session and identified wider learning. In May 2023, the Board received an Action Plan based on the 2022-23 review, plus an update on progress in implementing last year's action plan. Last year, we reported the Health Board's plans to conduct its 2022-23 effectiveness review via facilitated discussions; however, this did not happen. The Health Board may want to consider this approach in 2023-24 to help better understand any concerns identified via the effectiveness surveys, particularly as it will be the first review since the new committee structure was implemented.

Corporate systems of assurance

63 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

64 We found that **whilst the Health Board has maintained good corporate systems of assurance, there are opportunities to enhance operational risk management arrangements, performance reporting, and overseeing recommendations tracking.**

Corporate approach to overseeing strategic and corporate risks

65 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;

- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

66 We found that **the Board continues to have good arrangements for overseeing strategic and corporate risks**. **However, there is scope to improve operational risk management arrangements.**

67 The Health Board's continues to have clearly documented strategic risks in its Board Assurance Framework (BAF) and has maintained its well-established regime to ensure appropriate scrutiny by the Board, committees, and executive leads. As recommended last year, the Health Board has updated its BAF to ensure the strategic risks align with the refreshed strategic objectives, priorities, and workstreams (see **Appendix 2 2022 R1**). The revised BAF was presented to the Board in November 2023. The Health Board is yet to review its overall risk appetite, and it remains as 'cautious moving towards seek'[13]. However, there is a risk appetite for each of the 15 strategic risks. The BAF is publicly available through Board papers. It is also available on the Health Board's website; however, at the time of our review, this was not the most recent version **(Recommendation 3)**.

68 The Board also continues to receive the Corporate Risk Register (CRR) for information at each meeting. The CRR focuses on extreme risks (those scoring over 20), of which there were 55 in November 2023. The cover report which accompanies the CRR continues to provide a good summary and now includes a high-level trend analysis. Most corporate risks align to the strategic risks as set out in the BAF relating to patient safety, capital assets, and workforce. The Board also receives an assurance map, which highlights any gaps in assurance mapped against the three lines of defence[14]. Each committee continue to review and scrutinise corporate and/or strategic risks with arrangements appropriate to their remit.

69 An Internal Audit Service review of the Health Board's risk management systems in May 2023 gave a reasonable assurance rating. The review was complementary about the Health Board's risk strategy and procedures. However, it made recommendations on operational risk management arrangements, specifically in relation to inconsistent / incomplete operational risk registers, completing risk

[13] The Health Board defines a 'cautious' risk appetite as "preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward". It defines a 'seek' risk appetite as "eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)".

[14] The Health Board's three lines of defence set out levels of assurance. These are: first line – management level assurance, second line – Health Board's Risk and Regulation Team, Patient Experience Team, Patient Safety Team, Workforce Governance, Information Governance assurance, and third line – Independent level Assurance such as Internal Audit, Audit Wales, Health Inspectorate Wales, and Counter Fraud Service.

assessment forms for newly identified risks, risk escalation and de-escalation processes, and risk monitoring.

Corporate approach to overseeing organisational performance

70 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

71 We found that **the Board and its committees continue to provide good oversight of organisational performance. However, opportunities remain to further strengthen the improved Integrated Performance Report and ensure the Performance Management Framework supports delivery of the refreshed strategic objectives**.

72 Last year, we recommended that the Health Board should review its Performance Management Framework (PMF), which it approved in 2020, alongside its 10-year strategy and committee structure refresh (see **Appendix 2 2022 R1**). At the time of our work, the Health Board was in the early stages of planning this work. The Health Board should expedite this work to ensure its performance management arrangements are fully aligned to its refreshed strategic objectives and support the monitoring and delivery of the refreshed strategy.

73 The Board and its committees continue to provide good oversight of the Health Board's performance. The Board receives the Integrated Performance Report (IPR) at each meeting, following in-depth scrutiny by the newly established Finance and Performance Committee. The committee also routinely receives deep dives into areas where performance is below target. During 2023, the committee has undertaken deep dives into the cancer pathway, orthopaedics waiting list, planned care update, and mental health financial position. Each Executive Director provides an update for their area of work at Board meetings, which shows collective leadership and joint responsibility for performance.

74 The Health Board has made considerable improvements to its IPR. The Board received the new format IPR in July 2023. The first section focusses on the Health Board's progress against the six Ministerial priorities[15], whereas the second section is arranged around the quadruple aims set out in A Healthier Wales, focusing on the NHS Performance Framework and the Health Board's Annual Plan

[15] The Minister for Health and Social Care has set six priorities areas, these relate to improving: delayed transfers of care, access to primary care services, urgent and emergency care, planned care, cancer, and mental health services.

commitments. Together, the two sections provide a good summary of the Health Board's performance. The IPR is supported by a clear, well written cover report which provides a summary of keys points and issues in relation to public health; operational performance; people and culture; quality, safety, and experience; and finance. Whilst we recognise that the IPR is a new report and is still evolving, the report lacks some important information to aid monitoring and scrutiny:

- There is not always a summary provided on the actions being taken to tackle underperformance (see **Appendix 2 2022 R2**).
- Section two of the IPR does not provide clarity about which metrics are on target or not, whereas section one does so by making use of a RAG[16] rating system.
- Section two often omits data charts and leaves the section blank without providing an explanation for why data is not available.
- No benchmarking data is included to demonstrate how the Health Board compares to other health bodies.

The Health Board should address these matters to further enhance the Board's approach to overseeing organisational performance **(Recommendation 6)**.

Corporate approach to overseeing the quality and safety of services

75 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

76 We found that **the Health Board is taking appropriate steps to ensure compliance with the new duties of quality and candour and to improve its overall approach to overseeing the quality and safety of services.**

77 The Health Board has taken appropriate steps to assess its arrangements for complying with the new duties set out in the Health and Social Care (Quality and Engagement) Act (2020). Board members have received briefings on the duties of candour and quality at public Board meetings and Board Development Sessions.

[16] Red, Amber, Green.

Furthermore, Board members and staff have ongoing access to training and support. The IPR also includes a section on the Duty of Candour which enables the Board to maintain oversight of the number of reported incidents and progress made to embed the new responsibilities. The Quality, Safety and Experience (QSE) Committee also receive regular updates through the Assurance Reports provided by the Clinical Boards.

78 The QSE Committee continues to oversee the Health Board's 2021-26 Quality, Safety, and Patient Experience Framework. It receives periodic updates on the Framework's implementation and its sub-committees which were approved as part of the Framework. The QSE Committee also maintains oversight of the quality and safety of services through its bi-monthly quality indicators report, which is organised around the new health and care quality standards. Since July 2023, the report is presented in an improved, data rich, format. It provides updates on metrics such as national reportable incidents and never events; infection prevention and control; medication incidents; mortality rates; falls and pressure damage; clinical effectiveness; COVID-19 investigations; and concerns and patients experience. The committee also receives bi-monthly service specific deep dives and monthly Clinical Board Assurance Reports.

Corporate approach to tracking recommendations

79 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

80 We found that **whilst the Health Board has strong arrangements for tracking audit and review recommendations, there are opportunities for enhancement**.

81 In September 2023, the Internal Audit Service issued a substantial assurance report on the Health Board's recommendation tracking arrangements. Overall, the review found good monitoring, reporting, and scrutiny of the recommendation trackers, but made recommendations to improve the narrative to support the closure of internal and external audit recommendations, to improve the accuracy of reporting for review bodies, and to enhance the scrutiny of the recommendation trackers.

82 We agree that the Health Board has a clear and well-established recommendations tracking process, but there is potential to enhance the impact of this process. Last year, the Health Board introduced a system which allowed deeper consideration of high-risk or longstanding actions, but we have seen little evidence of its implementation. Some audit and inspection reports are referred to the appropriate committees for deeper scrutiny, but this is not a formal process. There is scope for recommendations to be formally assigned to relevant committees for deeper

scrutiny, with arrangements in place to report back to the Audit Committee for assurance **(Recommendation 7a)**. The separate internal, external, and regulatory compliance trackers and accompanying reports are clear, actively managed and contain sufficient information for scrutiny at every other Audit Committee. However, the separate reports do not allow recommendations themes to be picked out to enhance learning, and highlight common issues and shared solutions **(Recommendation 7b)**. In September 2023, there were 31 open Audit Wales recommendations, 24 partially complete and 5 with no action taken.

Corporate approach to managing financial resources

83 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

84 We found that **despite clear processes for financial planning, management, and monitoring, the Health Board's financial position for 2023-24 is challenging**.

Financial objectives

85 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation being on course to meet its objectives and duties in 2023-24.

86 We found that **the Health Board did not achieve its financial duties in 2022-23, and the financial position for 2023-24 remains challenging.**

87 The Health Board did not meet its financial duties in 2022-23. It did not operate within its resource limit for the year or within its cumulative resource limit for the three-year rolling period 2020-21 to 2022-23. However, as agreed with Welsh Government, the Health Board met its planned deficit of £26.9 million for 2022-23. This was made up of £17.1m identified in its initial financial plan, and an additional £9.8 million agreed with Welsh Government mid-year to address unforeseen operational pressures. As in previous years, the Health Board operated within its capital resource limit during 2022-23.

88 As set out in **paragraph 26**, the Health Board was unable to submit a balanced financial plan to support its Integrated Medium-Term Plan for 2023-26. Instead, it is working to an Annual Plan which sets out a forecast deficit of £88.4 million for 2023-24. However, in October 2023, Welsh Government informed the Health Board that it will make £63 million additional monies available to offset cost pressures. This will reduce the Health Board's forecast deficit for 2023-24 to £16.4

million. However, to achieve this revised financial target, the Health Board must deliver its £32 million savings target for the year, plus 10% of its original forecast deficit which equates to £8.8 million. At Month 8 2023-24, the Health Board reported a £6.4 million overspend against its planned deficit position for the month due to unidentified savings and operational pressures.

Corporate approach to financial planning

89 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

90 We found that **Health Board has a good approach to financial planning and has set an ambitions savings target with a clear focus on quality improvements and achieving financial sustainability**.

91 The Health Board adopted a robust and integrated approach to developing its 2023-24 financial plan, with appropriate Board and operational level engagement. Clinical Boards and the Strategy Development and Delivery Group were also involved in developing and agreeing the financial and annual plan. The former Finance Committee routinely discussed the financial plan's development from January 2023, with the final version reviewed at the March 2023 private committee meeting. The plan was approved by the Board in March 2023, as part of the 2023-24 Annual Plan approval.

92 In 2022-23, the Health Board marginally failed to meet its savings target by £57,000. As stated in **paragraph 88**, this year's financial plan includes an ambitious 4% savings target of £32 million, with 1% delegated to Clinical Boards and 3% focused on quality improvement themes. Delivery of the 3% quality improvement savings involves implementing new models of care and redesigning existing clinical pathways, particularly focusing on reducing length of stay in acute beds, identifying operational efficiencies and productivity improvements, continuing healthcare, medicines management, procurement, and maximising the workforce. Through these initiatives, the Health Board is hoping to both reduce its cost base as well as improve outcomes. As at Month 8 2023-24, the Health Board had a £2.2 million savings plan shortfall compared to the forecast position. However, as stated above, the Health Board must also save an additional £8.8 million. At month 8 2023-24, the Health Board reported it had identified £5.4 million against this additional savings target. Savings performance is routinely scrutinised at the

monthly Finance and Performance Committee meeting and at the fortnightly Sustainability Programme Board[17].

93 The Health Board has plans to achieve financial sustainability over a 5-year period and as recommended last year, it is modelling long-term financial plans (see **Appendix 2 2022 R1**). These have been discussed with Board members at Board Development Sessions and private Board meetings. The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

94 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

95 We found that **the Health Board has strengthened its approach to overseeing and scrutinising financial management and controls**.

96 The Audit Committee continues to receive regular assurance reports on financial controls, including reports on counter fraud, single tender actions, losses and special payments, and over payments of Health Board salaries. Since last year, the Health Board has tightened its internal financial controls and scrutiny to deal with the financial pressures and to meet the planned deficit position. Actions taken by the Health Board include trying to eliminate spend on agency and overtime, reviewing vacancies (initially for administrative staff only), and not recruiting or investing at risk. The Health Board is continuing with its 'no PO (Purchase Order), no pay' initiative and restricting spend on non-essential items such as furniture, stationery, and IT equipment. Whilst internal controls have been tightened, there is an exception process in place.

97 The Health Board submitted its draft Financial Statements for external audit within the required timescales following consideration by the Audit and Assurance

[17] The Board was established in April 2023 and is chaired by the Chief Executive.

Committee and the Board in July 2023. For 2022-23, we issued an unqualified true and fair audit opinion, but issued qualified regularity opinion because the Health Board did not meet its revenue resource allocation over the three-year period.

Board oversight of financial performance

98 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

99 We found that **the Health Board continues to have robust arrangements for overseeing and scrutinising financial performance, with clear financial reports which are open about financial challenges and risks**.

100 The monthly finance report, which is received by the newly established Finance and Performance Committee, continues to provide a clear and open narrative on the Health Board's financial performance, risks, and challenges. The Board takes assurance from the Committee Chair's Report, committee minutes, and the finance section of the Integrated Performance Report presented by the Executive Director of Finance.

101 The new Finance and Performance Committee provides an opportunity to triangulate financial and performance challenges. The committee has started to conduct financial deep-dives on struggling Clinical Boards, whilst also considering related performance risks and mitigation. For example, in August 2023 the Committee received a deep dive on the Mental Health Clinical Board. The report highlighted financial and service issues, and included benchmarking information, detailed mitigating actions, and an overview of long-term planning.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit Committee; • Digital Health Intelligence Committee; • Finance and Performance Committee; • Mental Health Legislation and Mental Capacity Act Committee; • Quality, Safety and Experience Committee; and • People & Culture Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of Board; • Chief Executive; • Executive Director of Finance; • Executive Director of Strategic Planning; • Executive Director of Public Health; • Interim Director of Corporate Governance; • Vice Chair of Board; • Chair of People and Culture Committee; • Chair of Audit and Assurance Committee; • Chair of Digital and Health Intelligence Committee; • Deputy Director of Strategic Planning; and • Consultant in Public Health.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports

Recommendation	Description of progress
R1 The Health Board plans to refresh its ten-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements to ensure they are fully aligned to the organisation's refreshed strategic objectives and associated risks, with a particular focus on its (**2022 Structured Assessment**): • Board Assurance Framework • Performance Management Framework • Committee structures, terms of reference, and workplans • Long-term financial plan	In progress – see paragraphs: • Board Assurance Framework – see paragraph 67. • Performance Management Framework - see paragraph 72. • Committee structures, terms of reference, and workplans – see paragraphs 49, 50 and 2023 R4. • Long-term financial plan – see paragraph 93.

Recommendation	Description of progress
R2 The Integrated Performance Report provides a good overview of the Health Board's performance. However, details of the actions being taken to sustain or improve performance that falls below target appears in some sections of the report but not others. The Health Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance (**2022 Structured Assessment**).	In progress – see paragraph 72
R3 Whilst the Health Board has good arrangements in place for conducting Board and committee business effectively and transparently, opportunities exist to enhance these arrangements further. The Health Board, therefore, should (**2022 Structured Assessment**): a) post more frequent reminders about Board and committee meetings on social media and provide links to papers; b) ensure the papers for all Advisory Group meetings are published on the Health Board's website in a timely manner; c) make abridged minutes of private Board and committee meetings available publicly as soon as possible after each meeting; d) ensure the dates Terms of Reference were last reviewed and approved are clearly displayed on the documents;	a) Not complete – see paragraph 38 b) In progress – see paragraph 39 c) Not complete – see paragraph 40 d) Complete – see paragraph 50 e) Complete – see paragraph 52 f) Complete – see paragraph 40

Recommendation	Description of progress
e) circulate presentations in advance of meetings or, where this is not possible, make copies available to members and the public (via the website) as soon as possible afterwards; and f) ensure public papers include an explanation as to why some matters are being discussed in private rather than in public.	
R2 The Health Board's approach to planning remains robust. However, the Health Board's arrangements for monitoring and reporting on plan delivery are less robust. The Health Board, therefore, should strengthen its arrangements for monitoring and reporting on the overall delivery of its Annual Plan and future Integrated Medium Term Plans by (**2021 Structured Assessment**): a) ensuring these plans contain clear summaries of key actions/deliverables, timescales, and measures to support effective monitoring and reporting; and b) providing more information to the Board and Strategy and Delivery Committee on progress against delivery of these plans to enable full scrutiny and assurance.	a) Complete – see paragraph 31 b) Complete – see paragraph 32

Appendix 3

Organisational response to audit recommendations

Exhibit 4: Health Board's response to our audit recommendations

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Well-being Objectives** Whilst the Health Board's new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner	The Future Generations and Wellbeing Steering Group commenced this work in parallel to the strategy refresh and it will be discussed at Board as it progresses	Probable Board Discussion Apr 24 and overarching response/update to Audit Committee 2nd July	Executive Director of Strategic Planning

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	organisations. The Health Board, therefore, should: a) consider incorporating additional priorities that encompass all aspects of sustainable development, particularly those that relate to the environment; and b) set out how each individual well-being objective aligns to the national well-being objectives and the well-being objectives of it partners.			
R2	**Accessibility of public Board meetings** In order to enhance public transparency of Board business, the Health Board should improve public access to Board meetings by:	An initial test of livestreaming was conducted in Sep 23 and the Jan 24 Board will also be livestreamed. Assuming success, the intention is that all subsequent public Board meetings will be livestreamed.	The Jan 24 Board meeting will be livestreamed. An update to Audit Committee will be provided 2nd July.	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• livestreaming and recording public Board meetings; and • making the recordings available on the Health Board's website shortly after each meeting.			
R3	**Public accessibility of governance documents** We found a number of outdated or unavailable governance related documents on the Health Board's website for example Standing Orders and Standing Financial Instructions. The Health Board should review its website, ensuring the latest versions of governance documents and papers are available.	A new Corporate Governance SharePoint online site has been launched which will host a lot of documentation for internal audiences and link to the externally facing website for other elements. As part of this ongoing work this will include an audit of documents.	This will form part of the 2024 work plan with an update to Audit Committee 2nd July.	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R4	**New committee structure effectiveness review** As part of its 2023-24 Board and committee effectiveness review, the Health Board should review the effectiveness of its new committee structure. The review should pay particular attention to whether: • the committee structure supports sufficient oversight of the refreshed strategic objectives; • committee terms of reference and workplans adequately cover all aspects of Board business; • there is merit in instigating a regular meeting for committee chairs; • there is an appropriate training and development for new committee chairs and new committee members; and	In accordance with 10.2 of Standing Orders Board and Committee effectiveness reviews are now embedded as a constant feature both of the meetings themselves and as a standing item in the Chair/DCG weekly 1-1 meetings. The expectation is that rather than conduct an annual, wide ranging review that it will exist as a standing design principle. Annual reports from committees will form part of this process. The embedding of a standing agenda item in Board Development sessions to discuss the strategy means that committee structure can be considered in parallel with the strategy and other connecting factors such as annual planning, the BAF and so on. Wider elements such as Chairs meetings, training, induction etc are all	Ongoing.	Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• officers and Members have the capacity and resources to support more frequent committee meetings.	contained within the above 1-1, IM Management Group, Chair's Governance Group and so on.		
R5	**Hearing patient stories** Currently the Quality, Safety, and Experience Committee does not receive patient stories. The committee should start every other meeting with a patient story to usefully set the tone for the remaining meeting and to ensure that members hear about patient experiences and related learning.	Patient stories are heard at Board every 2 months. The QSE Committee has been reviewed and amended in the last year in terms of content, frequency and administration and so there is a pattern of review in place. It is anticipated that incorporating patient stories back into those agendas as recommended will commence before the Jul 24 Audit meeting.	This will form part of the 2024 work plan with an update to Audit Committee 2nd July.	Executive Director of Nursing and Director of Corporate Governance

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R6	**Improving performance reporting** The Health Board has improved its Integrated Performance Report (IPR). Whilst we recognise it is a new and evolving report, we have found potential to enhance it by: • strengthening its links with the Annual Plan Delivery Report to ensure the relationship between some of the delivery milestones and key performance indicators is clearer; • having a more consistent focus on actions being taken to tackle underperformance in both the IPR and its cover report; • being clearer about whether the metrics in section two of the IPR are on target or not; • being consistent in providing reasons why data charts are	The IPR is under constant review and has a standing slot on both public Board and Board Development sessions of a minimum hour that allows Board Members to interrogate and scrutinise the information that also leads to 'deep dives' being brought back to Board or the appropriate Committee. The comments and recommendations in the SA will be factored into the ongoing review of the IPR as it evolves in presentation and use. In relation to the specific recommendations: • Links with the annual plan, milestones and performance indicators will be reviewed and consideration given to how changes to format could improve clarity	Review of SA recommendations and actions/changes will be reported to Audit Committee 2nd July.	Chief Operating Officer

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	unavailable in section two of the IPR, instead of leaving the section blank; and • providing benchmarking data (where available) to show how the Health Board compares to other health bodies.	• A review of how actions are monitored will be undertaken with particularly thought to the correlation / integration with the Board Assurance Framework (BAF). The BAF includes risks and associated actions for many of the performance domains. • Work will continue to ensure all relevant sections of the IPR have data tables and that performance against standards are clear. • The organisational approach to reporting benchmarked performance will be considered. Consideration will be given to integrating it within the IPR or developing a complementary approach.		

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	**Enhancing recommendation tracking** The Health Board has good recommendation tracking arrangements but there are opportunities to enhance them further to support learning and improvement. The Health Board should: a) formally refer recommendations and/or audit and review reports to relevant committees for deeper scrutiny, with the committees reporting back to the Audit and Assurance Committee for assurance, and b) develop a report for the Audit and Assurance Committee pulling together common themes, issues and learning from the internal, external and regulatory compliance reports.	A review of these processes will also be factored into the Corporate Governance work plan. Work has been done to understand how the AMAT software might be better used for policy tracking, recommendation tracking and risk management with policy tracking being the primary focus initially following an internal audit recommendation. Work has commenced with AMAT to develop a risk module with CAV as the lead NHS organisation on this matter.	An update will be brought to Audit Committee 2nd July.	Director of Corporate Governance

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Report Title:	Procurement Compliance Report				Agenda Item no.	2.4	
Meeting:	Audit Committee		Public	X	Meeting Date:	6th February 2024	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that the purchase of all goods and services be subject to competition in accordance with good procurement practice, making reference to minimum thresholds for quotes and competitive tendering arrangements.

There are some situations where this is not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) are made in accordance with the Procedure for the Approval of Single Tender Action. There are sound reasons why STA/SQA's are permitted within the Health Board, these are as follows but not limited to:-

- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

To support the management of STA/SQA requests, an online quotation system was implemented in April 2019, to test the market and promote competition, this should reduce the number of STA/SQA's.

There are also some situations where contracts are extended outside of the original contract scope to ensure patient safety and operational delivery of the Health Board's core services.

Unfortunately, there are times where individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (22)

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Description Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/ Breach	Clinical Board	Reason	Action/Status
PICCOS CTU Trial	£165,402.85	N/A	10 months	Surgery Services and Dental	No engagement with Procurement at commencement of the requirement	In Progress – Contract currently being put in place for the rest of this R&D project. This project is being funded by NIHR.
Consultancy for Ophthalmology Services	£21,800.00	N/A	2 months	Surgery Services and Dental	No engagement with Procurement	In Progress – Contract currently being put in place.
Agency Staffing	£45,862.80	N/A	3 months	Surgery Services and Dental	Old contract finished on 31st July and Finance did not approve renewal. Service informed agency provision should cease	Closed – Agency ceased.
CSP Commit Azure Wallet	£47,291.00	N/A	One Off Requirement	Executives	No Procurement involvement in the engagement of the service.	Closed – Included in workplan for future purchases.
Epileptic Networks Brain Mapping	£12,696.70	N/A	3 months	Specialist	No engagement with procurement	In Progress – Discussions with Service on whether there are any future requirements
Oracle Tuning Pack	£35,520.08	N/A	12 months	Executives	Service did not engage with Procurement	Closed – Included in workplan for future purchases.
Physiotec Online	£9,817.20	N/A	One Off Requirement	Clinical Diagnostics & Therapies	Service did not engage with Procurement	Closed - One Off Requirement
Eye Care Education Course	£99,236.00	N/A	12 months	Executives	Service did not engage with Procurement	Closed - One Off Requirement
Medical Education Licences - PGCert	£25,200.00	N/A	9 months	Executives	Service did not engage with Procurement	Closed - One Off Requirement

Medical Education Licences - Diploma	£4,200.00	N/A	9 months	Executives	Service did not engage with Procurement	Closed - One Off Requirement
Cyted Outsourcing	£23,125.00	N/A	One Off Requirement	Clinical Diagnostics & Therapies	The service outsources dermatology cases to Cyted, the cases reported to audit committee are for cases which exceed the value and governance agreed.	In Progress – Discussions with Service on whether there are any future requirements
Prometheus complex care staffing agency	£23,527.50	N/A	One Off Requirement	Medicine	No engagement with Procurement	In Progress – Discussions with Service on whether there are any future requirements
Tuition fees for 3 students	£11,202.50	N/A	One Off Requirement	Clinical Diagnostics & Therapies	Service did not engage with Procurement	Closed – one off requirement.
Young Carers In School and Carer Friendly Services	£100,000.00	N/A	12 months	Executives	Service did not engage with Procurement	In Progress - Renewal contract being completed by Procurement
Admin Agency Staff	£5,537.78	N/A	1 month	Surgery Services and Dental	Service did not engage with Procurement	In Progress – Discussions with Service on whether there are any future requirements
Acorn Alac Driver	£5,000.00	N/A	4 months	Specialist	Service did not engage with Procurement	In Progress – Discussions with Service on whether there are any future requirements
Forget me not Chorus Patient workshops	£8,464.00	N/A	12 months	Executives	Service did not engage with Procurement	Closed – workshops completed
Database network	£5,327.04	N/A	One off requirement	Children and Women	Service did not engage with Procurement	Closed – No future requirement
Contraception Telephone Consultation	£12,472.00	N/A	One off requirement	Children and Women	Service did not engage with Procurement	In Progress – Discussions on compliant contract to be arranged
HFMA Wales Branch Annual Conference	£5,593.00	N/A	One off event	Executives	Service did not engage with Procurement	In Progress – Discussions with Service on whether there are any future requirements
LGC Subscription	£5,465.40	N/A	12 months	Clinical Diagnostics & Therapies	Service did not engage with Procurement	In Progress – Discussions on compliant contract to be arranged
Physiotec	£19,634.40	N/A	24 months	Clinical Diagnostics & Therapies	Service did not engage with Procurement	Closed - Contract requirement included on workplan for compliant renewal

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (4)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Reprographics Print Unit Devices	£8,760.34	1st April 2024	2 months	Clinical Diagnostics & Therapies	Higher printing volumes than anticipated	Closed – additional value approved and renewal being completed
Admin Agency Staff	£15,000.00	Ceased	5 months	Children and Women	Department exceeded ceiling limit for staffing hours	In progress – New contract being put in place
Water Safety Control Measures	£114,516.50	Ongoing	7 months	Capital, Planning, Estates and Facilities	Acorn continued to provide service without procurement knowledge of out of contract activity.	Closed - Interim contract agreed whilst new tender conducted for long term contract
Cardiac System - Ambulatory Care	£6,051.77	In Process	1 week	Specialist	Terms and Conditions and IG hold up in the signoff of contract renewal	Closed – Contract agreed with supplier

Other Non-Compliant Activity (6 Return)

This section details activities which were out of the Department/Health Board's control as a result of any of the following;

- Emergency activity
- Unforeseen/Unplanned circumstances
- Exemptions

Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Various Legal Barrister Fees	£111,547.92	N/A	One off services	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
Legal Barrister Fees	£15,000.00	N/A	One off services	Clinical Diagnostics & Therapies	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
SMPU Chiller Hire Extension	£24,055.00	N/A	Emergency hire	Clinical Diagnostics & Therapies	Chiller broke and Service required a hired chiller to	In Process – Capital purchase bid submitted to replace kit

					continue provision	
Emergency Helium refill for Mobile MRI Scanner	£54,974.95	N/A	Emergency one off service	Clinical Diagnostics & Therapies	Emergency requirement to refill Mobile MRI Scanner	Closed – Emergency refill
National Resources Wales – Civil Penalty Notice	£211,194.10	N/A	One off fee	Capital, Planning, Estates and Facilities	Penalty Notice	Closed – One off payment
Complex care for patient on Elm ward (Prometheus)	£201,468.00	N/A	1 month	Mental Health	Emergency patient care required	Closed – Emergency temporary provision

Contracts engaged at risk as a result of Covid-19 requirements (Nil Return)

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status

Report of Single Tender/Quotations Actions

Retrospective – (Nil Return)

The report outlines all SQA/STA (Nil Return) requests during the period the 1st October 2023 to 31st December 2023.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type

Should Retrospective STA/SQA's occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Prospective (within the permitted guidelines)

The report outlines all SQA/STA (15) requests during the period the 1st August 2023 to 30th September 2023. The volume processed was higher than normal activity, as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19/ Unforeseen circumstances/Emergencies
12. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
Surgery (Dental)	W&H UK	Maintenance of Lisa Vacuum Sterilisers	£10,557.54	Sole Supplier of Goods or Services
Clinical Diagnostics and Therapies	Hitachi Hi-Tech Europe GmbH	Maintenance of HT7800 TEM Microscope	£74,352.00	Sole Supplier of Goods or Services
Surgery	Johnson and Johnson	Purchase of reciprocating saw attachments	£8,084.34	Sole Supplier of Goods or Services
PCIC	Reveal Service 2011 Ltd	Security Provision for the Alternative Treatment Service	£70,357.56	Urgent Operational Requirement
Executives	London School of Business	Executing Strategy for Results Course	£9,500.00	Sole Supplier of Goods or Services
Executives	Cardiff Met	Move More - Eat Well Project	£7,200.00	Capability with existing equipment or service
Clinical Diagnostics and Therapies	Bayer	Maintenance Contract for 5 Bayer Injectors	£39,027.00	Capability with existing equipment or service
Capital Planning, Estates and Facilities	A2H live	Temporary Storage Unit	£65,310.00	Capability with existing equipment or service
Executives	Forget Me Not	Calon Chorus - Forget Me Not	£9,722.00	Sole Supplier of Goods or Services
Executives	R&D Forum	Research and Development Forum for MHRA Inspection Readiness	£7,350.00	Sole Supplier of Goods or Services
Executives	3MM	Annual support and software licence for Medlink system	£25,910.00	Sole Supplier of Goods or Services
Executives	St George's House, Windsor Castle	Development event of the Commonwealth / Global Health and Care Leaders' Institute	£28,800.00	Sole Supplier of Goods or Services
PCIC	DH OpCo UK LTD – Dedalus	DoSH bespoke IT System Support	£24,306.48	Sole Supplier of Goods or Services
Specialist	ClearPoint Neuro Inc	Lease of Clearpoint Therapy Enabling platforms	£47,700.00	Sole Supplier of Goods or Services
Children and Women	Cerebral Palsy Cymru	Provisions of Bobath Therapy Services	£15,432.76	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	2022/23			2023/24		
Clinical Board	**Non-Compliant Breaches**	**Exemption**	**Covid-19**	**Non-Compliant Breaches**	**Exemption**	**Covid-19**
AWMGS	1	0	0	1	0	0
Children and Women	2	0	0	3	0	0
Capital Planning, Estates and Facilities	3	2	1	2	3	0
Clinical, Diagnostics and Therapies	2	0	0	11	4	0
Executives	8	5	0	21	9	0
Medicine	2	1	0	1	0	0
Mental Health	0	0	0	2	1	0
PCIC	0	0	0	2	0	0
Specialist	3	1	0	10	1	0
Surgery and Dental	9	1	0	10	0	0
TOTALS	**31**	**10**	**1**	**63**	**18**	**0**

Please note that in February 2021, the reporting of non-compliant activity was spilt into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

	2021/22		2022/23		2023/24 (Year To Date)	
Clinical Board	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**
AWMGS	4	3	3	3	0	0
Children and Women	2	0	3	1	4	0
Capital Planning, Estates and Facilities	2	0	15	2	2	0
Clinical, Diagnostics and Therapies	14	1	26	2	23	0
Executives	9	3	23	1	13	2
Medicine	6	1	4	0	0	0
Mental Health	1	0	3	0	1	0
PCIC	2	0	11	3	3	0
Public Health Commissioning Team	1	0	7	0	0	0
Specialist Services	6	2	11	1	3	0
Surgery Services and Dental	5	1	11	0	5	1
Grand Total	**52**	**11**	**117**	**13**	**54**	**3**

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
29/01/2024 17:21:57

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Cardiff and Vale University Health Board

Audit year: 2022-23

Date issued: January 2024

Document reference: 3968A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Cardiff and Vale University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts; and
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 28 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing

that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We will be presenting it to the Audit and Assurance Committee on 6 February 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Health Board's 2022-23 accounts[2] were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

13 However, I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2020-21 to 2022-23 the Health

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

[2] I audit and certify the Health Board's Performance Report, Accountability Report and Financial Statements. 'Accounts' is a generic term.

Board expended £26.467 million over the three-year revenue limit that the Welsh Government had authorised. The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2020-21 to 2022-23.

14 I found no other regularity matters of a material adverse nature. I did however report that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2022-23 to 2024-25. This financial duty requires Health Boards to prepare, and have approved by the Welsh Ministers, a rolling three-year integrated medium-term plan.

15 I reported nine audit recommendations for improvement to the Health Board's Audit and Assurance Committee. Management fully accepted all the recommendations and they have put actions in place to implement them. I will review the Health Board's progress with the actions as part of my 2023-24 audit.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- Urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There's a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.
- From an all Wales perspective, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Health Board is taking appropriate action to address its significant workforce challenges. However, it needs to ensure that it has sufficient workforce planning resources to support delivery of the Health Board's people plan and better understand the impact of the actions it is taking.
- The Health Board has maintained effective arrangements to ensure good governance and has adopted a refreshed long-term strategy. Opportunities exist to enhance certain arrangements to support the delivery of the organisation's refreshed strategic objectives and address the challenges facing the Health Board.

17 These findings are considered further in the following sections.

Detailed report

Audit of accounts

18 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

19 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

20 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

21 I concluded that the Health Board's accounts were properly prepared and materially accurate (true and fair) and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

22 I reported nine audit recommendations, to management and to the Health Board's Audit and Assurance Committee. Management accepted all the recommendations and formally agreed management actions and dates of implementation.

23 I must report issues arising from my work to those charged with governance (the Members of the Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues to the Board on 25 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were no non-trivial uncorrected misstatements.
Corrected misstatements	I reported the five most significant areas of corrected misstatements. They related mainly to accounting classifications and disclosures.
Other significant issues	I reported nine recommendations for improvement, with management's formal responses (including their

acceptance of the nine recommendations). The Health Board's Audit and Assurance Committee considered them on 7 November 2023.

24 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

25 My separate audit of the Health Board's Charity's annual report and accounts is substantially complete, and I will be reporting my findings to Trustee Members on 24 January 2024. I expect to certify the annual report and accounts on 26 January. The Charity Commission's deadline is 31 January.

Regularity of financial transactions

26 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

27 Where a Health Board does not achieve financial balance, its revenue and/or capital expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

28 I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2020-21 to 2022-23 the Health Board expended £26.467 million over the three-year revenue limit that the Welsh Government had authorised.

29 The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2020-21 to 2022-23. For the three-year period 2020-21 to 2022-23 the Health Board expended £233,000 below the three-year capital limit that the Welsh Government had authorised.

30 I have the power to place a substantive report on the Health Board's accounts, alongside my opinions, where I want to highlight an issue(s). Due to the regularity issue set out above, I issued a substantive report setting out the factual details of my qualification of my regularity opinion.

31 My substantive report also highlighted that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2022-23 to 2024-25. This financial duty requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. The duty is an essential foundation to the delivery of sustainable quality health services.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

32 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- commenting on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments.
- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally.
- reviewing the effectiveness of the Health Board's workforce planning arrangements.
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.
- assessing, as part of my structured assessment work, the extent to which the Health Board acted in accordance with the sustainable development principle when setting its well-being objectives as required under The Well-being of Future Generations (Wales) Act 2015.

33 My conclusions based on this work are set out below.

Orthopaedic Services in Wales

34 In March 2023, I commented on orthopaedic services across Wales. My national report 'Orthopaedic Services in Wales – Tackling the Waiting List Backlog' sets out the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the nationally co-ordinated work to modernise services. My report also set out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services.

35 My work found that securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with the COVID-19 pandemic making this significantly worse. Previous monies allocated by Welsh Government have resulted in short term improvements but have not achieved the sustainable changes to services that were necessary with orthopaedic waiting list targets not met since they were first established in 2009.

36 Since the impact of the pandemic has lessened, orthopaedic services have been slow to restart, and while necessary infection control regimes will continue to have an impact on throughput, there is scope for current capacity to be used more

efficiently. My scenario modelling indicates that it could take between three to five years to return orthopaedic waits to pre-pandemic levels across Wales. This is based on both a significant drive on community-based prevention and an increase in capacity and activity. Without this, services may never return to pre-pandemic levels.

37 My work found that there is a clear commitment to improve orthopaedic services. NHS Wales commissioned efficiency and effectiveness reviews both nationally and locally, which set out a suite of recommendations. A national clinical strategy for orthopaedics was also commissioned which sets out service options and a clear clinical voice on what needs to be done. However, urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

38 In addition to my national report, my team set out how the Health Board's orthopaedic services compare to other health boards across Wales. My comparative report highlighted that the Health Board has:

- Fewer people on its waiting list per head of population, with the lowest proportion of patients on the waiting list for longer than two years in Wales. The proportion of patients waiting longer than a year for a first outpatient appointment is, however, above the all-Wales average;
- average levels of potential latent 'lost' demand as an impact of patients not going to their GP during the pandemic;
- the highest level of orthopaedic bed and medical workforce capacity;
- below average waits for radiology services, and the shortest waits for physiotherapy in Wales; and
- the highest uptake of 'see on symptom' pathways to reduce unnecessary follow-up outpatient demand, but limited uptake of patient-initiated follow-ups.

39 My scenario modelling indicates that optimistically the orthopaedic waiting list for the Health Board could return to pre-pandemic levels by early 2025, and realistically by 2026 but without concerted effort may take many years to return to pre-pandemic levels, if at all.

40 My local report sets out a series of prompts and questions for Board members to inform debate and obtain assurance that improvement actions at a local level are having the desired effect.

NHS workforce data briefing

41 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

42 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

43 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

44 My review examined whether the Health Board has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

45 My work found that the Health Board is taking appropriate action to address its significant workforce challenges. However, it needs to ensure that it has sufficient workforce planning resources to support delivery of the Health Board's People Plan and better understand the impact of the actions it is taking.

46 Despite the Health Board steadily increasing its workforce numbers over the past decade, it still faces serious workforce challenges with recruitment and retention, which threaten the stability of services. This has caused a sharp rise in the use of agency staff, which cost the Health Board over £28 million in 2022-23, further exacerbating an already pressurised financial situation. The Health Board's staff turnover (11.5%) and sickness rates (7%) are amongst the highest in Wales and present significant challenges. In 2022-23, the Health Board's workforce spend was £879 million, which is a 30% increase in the four years since 2018-19. Financial pressures facing the Health Board could pose a risk to the sustainability of the workforce in the short and longer term, although effective workforce planning would support more efficient and effective use of the Health Board's existing resource.

47 The Health Board's People Plan is clearly focused on addressing workforce challenges in the short- and medium-term, but more attention is needed on addressing long-term risks. Although the Health Board is at the initial stages of understanding its current service capacity, it needs to strengthen how it predicts service demand to allow it to model and plan for the future. The Health Board is working effectively with internal and external stakeholders to find shared solutions to current and future workforce challenges.

48 The Health Board has clear intent to improve workforce planning capability but should ensure it has the resources to support delivery of its People Plan. It has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date. The Health Board is also appropriately focussing on its current workforce challenges at an operational level through a range of recruitment, retention, and development activities. However, significant challenges remain, and education commissioning is not yet supporting a sustainable workforce, leaving gaps in some key areas.

49 The newly established People and Culture Committee is starting to receive timely and comprehensive workforce performance reports, but the Health Board needs to strengthen the focus on the impact of People Plan actions.

Structured assessment

50 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

51 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. To help discharge my duties under Section 15 of the Well-being of Future Generations (Wales) Act 2015, my team also assessed the Health Board's corporate approach to setting its new well-being objectives in accordance with the sustainable development principle. Auditors also paid attention to progress made to address previous recommendations.

52 At the time of my structured assessment work, the Health Board was subject to "enhanced monitoring" by the Welsh Government for its planning and finance arrangements.

Corporate approach to planning

53 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- Producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan (IMTP); and
- Overseeing the delivery of corporate strategies and plans.

54 My work found that the Health Board's arrangements for producing, overseeing, and scrutinising the development of corporate strategies and plans are robust. The

Health Board has taken positive steps to refresh its long-term strategy and has adopted a new long-term vision and strategic objectives. However, like other Health Boards in Wales, it has been unable to produce an approvable IMTP for 2023-26 due to its challenging financial position and is working to an Annual Plan for 2023-24 instead.

55 The Health Board's new strategic objectives are also its well-being objectives as required under the Well-being of Future Generations (Wales) Act 2015. Whilst the well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations.

56 Key corporate strategies and plans, such as the long-term strategy and 2023-24 Annual Plan, contain clear strategic objectives and priorities and SMART[3] milestones, targets, and outcomes. The Health Board also has good arrangements in place to enable the Board to oversee and scrutinise the delivery of key corporate strategies and plans. However, opportunities exist to enhance reports to provide greater assurance to the Board on the delivery of intended benefits and outcomes.

Board transparency, effectiveness, and cohesion

57 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business;
- Arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

58 My work found that the Board and its committees continue to operate effectively, and maintain a good focus on public transparency, good governance, and continuous improvement. Opportunities remain to further enhance public transparency of Board business as well as to review the effectiveness of the new committee structure.

59 The Board continues to have good arrangements in place to conduct its business transparently, but opportunities remain to improve public accessibility of Board meetings and keeping governance related documents on its website up to date. Whilst arrangements continue to support the effective conduct of Board business, the substantial backlog of outdated polices poses a potential risk to breaching regulatory and statutory requirements.

60 The Health Board's new committee structure appears to be bedding down well, but it is too early to comment on its overall effectiveness. There is an opportunity for

[3] Specific, measurable, achievable, relevant, and time-bound.

the Health Board to review the new committee structure, as part of the 2023-24 Board and committee effectiveness review, to ensure it is operating as intended and supporting the delivery of the refreshed strategic objectives. The Board and its committees continue to receive timely, well written papers, and the Health Board is taking steps to further improve their content and quality.

61 The Health Board continues to have a stable and experienced Board. Whilst there are some Independent Member vacancies, the Health Board has taken steps to ensure committees remain quorate whilst recruitment is underway. As in previous years, the Health Board maintains a strong focus on continuous improvement. It also remains committed to hearing from patients and service users, but opportunities exist to make greater use of patient stories at Quality, Safety, and Experience Committee meetings.

Corporate systems of assurance

62 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- Overseeing strategic and corporate risks;
- Overseeing organisational performance;
- Overseeing the quality and safety of services; and
- Tracking recommendations.

63 My work found that whilst the Health Board has maintained good corporate systems of assurance, there are opportunities to enhance operational risk management arrangements, performance reporting, and overseeing recommendations tracking.

64 The Board continues to have good arrangements for overseeing strategic and corporate risks and it has updated its Board Assurance Framework to align risks to the Health Board's refreshed strategic objectives, priorities, and workstreams. However, opportunities remain to improve operational risk management arrangements. The Board maintains good oversight of organisational performance, but we found opportunities to strengthen the improved Integrated Performance Report as well as to review the Performance Management Framework to ensure it supports delivery of the refreshed strategic objectives. The Health Board is taking appropriate steps to ensure compliance with the new duties of quality and candour and is improving its overall approach to overseeing the quality and safety of services. There is a clear and well-established recommendations tracking process, but there is potential to enhance its impact by developing a report which pulls together common themes, issues and learning from the internal, external and regulatory compliance reports and by formally assigning recommendations to relevant committees for deeper scrutiny.

Corporate approach to managing financial resources

65 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- Achieving its financial objectives;
- Overseeing financial planning;
- Overseeing financial management; and
- Overseeing financial performance.

66 My work found that despite clear processes for financial planning, management and monitoring, the Health Board's financial position for 2023-24 is challenging.

67 The Health Board did not achieve its financial duties and objectives for 2022-23, and the financial position for 2023-24 remains challenging. The Health Board has a good approach to financial planning and has set an ambitions savings target with a clear focus on quality improvements and achieving financial sustainability. Arrangements for overseeing and scrutinising financial management and controls have been strengthened. The Health Board continues to have robust arrangements for overseeing and scrutinising financial performance, with clear financial reports which are open about financial challenges and risks.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2023.

Report	Month
Financial audit reports	
Audit of Accounts Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of Accounts Addendum Report	September 2023
Charitable Funds Audit of Accounts Addendum Report (2021-22 Accounts)	February 2023
Charitable Funds Audit of Accounts Addendum Report (2022-23 Accounts)	January 2024
Performance audit reports	
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog: A comparative picture for Cardiff and Vale University Health Board.	March 2023
NHS Workforce Data Briefing	September 2023

Report	Month
Review of Workforce Planning Arrangements	November 2023
Structured Assessment 2023	December 2023
Other	
2023 Audit Plan	April 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway or planned at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Primary Care Follow Up Review	February 2024
Unscheduled Care: Flow out of Hospital – Cardiff and Vale Region	March 2024
Discharge Planning: Progress Update	March 2024
Review of Financial Efficiencies	March 2024
Unscheduled Care: Arrangements for Managing Access	June 2024
Review of Planned Care Services Recovery	July 2024
Follow-up of 2019 Clinical Coding follow-up review	July 2024

Appendix 2

Audit fee

My 2023 Audit Plan set out my fee estimate of £437,662 (excluding VAT, which is not chargeable). I also set a fee estimate of £23,784 in the 2023 Audit Plan for my audit of the Health Board's Charity's annual report and accounts. My staff will determine the final audit costs once all audits are fully concluded. My audit team will then notify management of the closing position, which I will set out as usual in my 2024 Audit Plan.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks for the audit of the Health Board's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed numerous accounting estimates and samples of transactions that included journal entries. The results of my testing were satisfactory.
Under the NHS Finance (Wales) Act 2014, health boards moved to a rolling three-year resource limit for both revenue and capital. For 2022-23 and the three years to 31 March 2023, the	I monitor the Health Board's financial position for 2022-23 and the cumulative three-year position to 31 March 2023. My review will also consider the impact of	As set out in this report, my audit confirmed that the Health Board met its three-year capital resource limit but did not meet its three-year resource limit and I therefore qualified my regularity opinion.

Audit risk	Proposed audit response	Work done and outcome
Health Board forecasts[4] to exceed its revenue resource limit by £26.9 million. This outcome could affect my regularity opinion, as the Health Board has experienced for some of its past financial years.	any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2022-23 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen. Also, I will focus my testing on areas of the financial statements which could contain judgements such as provisions. We will also focus on year-end accruals with a focus on ensuring transactions have been reported in the correct accounting period.	
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in	I will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of	The results of my prescribed audit testing were satisfactory.

[4] Based on the Health Board's 'month 11' financial reporting to the Welsh Government.

Audit risk	Proposed audit response	Work done and outcome
the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date of 31 March 2023.	asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Welsh Government's Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	
A new accounting standard, IFRS16[5] Leases, has been introduced from 2022-23. The standard significantly changes how most leased assets are to be accounted for, with leased assets needing to be recognised as assets and liabilities in the Statement of Financial Position (the balance sheet).	I will: • consider the completeness of the lease portfolios identified by the Health Board, as needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in	The results of my prescribed audit testing were satisfactory. There was one audit correction to reclassify an amount of £2.388 million.

[5] International Financial Reporting Standard 16.

Audit risk	Proposed audit response	Work done and outcome
There are also significant additional disclosure requirements specific to leased assets that need to be reflected in the financial statements.	accordance with the new requirements; and • ensure that all material disclosures have been made. As part of my audit planning I have liaised with officers and provided them with the main audit questions to be raised.	

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Cardiff and Vale University Health Board

Audit year: 2023

Date issued: January 2024

Document reference: 3706A2023

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Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector, which is complementary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over the short, medium, and long term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pension taxation issues;
- shifts in attitudes towards full and part-time working;
- developing home grown talent and the ability to attract talent from outside the country into Wales; and
- service transformation which can change roles and result in increasing specialisation of roles.

4 Cardiff and Vale University Health Board's (the Health Board) People and Culture Plan (the People Plan) was approved by the Board in January 2022. The People Plan is supported by an implementation plan which focuses on the first year of delivery.

5 The key focus of our review has been on whether the Health Board's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Health Board's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management arrangements, such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing, fall outside the scope of this review.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7 Overall, we found that **the Health Board is taking appropriate action to address its significant workforce challenges. However, it needs to ensure that it has sufficient workforce planning resources so support delivery of the Health Board's people plan and better understand the impact of the actions it is taking**.

Key workforce planning challenges

8 The Health Board is facing significant workforce challenges across a range of services and professions, causing greater workload pressures on existing members of staff. The workforce indicators presented in **Appendix 2** highlight that despite the Health Board steadily increasing its workforce numbers over the past decade, it still faces serious workforce challenges with recruitment and retention, which threaten the stability of services. This has caused a sharp rise in the use of agency staff, which cost the Health Board over £28 million in 2022-23, further exacerbating an already pressurised financial situation. The Health Board's staff turnover (11.5%) and sickness rates (7%) are amongst the highest in Wales and present significant challenges. In 2022-23, the Health Board's workforce spending was £879 million, which is a 30% increase in the four years since 2018-19. Financial pressures facing the Health Board could pose a risk to the sustainability of the workforce in the short and longer term, although effective workforce planning would support more efficient and effective use of the Health Board's existing resource.

Strategic approach to workforce planning

9 **The Health Board is clear about its workforce challenges and is taking steps to improve its strategic approach. However, there are opportunities to improve workforce planning analysis and ensure a greater focus on addressing future risks**.

10 The Health Board's People Plan is clearly focused on addressing workforce challenges in the short and medium term, but more attention is needed on addressing long-term risks. Although the Health Board is at the initial stages of understanding its current service capacity, it needs to strengthen how it predicts service demand to allow it to model and plan for the future. The Health Board is working effectively with internal and external stakeholders to find shared solutions to current and future workforce challenges.

Operational action to manage workforce challenges

11 **The Health Board is proactively managing its workforce challenges, although it needs to sustain its arrangements to address medium-term and future risks. Additional resources may also be required to effectively support the proposed work**.

12 The Health Board has clear intent to improve workforce planning capability but should ensure it has the resources to support delivery of its People Plan. It has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date. The Health Board is also appropriately focussing on its current workforce challenges at an operational level through a range of recruitment, retention, and development activities. However, significant challenges remain, and education commissioning is not yet supporting a sustainable workforce, leaving gaps in some key areas.

Monitoring and oversight of workforce plan/strategy delivery

13 **There is effective oversight of operational workforce performance. However, the Health Board needs to better understand whether its People Plan is making a difference**.

14 The newly established People and Culture Committee is starting to receive timely and comprehensive workforce performance reports, but the Health Board needs to strengthen the focus on the impact of People Plan actions.

Recommendations

15 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Reviewing the People Plan's priorities R1 We found the Health Board recently refreshed its long-term strategy 'Shaping Our Future Well-being'. When the Health Board reviews its People Plan's priorities, it should ensure it supports the delivery of the Health Board's refreshed long-term strategy 'Shaping Our Future Well-being' (**medium priority**).
Shared learning R2 To help ensure consistency of workforce information, the Health Board should share the baseline document developed by the Children and Women Clinical Board with other clinical professions to ensure they adopt a consistent approach (**high priority**).
Evaluate the new structure R3 Whilst the People and Culture Team has been restructured to align with the People Strategy, we found insufficient resources for strategic workforce planning. Specifically, there is no dedicated workforce planning manager and workforce planning is only a proportion of the Heads of People and Culture's role. Once the new structure has been operational for a year, the Health Board should evaluate the new structure to assess if Clinical Boards have enough strategic workforce planning support. Findings of the evaluation and any improvement actions should be reported to the People and Culture Committee (**medium priority**).

Recommendations

Restarting workforce planning training

R4 We found that the Health Board was strengthening workforce planning capability through delivery of training workshops, but due to limited capacity this training has now stopped. The Health Board should restart its workforce planning training in order to enable services to plan sustainable workforce models **(high priority)**.

Managing risk

R5 The scale of the Health Board's workforce challenges means that the actions it is taking are having limited effect on reducing workforce risks. The Clinical Board's high-level clinical plans and workforce baseline plans have the potential to highlight new workforce risks. The Health Board should review the information in its corporate and strategic risk registers, using fresh insight from the high-level clinical plans and workforce baseline plans, to identify potential additional sources of assurance and new risks **(high priority)**.

Performance monitoring

R6 We found that currently it is difficult to gauge the progress and impact of the Health Board's People Plan delivery. The Health Board needs to strengthen its focus on the impact that delivery of the People Plan is achieving, and should update the People and Culture Committee twice a year on its progress and impact **(high priority)**.

Detailed report

Our findings

16 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- the health body's approach to strategic workforce planning (**Exhibit 2**);
- operational action to manage workforce challenges (**Exhibit 3**); and
- monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: the Health Board's approach to strategic workforce planning

This section focusses on the Health Board's approach to strategic planning. Overall, we found that **the Health Board is clear about its workforce challenges and is taking steps to improve its strategic approach. However, there are opportunities to improve workforce planning analysis and ensure a greater focus on addressing future risks**.

What we looked at	What we found
We considered whether the Health Board's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • identifies current and future workforce challenges; • has a clear vision and objectives; • is aligned to the organisation's strategic objectives and wider organisational plans; • is aligned to relevant national plans, policies, and legislation, including the	We found that **the Health Board's People Plan is clearly focused on addressing workforce challenges in the short and medium term, but more attention is needed to identify and target specific areas requiring improvements**. The Health Board's 2022-25 People Plan sets a clear and logical focus for improving the wellbeing, inclusion, capability, and engagement of its workforce. Its high-level objectives focus on: • building seamless workforce models; • having an engaged, motivated, and healthy workforce; • attracting, recruiting, and retaining its staff; • having a digitally ready workforce; • providing education and learning opportunities; • leadership and succession; and

national workforce strategy for health and social care; and • is supported by a clear implementation plan.	• having a sufficient and sustainable workforce. The Health Board is starting to improve how it identifies its specific workforce challenges using its workforce baseline plans as a starting point, although the current evidence-based is limited. The challenges it describes in the People Plan are not a comprehensive assessment nor specific enough to help the organisation target its improvement activity. The People Plan appropriately supports the ambitions set out in the National Workforce Strategy for Health and Social Care[1], using the same seven national themes set in the context of Cardiff and Vale University Health Board. The People Plan also aligns to relevant national legislation, such as the Well-being of Future Generations (Wales) Act 2015, Nurse Staffing Levels (Wales) Act 2016, and the Welsh Language Standards[2]. The People Plan supports the delivery of the Health Board's long-term strategy, and Annual Plan[3] through the Shaping our Future Workforce enabling programme. The Health Board recently refreshed its long-term strategy 'Shaping Our Future Well-being', gaining Board approval in July 2023. As part of the Health Board's annual work of reviewing the People Plan priorities, the Health Board should take the opportunity to ensure it aligns to the refreshed long-term strategy 'Shaping Our Future Well-being' (**Recommendation 1**). The People Plan is supported by a separate annual implementation plan detailing how the Health Board plans to implement its workforce ambition. The implementation plan aligns to the Health Board's wider 2023-24 Annual Plan and includes measures of success and quarterly Key Performance Indicators.
We considered whether the Health Board has a good understanding of current and future service demands. We expected to see:	We found that **the Health Board is at the initial stages of understanding its current service capacity. However, it needs to strengthen how it models and plans its workforce to ensure it is sustainable**.

[1] 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' is a ten-year strategy launched in October 2020 by HEIW and Social Care Wales.

[2] Welsh Language (Wales) Measure 2011.

[3] The Health Board does not currently have an approved Integrated Medium Term Plan (IMTP), instead the Health Board works to and Annual Plan set within a three-year context.

• use of reliable workforce information to determine workforce need and risk in the short and longer term; and • action to improve workforce data quality and address any information gaps.	The Health Board did not include workforce analysis and service modelling in its development of the People Plan. However, it is now starting to understand its workforce gaps and what this will look like in future if, for example, it takes no action. Each Clinical Board[4] is developing high-level clinical plans accompanied by workforce baseline plans to feed into the IMTP planning cycle. At the time of our fieldwork, the Health Board had already produced a baseline for the nursing workforce of the Children and Women Clinical Board. This provides good analysis on current nursing workforce levels and demand, workforce availability, workforce growth, performance and areas of concern, and sets out improvement action. We understand that nursing workforce baselines have now also been developed by all other Clinical Boards. The Health Board should share this baseline as a template with other clinical professions with the aim of ensuring consistent collection, analysis and presentation of workforce information across the organisation (**Recommendation 2**). The Health Board also needs a clearer understanding of its future service models for acute and community services. Without this, it will not be able to effectively develop its workforce and associated new roles or forecast capacity and demand to ensure workforce sustainability in the medium to long term. The Health Board has reasonable operational data, such as sickness levels, vacancy, and appraisal rates which it sources from the Electronic Staff Record system (ESR). This supports workforce planning and analysis. The implementation of EsrGo[5] will help to ensure that managers only need to update staff changes once. It will also help to ensure that budgeted workforce establishments[6] and daily staffing levels are correct. The Health Board has agreed nurse establishments and these are updated in ESR to ensure that the workforce data is accurate. The Health Board is taking steps to improve service-level access to workforce data using management dashboards. These will start initially with metrics on appraisal and statutory and mandatory training, sickness and maternity absence rates, and turnover and vacancy rates.

[4] The Health Board is structured and designed into eight Clinical Boards: Children and Women; Clinical Diagnostics and Therapeutics; Dental; Medicine; Mental Health; Specialist Services; Surgery; Primary, Community and Intermediate Care – which cover the four main service areas Our Health Board Structure – Cardiff and Vale University Health Board.

[5] EsrGo is an automated interface between the Electronic Staff Records payroll system and Allocate Software's HealthRoster rostering system.

[6] Establishment is the term for the workforce levels, staff roles and the NHS Agenda for Change banding, which is financially budgeted for.

We considered whether the Health Board is working with partners to help resolve current and anticipated future workforce challenges. We expected to see:

- effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues; and
- shared solutions identified with key stakeholders to help address workforce challenges.

We found that **the Health Board is working proactively with internal and external stakeholders to find shared solutions to current and future workforce challenges**.

The Health Board is effectively engaging with internal and external stakeholders to develop its strategic workforce approach. The development of the People Plan was informed by good engagement with staff, the Board and external stakeholders using development days and workshops, and by circulating the draft Strategy for comment. Each of the People Plan's themes has a named People and Culture Team lead and Trade Union representative. Now that the Heads of People and Culture[7] have been reintroduced into Clinical Boards, it will help strengthen relationships and help to better understand services' current and future needs.

The Health Board also recognises the importance of regional working to support the development of sustainable services. It actively engages its local authority partners[8] to find shared workforce solutions, through the Regional Partnership Board[9] (RPB). They are collectively working on an integrated workforce model for health and social care to set out their joint working approach over the next ten years, with regular workshops held between the RPB partners to progress the work.

There are also several regional transformation projects at various stages, which have workforce implications and will need regional workforce modelling and plans. These include Orthopaedics, Regional Cataracts expansion and improvements to the Community Diagnostic Centres and Endoscopy programmes. The Health Board routinely engages with Health Education Improvement Wales (HEIW) on local and regional workforce issues. For example, HEIW was involved in developing the South East Wales Vascular Network.

[7] Based on a Human Resources Business Partnering model.

[8] Two local authorities cover the Health Board area: these are Cardiff and the Vale of Glamorgan county councils.

[9] The Cardiff and Vale Regional Partnership Board was established by the Social Services and Well-being (Wales) Act 2014 to ensure local health boards, local authorities and the third sector work together to deliver services, care and support that meet the needs of people who live in Cardiff and the Vale.

Exhibit 3: operational action to manage workforce challenges

This section focusses on the actions the Health Board is taking to manage workforce challenges. Overall, we found that **the Health Board is proactively managing its workforce challenges, although it needs to sustain its arrangements to address medium-term and future risks. Additional resources may also be required to effectively support the proposed work**.

What we looked at	What we found
We considered whether the Health Board has identified sufficient resources to support workforce planning over the short, medium, and long term. We expected to see: • clear roles and responsibilities for workforce planning; • appropriately skilled staff to ensure robust workforce planning; • sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan; and • sufficient financial resources to deliver the workforce strategy or plan.	We found that **the Health Board has clear intent to improve workforce planning capability but should ensure it has the resources to support delivery of its People Plan**. In the last year, the Health Board has restructured its People and Culture Team to align with the People Strategy. The new team structure has been fully operational since April 2023 and has continued to embed over the last six months. The People and Culture directorate, led by the Executive Director of People and Culture, includes a Deputy Director, two Assistant Directors with ten teams sitting within the directorate[10]. The Health Board's four Heads of People and Culture are each assigned to two Clinical Boards as business partners. The recent reorganisation resulted in the establishment of two additional teams to deal with day-to-day HR matters[11]. Despite these changes, the Health Board has not sufficiently invested in strategic workforce planning resources and does not have a dedicated workforce planning manager. Workforce planning is only a proportion of the Heads of People and Culture's role. Although the new structure seems logical, it is too early to judge whether it is appropriately supporting effective workforce planning. The Health Board should review its model to assess if Clinical Boards have enough strategic workforce planning support (**Recommendation 3**).

[10] The Directorate teams include: Education, Culture and Organisational Development; E-Rostering Project Team; Medical Resourcing Team; People Assurance and Experience; People Resourcing; Equity and Inclusion; Health and Safety; People Analytics; People Health and Wellbeing Services; and People Services.

[11] The two new teams include a specialist team responsible for employee relations and a generalist team responsible for change management, managing attendance, job descriptions, recruitment queries, redeployment, and fixed-term contracts guidance.

What we looked at	What we found
	We met with Service Leads as part of this audit. They indicated they understood their role in workforce planning. However, we found capacity constraints are affecting operational workforce plan development. The Health Board is strengthening workforce planning capability by providing training for managers based on HEIW's six-step model[12]. We met service leads who have attended the training. While they thought it was helpful, they felt they did not have sufficient time to 'think strategically', put their learning into action and develop workforce plans and solutions. We understand from the Health Board that training has been postponed due to limited capacity to deliver. The Health Board should restart its workforce planning training in order enable services to plan sustainable workforce models. (**Recommendation 4**). The Health Board's workforce plan is costed as part of its annual IMTP, but beyond this, the Health Board has not identified the longer-term costs, skills or other resources associated with delivering its People Plan. **Exhibits 6** and **7** show historical growth in staffing levels and costs, which may not be sustainable in the long term. The Health Board is working in a very challenging financial environment. This means services will need to think differently to tackle workforce challenges and exercise tighter control on workforce spending. In 2023-24, the Health Board is aiming to create efficiencies by reducing agency staff use by around £6 million compared to 2022-23.

[12] Health Education and Improvement Wales has developed a workforce planning toolkit based on the following six steps: 1, Define your plan, 2. Map the service change, 3. Define the workforce, 4. Workforce supply, 5. Define actions required, 6 Implement and monitor.

What we looked at	What we found
We considered whether the Health Board has a good understanding of the short and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • a good understanding of the barriers that might prevent delivery of the workforce strategy or plan; • plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions; and • clearly documented workforce risks that are managed at the appropriate level.	We found that **the Health Board has a good understanding of the risks that might prevent the delivery of its workforce ambitions, but actions to mitigate these risks have had minimal effect to date**. The Health Board has clearly articulated its workforce ambitions, but there are a range of risks which may prevent its delivery. These relate to workforce shortages, financial pressures, and a lack of clarity about future clinical models, primary care, care closer to home, and more services delivered in the community. The Health Board identifies risks to the delivery of the People Plan in its monthly flash progress reports using a RAG rating[13]. These flash reports also include major workforce programme risks and mitigating actions, which prompt any necessary decision or intervention from relevant Executives. Workforce shortages are limiting the Health Board's ability to meet the requirements of the Nurse Staffing Levels Act (Wales)[14]. Despite taking mitigating actions at corporate and operational levels, during 2022-23, the Health Board struggled in many areas to ensure it appropriately complied with the Act[15]. Corporately, the Health Board appropriately reflects high-level, short and longer-term workforce risks, which it manages through the Board Assurance Framework (BAF) and corporate risk framework. The newly established People and Culture Committee[16] is responsible for overseeing these risks, routinely scrutinising mitigating actions. As of September 2023, there were seven high-scoring corporate risks related to workforce, specifically staffing levels and vacancies. Operationally, Clinical Boards routinely review risk registers at bi-monthly Clinical Board meetings. Workforce risks are discussed at executive level clinical board performance reviews to understand workforce issues, priorities and identify contingency plans. The Health Board has also reintroduced its Nursing Productivity Group. However, the scale of the workforce challenges mean that mitigating actions are having a minimal effect on reducing workforce risks, as shown by the Health Board's inability to meet the targets risk scores set on their corporate risk register. As Clinical Boards, high-level clinical plans and workforce baseline plans have the potential to highlight new workforce risks. The Health Board should review the information in its corporate and strategic risk registers using fresh insight from the high-level clinical plans and workforce baseline plans to identify potential additional sources of assurance and new risks (**Recommendation 5**).

What we looked at	What we found
We considered whether the Health Board is effectively addressing its current workforce challenges. We expected to see: • effective reporting and management of staff vacancies; • action to improve staff retention; • efficient recruitment practices; • commissioning of health education and training which is based on true workforce need; and • evidence that the organisation is modernising its workforce to help meet current and future needs.	We found that **overall, the Health Board is taking appropriate steps to address current workforce challenges at an operational level through a range of recruitment, retention, and development activities. However, significant challenges remain, and education commissioning is not yet supporting a sustainable workforce**. The Health Board is actively managing vacancy rates and agency spending using bank staff. Between 2018 and 2023, it has undertaken a rolling programme of international recruitment for nurses. In total, it has supported 445 international nurses through professional registration resulting in their employment in the Health Board. However, due the cost involved, the Health Board paused this programme at the beginning of 2023. Instead, it has progressed other approaches, such as increasing the number of registered nurses and healthcare support workers registered with its bank and increasing the focus on domestic recruitment. The Health Board is also experiencing challenges with staff retention **(Exhibit 9)**. To determine the causes, it is taking steps to improve exit survey response rates. The Health Board is seeking to address its staff retention issues through its wellbeing support, and it is considering other practical solutions to further help address the loss of staff. These include flexible working, reviews of rostering, supporting staff rotation and the establishment of the Nursing Hub[17]. These actions are

[13] Red, Amber, and Green.

[14] Nurse Staffing Levels (Wales) Act 2016 was passed in March 2016. The Act places a duty on health bodies to have regard to providing appropriate nurse staffing levels. This is to ensure their nurses have the time to provide the best possible care for patients. Currently the Act only applies to adult acute medical and surgical, and paediatric inpatient wards.

[15] In May 2023, the Board received the 2022-23 Nurse Staffing Levels Annual Assurance Report, covering the period between April 2022 and April 2023.

[16] The People and Culture Committee met for the first time in May 2023, prior to its establishment workforce matters were scrutinised by the Strategy and Delivery Committee.

[17] The Hub is responsible for Nurse Resourcing, Nurse Retention, Nurse workforce planning and the Band 4 Assistant Practitioners programme.

What we looked at	What we found
	demonstrating some positive impact on the workforce metrics[18]. The Health Board has also introduced a starter survey for students to capture intelligence about their experiences and to try to rectify issues early on. To help address low survey response rates, the Health Board is giving students earlier notice and following the text up with an e-mail. The Health Board also has a relatively high sickness rate **(Exhibit 11)** and like many other health bodies, it is not meeting the national target. A task and finish group was established in September 2022 to take forward an agreed action plan to support staff with their financial wellbeing. Working with both internal and external colleagues, the Health Board has delivered a series of staff support interventions such as financial wellbeing roadshows, dedicated webpages to provide information to colleagues, the provision of online training for Wellbeing Champions and line managers, and the development of a staff 'Financial Wellbeing' framework. The Health Board is introducing new staff career progression opportunities including enhancing existing 'grow your own' and apprenticeship schemes through the Apprenticeship Academy. The academy has a dual role in upskilling existing staff and creating new employment opportunities. These include administrative, building service engineer, IT and Healthcare Science professions. The Health Board is also assisting healthcare support workers' re-registration as part of their nursing programme training. The first cohort of Assistant Practitioners in Peri-Operative Care have completed their Level 4 qualification and moved into Band 4 Assistant Practitioner roles. Given the Health Board's substantial vacancies, it also needs to have effective recruitment practices. The Health Board is taking steps to streamline and centralise recruitment to address inefficiencies in its internal recruitment process. This includes managing nursing vacancies centrally through the Nursing Hub and fast-tracking appointment to urgent posts. There are weaknesses in the education commissioning process that mean that the pipeline of newly qualified staff does not meet demand. For 2022-23, the Health Board completed the education and training commissioning process alongside a review of its nursing workforce baseline to ensure

[18] Turnover - May 2023 12.51%, fallen from 13.66% in November 2022 – net decrease of 0.72% equating to 99 (whole time equivalent) fewer leavers.

What we looked at	What we found
	commissioning numbers accurately reflect service needs. However, the Health Board reported it appoints significantly less staff than it trains through the commissioning process. The Health Board recognises the need to use the workforce differently and is starting to seek alternative solutions to ensure a sustainable workforce, for example, it has established its Assistant Practitioner role. The Health Board has ambitions to develop academic fellows, physician associates, anaesthetic associates, dietetic assistants, and acute care physicians.

Exhibit 4: monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that t**here is effective oversight of operational workforce performance. However, the Health Board needs to better understand whether its People Plan is making a difference**.

What we looked at	What we found
We considered whether delivery of the Health Board's workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels; • effective action where progress on elements of the workforce strategy or plan are off-track; • performance reports showing the impact of delivering the workforce strategy or plan; and • the organisation benchmarking its workforce performance with similar organisations.	We found that **the Health Board has reasonable mechanisms to monitor workforce strategy delivery, but it needs to strengthen its focus on the impact of the actions it takes. The Health Board is taking steps to strengthen its approach to benchmarking**. The newly established People and Culture Committee, which met for the first time in May 2023, is responsible for scrutinising workforce performance and delivery against the People Plan. This responsibility previously fell to the Strategy and Delivery Committee, which was stood down in March 2023. The dedicated People and Culture Committee is providing greater focus on workforce performance and challenges, which is one of the Health Board's biggest risks. While the People and Culture Committee oversees delivery of its people plan and operational key performance indicator trends, there needs to be a stronger and more integrated approach to reporting on the impact of the Health Board's actions and the difference the People Plan is making, bringing together key actions, relevant performance measures and an evaluation of impact (**Recommendation 6**). The Health Board has a range of sensible approaches to monitor workforce performance. These approaches include the Health Board's Senior Management Team receiving monthly in-depth progress updates for each of the People Plan's seven themes. Alongside the reports, the Health Board shares dashboards allowing them to scrutinise performance such as sickness, vacancies, and data on recruitment. The Strategic Programme Portfolio Steering Group receives high-level progress reports through flash reports. Positively, the Health Board has recently started benchmarking its workforce performance with other health bodies in Wales and beyond. The Health Board has collected key workforce metrics (where available) from published Board papers from a selection of Trusts in England. It intends to continue to build relationships with these Trusts with an aim of sharing and obtaining up-to-date data.

Appendix 1

Audit methods

Exhibit 5: audit methods

This exhibit sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

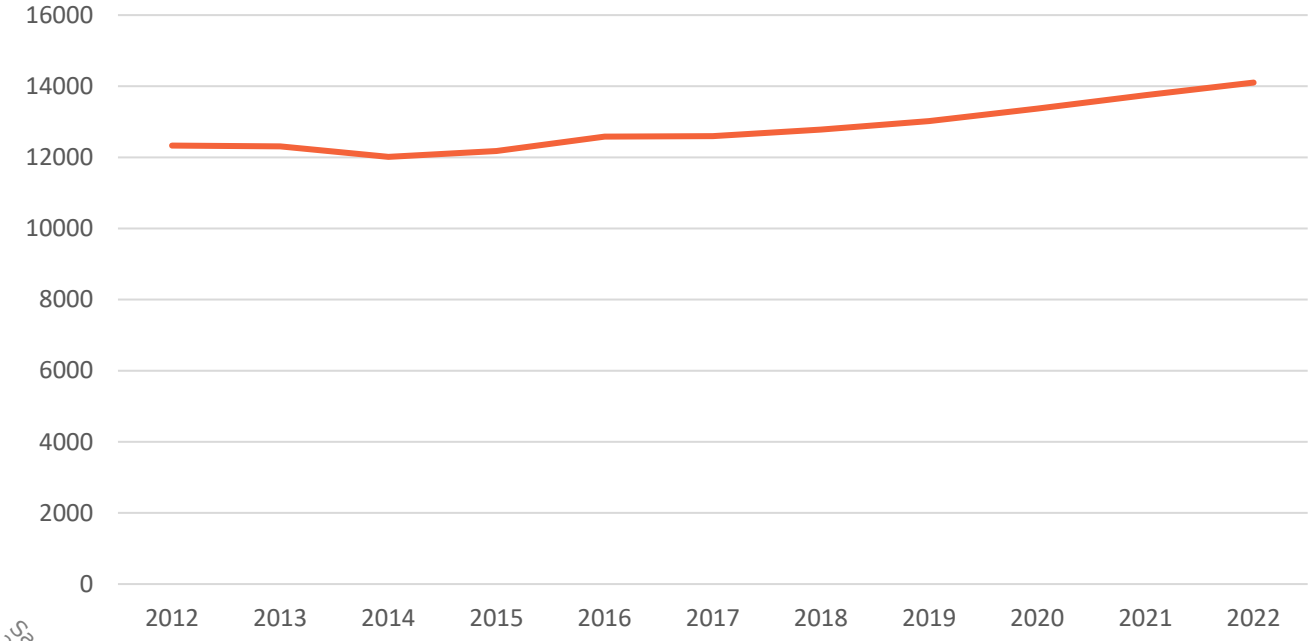
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s) • Implementation/delivery plans for workforce strategy • Integrated Medium Term Plan • Evidence of evaluation of workforce strategy and/or associated initiatives • Structure charts for workforce planning functions • Examples of workforce planning training offered to staff, eg CIPD, other training (formal or informal) • Workforce finance and resource plans • Corporate and operational risk registers • Document showing recruitment process, and recruitment and retention initiatives • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following: • Interim Director of Primary, Community and Urgent Care • Executive Nurse Director • Director of Nursing Strategic Nursing and Midwifery Workforce • Nurse Resourcing Programme Manager • Senior Nurse for Nurse Education

Element of audit approach	Description
	• Deputy Director of Finance • Executive Director of People and Culture • Deputy Director of People and Culture • Assistant Director of Wellbeing, Culture and Organisational Development • Independent Member • Assistant Director of People Resourcing • Head of People Analytics • Head of People and Culture x3
Focus groups	We ran a focus group with a selection of service leads involved in clinical workforce planning and a selection of service leads involved in the workforce planning of enabler services.

Appendix 2

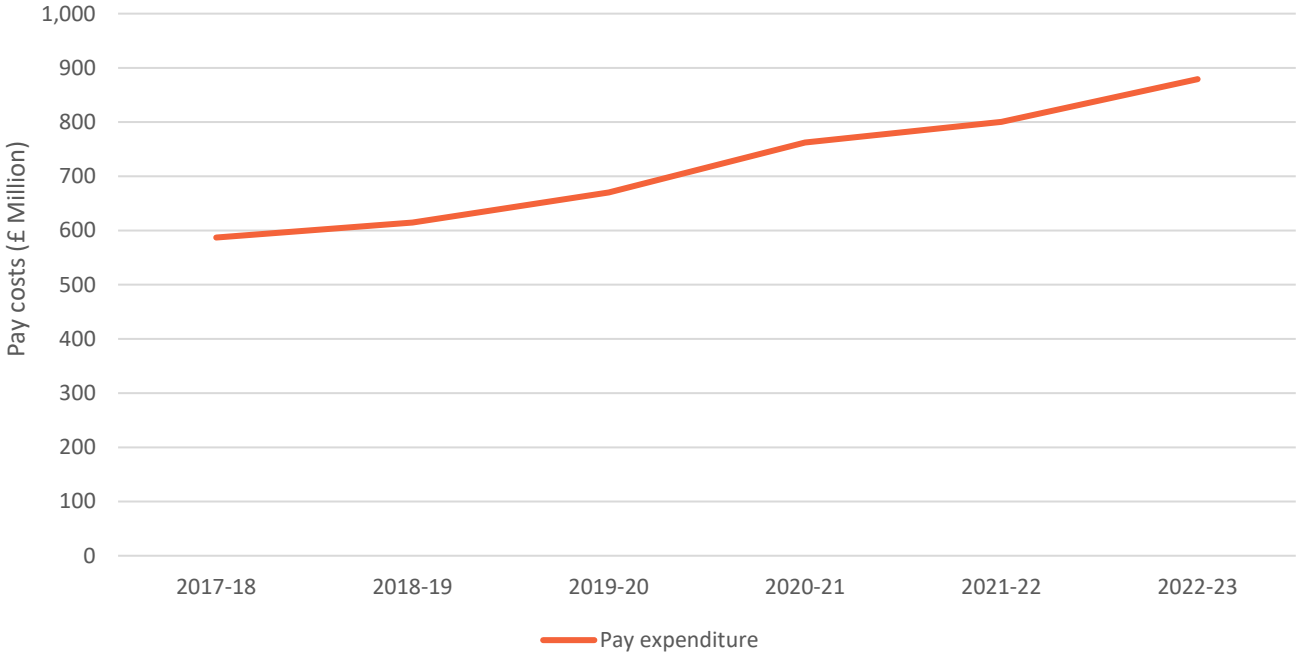
Selected workforce indicators

Exhibit 6: trend in workforce numbers (full-time equivalent), Cardiff and Vale University Health Board



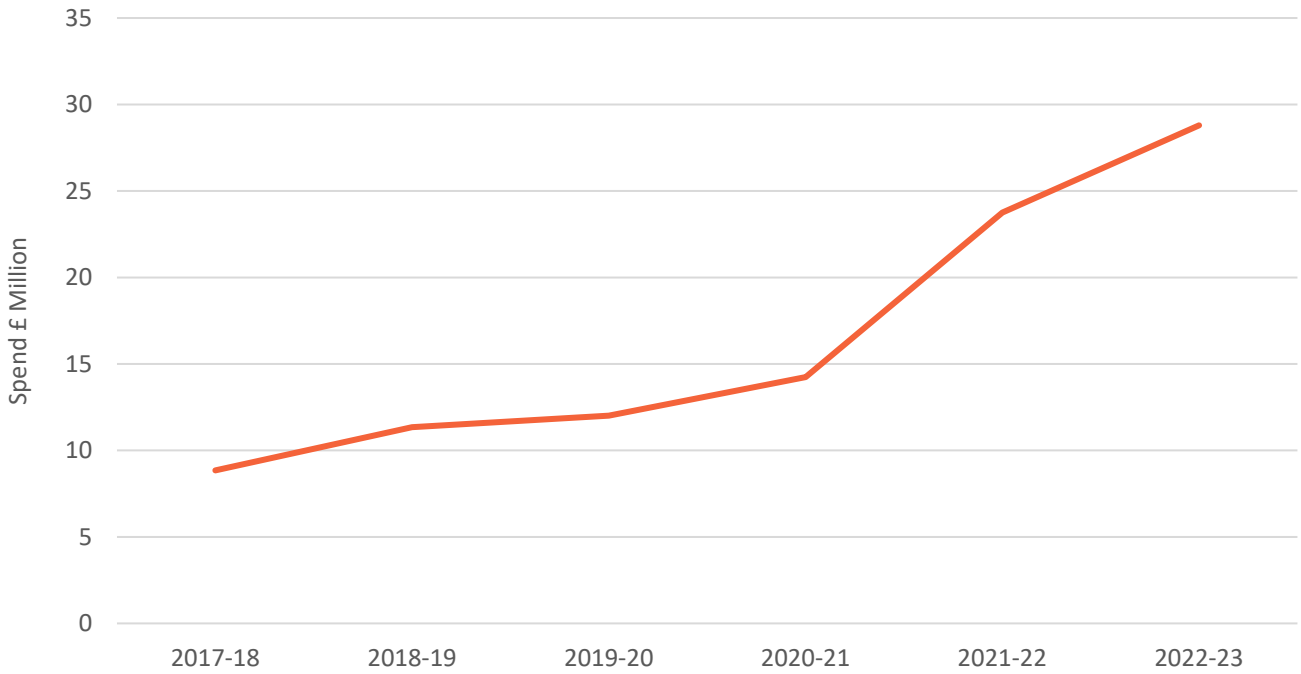
Source: Welsh Government, Stats Wales

Exhibit 7: trend in actual workforce costs, Cardiff and Vale University Health Board



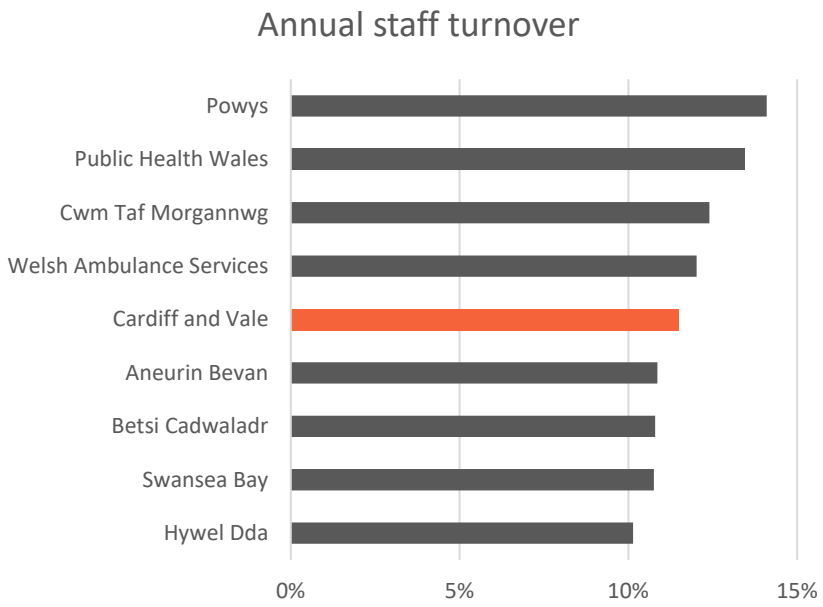
Source: Monthly Monitoring Returns reported to the Welsh Government

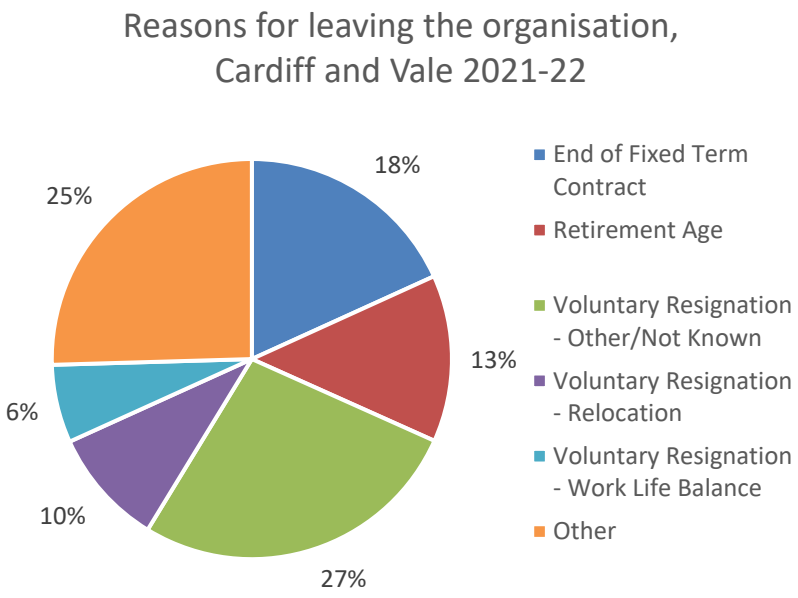
Exhibit 8: trend of expenditure on workforce agency £ million, Cardiff and Vale University Health Board



Source: Monthly Monitoring Returns reported to the Welsh Government

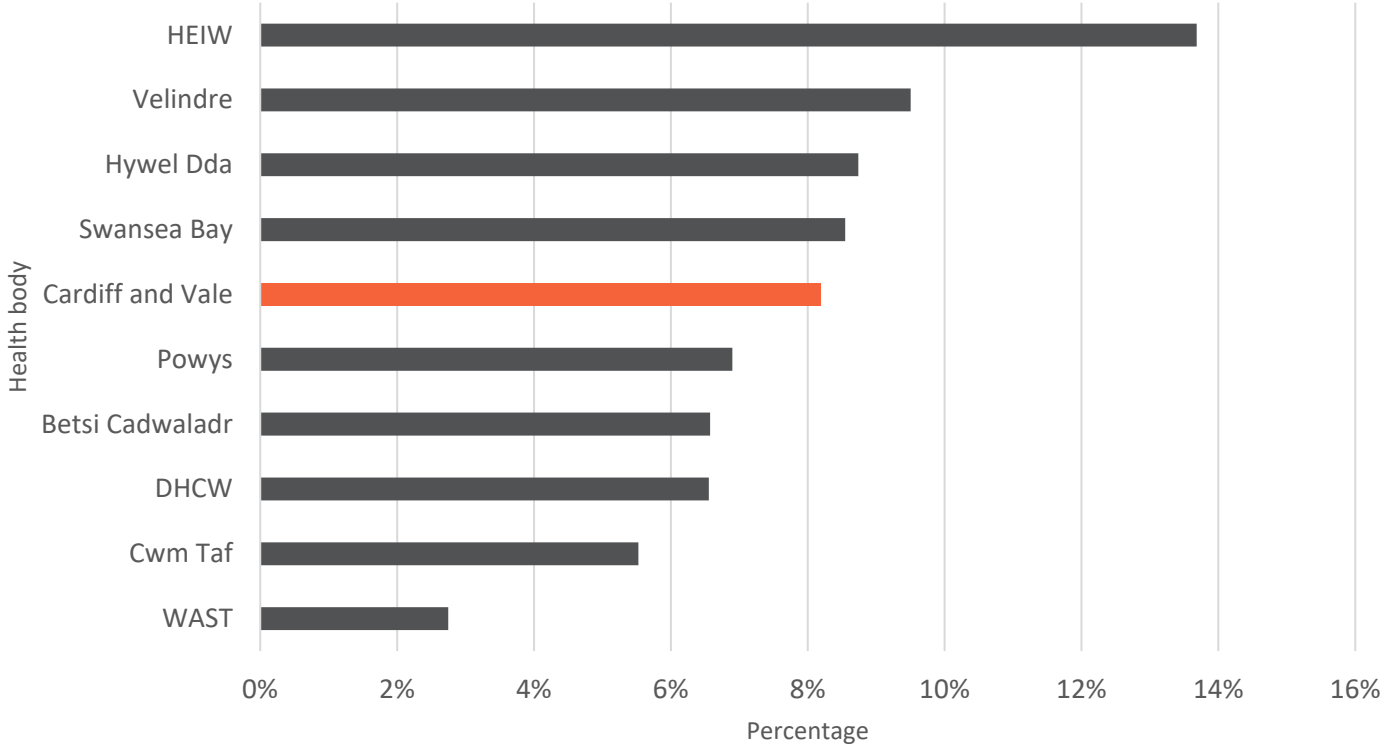
Exhibit 9: annual staff turnover and reason for leaving, 2021-22, Cardiff and Vale University Health Board





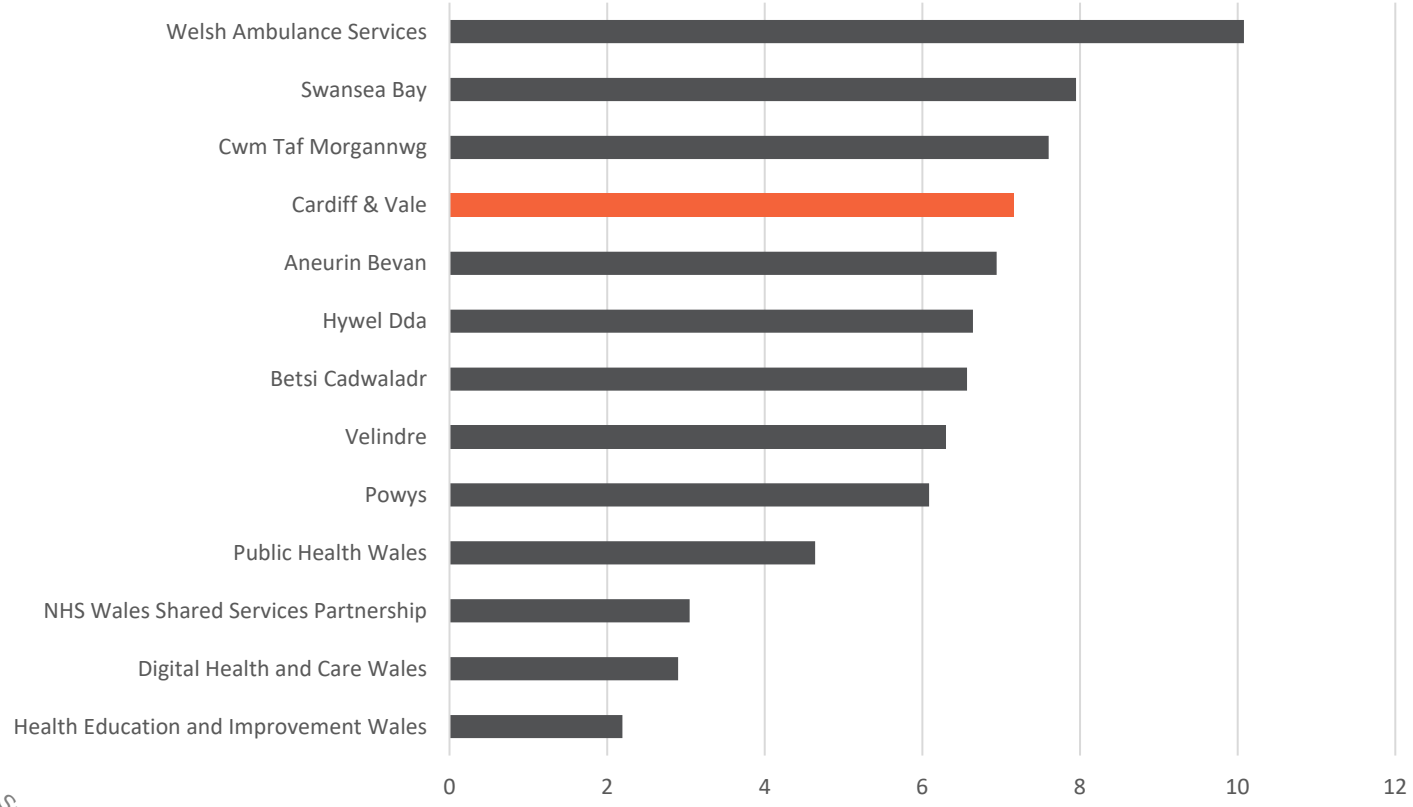
Source: staff turnover data sourced from Health Education and Improvement Wales. Reason for leaving data sourced from health body data request

Exhibit 10: vacancies as a percentage of total establishment, March 2022



Source: health body data request

Exhibit 11: sickness absence by organisation, 2022



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 12: Cardiff and Vale University Health Board's response to our audit recommendations

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Reviewing the People Plan's priorities** We found the Health Board recently refreshed its long-term strategy 'Shaping Our Future Well-being'. When the Health Board reviews its People Plan's priorities, it should ensure it supports the delivery of the Health Board's refreshed long-term strategy 'Shaping Our Future Well-being' (**medium priority**).	The UHB are in the process of reviewing the People and Culture Plan priorities as part of the 2024-25 Annual Plan/IMTP. Priorities and deliverables will be linked to the SOFW objective: Putting People First and the following objectives: • People will feel valued, developed, supported and engaged • We will have an inclusive culture, where the diversity of the Health Board's people will be representative of the Health Board's local populations	31 January 2024	Deputy Director of People and Culture

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	**Reviewing the People Plan's priorities** We found the Health Board recently refreshed its long-term strategy 'Shaping Our Future Well-being'. When the Health Board review its People Plan's priorities, it should ensure it supports the delivery of the Health Board's refreshed long-term strategy 'Shaping Our Future Well-being' (**medium priority**).	The seven themes within the plan have been merged into three for 2024-25 with priority objectives and deliverables aligned. The refresh of the People and Culture Plan will commence in the Autumn of 2024 and will be aligned to SOFW and the Workforce Strategy for Health and Social Care.	January 2025	Executive Director of People and Culture
R2	**Shared learning** To help ensure consistency of workforce information, the Health Board should share the baseline document developed by the Children and Women Clinical Board with other clinical professions to ensure they adopt a consistent approach (**high priority**).	The HoPC are currently working with CBs to obtain an accurate baseline for all staff groups and to translate operational delivery plans into an operational/tactical workforce plan for the next 24 months. This work is being undertaken as part of the Annual Plan/IMTP 2024-25 submission.	31 January 2024	Heads of People and Culture

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R3	**Evaluate the new structure** Whilst the People and Culture Team has been restructured to align with the People Strategy, we found insufficient resources for strategic workforce planning. Specifically, there is no dedicated workforce planning manager, and workforce planning is only a proportion of the Heads of People and Culture's role. Once the new structure has been operational for a year, the Health Board should evaluate the new structure to assess if Clinical Boards have enough strategic workforce planning support. Findings of the evaluation and any improvement actions should be reported to the People and Culture Committee (**medium priority**).	The structure would have been fully operational for 1 year in April 2024 and will be evaluated at that point. Even without the evaluation, it is evident that we do not have enough dedicated expertise to support the UHB with longer-term/strategic workforce planning. Unfortunately, we were unable to recruit to a newly created role of Head of Strategic Workforce Planning, due to current financial constraints. The outcome of the audit will form part of a wider paper for P&C Committee, highlighting the challenges and the risks.	June 2024 July 2024	Deputy Director of Resourcing Heads of People and Culture

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R4	**Restarting workforce planning training** We found that the Health Board was strengthening workforce planning capability through delivery of training workshops, but due to limited capacity this training has now stopped. The Health Board should restart its workforce planning training to enable services to plan sustainable workforce models (**high priority**).	Unfortunately, we do not have the capability or capacity to restart the training, but instead will be utilising the pre-recorded workforce planning training that HEIW will be launching in February 2024. The HEIW training will be supplemented by ongoing advice and support via the HoPC.	March 2024	Deputy Director of People and Culture

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	**Managing risk** The scale of the Health Board's workforce challenges means that the actions it is taking are having limited effect on reducing workforce risks. The Clinical Board's high-level clinical plans and workforce baseline plans have the potential to highlight new workforce risks. The Health Board should review the information in its corporate and strategic risk registers, using fresh insight from the high-level clinical plans and workforce baseline plans, to identify potential additional sources of assurance and new risks (**high priority**).	Clinical Board plans will be reviewed as part of the Annual Planning cycle and any new workforce risks will be escalated to Board via the BAF and Risk Registers. Appropriate plans will then be developed to mitigate the risks.	April 2024	Deputy Director of People and Culture

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R6	**Performance monitoring** We found that currently it is difficult to gauge the progress and impact of the Health Board's People Plan delivery. The Health Board needs to strengthen its focus on the impact that delivery of the People Plan is achieving and should update the People and Culture Committee twice a year on its progress and impact (**high priority**).	An end of year report is currently being compiled for the January People and Culture Committee which will include highlights, achievements and key deliverables, with an emphasis on the difference they have made. As part of the IMTP/Annual Plan for 2024-25, the proposed priorities, objectives and quarterly deliverables will be discussed and approved by People and Culture Committee and Board. Performance against the plan will be reported to P&C Committee and WG on a quarterly basis. An interim report showing progress for the first six months of 2024-25 will be shared with P&C Committee.	31 December 2023 31 March 2024 August 2024	Head of People Assurance and Experience Head of People Assurance and Experience Head of People Assurance and Experience

Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Report Title:	Counter Fraud Progress Report				Agenda Item no.	4.2	
Meeting:	Audit Committee		Public	x	Meeting Date:	06/02/2024	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Catherine Phillips						
Report Author (Title):	Gareth Lavington						

Main Report
Background and current situation:

The Counter Fraud Progress report seeks to provide assurance to members of the Audit Committee that the Counter Fraud work being undertaken is satisfactory, robust and compliant with NHS Counter Fraud Authority requirements.

The report provides information around key areas of work including, fraud awareness and learning, fraud risk assessment, investigation and reactive work, and promotional activity.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Progress made against the Annual Counter Fraud Plan
Promotional /Educational Activity
Summary of Investigations
Prevention activity
National Fraud Initiative work

Recommendation:

The Board / Committee are requested to: note the report

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/~~No~~
Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.
Safety: ~~Yes~~/No
Financial: Yes/~~No~~
All fraud occurring in the organization has a financial loss to the organization.
Workforce: Yes/~~No~~
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes/No
Reputational: Yes/~~No~~
As at Risk
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
29/01/2024 17:21:57

NHS WALES

Counter Fraud Progress Report

24/10/2023 – 31/12/2023

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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NA 9

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of the Health Board.

This report relates to activity for the reporting period 24/10/2023-31/12/2023.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2023-2024, and the NHS CFA functional standards. The below activity has taken place -

i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.

ii. Continued maintenance of Counter Fraud digital platform – **Members of the Audit Committee are encouraged to visit the site at the link/QR code here**

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

Corporate Induction– Two market place corporate induction events attended with 12 presentations provided to new starters. Counter Fraud remains a standing item on the corporate induction agenda.

International Fraud Awareness Week – this event took place as usual in October. During the course of the week various support material was issued. Awareness and advice was provided via our digital platform on a daily basis which addressed the following areas:-

- Expenses and allowances
- Festive Fraud
- Salary Overpayments
- Working elsewhere
- Fraud under the magnifying glass

The 'Sway' packages that were produced can be seen at the Counter Fraud Share Point pages or by clicking the link here. International Fraud Awareness Week - 2023 (sharepoint.com)

Bespoke Awareness Sessions – one session delivered to the General Surgery Department, focussing on private work and job planning.

E- Learning – The new e-Learning package is now Live on the ESR system and available to staff. This is not mandatory learning at the organisation.

Since launch **??** members of staff at CAVUHB have completed the learning. During the same time period across NHS Wales as a whole, **????** members of staff have completed the learning. (Figures not available at time of reporting. Verbal update at meeting)

Prevention

Local Bulletins – No local bulletins have been issued during this period.

FPN / IBURN – (issued by NHSCFA)

1. 1 x FPN has been issued - relating to the generic subject of mandate fraud during the festive period. Support material and advice cascaded to finance teams.

Referrals

During this reporting period there have been a total of 28 referrals made to the team. (Of the 28 referrals received; 20 have been closed/informally resolved with no further action required; and 7 have been promoted to formal investigation (1 investigation has been referred to the CFS Wales Team to Investigate - this relates to a high value overpayment of salary); 1 referral remains open awaiting further information prior to disposal.)

Investigations

A total of 7 new formal Investigations have been commenced this period. A summary of the investigations for 23-24 are provided below. At the time of reporting 13 investigations remain open and are being investigated by the team. Summary of 23/24 investigations to date is provided below.

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/22/00730	False On Call Claims	CARRIED OVER - 24/06/2022	04/12/2023	Dismissed and recovery of 36 with cci
INV/22/01558	False Bereavement	CARRIED OVER - 25/10/2022	04/07/2023	Subject has been dismissed for Gross Misconduct following Disciplinary Hearing. Financial Recovery made of £520.61
INV/23/00079	Staff Over Payment	CARRIED OVER - 10/01/2023		
INV/23/00096	Overpayment of Salary - Non Starter	CARRIED OVER - 12/01/2023		
INV/23/00113	Suspected Overtime Fraud (EW)	CARRIED OVER - 13/01/2023		
INV/23/00263	Working elsewhere during HB Hours	CARRIED OVER - 06/02/2023	02/05/2023	No fraud identified, all avenues of investigation completed under available powers.
INV/23/00412	Patient letters to different address	CARRIED OVER - 28/02/2023	04/07/2023	Reported in good faith, no offences identified.
INV/23/00415	Working whilst sick / NFI match	CARRIED OVER - 27/02/2023	23/06/2023	Case transferred to National Investigations Team NHSCFA - outcome awaited

INV/23/00646	Theft of Cyclizine	03/04/2023	02/05/2023	Evidence of theft to the value of £11.33, passed evidential test however did not pass public interest test for criminal prosecution. Subject work with organisation terminated.
INV/23/00648	Overpayment Of Salary - Career Break	03/04/2023	01/06/2023	Non Fraud Recovery £10,847.74. Subject on career break out of the country, civil recovery only.
INV/23/00702	Overpayment / On-Call Banding error	06/04/2023	18/05/2023	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/23/00737	Salary Overpayment Following Termination	18/04/2023		
INV/23/00764	Salary Overpayment Following Termination	21/04/2023	04/07/2023	Non fraud recovery - £5,525.37. Subject no longer employed by organisation.
INV/23/00824	Salary Overpayment Following Termination	02/05/2023	04/07/2023	Non Fraud recovery - £2,967.57. Subject no longer employed by organisation.
INV/23/00825	Salary Overpayment for Sick Pay	02/05/2023		
INV/23/00826	Salary Overpayment Reduction in Hours	02/05/2023		
INV/23/00827	Salary Overpayment Following Termination	02/05/2023		
INV/23/00828	False Reference - Bank Worker	02/05/2023	18/05/2023	Subjects recruitment with the organisation was terminated. Intelligence shared with counter parts across Wales regarding Subject.
INV/23/00884	Overpayment of Salary - Career Break	10/05/2023	21/11/2023	Overpayment repayment commenced
INV/23/00896	Overpayment of Salary - Late termination	11/05/2023	04/07/2023	Non Fraud Recovery - £6,589.22. Subject no longer in employment
INV/23/00991	CV Issues	23/05/2023	30/05/2023	Investigation complete, no issues found
INV/23/01060	Falsified managers signature on training form	02/06/2023	14/07/2023	Internal Disiplinary sanction / closed
INV/23/01204	Suspicious Claiming Activity	21/06/2023	18/10/2023	Visit conducted no fraud identified
INV/23/01228	CV Issues	27/06/2023	27/06/2023	Duplicate of INV/23/00991
INV/23/01310	Working elsewhere in contracted time	05/07/2023	05/07/2023	Enquiries completed, no fraud issues identified, matters reported have already been dealt with

				historically at managerial level. DOI to be submitted regarding voluntary work.
INV/23/01403	Overpayment of Salary - Late Termination	18/07/2023	21/11/2023	Overpayment repayment commenced
INV/23/01578	Mis use of Research Budget	01/08/2023	06/10/2023	no offences identified
INV/23/01619	Sending prescription overseas	03/08/2023	06/09/2023	No fraud identified
INV/23/01633	Agency Worker False Timesheets	03/08/2023	04/10/2023	Internal Disciplinary anction - Removed from Bank staff list and restricted from any future agency work with the organisation. No financial loss to the organisation.
INV/23/01634	Salary Sacrifice Vehicle not transferred when subject left organisation, no further deductions/payments made	03/08/2023		
INV/23/01636	Suspect has been carrying out UBER work whilst off sick from HB with chronic Back issues	07/08/2023	21/11/2023	Interview under caution, full and frank admission, restorative justice, disciplinary outcome (employment terminated), monies recovered
INV/23/01681	Optical Claim Fraud	10/08/2023	16/08/2023	No offences identified
INV/23/01680	Optical Claim Fraud	10/08/2023	25/09/2023	No fraud identified, measures put in place to reduce risk of future occurrence
INV/23/01679	Optical Claim Fraud	10/08/2023	04/12/2023	No Fraud Identified. Advice letter only.
INV/23/01696	No Termination	14/08/2023		
INV/23/01703	Intel report re staff at St Davids acting nepotistically	14/08/2023	30/08/2023	No offences identified
INV/23/01644	Intel from CFA	14/08/2023	30/08/2023	Suspected malicious report, no issues identified
INV/23/01732	Salary Overpayment	16/08/2023	21/11/2023	Overpayment repaid in full
INV/23/01736	Salary Overpayment	16/08/2023	16/08/2023	Transferred to CFS WALES
INV/23/01806	Working elsewhere in contracted time	24/08/2023	14/09/2023	No offences identified
INV/23/01968	Referral form from directorate - staff member working abroad whilst of sick	13/09/2023	21/11/2023	Employment terminated folowing disciplinary investigation.
INV/23/02002	Staff member stealing CD's from Omnicell	15/09/2023		
INV/23/02137	Administrator at GP created false prescriptions	28/09/2023	04/10/2023	Disciplinary sanction - subjects work within the GP practice terminated.
INV/23/02182	Dual claims for optom services	03/10/2023	06/11/2023	Unable to prove offence - Letter of advice sent
INV/23/02097	Altered prescriptions	26/09/2023	16/11/2023	Insufficient evidence to prove who is responsible. Letter of advice sent out.

INV/23/02207	Working Elsewhere whilst sick	12/10/2023		
INV/23/02286	Working elsewhere whilst sick	12/10/2023	23/10/2023	No further action. Managerial informal discussion held.
INV/23/02420	NURSE at HMP Cardiff believed to have carried out work for an agency	26/10/2023	01/11/2023	No overlaps in shifts identified. No offences.
INV/23/02421	Money missing suspected stolen	26/10/2023		
INV/23/02436	Dual claims for optom services	30/10/2023	21/11/2023	Letter of advice sent - unable to prove offence
INV/23/02479	Working for ABUHB whilst sick at CAVUHB	03/11/2023	16/11/2023	No offences identified. Shifts worked at ABUHB but legitimately.
INV/23/02496	CIT report - false sickness	10/11/2023	16/11/2023	Subject is involved in a domestic abuse situation with ex partner. Believed malicious.
INV/23/02613	NHS Uniform for sale on Facebook	21/11/2023	21/11/2023	Link no longer active, no information available to investigate
INV / CFS WALES	Overpayment	28/12/2023		

Fraud Risk

A total of 2 Fraud Risk Assessments are being conducted at this time. These are incomplete and will be reported upon further when complete.

The areas that the risk assessments that are ongoing are:

1. Impersonating a medical professional
2. Petty Cash processes

National Fraud Initiative

Work has continued into the latest NFI data dump. The below table provides the total matches that are addressed by the Counter Fraud Team.

Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	311	161
Payroll to Payroll - Tel. No.	54	53
Payroll to Payroll - Email	1	1

Payroll to Pension	132	132
Payroll to Company Director/Trade Creditor	116	45
Payroll to Creditor	190	146

3. Other

NA

Report Title:	Counter Fraud Progress– Good Practice Assessment by NHS Counter Fraud Authority				Agenda Item no.	4.2 (Addition to main item)	
Meeting:	Audit Committee	Public	x		Meeting Date:	06/02/2024	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		x
Lead Executive:	Catherine Phillips						
Report Author (Title):	Gareth Lavington						

Main Report
Background and current situation:

Introduction

The report attached provided under this cover sheet has been completed by the NHS Counter Fraud Authority following a quality assurance and good practice visit made to the Cardiff and Vale UHB Counter Fraud Offices in November 2023.

During the course of this visit the NHSCFA team met with the Counter Fraud Manager, the Local Counter Fraud Specialists and separately with the Executive Director of Finance and the Audit Committee Chairperson.

The purpose of the visit was mainly to discuss the good practice displayed by the team as Cardiff and Vale UHB Counter Fraud had been identified as displaying above average outcomes in the 2022/2023 Counter Fraud Functional Return (a mandatory report completed annually by the Counter Fraud Manager and provided to the NHS Counter Fraud Authority to evidence compliance of the Functional Standard NHS Requirements).

The 2022-2023 Counter Fraud Functional return completed by the Counter Fraud Manager for CAVUHB identified that the organization had a fully compliant rating (green) overall but that the organization was only able to provide a partially compliant (amber) rating in relation to Requirement 3 of the Counter Fraud Standard – Risk assessment.

During the NHS CFA visit it also identified that the uptake of the Fraud Awareness e-Learning package provided on the ESR platform was extremely low within CAVUHB.

The report has raised these two areas as considerations for the organisation moving forward.

Background

1. NHS Standards - Requirement 3 – Fraud Risk Assessment
   Since April 2022 a considerable amount of work has been carried out in relation to the provision of Fraud Risk assessment work. Prior to this date this aspect of Counter Fraud work did not exist at CAVUHB. To date the following work has been completed. This has allowed the organisation to move to an amber rating of partial compliance.

   - A fraud risk assessment template has been designed and implemented that is compliant with the cabinet office methodology on reporting risk.
   - The counter fraud team have all undertaken fraud risk assessment training provided by the NHS CFA.
   - The deputy Counter Fraud Manager has obtained a Certificate in Fraud Risk Management (CFRM) that was awarded by Chartered Institute of Public Finance and Accountancy (CIPFA) and he has been delegated responsibility of managing this area of work. The CFRM is a professional accredited qualification created by CIPFA's experts in fraud risk management.
   - A comprehensive fraud risk profile has been designed and introduced that identifies all known inherent and emerging fraud risks to the organisation. These risks have been identified both locally and nationally. This profile identifies and describes the risk and provides a record of the work carried out by the team and the progress of the reporting process i.e. when the report was completed and disseminated, who disseminated to and

what response has been provided from the risk owner, and whether the risk has been added to the local risk register as per the risk management policy.

- All risks are now reported and recorded upon the CLUE case management database and reported to NHSCFA
- The risks identified and assessment work being carried out also inform upon areas of weakness and identifies areas of future work in relation to Local Proactive Exercises (LPE). It is intended that there will be an increase in volume of this proactive work in the upcoming financial year.
- All Fraud Risk work and the Fraud Risk profile has been presented at each Audit Committee meeting throughout the year.

The work highlighted above is indicative of a successful provision within this area and assurance can be provided that the work carried out is of both a high value and a high standard. To provide clarity around the reasoning for the partially compliant (amber) rating in 2022-2023 and likelihood of the same for 2023-2024; this is as a result of the lack of compliance with the Risk Management Policy of the organisation. Requirement 3 of the NHS Counter Fraud Standard states *'The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers'*.

The CAVUHB Risk Management Policy Documents consist of the Risk Management and Board Assurance Framework Strategy and The Risk Management Procedure. They state respectively:

Risk Management Procedure Page 18:

2.3 Risk Registers

A risk register is a central collation of risks recorded in order to inform the decision making of managers, risk committees and potentially the UHB. The Risk Register records all identified risks; it then progressively describes their controls, their risk scores and any ongoing action necessary to reduce the risk as low as reasonably practicable.

Each risk should be assigned a Risk Owner (e.g. Ward Manager at Ward Level, Clinical Board Director at Clinical Board Level etc.). A UHB Board Committee should also be identified for all risks that are contained within the UHB's Corporate Risk Register for assurance purposes.

Each Directorate will maintain a central file of Risk Registers from their Wards/Departments. The Clinical Board Risk Lead will ensure that Directorate Registers are collated and amalgamated at a Clinical Board Level.

Risk Management Procedure page 19

2.3.5 Risk Acceptance or Closure. Risks are accepted when the risk score equals that of the target risk rating i.e. where all reasonable actions have been effectively carried out and the risk owner, cognisant of the risk appetite, is in all other respects confident that the risk has been reduced as low as reasonably practicable. A clear rationale for accepting the risk should be added to the risk register entry. Accepted risks should be held on a register and reviewed annually to see if anything changes.

Where risks have been agreed for removal from the Risk Register or are covered by an existing risk, the risk can be closed.

Risk Management and Board Assurance Framework Strategy – Page 16

5.8.1 Local Counter Fraud Services. The UHB's Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The UHB's Annual Counter Fraud Work Plan, as agreed by the Audit and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit and Assurance Committee as appropriate. The LCFS works with the Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned and are then escalated through the UHB's escalation process.

Risk Management and Board Assurance Framework Strategy – Page 24

Any risks identified and evaluated as having a low/moderate current risk rating (1-6) can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded in the local risk register within each ward / department; the Clinical Board/Corporate Directorate to which the ward/department belongs are responsible for the oversight and governance of these risk registers.
Risks identified and evaluated as having a high rating current risk rating (8-12) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead who will place the risk onto the Clinical Board/Corporate Directorate risk register and monitor/report the progress of the risk thereafter.
Risks identified and evaluated as having an extreme current risk rating (15-25) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead. The Risk Lead will immediately report risk greater than 20 to the relevant Executive Director who will inform the Chief Executive. In the event that this will cause delay the Clinical Board Director can report directly to the Chief Executive. Following this urgent notification process, risks greater than 20 should be notified to the Risk and Regulation Team for placement onto the Corporate Risk Register

At this time the majority of reported Fraud Risks reported are not placed on any risk register.

To date

- 11 Fraud Risk Assessments (FRA) have been completed
- 5 FRA's have been responded to
- 3 FRA's have been added to a local risk registers
- 6 FRA's remain not responded to – (1x 13 months, 2 x 10 months, 2 x 8 Months, 1 x 5 Months)
- The time for response to the reported risk (of the 5 responded to) ranges between – 4 and 36 weeks

This issue was probed at length by the NHSCFA during the course of their visit. Following discussion between the Counter Fraud Manager, the Executive Director of Finance and the NHSCFA representatives it was proposed that the most suitable course of action would be add the influence of the Audit Committee into the process. In order to achieve this the proposal would necessitate the adding of reported fraud risks as they arise to the Audit Recommendation Tracker in order that the timeliness and level of response can be more closely monitored and assurance provided.

Liaison has taken place with the Director of Corporate Governance and arrangements made to meet with delegated corporate governance staff members to discuss further.

2. Counter Fraud E Learning

'*NHS Standards Requirement 11 states 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media.*
Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.'

In relation to this area CAVUHB attain a fully compliant (Green) rating. The success of the work that has gone into promoting the awareness of fraud in the NHS by the team can be directly measured in the significant year on year increase seen in the referrals received by the team and investigations subsequently carried out. A number of actions have been undertaken in this area over the last two years including:

- Regular fraud pop up stalls at HB sites
- The development of a completely new Intranet site
- Regular Newsletters published to the Intranet site
- A dedicated QR code intranet link to make requests for awareness sessions
- Attendance at all Corporate Induction events providing awareness to new starters
- The development and introduction of publicised 'access to all' webinar sessions on Microsoft Teams. (Cancelled as a result of poor uptake – 8 sessions delivered over 9 Months, 1 staff attended)
- The introduction of the new All Wales Fraud Awareness package on ESR

In spite of these actions, during the course of 2023-2024 only 209 (inclusive of E Learning) staff have been provided with fraud awareness education/training in some form. The organisation's head count is 17500 employees rising to over 20,000 when including locum and bank staff.

Provided below are the NHS Wales E Learning figures 01/01/2023 – 17/01/2023 (figures provided by NWSSP- organisations with Counter Fraud learning as mandatory provided in red)

CAVUHB	52
WAST	2872
DHCW	33
PHW	50
NWSSP	107
BCUHB	2562
Powys	0
HEIW	1
HDUHB	1821
CTUHB	17
Velindre	31
SBUHB	252
AB	50

When the figures obtained from across NHS Wales are benchmarked it can be easily identified that the most impactive method of staff members obtaining fraud awareness training and education is via the mandating of the Fraud Awareness E Learning package. If it is a real goal of the organisation to achieve a high percentage of staff educated in Fraud Awareness then this is the only realistic pathway.

Whilst this subject area has been discussed at many audit committee sessions historically it is requested that due consideration and discussion be again given to the proposal of adding Fraud Awareness package to the mandatory training list.

A request has been made to meet with the ECOD team and discuss the options moving forward.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The two considerations identified in the attached report - Counter Fraud risk assessment work and the Counter Fraud e Learning package.

Recommendation:

The Board / Committee are requested to discuss the considerations raised in the report with a view to identifying solutions to the concerns raised.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~

Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.

Safety: ~~Yes~~/No

Financial: Yes/~~No~~

All fraud occurring in the organization has a financial loss to the organization.

Workforce: Yes/~~No~~

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes/No

Reputational: Yes/~~No~~

As at Risk
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
29/01/2024 17:21:57

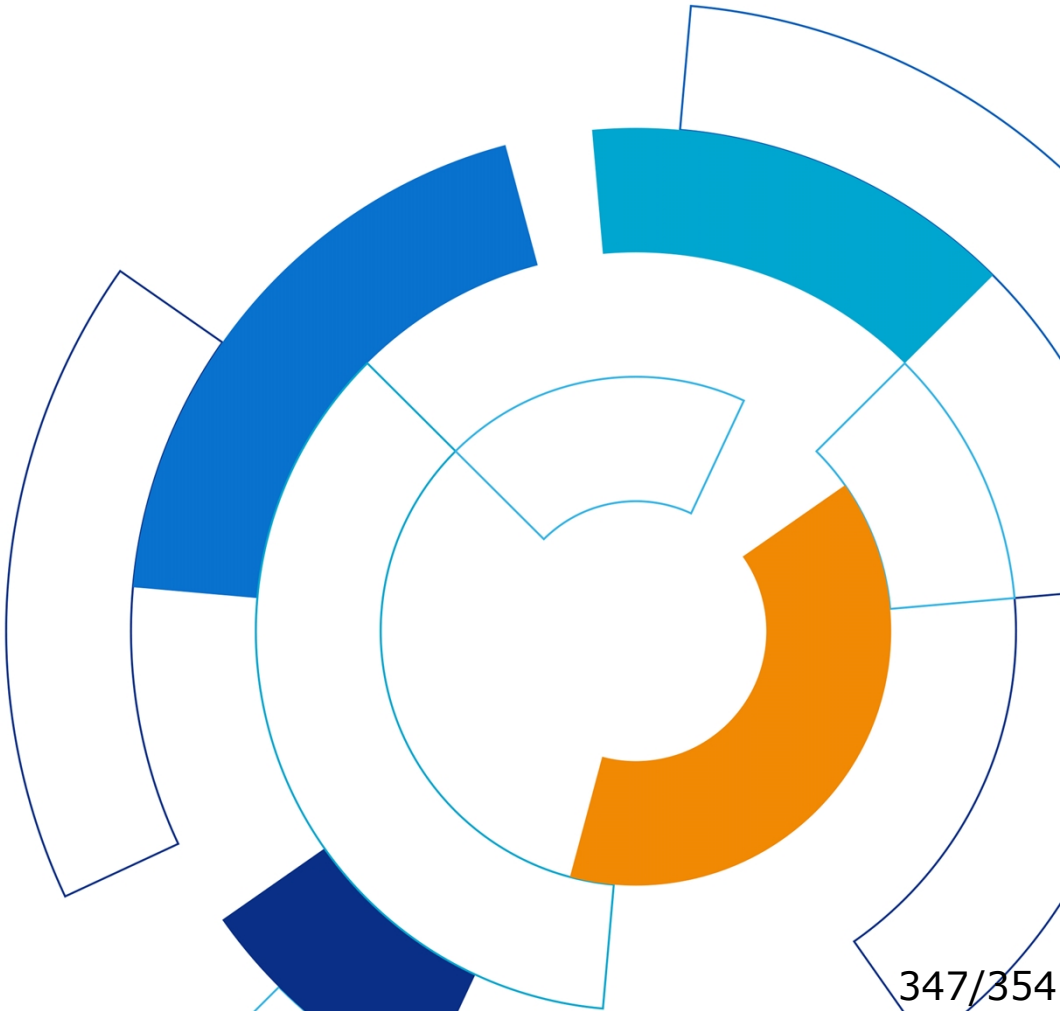
Counter Fraud Authority

GOOD PRACTICE

Thematic Engagement Exercise – Cardiff and Vale University Health Board

JANUARY 2023

Version 1.0



NHS fraud.
Spot it. Report it.
Together we stop it.

Version control

Version	Name	Date	Comment
0.1	R Barker-Jones	27/12/2023	Initial version
0.2	F McIlwraith	09/01/2024	Comments
1.0	R Barker-Jones	12/01/2024	Final version

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Executive summary

Background

The NHS Counter Fraud Authority (NHSCFA) is a Special Health Authority, established on 1 November 2017 and charged with identifying, investigating and preventing fraud within the NHS and the wider health group. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care.

In Wales the NHSCFA provides specialist counter fraud support functions to the Welsh Government under section 83 of the Government of Wales Act 2006. On 1st November 2017, a new section 83 arrangement was finalised and signed by both parties following the establishment of the NHSCFA.

Since April 2021, all NHS funded services have been required to provide assurance against the Government Functional Standard GovS 013: Counter Fraud to the NHSCFA. To enable NHS funded services to meet the Government Functional Standard, the NHSCFA released a suite of NHS requirements in January 2021. These requirements provide a detailed description of the necessary counter fraud arrangements and how to meet them to comply with the Functional Standard. The requirements are published annually for NHS funded organisations.

Organisations are required to provide an annual statement of compliance with the requirements via an on-line Counter Fraud Functional Standard Return (CFFSR). Once received, the data from these returns is amalgamated with investigations data entered throughout the year on the NHS case management system, Clue.

Upon reviewing the data, it is apparent that some organisations receive a better service in terms of investigative outcomes than others. We therefore devised a thematic exercise where we would visit identified good practice organisations to find out what factors supported successful outcomes.

Summary of findings

We would like to thank Cardiff and Vale University Health Board (the organisation) for their hospitality and professionalism during this exercise.

Fiona McIlwraith (Fraud Hub Engagement Lead) and Ruth Barker-Jones (Senior Fraud Hub Engagement Officer) visited the board on 15th November. During the engagement visit, we spoke with Gareth Lavington, the Local Counter Fraud Specialist (LCFS), John Union, the Audit Committee Chair (ACC) and Catherine Phillips, the Director of Finance (DoF). Each of them provided excellent insight into what they feel are the key requirements of a good counter fraud service and, specifically what worked best at Cardiff and Vale. We also had input from Graham Dainty, Head of Counter Fraud Wales.

During the engagement, we found that Cardiff and Vale demonstrated the following features of good practice;

The LCFS was able to demonstrate considerable operational links across the organisation, which facilitated the work conducted. Local links of this type, as well as a strong and mutually beneficial relationship between the LCFS and the Audit Committee, are critical in establishing trust in, and the legitimacy and importance of counter fraud work.

This was particularly evident in reactive, investigatory work and also progress made in respect of the local counter fraud risk assessment process, which is a key part of requirement 3 of the Counter Fraud Standard. The CFFSR for 22-23 indicated that Cardiff and Vale was partially compliant with requirement 3, as they had rated themselves as amber.

Whilst the local counter fraud risk assessment is in progress, Cardiff and Vale acknowledge that the process has not been fully developed and were keen to ensure a mechanism is introduced for action monitoring through Audit Committee. This will be key to ensure that actions outside the area of LCFS control are implemented, with a clear escalation process where action is not taken.

The evident support for counter fraud work, and for the LCFS, from the senior management resulted in increased visibility and empowerment. The importance of 'soft power' in terms of supporting counter fraud work, and critically breaking down barriers where they exist cannot be underestimated and is a common thread in organisations that consistently demonstrate good practice.

It was beneficial to speak with key staff from within the organisation with responsibility for this area of work, and we thank them for their time.

Suggested Next Steps

As this is a good practice engagement with successful outcomes, there are no recommendations that we would make at this stage. In relation to requirement 3 (comprehensive local fraud risk assessments) we are confident that if the trajectory of improvement is maintained and the organisation monitors and reduces the risk identified, the board would be fully compliant.

NHSCFA will assist and continue to provide support to organisations as required in order to drive up standards and reduce the risk of fraud occurring.

NHSCFA will deliver a bespoke report directly to the organisation and produce an overall report, which will be made available to the whole sector which will cover the findings of the good practice exercise.

Objectives

To undertake an exercise applied to those NHS provider organisations (including Wales if applicable) who submitted a CFFSR for 22/23, and who have been identified as demonstrating above average outcomes in relation to investigations, sanctions and redress outcomes.

To support the sector with guidance and share good practice with stakeholders to promote the benefits of shared learning and ensuring the best possible return on investment for counter fraud work undertaken across the sector.

To report on our findings to NHSCFA and to those NHS provider organisations who formed part of the exercise (Directors of Finance, Audit Committee Chairs, Fraud Champions and Local Counter Fraud Specialists).

A link to the requirements of the standard is here.

Purpose

The purpose of the exercise was to begin to develop the key characteristics of good performance and share these with the sector, as part of the development of a good practice model. We would also provide good practice assurance to DHSC AFU and NHSCFA.

Scope / Out of Scope

The exercise only engaged with those NHS provider organisations who submitted a CFFSR for 22/23 and who demonstrated above average success in relation to investigations, sanctions and redress. No other organisations were considered as part of this exercise.

Methodology

Organisation Selection

The data from the CFFSR 2022-23 was reviewed along with data from the NHS case management system, Clue to identify organisations who had significantly above average reactive outcomes.

NHS Requirements

An organisation may be able to demonstrate good practice across all or some of the standards so no specific standards are referenced in this section. However, we provide a

brief breakdown of the **overall** self-declared score for organisations in England and Wales. The overall score is calculated from the self-declared scores for each requirement.

A total of 315 CFFSRs were made for 22/23 with the following responses -

Of the 315 organisations, 310 organisations (98%) had rated themselves as **Green** and meeting requirements in full.

Four organisations (1.5%) had rated themselves as **Amber** and partially meeting the requirements.

One organisation (0.5%) had rated themselves as **Red** and not meeting the requirements.

Findings

The LCFS demonstrates a strong and positive relationship with the DoF and ACC, with regular meetings scheduled with the DoF and access to the ACC as required, in addition to the planned Audit Committee meetings. These relationships empower the LCFS to conduct their work effectively, by supporting organisation-wide awareness of the importance of counter fraud work and in developing links with key operational contacts.

The benefits of those positive relationships are evident across the counter fraud work, particularly in the level of investigative outcomes achieved, including sanctions, redress and financial recovery, on which basis Cardiff and Vale were selected for this good practice review.

The CFFSR for 22-23 indicated that Cardiff and Vale was partially compliant with requirement 3, which relates to the local counter fraud risk assessment process, self-assessing themselves as amber. Significant progress has been made in developing and progressing the local counter fraud risk assessment process, with identified fraud risks thoroughly assessed, assigned to an appropriate risk owner (not the LCFS) and with recommendations made to reduce or mitigate risks where appropriate.

It was acknowledged that the local counter fraud risk assessment process is not yet fully developed and Cardiff and Vale were keen to ensure a mechanism is introduced for action monitoring through Audit Committee. There is currently no process in place for action monitoring in respect of fraud recommendations, and this will be key to ensure that actions outside the area of LCFS control are implemented, with a clear escalation process where action is not taken. Introduction of a fraud action monitoring process would be a positive development not only for recommendations resulting from local fraud risk assessments but also from local proactive exercises, investigatory work and national exercises. An amber rating continues reflect the current status in respect of requirement 3.

The LCFS was able to demonstrate a number of initiatives introduced to raise fraud awareness across the organisation, including an e-learning training package developed through the Welsh Government's Counter Fraud Service and a series of webinars developed by Cardiff and Vale's LCFS team. Both initiatives were reported to have poor uptake, with attendance at the webinars low enough to result in their cancellation, despite being promoted across the organisation by the LCFS and reported to Audit Committee as part of the LCFS's update. Given the influence potential of those in attendance at Audit

Committee, this indicates that those in a position to cascade an instruction to complete training or attend a webinar to staff in their respective areas are not doing so.

Completion levels for the e-learning is available for all Welsh health bodies for comparison purposes, and clearly demonstrates the surest way to high completion is through the organisation setting out the priority placed on counter fraud work through inclusion in the local mandatory training suite.

Recommendations

As indicated, as this is a good practice engagement, there are no recommendations to make at this stage.

However, there are a small number of areas for consideration that would support further improvement of counter fraud arrangements:

> Cardiff and Vale should progress with current plans to develop a mechanism for monitoring completion of fraud actions.
>
> All Audit Committee members should consider using the power of their influence to support LCFS activities by cascading directions for completion of e-learning training and any other initiative designed for all staff across the organisation.
>
> Cardiff and Vale should consider including the fraud awareness e-learning package in the suite of local mandatory training.

Should the organisation require any further information or advice on this matter then please feel free to contact us at fraudhub@nhscfa.gov.uk.