

Public Audit Committee Meeting

Thu 11 May 2023, 09:00 - 11:30

Agenda

09:00 - 09:10 1. Welcome and Introductions

10 min

John Union

09:10 - 09:10 2. Apologies for Absence

0 min

John Union

09:10 - 09:10 3. Declarations of Interest

0 min

09:10 - 09:10 4. Minutes of the Committee meeting held on 4th April 2023

0 min

John Union

09:10 - 09:10 5. Action log following meeting held on 4th April 2023

0 min

John Union

09:10 - 09:10 6. Any other urgent business


0 min

09:10 - 09:10 7. Items for Review and Assurance

0 min

7.1. Internal Audit Progress Report

Ian Virgil

 7.1 A&A Progress Report May 23 cover.pdf (2 pages)

 7.1a A&A Progress Report May 23.pdf (23 pages)


7.2. Audit Wales Orthopaedic Report

Wales Audit

7.3. Compliance with the UK Corporate Governance Code

James Quance

 7.3 UK Corporate Governance Code report.pdf (3 pages)

 7.3a Appendix 1 - Annual Assessment UK Corporate Governance Code 2022-2023.pdf (10 pages)

7.4. Board and Committee Effectiveness Surveys 2022-23

Mohamed Saif
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James Quance

- 📄 7.4 - Board and Committee Self Effectiveness surveys.pdf (4 pages)
- 📄 7.4 Appendix 1 - Board Effectiveness Action Plan 2021-2022.pdf (7 pages)
- 📄 7.4 Appendix 2 - Board Effectiveness Action Plan 2022-2023.pdf (8 pages)
- 📄 7.4 Appendix 3 Audit Committee Self Effectiveness Survey results.pdf (12 pages)
- 📄 7.4 Appendix 4 Board Self Effectiveness survey results.pdf (6 pages)
- 📄 7.4 Appendix 5 Finance Committee Self Effectiveness survey results.pdf (7 pages)
- 📄 7.4 Appendix 6 - MHLMCA Committee Self Effectiveness Survey Results.pdf (6 pages)
- 📄 7.4 Appendix 7 CFC Committee Self Effectiveness Survey results.pdf (6 pages)
- 📄 7.4 Appendix 8 DHIC Committee Self Effectiveness Survey Response.pdf (6 pages)
- 📄 7.4 Appendix 9 QSE Committee Self Effectiveness Survey results.pdf (6 pages)
- 📄 7.4 Appendix 10 - H&S Committee self effectiveness survey results.pdf (6 pages)
- 📄 7.4 Appendix 11 S&D Committee Self Effectiveness Survey results.pdf (6 pages)
- 📄 7.4 Appendix 12 RATS Committee self effectiveness survey results.pdf (7 pages)

7.5. Annual Review of the Standing Orders

James Quance

- 📄 7.5 Annual Review of Standing Orders.pdf (3 pages)

7.6. Audit Wales Annual Plan

Wales Audit

09:10 - 09:10 8. Items for Approval / Ratification

0 min

8.1. Counter Fraud Annual Report 2022/23

Gareth Lavington

8.2. Policies:

Catherine Phillips/Gareth Lavington

Counter Fraud and Corruption Policy and Procedure (UHB 054)

- 📄 8.2 Counter Fraud Bribery and Corruption Policy and Procedure Cover Sheet.pdf (2 pages)
- 📄 8.2a Counter Fraud Bribery and Corruption Policy.pdf (2 pages)
- 📄 8.2b Counter Fraud Bribery and Corruption Procedure.pdf (23 pages)

8.3. Standing Orders – Temporary variation (AGM date)

James Quance

- 📄 8.3 Variation to Standing Orders covering report.pdf (3 pages)

09:10 - 09:10 9. Items for Information and Noting

0 min

9.1. Internal Audits reports for information:

- 📄 9.1 A&A Internal Audit Reports for Information cover.pdf (2 pages)

9.1.1. Individual Patient Funding Requests

- 📄 9.1a IPFR Final Internal Audit Report.pdf (13 pages)

9.1.2. Follow-up: Clinical Audit

- 📄 9.1b Clinical Audit Follow up Final Report.pdf (8 pages)

Mohamed, Sarah
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9.1.3. Follow-up: Nurse Bank (Temporary Staffing Department)

 9.1c Nurse Bank Follow Up Final Report.pdf (13 pages)

9.1.4. Charitable Funds

 9.1d Charitable Funds Final Report.pdf (21 pages)

9.1.5. Community Patient Appliances (Specialist Services CB)

 9.1e Community Patient Appliances Final Internal Audit Report.pdf (21 pages)

9.1.6. Data Warehouse

 9.1f Data Warehouse Final Internal Audit Report.pdf (19 pages)

9.1.7. Inclusion & Equality

 9.1g Inclusion and Equality Final Internal Audit Report.pdf (14 pages)

9.1.8. Risk Management

9.1.9. Management of Health Board Policies

9.2. Audit & Assurance External Quality Assessment of Conformance to the Public Sector Internal Audit Standards

Ian Virgil

09:10 - 09:10 10. Agenda for Private Audit and Assurance Committee

0 min

John Union

10.1. Private Audit Minutes – 4th April 2023

10.2. Counter Fraud Progress Update (Confidential – ongoing investigations)

10.3. Salary Overpayment (Confidential Discussion)

09:10 - 09:10 11. Any Other Business

0 min

09:10 - 09:10 12. Review and Final Closure

0 min

12.1. Items to be deferred to Board / Committee

John Union

12.2. Note the date, time and venue of the next Committee meeting:

Tuesday 4th July 2023 at 9am via MS Teams

Mohamed Sarah
02/05/2023 17:42:26

09:10 - 09:10
0 min

13. 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].

Mohamed Sarah
02/05/2023 17:42:26

Report Title:	Internal Audit Progress Report			Agenda Item no.	7.1
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	11/05/23
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	X	Information
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 UHB.

The 2022/23 plan was formally approved by the Audit Committee at its April 22 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 and proposed amendments to the plan.

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 from the 2022/23 plan have been finalised since the April 23 meeting:

- Individual Patient Funding Requests - (Substantial Assurance)
- Follow-up: Clinical Audit - (Substantial Assurance)
- Follow-up: Nurse Bank (Temporary Staffing Department) - (Reasonable Assurance)
- Charitable Funds - (Reasonable Assurance)
- Community Patient Appliances (Specialist Services CB) - (Reasonable Assurance)
- Data Warehouse - (Reasonable Assurance)
- Risk Management - (Reasonable Assurance)
- Inclusion & Equality - (Reasonable Assurance)
- Management of Health Board Policies - (Limited Assurance)

The progress report also includes details of a proposed adjustment to the 2022/23 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 reports.
- **Approve** the proposed adjustment to the 2022/23 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	
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	X	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	
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	x	Integration	x	Collaboration	x	Involvement	
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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

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 financial controls and processes.

Workforce: 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 workforce issues.

Legal: Yes/No

Reputational: Yes/No

The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes a number of audits which provide assurance around reputational risks.

Socio Economic: Yes/No

Equality and Health: Yes/No

The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes an audit which provides assurance around equality.

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec Date:

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Approved by Sarah
 2023-11-17 11:42:26

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee May 2023

NWSSP Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Cydwasaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



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

Mohamed Sarah
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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 2022/23 Internal Audit plan.

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

The plan for 2022/23 was agreed by the Audit & Assurance Committee in April 2022 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 May Audit Committee but have not met that deadline.




Audit	Current Position	Draft Rating	Reason
UHW-Hybrid and Major Trauma Theatres	Draft	Reasonable	Delay in progressing fieldwork due to provision of information by management
Planned Care Transformation Delivery (Recovery of Services)	Work in Progress		Delay in progressing fieldwork due to availability of Internal Audit resources
Consultant Job Plans (Surgery CB)	Work in Progress		Delay in meeting key contacts in order to develop brief
Medical Staff Additional Sessions	Planning		Delay in planning audit due to availability of Internal Audit resources

3. Outcomes from Completed Audit Reviews

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

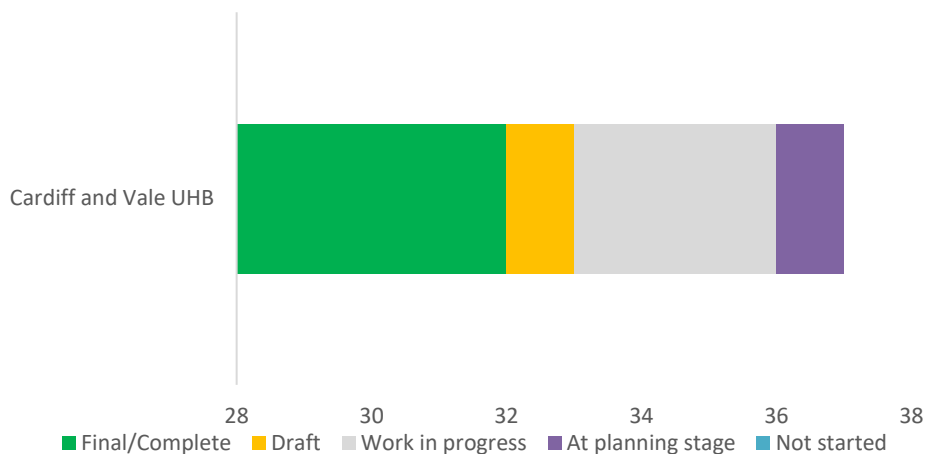
The Executive Summaries from the final reports are provided in Section seven. The full reports are included separately within the Audit Committee agenda for information.

Mohamed Sarah
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FINALISED AUDIT REPORTS	ASSURANCE RATING	
Individual Patient Funding Requests (IPFR)	Substantial	
Follow-up: Clinical Audit		
Follow-up: Nurse Bank (Temporary Staffing Department)	Reasonable	
Charitable Funds		
Community Patient Appliances (Specialist Services CB)		
Data Warehouse		
Risk Management		
Inclusion & Equality		
Management of Health Board Policies	Limited	

4. Delivery of the 2022/23 Internal Audit Plan

There are a total of 37 reviews within the 2022/23 Internal Audit Plan (including the adjustment highlighted below), and overall progress is summarised below.



From the illustration above it can be seen that thirty two audits from the 2022/23 plan have been finalised so far this year and one has reached the draft report stage.

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

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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 B highlights the times for responding to Internal Audit reports. There have been twelve instances where management responses have not been provided within the required 15 working days, as stipulated in the Internal Audit Charter. Analysis of the delayed responses identified the following:

- **Six** were up to two weeks late;
- **Three** Were between two and four weeks late; and
- **Three** were more than 4 weeks late, with the longest being 41 days late.

Appendix C shows the current level of performance against the Audit & Assurance Key Performance Indicators (KPI). The delays in provision of management responses means that performance against that KPI is red.

5. Changes to the 2022/23 Plan

The following audit has been identified for removal from the 2022/23 plan:

- Performance Reporting – The planned advisory audit has been identified for removal from the 22/23 plan. An assurance review of performance reporting has been included in the plan for 23/24.

The 37 audits remaining within the 22/23 plan will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

Mohamed Sarah
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6. Final Report Summaries

6.1 Individual Patient Funding Requests (IPFR)

Purpose

To establish and review the systems and processes in place to assess, make decisions on, and monitor spend related to Individual Patient Funding Requests (IPFRs).

Overview

We have issued substantial assurance on this area.

The findings of our audit have highlighted that the Health Board processes IPFR applications in line with the requirements of the All-Wales IPFR Policy. The IPFR Panel members were suitably represented at the meetings we reviewed, and decisions made were adequately supported by a decision record. The IPFR team and IPFR panel undertake effective monitoring of the IPFR following approval to ensuring their continued relevance and benefit to the patient. The costs of IPFR are managed as required, either by the Clinical Boards or corporately by the Health Board's Finance team.

The key matter requiring management attention relates to:

- The consistent use of standard documentation and ensuring the timely processing of IPFR applications, as outlined in the IPFR Policy.

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

Report Opinion

Substantial



Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary¹

Objectives	Assurance
1 IPFRs are processed in line with the all-Wales IPFR Policy	Reasonable
2 There is appropriate representation at the Health Board's IPFR panel meetings. Decision-making is in line with guidance in the all-Wales IPFR policy and the decisions and rationale are clearly documented	Substantial
3 Approved IPFRs are regularly monitored and reported to the Health Board's IPFR Panel, to ensure expenditure remains within the funding limit and timeframe	Substantial

¹The 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	IPFR application review	1 Operation	Medium

Mohamed Sarah
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6.2 Follow-up: Clinical Audit

Purpose

The overall objective of the audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Clinical Audit (2122-15) review that was reported as part of our 2021/22 work programme.

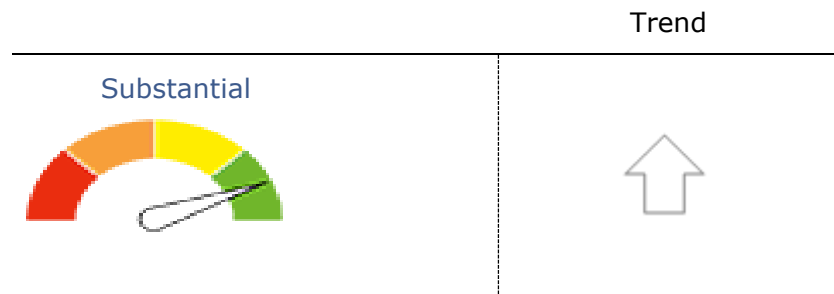
Overview of findings

Management have made significant progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the nine recommendations made, eight of them have been closed including three high priority recommendations. There is only one outstanding high recommendation which has been moved to a low priority as actions have been undertaken to address this recommendation, however, the Clinical Audit Policy has yet to be formally approved by the Quality, Safety and Experience Committee.

Mohamed Sarah
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Follow-up Report Classification



Progress Summary

Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1 Absence of a Health Board approved Clinical Audit Strategy	High	Closed
2 Lack of Clinical Audit Policy and Procedures	High	Low
3 Inadequate staff resources for monitoring Clinical Audits	High	Closed
4 Limitations of current systems to monitor clinical audits	High	Closed
5 Absence of a Clinical Audit Training Plan	Medium	Closed
6 Lack of clarity of Local Clinical Audit Plans	Medium	Closed
7 Inadequate registration and oversight of Local Clinical Audits	Medium	Closed
8 Limited scrutiny of Local Clinical Audits	Medium	Closed
9 Risk Management	Low	Closed

6.3 Follow-up: Nurse Bank (Temporary Staffing Department)

Purpose

The overall objective of this audit it to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Nurse Bank (Temporary Staffing Department)' review that was reported as part of our 2021/22 work programme.

Overview of findings

Management have made good progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the eight recommendations made, five of them have been closed including one high priority recommendation. Two of the recommendations have been moved to low priority as actions had been undertaken within these areas. One of the high recommendations has moved down to medium and still requires a review to be undertaken of the agencies as no further agencies are currently being utilised by the Health Board.

Mohamed Sarah
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Follow-up Report Classification

Reasonable



Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.

Trend



Progress Summary

Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1 Lack of Temporary Staffing Guidance	Medium	Low
2 Inadequate structure within the Temporary Staffing Department	High	Closed
3 Resilience of the Temporary Staffing Department	High	Low
4 Roles and responsibilities for Bank recruitment	Medium	Closed
5 Lack of engagement with service users	Medium	Closed
6 Operational management of the Temporary Staffing Department	Medium	Closed
7 Range of agency usage	High	Medium
8 Ward verification of agency shifts	Medium	Closed

6.4 Charitable Funds

Purpose
 The objective of the audit was to review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.



Overview
 We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Ensuring consistent compliance with the processes for requesting and approving expenditure from Charitable Funds;
- The governance arrangements for the Fundraising Team require reviewing; and
- The governance arrangements for fundraising events require reviewing and enhancement.

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

Report Opinion

	Trend	
<p>Reasonable</p>  <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved.</p>	 2020/21	

Assurance summary¹

Objectives	Assurance
1 Financial Control Procedure in place	Substantial
2 Charitable Funds Income Received	Substantial
3 Charitable Funds Expenditure	Reasonable
4 Funds held in Trust are monitored	Substantial
5 Role of the Charitable Funds Committee	Substantial
6 Fundraising Team Governance	Limited
7 Appropriate Guidance in Place	Substantial
8 Fundraising Events Governance	Reasonable

¹The 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
3	Charitable Funds Expenditure	3 Operation	Medium
5	Fundraising Team Structure	6 Design	High
7	Effectiveness of Fundraising Events	8 Design	Medium

Mohamed Sarah
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6.5 Community Patient Appliances (Specialist Services CB)

Purpose

To review the systems in place to monitor and manage the risks of posture and mobility equipment that needs to be repaired or replaced. Including how cases are managed when there are delays to equipment ordering / delivery because of supply chain issues.

Overview

We have issued **Reasonable** assurance overall. Our audit testing was predominantly informed by reviewing data within the BEST patient management system and from system reports, which highlighted the following anomalies:

- Absence of documentation held within the system;
- The timeliness of moving open repairs to complete; and
- The system has the ability to generate a variety of management information reports, which could be better utilised by management.

We reviewed stock management arrangements which appeared ad-hoc at the time of our review. We noted that the 'Request for Repair' Procedure has been 'draft' since 2019 and requires finalisation.

Whilst the service has a 'Declaration of the Terms and Conditions of Loan of Equipment', there were instances where these were not signed and dated by service users in receipt of equipment.

We make one low priority recommendation which is referred to in section two and Appendix A 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 summary¹

Objectives	Assurance
1 Policies and Procedures	Reasonable
2 Use of the BEST Patient Management System	Reasonable
3 Terms and Conditions of Loan of Equipment	Reasonable
4 Ordering and Supply of Equipment	Reasonable
5 Management Information	Reasonable

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	'Request for Repair' Procedure remains draft	1 Design	Medium
2	Absence and incomplete Repair Worksheet Documentation	2 Operation	Medium
3	Timeliness of updates to the BEST system to close repairs	2 Operation	Medium
5	Terms and Conditions documentation not signed by service users	3 Operation	Medium
6	Ad-hoc monthly stock counts and stock management	4 Operation	High
7	Better use of management information	5 Operation	Medium

Mohammed Salah
6/2/2023 17:42:26

6.6 Data Warehouse

Purpose

The purpose of the audit was to review the effectiveness of the data warehouse and ensure that it continues to be fit for purpose.

Overview

We have issued reasonable assurance on this area.

The data warehouse has been in place for many years and provides a large amount of useful information. There are good processes in place to define user needs, and develop appropriate information products, with a data quality process in place.

We note security weaknesses with the database, and a lack of documentation regarding feeds in and report products out.

Going forward there is an intent to improve the use of data, however there is no formalised plan for this. The Digital directorate have started working towards more advanced analytics, however there is a lack of staff resource and skills.

The matters requiring management attention include:

- Upgrading the database to a newer, more secure version;
- Defining a structure to fully identify Health Board needs;
- Developing advanced analytical skills; and
- Developing a data strategy and plan.

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 summary¹

Objectives	Assurance
1 Data Feeds	Reasonable
2 Understanding of Business Requirements	Reasonable
3 Information Provision	Reasonable

¹The 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	Manual Feeds	1 Design	Medium
3	Database	1 Operation	High
4	Health Board Needs	2 Design	Medium
5	Report Catalogue	3 Operation	Medium
6	Skills Identification	3 Operation	Medium
7	Data Strategy	3 Operation	Medium

6.7 Risk Management

Purpose
 The overall objective of the review was to determine and evaluate the ongoing development and implementation of the Risk Management and Board Risk Assurance Framework Strategy and associated Risk Management Procedures.

Overview
 We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Testing identified numerous gaps of information and risk scoring inconsistencies within directorate/departmental risk registers reviewed.
- The risk identification process is not always documented in line with the Health Board’s risk management procedures.
- Directorates and Clinical Boards need to ensure they are actively engaging in the escalation/de-escalation of risks.
- Risk Owners must ensure that they are regularly monitoring and documenting progress of actions within risk registers.

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

Report Opinion

Reasonable

Trend

2021/22

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives	Assurance
1 Strategy and Procedures	Substantial
2 Risk Registers	Reasonable
3 Risk identification and scoring	Reasonable
4 Risk monitoring	Reasonable
5 Recommendations from 2021/22	Substantial

¹The 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 Management Training	2&3	Design
2	Risk identification process not formally documented	3	Operation
3	Escalation/De-escalation engagement	3&4	Operation
4	Risk Monitoring	4	Operation

Mohamed Sarah
 02/05/2023 17:42:26

6.8 Inclusion & Equality

Purpose

The overall objective of the audit was to review the structure of the Equity and Inclusion Team and the plans in place to take key actions forward relating to areas such as the Welsh Government’s Anti-Racist Wales Action Plan.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Terms of Reference, membership and remit of the Equality Strategy & Welsh Language Standards Group need to be reviewed to ensure appropriate oversight of all current and future requirements.
- A review is required of the responsibilities of the Equity and Inclusion team and the structures in place within the Health Board to support them in delivery.
- An effective process and structure need to be implemented to enable the development of required action plans to ensure that the Health Board complies with all current and future inclusion and equality requirements.

Other recommendations / advisory points are 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 summary¹

Objectives	Assurance
1 Governance arrangements in place	Reasonable
2 Adequately structured and operating effectively	Limited
3 Plans in place ensure adherence to relevant Inclusion and Equality legislation	Reasonable
4 Regular monitoring and reporting	Substantial

¹The 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	ESWLSG Terms of Reference, membership and remit	1	Design	Medium
2	Workload of the Equity and Inclusion Team	2	Design	High
3	Development and Delivery of Equality actions	3	Operation	Medium

Mohamed Sarah
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6.9 Management of Health Board Policies

Purpose
 The overall objective of the review was to determine and evaluate the ongoing development and implementation of the Risk Management and Board Risk Assurance Framework Strategy and associated Risk Management Procedures.



Overview
 We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Testing identified numerous gaps of information and risk scoring inconsistencies within directorate/departmental risk registers reviewed.
- The risk identification process is not always documented in line with the Health Board’s risk management procedures.
- Directorates and Clinical Boards need to ensure they are actively engaging in the escalation/de-escalation of risks.
- Risk Owners must ensure that they are regularly monitoring and documenting progress of actions within risk registers.

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

Report Opinion

	Trend
	
<p>Reasonable</p> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved</p>	<p>2021/22</p>

Assurance summary¹

Objectives	Assurance
1 Strategy and Procedures	Substantial
2 Risk Registers	Reasonable
3 Risk identification and scoring	Reasonable
4 Risk monitoring	Reasonable
5 Recommendations from 2021/22	Substantial

¹The 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 Management Training	2&3 Design	Medium
2	Risk identification process not formally documented	3 Operation	Medium
3	Escalation/De-escalation engagement	3&4 Operation	Medium
4	Risk Monitoring	4 Operation	Medium

Mohamed Sarah
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ASSIGNMENT STATUS SCHEDULE

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
2021/22 Plan							
Monitoring and Reporting of Staff Sickness Absence		People & Culture			Final	Reasonable	September
Capital Systems Management		Finance			Final	Reasonable	February
2022/23 Plan							
IMTP 2022-25: Development Process	37	Strategic Planning	Q1		Final	Substantial	September
Follow-up: Ultrasound Governance	26	Therapies & Health Science	Q1		Final	Reasonable	September
Stock Management – Neuromodulation Service (Specialist Services CB)	42	COO	Q1		Final	Reasonable	September
Staff Wellbeing – Culture & Values	07	People & Culture	Q1		Final	Reasonable	November
Follow-up: 5 Steps to Safer Surgery	18	Medical	Q1		Final	Substantial	November
Implementation of National IT Systems (WNCR)	20	Digital & Health Intelligence	Q1		Final	Reasonable	November
Digital Strategy	21	Digital & Health Intelligence	Q2		Final	Reasonable	November
Medical & Dental Staff Bank	06	People & Culture	Q1	Q2	Final	Substantial	November
Medical Equipment & Devices (Deferred from 21/22)	25	Therapies & Health Science	Q2		Final	Reasonable	November
Core Financial Systems (Treasury Management)	02	Finance	Q4	Q2	Final	Reasonable	February

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Assurance Mapping	05	Corporate Governance	Q1	Q2	Final	Advisory	February
Management of Locum Junior Doctors (Women & Children's CB)	35	Chief Operating Officer	Q4	Q3	Final	Reasonable	February
Endoscopy Insourcing (Medicine CB)	31	Chief Operating Officer	Q3	Q2	Final	Reasonable	February
Medical Records Tracking (CD&T CB)	34	Chief Operating Officer	Q2		Final	Limited	February
Access to In-Hours GMS Service Standards (PCIC Clinical Board) (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3		Final	Reasonable	February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3		Final	Reasonable	February
Decarbonisation (Deferred from 21/22)	15	Finance	Q2		Final	Advisory	April
Financial Reporting & Savings Targets (Deferred from 21/22)	12	Finance	Q2	Q3	Final	Substantial	April
Cyber Security	24	Digital & Health Intelligence	TBC	Q3	Final	Limited	April
Nurse Staffing Levels Act	10	Nursing	Q3		Final	Reasonable	April
Charitable Funds	13	Finance	Q3	Q2	Final	Reasonable	May
Follow-up: Clinical Audit	17	Medical Director	Q2	Q4	Final	Substantial	May
Follow-up: Nurse Bank (Temporary Staffing Department)	45	People & Culture	TBC	Q4	Final	Reasonable	May
Community Patient Appliances (Specialist Services CB)	33	Chief Operating Officer	Q2		Final	Reasonable	May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Data Warehouse	23	Digital & Health Intelligence	Q4		Final	Reasonable	May
Risk Management	01	Corporate Governance	Q4		Final	Reasonable	May
Management of Health Board Policies	04	Corporate governance	Q4		Final	Limited	May
Individual Patient Funding Requests (IPFR)	38	Strategic Planning	Q3		Final	Substantial	May
Inclusion & Equality	08	People & Culture	Q4		Final	Reasonable	May
Planned Care Transformation Delivery (Recovery of Services)	27	Chief Operating Officer	Q3	Q4	Work in Progress		July
Consultant Job Plans (Surgery CB)	32	Chief Operating Officer	Q4		Work in Progress		July
Shaping Our Future Wellbeing – Future Hospitals Programme (Advisory)	40	Strategic Planning	Q1-4		Work in Progress		July
Medical Staff Additional Sessions	16	Medical	Q3	Q4	Planning		July
<i>Development of Integrated Audit Plans:</i>	41	<i>Strategic Planning</i>					
• <i>Development of Genomics Partnership Wales</i>			Q3		<i>Final</i>	<i>Reasonable</i>	<i>February</i>
• <i>University Hospital Llandough – Endoscopy Expansion</i>			Q2		<i>Final</i>	<i>Reasonable</i>	<i>November</i>
• <i>University Hospital Llandough – Engineering Infrastructure</i>			Q2		<i>Final</i>	<i>Reasonable</i>	<i>February</i>
• <i>UHW-Hybrid and Major Trauma Theatres</i>			Q4		<i>Draft</i>	<i>Reasonable</i>	<i>July</i>

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reviews removed from the plan							
<i>Implementation of People & Culture Plan</i>	09	<i>People & Culture</i>			Removed from the 22/23 plan as the majority of the implementation plan has already been reviewed as part of the Staff Wellbeing audit - Agreed by February 23 AC		
<i>Reporting of Covid Deaths</i>	11	<i>Nursing</i>			Removed from the 22/23 plans due to the implementation of the Medical Examiner role and the different Covid position - Agreed by February 23 AC		
<i>Application of Local Choices Framework</i>	28	<i>Chief Executive / COO</i>			Removed from the 22/23 plan as unclear on the potential scope or benefit in current position / lack of comparability to other organisations - Agreed by February 23 AC		
<i>Administration Services (Mental Health CB)</i>	29	<i>Chief Operating Officer</i>			Removed from the 22/23 plan due to delays in receiving information to commence audit have impacted on the availability of Internal Audit resources - Agreed by February 23 AC		
<i>Regional Planning Arrangements</i>	39	<i>Strategic Planning</i>			Removed from the 22/23 plan as focus would be on identifying lessons to take forward into future regional planning so not a key risk area in the current year - Agreed by February 23 AC		
<i>Strategic Programmes / Recovery & Redesign Governance Arrangements</i>	36	<i>Strategic Planning</i>			Removed from the 22/23 plan as the governance arrangements will be reviewed as part of the separate audit of Planned Care Transformation Delivery (Recovery of Services) - Agreed by February 23 AC		
<i>Capital Systems</i>	14	<i>Finance</i>			Deferred to 23/24 as the 21/22 audit has only recently been finalised, so there would be little benefit in reviewing again in 22/23 - Agreed by February 23 AC		
<i>Network & Information Systems (NIS) Directive Follow-up</i>	44	<i>Digital & Health Intelligence</i>			Follow-up of management actions to be covered as part of the Cyber Security audit - Agreed by February 23 AC		
<i>QS&E Governance (Deferred from 21/22 plan)</i>	03	<i>Nursing / Medical</i>			Advisory review to be moved to Q1 23/24 to allow coverage of developments around the Duty of Quality - Agreed by April 23 AC.		
<i>ChemoCare IT System Follow-up</i>	43	<i>Digital & Health Intelligence</i>			Deferred to 23/24 plan due to delay with implementation of new system – Agreed by April 23 AC		
<i>Performance Reporting</i>	19	<i>Digital & Health Intelligence</i>			The advisory review has been removed from the 22/23 plan. An assurance review of performance reporting has been included in the plan for 23/24 – To be agreed by May 23 AC		

REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
IMTP 2022-25: Development Process	Substantial	Final	20/07/22	10/08/22	26/07/22	27/07/22	G
Follow-up: Ultrasound Governance	Reasonable	Final	03/08/22	24/08/22	18/08/22	18/08/22	G
Stock Management – Neuromodulation Service (Specialist Services CB)	Reasonable	Final	02/08/22	23/08/22	19/08/22	19/08/22	G
Staff Wellbeing – Culture and Values	Reasonable	Final	30/08/22	20/09/22	10/10/22	12/10/22	R
Follow-up: 5 Steps to Safer Surgery	Substantial	Final	01/09/22	22/09/22	05/09/22	06/09/22	G
Digital Strategy	Reasonable	Final	28/09/22	19/10/22	19/10/22	20/10/22	G
Medical Equipment & Devices	Reasonable	Final	30/09/22	21/10/22	21/10/22	24/10/22	G
Medical & Dental Staff Bank	Substantial	Final	11/10/22	01/11/22	21/10/22	24/10/22	G
Implementation of National IT Systems (WNCR)	Reasonable	Final	28/09/22	19/10/22	24/10/22	25/10/22	R
<i>University Hospital Llandough – Endoscopy Expansion</i>	<i>Reasonable</i>	<i>Final</i>	<i>13/10/22</i>	<i>03/11/22</i>	<i>25/10/22</i>	<i>26/10/22</i>	<i>G</i>
<i>Development of Genomics Partnership Wales</i>	<i>Reasonable</i>	<i>Final</i>	<i>23/11/22</i>	<i>14/12/22</i>	<i>02/12/22</i>	<i>13/12/22</i>	<i>G</i>
Core Financial Systems (Treasury Management)	Reasonable	Final	20/12/22	19/01/23	19/01/23	20/01/23	G
Assurance Mapping	Advisory	Final	07/12/22	30/12/22	16/01/23	23/01/23	R
Management of Locum Junior Doctors (Women & Children's CB)	Reasonable	Final	04/01/22	25/01/23	20/01/23	23/01/23	G
<i>UHL Engineering Infrastructure</i>	<i>Reasonable</i>	<i>Final</i>	<i>14/12/22</i>	<i>09/01/23</i>	<i>23/01/23</i>	<i>23/01/23</i>	<i>R</i>

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Endoscopy Insourcing	Reasonable	Final	21/11/22	12/12/22	18/01/23	24/01/23	R
Medical Records Tracking (CD&T CB)	Limited	Final	13/12/22	06/01/23	19/01/23	24/01/23	R
Access to In-Hours GMS Service Standards (PCIC Clinical Board)	Reasonable	Final	22/12/22	17/01/23	17/01/23	24/01/23	G
IT Service Desk System	Reasonable	Final	12/01/23	02/02/23	25/01/23	25/01/23	G
<i>Decarbonisation</i>	<i>Advisory</i>	<i>Final</i>	<i>19/12/22</i>	<i>12/01/23</i>	<i>16/02/23</i>	<i>16/02/23</i>	R
Financial Reporting and Savings Targets	Substantial	Final	17/01/23	07/02/23	17/02/23	20/02/23	R
Cyber Security	Limited	Final	17/02/23	10/03/23	14/03/23	15/03/23	R
Nurse Staffing Levels Act	Reasonable	Final	09/03/23	30/03/23	17/03/23	20/03/23	G
Charitable Funds	Reasonable	Final	10/03/23	31/03/23	14/04/23	24/04/23	R
Follow-up: Clinical Audit	Substantial	Final	13/04/23	05/05/23	21/04/23	24/04/23	G
Follow-up: Nurse Bank (Temporary Staffing Department)	Reasonable	Final	29/03/23	21/04/23	20/04/23	20/04/23	G
Community Patient Appliances (Specialist Services CB)	Reasonable	Final	23/02/23	16/03/23	26/04/23	26/04/23	R
Data Warehouse	Reasonable	Final	17/03/23	11/04/23	26/04/23	26/04/23	R
Individual Patient Funding Requests (IPFR)	Substantial	Final	05/04/23	28/04/23	26/04/23	26/04/23	G
Inclusion & Equality	Reasonable	Final	13/04/23	05/05/23	26/04/23	27/04/23	G
Risk Management	Reasonable	Final	06/04/23	02/05/23	02/05/23	02/05/23	G
Management of Health Board Policies	Limited	Final	06/04/23	02/05/23	02/05/23	02/05/23	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2022/23	A	89% 32 from 36	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	94% 30 from 32	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	63% 20 from 32	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 32 from 32	80%	v>20%	10%<v<20%	v<10%

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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.

Mohamed Sarah
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Mohamed Sarah
02/05/2023 17:42:26

Report Title:	Compliance with the UK Corporate Governance Code			Agenda Item no.	7.3
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	11 May 2023
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report

Background and current situation:

NHS bodies are required to publish, as a single document, a three-part annual report and accounts which includes: the Performance Report, the Accountability Report, and the Financial Statements.

The Accountability Report (which includes the Annual Governance Statement) demonstrates how the Health Board has met key accountability requirements to the Welsh Government and includes a requirement to provide an assurance on compliance with the “Corporate Governance in Central Government Departments: Code of Good Practice” published in April 2017 (the Code), and the need to explain any areas of non-compliance.

The Code is the primary reference and overview of good practice for corporate governance in central government departments.

NHS Wales organisations are not required to comply with all elements of the Code. That said, the main principles of the Code stand as they are relevant to all public sector bodies. The Code operates as a “comply or explain” basis, whereby any deviation from the Code’s requirements must be explained as part of the Annual Governance Statement.

The purpose of this report is to outline the Health Board’s compliance against the Code for the period April 2022-March 2023, and to seek the Audit Committee’s approval to include the assessment in the Health Board’s Annual Report 2022-2023.

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

- An assessment has been undertaken against the applicable elements of the Code and the findings are presented within the **Appendix 1** for information.
- There were no reported/identified departures from the Code during the reporting period,

Whilst there is no requirement to comply with all elements of the Code, the Health Board considers that it is complying with the main principles of the Code where applicable, and follows the spirit of the Code to good effect and is conducting its business in an open and transparent manner and in line with the Code.

Recommendation:

The Committee is requested to:

- a) **NOTE** the assessment of compliance against the UK Code of Corporate Governance for April 2022 - March 2023 and

b) **APPROVE** the self-assessment of compliance against the UK Code of Corporate Governance for inclusion in the Accountability Report for 2022-2023.

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	xx	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: No

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the

development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES](#)

(If this has been addressed in the main body of the report, please confirm)

Equality and Health: No

Equality Health Impact Assessments (EHIA) are typically undertaken when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.

Useful guidance on the completion of an EHIA can be found at the following link: [EHIA toolkit - Cardiff and Vale University Health Board \(nhs.wales\)](#)

(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No

Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.

(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Committee/Group/Exec	Date:

Mohamed, Sarah
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**Cardiff and Vale University Health Board (CVUHB) Review Against the UK
Corporate Governance in Central Government Departments: Code of Good
Practice
2022-2023**

This review covers the period April 2022 - March 2023 to comply with the need for all NHS Wales bodies to assess themselves against the Corporate Governance in central government departments: Code of Good Practice 2017.

This Code has been reviewed to consider if the relevant provisions are applicable or non-applicable for Health Board.

Applicable items are outlined in full, those that do not relate to the business of the Health Board are shown as “non- applicable”. In some instances, the paragraph may not be directly applicable but the principles still apply.

Requirement of the Code	Evidence of CVUHB Compliance
Chapter 1 Parliamentary Accountability	
Not applicable	
Chapter 2 The role of the Board	
2.1 Each department should have an effective Board, which provides leadership for the department’s business, helping it to operate in a business-like manner. The Board should operate collectively, concentrating on advising on strategic and operational issues affecting the department’s performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the department.	CVUHB has a full Board in place comprising of Independent Members and Executive Directors in accordance with the Health Board’s Standing Orders.
2.2 The Board forms the collective strategic and operational leadership	<p>The Board is responsible for the oversight of the Health Board, including the implementation of the Integrated Medium-Term Plan (IMTP) and/or the Annual Plan, organisational strategy, the clinical services plan, providing leadership which is cascaded throughout the organisation.</p> <p>This year, due to the current financial climate, the Health Board has been unable to develop a three year IMTP which meets its statutory duties under the NHS Finance (Wales) Act 2014, and is therefore producing an Annual Plan for 2023/24.</p>

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Requirement of the Code	Evidence of CVUHB Compliance
2.3 The Board does not decide policy or exercise the powers of the ministers.	National policy decisions are made by the Welsh Government, with guidance issued through legislation and guidance. The Board is responsible for advising on and monitoring the effective implementation of policy.
2.4 The Board should meet on at least a quarterly basis.	Public Board meetings are held Board bi-monthly, with private Board Development Sessions being held in between.
2.5 Not applicable	
2.6 Not applicable	
2.7 The Board supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	<p>The Board receives a Financial update report from the Director of Finance at each meeting which outlines the ongoing financial position. The Finance Committee and the Audit Committee support the Board in providing scrutiny and assurance on financial management.</p> <p>Due to the current financial climate, the Board has also held detailed discussions with regards to the Health Board's financial position at its Board Development Sessions.</p>
2.8 Not applicable	
2.9 Not applicable	
2.10 Not applicable	
2.11 Not applicable	
2.12 Where Board Members have concerns, which cannot be resolved, they should ensure that their concerns are recorded in the minutes.	<p>If Board Members raise any issues or concerns during a meeting they are always captured in the minutes. Members also have further opportunities to raise issues when the meeting minutes are formally received and confirmed at the next meeting of the Board under the approval of minutes agenda item and under matters arising.</p> <p>Also, where an individual Chair of a Committee of the Board has any particular concern with regards to any matters discussed at the Committee, the Committee Chair can bring those concerns to the attention of Board members via the Chair's Report to the Board.</p>
Chapter 3 Board composition	

Requirement of the Code	Evidence of CVUHB Compliance
3.1 The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the Board should be balanced, diverse and manageable in size.	The Board comprises of Independent Members who are appointed by Welsh Government on the merit of their skills and experience.
3.2 The roles and responsibilities of all Board Members should be defined clearly in the department's Board operating framework.	<p>The Health Board's Standing Orders (which are based upon the Welsh Government's Model Standing Orders for NHS Wales) stipulate that:</p> <p>Officer Members - there should be 9 officer members (including the Chief Executive) appointed by the Board whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science.</p> <p>Non-Officer Members (Independent Members) - A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding. The IMs also have champion roles within the CVUHB.</p> <p>Associate Members - A total of 4 associate members may be appointed to the Board, to include a Director of Social Services (nominated by local authorities in the LHB area), Chair of the Stakeholder Reference Group and Chair of the Healthcare Professionals' Forum.</p>
3.3 Not wholly applicable, however one reference is:	The job description for the Executive Director of Finance stipulates that they must be a qualified accountant.

Requirement of the Code	Evidence of CVUHB Compliance
<p><i>“The Board should be balanced, with approximately equal numbers of ministers, senior officials and non-executive Board members. It should comprise:</i></p> <ul style="list-style-type: none"> <i>the Finance Director, who should be professionally qualified”</i> 	
3.4 Not applicable	
3.5 Non-executive Board Members will exercise their role through influence and advice, supporting as well as challenging the executive.	Independent Members understand that their role is to scrutinise and seek assurance through attending Board and Committee meetings. They provide advice and guidance on planning, organisational strategy, monitor performance and operational issues, financial management, effective governance and are also involved in the recruitment, ongoing appraisal and succession planning of the Executive Team.
3.6 Not applicable	
3.7 Not applicable	
3.8 Not applicable	
3.9 Not applicable	
3.10 The Board should provide collective strategic and operational leadership.	The Board provides collective, strategic and operational leadership through discharging its responsibilities through the Board and Committee meetings.
3.11 The Board should include people with a mix and balance of skills.	As outlined in 3.2 above, the Board includes people with a mix of balance and skills as prescribed by the model Standing Orders for NHS Wales.
3.12 The mix and balance of skills and understanding should be reviewed annually as part of the Board effectiveness evaluation.	<p>Board Members received annual performance appraisals.</p> <p>The Annual Committee effectiveness survey was undertaken in during February to April 2023 and the overall findings indicated that the Board was operating effectively.</p> <p>The Chair of the Board and each Committee, review the effectiveness of individual meetings as part of the agenda at each meeting.</p>
3.13 The search for Board candidates should be conducted, and appointments made, on merit, with due regard for the benefits of diversity on the Board, including gender.	Public Appointments are supported by the Welsh Government Public appointments team, who ensure that recruitment campaigns, and the appointments process take account of the diversity of the Board.

Mohammed Saad
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Requirement of the Code	Evidence of CVUHB Compliance
3.14 Not applicable	
3.15 The Board should agree and document in its Board operating framework a <i>de minimis</i> threshold and mechanism for Board advice on the operation and delivery of policy proposals.	The Health Board's Standing Orders provide that at least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.
3.16 Not applicable	
3.17 Not applicable	
3.18 Not applicable	
3.19 Not applicable	
Chapter 4 Board effectiveness	
4.1 The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively.	<ul style="list-style-type: none"> • There are formal procedures in place for the appointment of new Board Members. • Sufficient time is allowed for members to discharge their duties with provision in the Standing Orders (i) for Board papers to be circulated at least ten days prior to the relevant meeting and (ii) the Committees' Terms of Reference for Committee papers to be circulated at least seven days in advance of the meeting. • There is an induction training programme in place for new Independent Members. • The Board and Committees are supported by the Director of Corporate Governance and the dedicated Committee Secretariat function.
4.2 Not applicable	
4.3 Not applicable	
4.4 Not applicable	
4.5 The terms of reference for the Nominations Committee will include <ul style="list-style-type: none"> • identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the Board and of senior management, • scrutinising incentives and rewards for executive Board members and senior officials 	The Remuneration and Terms of Service Committee fulfils this function and is developing plans to monitor and deliver succession planning as well as developing leadership. As the Health Board is required to adhere to the agenda for change policy which sets out remuneration, incentives and rewards, these are not applicable as they are not part of the package.

Mohamed Saif
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Requirement of the Code	Evidence of CVUHB Compliance
4.6 The attendance record of individual Board Members should be disclosed in the Governance Statement and cover meetings of the Board and its Committees held in the period to which the resource accounts relate	The Accountability report within the Annual Report 2022-2023 provides the attendance record for Board members.
4.7 Not applicable	
4.8 Not applicable, although principles apply. In short, Board members should receive accurate, timely and clear information and Board information should be concise, fit for purpose and over the main areas of the Board's activities.	<p>In line with the Health Board's Standing Orders, Board papers are provided to Board members at least ten days prior to the Board meeting.</p> <p>An annual Work Plan detailing the main areas of business for the coming year is presented to Board Members for consideration and approval. The annual Work Plan for 2022-23 was approved by Board at its meeting held on 31 March 2022. The Board approved its annual Work Plan for 2023-24 on 30 March 2023.</p>
4.9 Not applicable, although principles apply. That is, that the information presented to Board Members should enable comparison with relevant organisations.	Wherever appropriate, benchmarking information is provided to Board Members as part of routine business. Whilst efforts have been made during the last year to improve upon this area, it is recognised that this could be strengthened further.
4.10 Where necessary, Board Members should seek clarification or amplification on Board issues or Board papers through the Board Secretary.	All members have access to the Director of Corporate Governance who is the main governance advisor to the Board.
4.11 An effective Board Secretary is essential for an effective Board.	<p>The Director of Corporate Governance:</p> <ul style="list-style-type: none"> • Ensures that there are regular agenda planning sessions with the Chair and Executive lead for the Board and Committees, with effective mechanisms in place to ensure information flows from these fora to the Executive Directors and Independent Members, as well as senior management. • Ensures the quality of Board and Committee papers are appropriate and received by members in accordance with the timetable set, • Provides governance support and advice to the Board, • Provides assurance on compliance with relevant legal and regulatory frameworks, including the Code,

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Requirement of the Code	Evidence of CVUHB Compliance
	<ul style="list-style-type: none"> • Acts as the focal point for interaction between Independent Board Members and the department • Records Board decisions accurately ensuring action points are followed up • Arranges Induction and development of Independent Board Members.
4.12 n/a principles apply	
4.13 n/a principles apply	
4.14 Evaluations of the performance of individual Board Members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for Board and committee meetings and other duties).	Board Members are subject to an annual performance appraisal by the Chair and Chief Executive. The Chair and Chief Executive are subject to appraisals involving the Minister for Health & Social Services, led by Welsh Government.
4.15 All potential conflicts of interest for Non-Executive Board Members should be considered on a case by case basis. All relevant interests of individual Board Members and any potential conflicts of interest, should be published in its governance statement.	<p>Each Board Member is required to complete and submit a declarations of interest form annually to declare any personal or prejudicial interests relating to the business of CVUHB. Each Member is required to update it should new conflicts of interest arise during the year.</p> <p>The DOI information is scrutinised by the Corporate Governance Department and the Audit Committee, and the information is included in the Annual Accountability Report.</p> <p>In addition, the agenda for each Board and Committee meeting includes an agenda item requesting that members declare any interest they have relevant to the meetings business discussions, these are recorded in the minutes.</p>
Chapter 5 Risk Management	
5.1 The Board should ensure that there are effective arrangements for governance, risk management and internal control.	CVUHB has a Risk Management Framework and Strategy in place which sets out the organisation's approach to governance, risk management and internal control, which is led by the Director of Corporate Governance.
5.2 The Board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year.	The Audit and Assurance Committee is responsible for reviewing the draft Annual Governance Statement, prior to it being submitted to the Board for final

Requirement of the Code	Evidence of CVUHB Compliance
	approval and inclusion in the Annual Report.
5.3 The Board's regular agenda should include scrutinising and advising on risk management.	<p>The Board receives regular updates on Risk Management and the Corporate Risk Register and Board Assurance Framework (BAF) are considered by the Board at each of its bi-monthly meeting, and by the Audit and Assurance Committee.</p> <p>The key risks detailed in the BAF and Corporate Risk Register are also shared at relevant sub-committees of the Board for further scrutiny and discussion.</p>
5.4 The key responsibilities of non-executive Board members include forming an audit and risk assurance committee.	The Audit and Assurance Committee has been in place since the inception of the Health Board.
5.5 The head of internal audit should periodically be invited to attend Board meetings, where key issues are discussed relating to governance, risk management processes or controls.	The Head of Internal Audit is invited to all Audit and Assurance Committees and attends the Audit and Assurance Committee, Board meetings and other Committee meetings as required.
5.6 The Board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The Board should give a clear steer on the desired risk appetite for the department.	<p>The Audit and Assurance Committee provide assurance to the Board on the effectiveness of the risk management system and systems of internal control through its own Audit and Assurance Committee annual report, and through the Accountability report. The Risk Management system also goes through an annual internal audit review.</p> <p>The Board revisited its Risk Appetite at a Board Development session in June 2021. This was to discuss Risk Appetite and to check that the direction of travel was right and that the Board was moving in the right direction from a position of 'Cautious' to 'Seek'.</p> <p>At its meeting on 30 March 2023, the Board approved the updated Assurance Strategy 2021-24 and the Risk Management and Board Assurance Framework Strategy.</p>
5.7 The Board should also ensure that the departments have appropriate and effective risk management processes through the department's teams.	The Board received the Board Assurance Framework at each of its meetings. This is cross referenced to the Corporate Risk Register which provides oversight of significant risks

Requirement of the Code	Evidence of CVUHB Compliance
	from each of the Clinical Boards. This provides assurance to the Board that robust risk management processes are in place throughout the organisation.
5.8 The Board should ensure there are effective arrangements for internal audit.	The Audit and Assurance Committee receives the annual Internal Audit Plan in March each year and the audit assessment findings of each review undertaken in the reporting period. The full reports are then referred to the relevant Board committee to follow-up the action plans of those which cause concern. In addition to this, all internal audit recommendations are tracked by the Corporate Governance Directorate and reported to the Audit and Assurance Committee at each meeting.
5.9 The Board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.	The Audit and Assurance Committee has been in place since the inception of the health Board and is chaired by the Independent Member for Finance, supported by at least two other Independent Members.
5.10 Advising on key risks is a role for the Board. The audit and risk assurance committee should support the Board in this role.	<p>The Board receives the BAF at each meeting which provides information on the key risks impacting upon the Strategic Objectives of the Health Board.</p> <p>The Audit and Assurance Committee reviews the Risk Management Strategy prior to Board approval.</p>
5.11 An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the Audit and risk assurance committee handbook. 3	Any decisions to be made are done so by the Board on the recommendation of the Audit and Assurance Committee.
5.12 The Board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function.	The Director of Corporate Governance and the Corporate Governance Team provide support to the Audit and Assurance Committee.

Requirement of the Code	Evidence of CVUHB Compliance
<p>5.13 The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the Board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the Board.</p>	<p>The draft Annual Governance Statement is presented to the Audit and Assurance Committee for endorsement, prior to submission to the Board.</p> <p>The Audit and Assurance Committee papers are published on the CVUHB website.</p>
<p>5.14 The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the Board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities.</p>	<p>The Terms of Reference for the Audit and Assurance Committee are published on the CVUHB website. The Committee produces an Annual Report outlining the business discussions of the Committee which is presented to the Board for assurance.</p> <p>The Terms of Reference and the Annual Report of the Audit and Assurance Committee were reviewed and approved by the Board on 30 March 2023.</p>
<p>5.15 All Boards should ensure the scrutiny of governance arrangements, whether at the Board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.</p>	<p>The Board and Committees are required to complete an annual committee effectiveness survey.</p> <p>The Head of Internal Audit is required to provide an annual assessment on the governance framework in place at CVUHB as part of the annual reporting process.</p>
<p>Chapter 6 Arm's Length Bodies</p>	
<p>Not applicable</p>	

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Report Title:	Board and Committee Effectiveness Surveys 2022-23	Agenda Item no.	7.4
Meeting:	Audit and Assurance Committee	Meeting Date:	11 May 2023
Status <i>(please tick one only):</i>	Assurance <input type="checkbox"/> x Approval <input checked="" type="checkbox"/> Information <input type="checkbox"/>		
Lead Executive:	Director of Corporate Governance		
Report Author (Title):	Head of Corporate Governance		

Main Report

Background and current situation:

Routine monitoring of the effectiveness of the Board and its Committees is a vital part of ensuring strong and effective governance within the Health's Board's governance structure. Under its Standing Orders (SO 10.2.1), the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Further, and where appropriate, the Board may determine that such evaluation may be independently facilitated.

The Health Board undertook an annual review of the effectiveness of its Board and its Committees during February and March 2023 using survey questions derived from best practice guides, including the NHS Handbook, and using the following principles:

- the need for sub-Committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives;
- the requirement for a Committee structure that strengthens the role of the Board in strategic decision making and supports the role of non-executive directors in challenging Executive management actions;
- maximising the value of the input from non-executive directors, given their limited time commitment; and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

For the 2022-2023 self-assessment, a survey was disseminated via Microsoft Forms to all Board and Committee Members and Board and Committee attendees, enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

This year, as part of the annual review, a session is scheduled to take place at the Board Development Session being held on 27 April 2023 so that the Board Members can discuss any common themes and Committee wider learning from the Board and Committees' survey results.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2022-2023, and to provide an update on the action plan following the survey undertaken in 2021-2022.

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

- Following the survey undertaken in 2021-2022, the Board Effectiveness Action Plan 2021-2022 is presented **within Appendix 1** and outlines the actions completed following the survey undertaken in 2021-2022.

- The survey questionnaires for the annual Board/Committee Effectiveness Surveys 2022-2023 were issued during February to March 2023 and attained a positive response rate overall.
- The overall findings are positive which provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committees are effectively supporting the Board in fulfilling its role.
- Out of the questions posed, room for improvement was identified in 9 areas and a Board Effectiveness Action Plan 2022-2023 has been developed to address them which is presented **within Appendix 2** and outlines proposed actions to strengthen and develop the areas identified. It is suggested that this action plan be progressed via Board Development sessions. Assurance is provided by work already in train in many of these areas as referenced in the action plan.
- The individual findings of the Annual Board/Committee Effectiveness Surveys 2022-2023 undertaken during February and March 2023 are presented **within Appendixes 3-12** for information.
- The individual Board/Committee survey findings will be presented to each relevant Committee for assurance.

To ensure effective governance the Board Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in February/March 2024 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2023-2024.

Recommendation:

The Committee is requested to:

- NOTE** the results of the Annual Board Effectiveness Survey 2022-2023, and the action plan for 2022-2023, to be progressed via Board Development sessions; and
- NOTE** the completed actions within the Board Committee Effectiveness Action plan 2021-2022.

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	
3. All take responsibility for improving our health and wellbeing	x	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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: No

The Socio-Economic Duty is designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES](#)

(If this has been addressed in the main body of the report, please confirm)

Equality and Health: No

Equality Health Impact Assessments (EHIA) are typically undertaken when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.

Useful guidance on the completion of an EHIA can be found at the following link: [EHIA toolkit - Cardiff and Vale University Health Board \(nhs.wales\)](#)

(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No

Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.

(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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Board Effectiveness – Self Assessment 2021-2022 Action Plan

The table below identified areas from the Annual Committee Effectiveness Survey 2021-2022 undertaken in April 2022, that suggested a need for Further Improvement

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
Board 8. We Identify and Share Best Practice and benchmark	<p>The Board are proactive in utilising business intelligence to support effective decision making and benchmarking is undertaken through the various NHS Wales professional peer groups, for example the NHS Wales Directors of Nursing Group, NHS Wales Board Secretaries Network etc.</p> <p>The Integrated Performance Report has been developed further to strengthen performance benchmarking and this was discussed at a recent Board Development session (April 2022).</p> <p>Action Consider strengthening and developing sharing best practice with/benchmarking against large teaching Health Board across the UK.</p>	Executive Nurse Director, Executive Director for Strategic Planning, Executive Medical Director, Chief Operating Officer, Executive Director of People and Culture, and Director of Digital Health Intelligence.	October 2022	<p>This work has progressed with strengthened benchmarking against and sharing good practice with other large teaching Health Boards in across the UK.</p> <p>During 2022/23 the Board has also considered and developed the Integrated Performance Report which includes Key Performance Indicators for Quality and Safety, Finance, Workforce, Performance and Public Health.</p>
Board 10. We invite effective feedback and use the lessons learned to develop and improve the	<p>The Chair of the Board reviews the effectiveness of the Board meeting as part of the agenda at each respective meeting.</p>	Director of Corporate Governance	July 2022	Each Board/Committee agenda includes an item to review the meeting at the end

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
Board's and senior management team's effectiveness.	<p>Action</p> <p>The Corporate Governance team will develop a series of prompts (eg did the meeting start and end on time, did all members receive a full set of papers prior to the meeting) which can be used as part of the review at the end of each Board and Committee meeting.</p>			of the meeting concerned.
<p><u>Quality, Safety and Experience Committee</u> <u>Strategy and Delivery Committee</u> <u>Shaping our Future</u> <u>Hospitals Committee</u> 9. Are changes to the Committee's current and future workload discussed and approved at Board level.</p>	<p>All Committees annually produce a Work Plan to reflect their respective Terms of Reference in order to ensure that the Committee concerned is discharging its responsibilities appropriately. The Committees' annual Work Plans and Terms of Business are approved by the Board on an annual basis (this year – on 31 March 2022).</p> <p>As part of the end of year arrangements, each Committee produces an Annual Report which provides a summary of the business undertaken by the relevant Committee and sets out how the Committee has complied with its Terms of Reference.</p> <p>Any other routine business (which is not recorded on the annual Work Plan) to be undertaken by a Committee is logged on the Forward Plan to ensure it is captured at the relevant agenda setting meeting.</p>	Director of Corporate Governance	March 2023	<p>During 2022/23 the Health Board undertook a full review of its Committee structure to ensure that it is fit for purpose and supports the Board in discharging its functions. The updated Committee structure arrangements were approved by the Board on 30 March 2023 and took effect on 1 April 2023.</p> <p>At its meeting on 30 March 2023, the Board also considered and approved the Committees' annual</p>

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Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				Work Plans and Terms of Reference.
<p><u>Health & Safety Committee</u> <u>Strategy and Delivery Committee</u> <u>Shaping our Future Hospitals Committee</u></p> <p>12. Has the Committee established a plan for the conduct of its work across the year.</p> <p>Mohamed Sarah 02/05/2023 17:42:26</p>	<p>All Committees annually produce a Work Plan to reflect their respective Terms of Reference in order to ensure that the Committee concerned is discharging its responsibilities appropriately. The Committees' annual Work Plans and Terms of Business are approved by the Board on an annual basis. This year the Committees' annual Work Plans for 2022-23 received Board approval on 31 March 2022).</p>	<p>Director of Corporate Governance</p>	<p>March 2023</p>	<p>During 2022/23 the Health Board undertook a full review of its Committee structure to ensure that it is fit for purpose and supports the Board in discharging its functions. The updated Committee structure took effect on 1 April 2023.</p> <p>As part of the updated Committee structure arrangements, the Health and Safety Committee became a Sub-Committee and will report to the newly established People and Culture Committee. Accordingly, the Terms of Reference and annual Work Plan of the Health and Safety Sub-Committee will be</p>

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				presented to the People and Culture Committee for consideration and ratification.
<p><u>Health & Safety Committee</u> <u>Charitable Funds Committee</u> <u>Shaping Our Future Hospitals Committee</u></p> <p>13. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?</p> <p>Mohamed Sarah 02/05/2023 17:42:26</p>	<p>The Committee's Terms of Reference detail the programme of work to be undertaken by the Committee concerned, including any appropriate standards which the Health Board should comply with. The Committees' Terms of Reference are designed to ensure there is no duplication of the work undertaken by the various Committees and the Board.</p>	<p>Director of Corporate Governance</p>		<p>During 2022/23 the Health Board undertook a full review of its Committee structure to ensure that it is fit for purpose and supports the Board in discharging its functions. The updated Committee structure took effect on 1 April 2023.</p> <p>As part of the updated Committee structure arrangements, the Health and Safety Committee became a Sub-Committee and will report to the newly established People and Culture Committee. Accordingly, the Terms of Reference and annual Work</p>

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				Plan of the Health and Safety Sub-Committee will be presented to the People and Culture Committee for consideration and ratification.
<p><u>Audit and Assurance Committee</u></p> <p>15. Is a Committee meeting scheduled to discuss proposed adjustments to the Accounts and issues arising from the audit, and does the Committee annual review the accounting policies of the organisation.</p> <p><i>Mohamed Sarah 02/05/2023 17:42:26</i></p>	<p>A Special Audit Committee meeting is scheduled each year to consider and discuss the reported financial performance in the draft accounts, any adjustments made to the same and any issues arising from the financial audit. In relation to the draft accounts 2021/22 a Special Audit and Assurance meeting has been scheduled to take place on 14 June 2022.</p> <p>The Audit and Assurance Committee undertakes an annual review of its Standing Financial Orders (which are based upon the Welsh Government’s model SFIs) and accounting policies. The last review took place at the Audit and Assurance Committee meeting held on 5 April 2022.</p>	<p>Director of Corporate Governance</p>	<p>October 2022</p>	<p>Last year a Special Audit and Assurance Committee took place on 14 June 2022 to consider the draft accounts, prior to the same being presented to the Board for sign off on 14 June 2022.</p> <p>This year a Special meeting of the Audit and Assurance Committee is scheduled to take place on 25 July 2023 to consider the draft accounts, with the same scheduled to go to Board for sign off on 27 July 2023 in readiness for submission to</p>

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				<p>the Welsh Government and Audit Wales by 31 July 2023.</p> <p>The Audit and Assurance Committee undertook an annual review of the Standing Financial Orders and accounting policies on 4 April 2023.</p>
<p><u>Audit and Assurance Committee</u></p> <p>20. Does the Board ensure that the Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters.</p> <p><i>Mohamed Sarah 02/05/2023 17:42:26</i></p>	<p>The Board ensures the Committee Members have sufficient knowledge to identify key risks and challenge management and the auditors by a number of actions. This includes the following:-</p> <ul style="list-style-type: none"> - Routine new Independent Member induction sessions. - Routine Business Development Sessions which are designed to support and equip Board Members with the knowledge they need in order deliver their responsibilities as set out within the Board and Committees' Annual Plans and the Health Board's 10 Year Strategy Shaping our Future Wellbeing. 	<p>Director of Corporate Governance</p>	<p>March 2023</p>	<p>During 2022/23 Audit and Assurance Committee members have had access to:-</p> <p>Board Development Sessions to support and equip Board Members with the knowledge to undertake their roles effectively;</p> <p>Access to the Director of</p>

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
	<ul style="list-style-type: none"> - Access to the Director of Corporate Governance should any member of the Committee feel that they are not equipped to deliver on a matter and/or have any particular concerns. - Chair and the Executive Lead of the Audit and Assurance are qualified accountants. 			<p>Corporate Governance;</p> <p>Access to the auditors without the presence of officials via a pre meeting to the routine Committee meetings.</p>

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Board Effectiveness – Self Assessment 2022-2023 Action Plan

The table below identified areas from the Annual Committee Effectiveness Survey 2022-2023 undertaken in February to March 2023, that suggested a need for Further Improvement

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
<p>Board</p> <p>5. The Board scrutinises and challenges performance against delivery of the strategy.</p> <p><i>Mohamed Sarah 02/05/2023 17:42:26</i></p>	<p>The Board Assurance Framework (BAF), which provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board’s Strategy ‘Shaping our Future Wellbeing’ (the Strategy) is presented at each Board meeting. Other agenda items presented to the Board flow from the BAF.</p> <p>During 2022/23 the Health Board reviewed its Committee structure and, as part of that review, the Board approved that the Strategy and Delivery Committee would cease with effect from 1 April 2023 and that the “strategy” element would become a standing item at each Board Development Session. The purpose being to allow the Board, as a whole, a greater opportunity to develop and review the Health Board’s Strategy and support its strategic plans.</p> <p>The Health Board is currently reviewing the Strategy and more time is being afforded to the Board, via its Board Development Sessions, to consider further how the Board can scrutinise and challenge the Health Board’s performance against the Strategy.</p>	<p><i>Director of Corporate Governance</i></p>	<p><i>October 2023</i></p>

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
<p><u>Board</u></p> <p>8. We identify and share best practice and benchmark.</p>	<p>The Board is proactive in utilising business intelligence to support effective decision making and benchmarking is undertaken through the various NHS Wales professional peer groups, for example the NHS Wales Directors of Nursing Group, NHS Wales Board Secretaries Network etc.</p> <p>The Integrated Performance Report was developed further during 2022/23 to strengthen performance benchmarking and was discussed at the Board Development sessions held in April, August, October 2022 and February 2023.</p> <p>The IPR is presented at each Board and Board Development Session and report authors are encouraged to provide benchmarking data to compare the Health Board’s performance against similar Health Boards across the UK.</p> <p>As of April 2023, the newly established Finance and Performance Committee will be considering a number of “deep dives” in relation to matters/issues flowing from the IPR.</p> <p>Action</p>	<p>Executive Nurse Director, Executive Director for Strategic Planning, Executive Medical Director, Chief Operating Officer, Executive Director of People and Culture, Executive Director of Public Health, and Director of Digital Health Intelligence</p>	<p><i>October 2023</i></p>

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Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	Consider further strengthening and developing sharing best practice with/benchmarking against large teaching Health Board across the UK.		
Board 13. There is timely provision of information in a form and of a quality that enables the Board to discharge its duties effectively.	<p>All Board papers received by the Corporate Governance Team are published at least 10 clear days before the relevant Board meeting.</p> <p>A task and finish group has recently been established to review the quantity and quality of Board papers in order to streamline the meeting pack / ensure appropriateness of matters which require the Board's consideration.</p>	Director of Corporate Governance	<i>October 2023</i>
Board 14. Committees inform the Board on their significant activities, actions, recommendations and performance through minutes and regular reports and have appropriate relationships with other Committees.	<p>The Committees provide copies of their minutes to the Board for approval and a written report by each Committee Chair is provided at the relevant Board meetings. This is to ensure that all Board members are sighted on major/significant issues and contribute to the assessment of assurance and provide scrutiny against the delivery of strategic objectives.</p> <p>Actions referred from a Committee to another Committees and /or Board are cross-referenced on the relevant Committee/Board Action Logs to ensure that they are appropriately captured.</p>	Director of Corporate Governance	March 2024

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Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	<p>Each Committee produces an Annual Report which provides a synopsis of the work undertaken by the Committee during the year. The purpose of the Committees' Annual Reports is to demonstrate how the Committees have met the requirements of their respective Terms of Reference and to provide assurance to the Board. The Committees' Annual Reports are presented to the Board for approval (this year that was on 30 March 2023).</p> <p>Independent Members are encouraged to attend other Committees of the Board (ie where they are not appointed members to other Committees).</p>		
<p><u>Quality, Safety and Experience Committee</u> 9. Committees are well organised, efficient, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities</p> <p><i>Mohamed Sarah 02/05/2023 17:42:26</i></p>	<p>During the year 2022-23, the QSE Committee met bi-monthly.</p> <p>As of 1 April 2023, the Committee will be meeting on a monthly basis for the foreseeable future in order to ensure sufficient time is afforded to quality improvement.</p> <p>An annual Work Plan has been produced to ensure appropriate reporting requirements are met/relevant matters are considered by the Committee. The Committee's Terms of Reference were reviewed by the Committee in December 2023 (and approved by Board</p>	<p>Director of Corporate Governance</p>	<p>March 2024</p>

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	<p>on 30 March 2023) and updated to reflect the new requirements of the Health and Social Care (Quality and Engagement)(Wales) Act 2020 which come into force in Spring 2023.</p> <p>As far as possible, the Committee’s meeting papers are published 7 clear days prior to the date of the relevant meeting in order to allow Committee Members sufficient time to consider the papers in advance of the meeting.</p> <p>This year the agenda included a time allocated per agenda item to assist with managing the meeting in a more timely manner.</p>		
<p><u>Quality, Safety and Experience Committee</u> 14. The Committee agenda setting process is thorough and led by the Committee Chair</p> <p><i>Mohamed Sarah 02/05/2023 17:42:26</i></p>	<p>All Board/Committee meetings are supported through an agenda setting meeting, the purpose of which is to review/discuss the agenda, draft minutes and draft Action Log, timings for agenda items and length of meeting. It is recognised that a copy of the draft minutes may not always be available in advance of the agenda setting meeting.</p> <p>The Committee Chair attends the meeting and is involved in setting the agenda with the Executive Leads for the Committee and the Director of Corporate Governance.</p>	<p>Director of Corporate Governance</p>	<p>March 2024</p>

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	<p>Action – to ensure that all relevant individuals (including the Committee Chair) are sent a copy of the draft agenda, draft minutes and draft Action Log in advance of the agenda setting meeting.</p>		
<p><u>Charitable Funds Committee</u></p> <p>8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.</p> <p>Mohamed Sarah 02/05/2023 17:42:26</p>	<p>All papers received by the Corporate Governance Team are published 7 clear days prior to the date of the meeting, in accordance with the Committee’s Terms of Reference.</p> <p>There are occasions where the Committee papers are received late by the Corporate Governance Team. The Corporate Governance Team’s Standard Operating Procedure (SOP) was updated to build in further prompts to email reminders to the relevant report authors.</p> <p>It is acknowledged that there is sometimes a delay in providing draft minutes following the relevant meeting.</p> <p>Action – The Corporate Governance Team will continue, in line with the SOP, to remind report authors for any outstanding papers prior to the relevant publication date.</p> <p>The Corporate Governance Team will endeavour to provide a copy of the draft minutes in accordance with the timescales set out in the SOP whilst having regard to work</p>	<p>Director of Corporate Governance</p>	<p>March 2024</p>

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	which may need to take priority and/or available resource within the Corporate Governance Team.		
<p><u>Mental Health Legislation and Mental Capacity Act Committee</u></p> <p>1. The Committee terms of reference clearly, adequately and realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and full Board.</p>	<p>The Committee's Terms of Reference detail the programme of work to be undertaken by the Committee concerned, including any appropriate standards which the Health Board should comply with.</p> <p>The Committee's Terms of Reference are reviewed annually by the Committee and Board. The Committee's Terms of Reference 2023/24 were last reviewed by the Committee and recommended to Board for approval on 31 January 2023 . The Board approved these Terms of Reference on 30 March 2023.</p>	Director of Corporate Governance	March 2024
<p><u>Mental Health Legislation and Mental Capacity Act Committee</u></p> <p>3. Are the terms of reference reviewed annually to take account of governance developments and the remit of other committees within the organisation.</p>	<p>Each Committee of the Board reviews its Terms of Reference on an annual basis before the same are presented to the Board for formal approval.</p> <p>The Committee's Terms of Reference detail the programme of work to be undertaken by the Committee concerned, including any appropriate standards which the Health Board should comply with.</p>	Director of Corporate Governance	March 2024

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Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	<p>Each Committee’s Terms of Reference are designed to ensure that there is no duplication of the work undertaken by the various Committees of the Board.</p> <p>During 2022/23 the Health Board undertook a full review of its Committee structure to ensure that it is fit for purpose and supports the Board in discharging its functions. The updated Committee structure took effect on 1 April 2023.</p>		

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Appendix 2 -Annual Board Effectiveness Survey - Audit & Assurance

8

Responses

1. The Audit & Assurance Committee terms of reference clearly, adequately & realistically set out the Committee’s role and nature and scope of its responsibilities in accordance with Welsh Government guidance and have been approved by the Committee and the Board.

● Needs Improvement	0
● Adequate	1
● Strong	7



2. The Board was active in its consideration of Audit & Assurance Committee composition, including the designation or consideration of an “audit committee financial expert.”

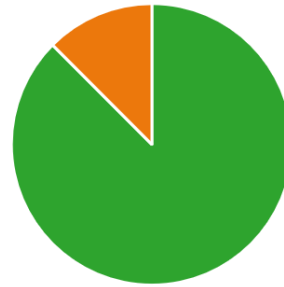
● Needs Improvement	0
● Adequate	2
● Strong	6



Mohamed Sarah
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3. Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation?

Yes	7
No	0
Unsure	1



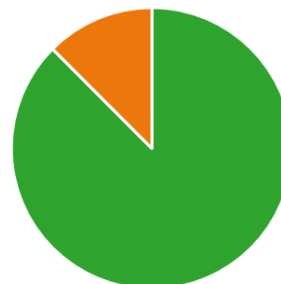
4. There is appropriate consideration of the UHB's financial reporting risks and the related internal controls, which are reflected in the Audit Committee's discussions and agenda items.

Needs Improvement	0
Adequate	2
Strong	6



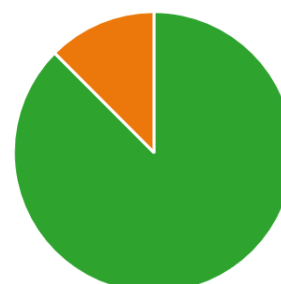
5. Is the Committee's role in the approval of the Annual Accounts clearly defined?

Yes	7
No	0
Unsure	1



6. Is a Committee meeting scheduled to discuss proposed adjustments to the Accounts and issues arising from the audit, and does the Committee annually review the accounting policies of the organisation?

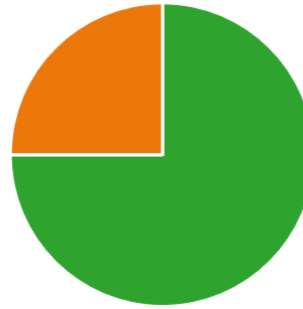
Yes	7
No	0
Unsure	1



Mohamed Sarah
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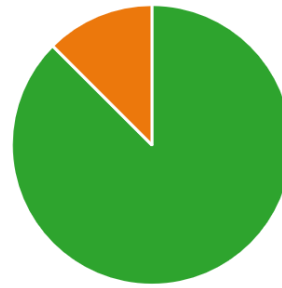
7. Has the Committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?

Yes	6
No	0
Unsure	2



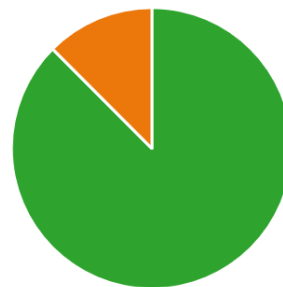
8. Has the Committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Statement of Internal Control, the Assurance Framework, Standards for better Health and the Head of Internal Audit's opinion?

Yes	7
No	0
Unsure	1



9. Has the Committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged?

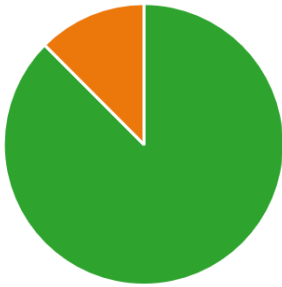
Yes	7
No	0
Unsure	1



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10. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters?

Yes	7
No	0
Unsure	1



11. There is active considerations of audit plans and results of external audit.

Needs Improvement	0
Adequate	1
Strong	7



12. There is appropriate consideration of Internal Audit's plan, resources, and ability.

Needs Improvement	0
Adequate	1
Strong	7



13. There is appropriate consideration of Internal Audit's reports, management's response, and improvement actions.

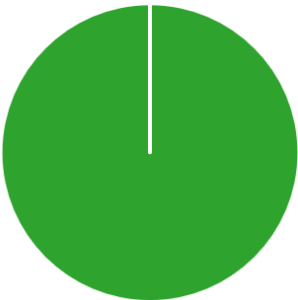
Needs Improvement	0
Adequate	1
Strong	7



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14. Are the terms of reference for Internal Audit approved by the Committee and routinely reviewed?

- Yes 8
- No 0
- Unsure 0



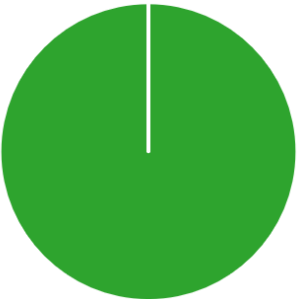
15. Does the Committee review and approve the internal audit plan at the beginning of the financial year?

- Yes 8
- No 0
- Unsure 0



16. Does the Committee approve any material changes to the Internal Audit plan?

- Yes 8
- No 0
- Unsure 0



17. Does the Committee effectively monitor the implementation of management actions arising from Internal Audit reports?

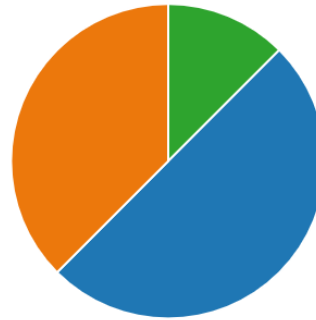
- Yes 8
- No 0
- Unsure 0



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18. Are any scope restrictions placed on Internal Audit and, if so, what are they and who establishes them?

Yes	1
No	4
Unsure	3



19. Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?

Yes	6
No	0
Unsure	2



20. Has the Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?

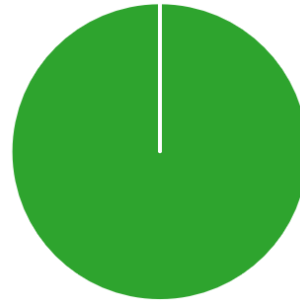
Yes	6
No	0
Unsure	2



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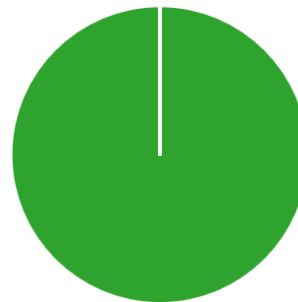
21. Does the Committee receive and monitor actions taken in respect of prior year External Audit plans?

Yes	8
No	0
Unsure	0



22. Does the Committee review the External Auditor's Annual audit letter and assess the performance of the External Audit?

Yes	8
No	0
Unsure	0



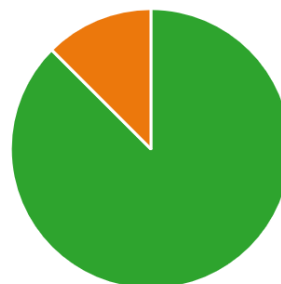
23. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Needs Improvement	0
Adequate	1
Strong	7



24. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

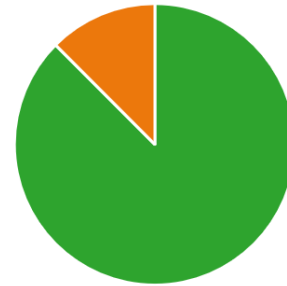
Yes	7
No	0
Unsure	1



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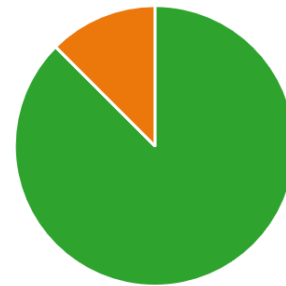
25. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	7
No	0
Unsure	1



26. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	7
No	0
Unsure	1



27. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Needs Improvement	0
Adequate	2
Strong	6



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28. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

Needs Improvement	0
Adequate	2
Strong	6



29. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

Needs Improvement	0
Adequate	1
Strong	7



30. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Needs Improvement	0
Adequate	2
Strong	6



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31. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Needs Improvement	0
Adequate	1
Strong	7



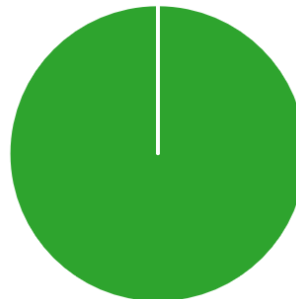
32. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	6
No	0
Unsure	2



33. Are Committee members independent of the management team?

Yes	8
No	0
Unsure	0



34. The Committee agenda-setting process is thorough and led by the Committee Chair.

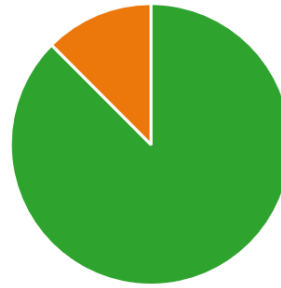
Needs Improvement	0
Adequate	1
Strong	7



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35. Has the Committee established a plan for the conduct of its work across the year?

● Yes	7
● No	0
● Unsure	1



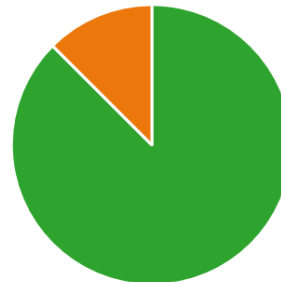
36. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

● Yes	6
● No	0
● Unsure	2



37. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

● Yes	7
● No	0
● Unsure	1



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38. The Committee's self-evaluation process is in place and effective.

● Needs Improvement	0
● Adequate	1
● Strong	7



39. What is your overall assessment of the performance of the Committee?

- The Committee functions extremely well.
- Committee is well chaired and has strong scrutiny. When low assurance is noted, the Clinical board attends the committee to show actions and improvement.
- Committee members continue to welcome feedback and ongoing improvement.
- Strong committee which is clear on its purpose and discharges that effectively.
- The Committee is effectively and efficiently run with excellent engagement with Internal Audit and Audit Wales
- The Committee has the appropriate expertise to provide adequate scrutiny and support. The relationship between IMs and Executives is collegiate but with appropriate independence to provide professional scrutiny.
- Adequate
- Operates effectively with a clear remit and effective oversight of key matters. The Committee is well chaired and supported by effective independent members with a reasonable level of scrutiny.

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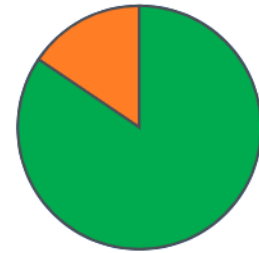
Annual Board Effectiveness Survey

Board Questions Appendix 1

Responses: 13

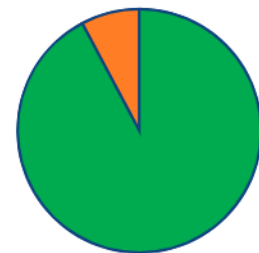
1. The Board is effective and provides leadership and a clear vision for the UHB's business.

● Strong	11
● Adequate	2
● Needs Improvements	0



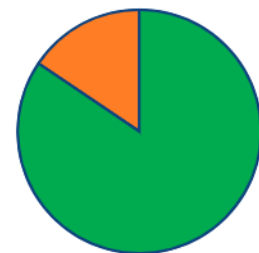
2. The Board has agreed and communicated clear values and behaviours for the organisation and its priorities reflect these.

● Strong	12
● Adequate	1
● Needs Improvements	0



3. The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services and the steps being taken to address them.

● Strong	11
● Adequate	2
● Needs Improvements	0






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4. The Board has a credible strategy to provide quality, sustainable services to patients and there is a robust plan to deliver this.

 Strong	7
 Adequate	6
 Needs Improvements	0






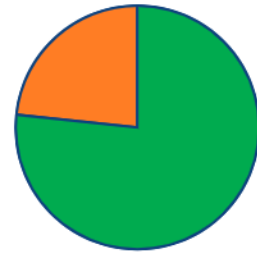
5. The Board scrutinises and challenges performance against delivery of the strategy.

 Strong	10
 Adequate	2
 Needs Improvements	1






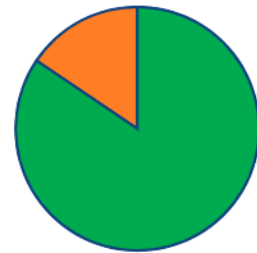
6. The Board identifies and engages with stakeholders, and has formal processes in place to capture feedback from them to inform future strategic planning.

 Strong	10
 Adequate	3
 Needs Improvements	0






7. The UHB is always learning and looking for creative ways and innovation to improve the delivery of services.

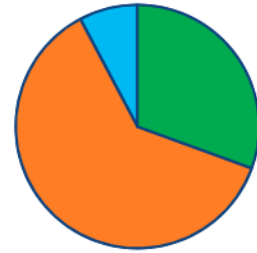
 Strong	11
 Adequate	2
 Needs Improvements	0






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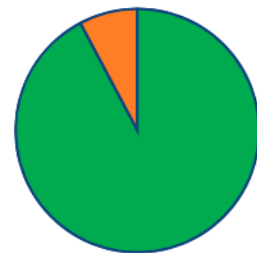
8. We identify and share best practice and benchmark.

 Strong	4
 Adequate	8
 Needs Improvements	1






9. Board members act in the public interest in keeping with the Nolan principles of public life.

 Strong	12
 Adequate	1
 Needs Improvements	0






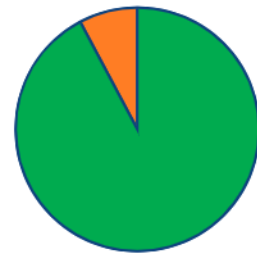
10. We invite effective feedback and use the lessons learned to develop and improve the Board's and senior management team's effectiveness.

 Strong	10
 Adequate	3
 Needs Improvements	0






11. Independent Members exercise their role through influence and advice, supporting as well as challenging the Executive.

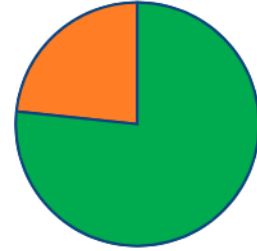
 Strong	12
 Adequate	1
 Needs Improvements	0






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12. There is a just / open culture which encourages staff to seek help and advice.

 Strong	10
 Adequate	3
 Needs Improvements	0






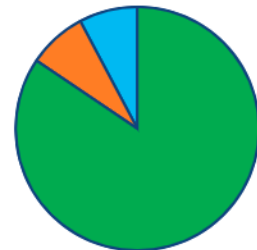
13. There is timely provision of information in a form and of a quality that enables the Board to discharge its duties effectively.

 Strong	8
 Adequate	4
 Needs Improvements	1



14. Committees inform the Board on their significant activities, actions, recommendations and performance through minutes and regular reports and have appropriate relationships with other Committees.

 Strong	11
 Adequate	1
 Needs Improvements	1



15. What is your overall assessment of the performance of the Committee?

- Board Meetings are chaired and Managed extremely well. the meetings are very well attended.
- I feel that the Board has matured and feel empowered to have open and honest conversations which are challenging but supportive. We have a strong sense of shared values. This is especially important given the challenging and complex environment in which we operate.
- I feel the BOARD has the patient at the centre of their decision making. The BOARD Is open and transparent in regards to their statutory duty. Ambitious but also understands the challenges post pandemic.
- Well functioning and able to take assurance from the detailed reports via the Board's sub committees as well as from the topic specific deep dives at board development sessions.
- Improvements required
- A strong board seeking assurance and questioning.
- We have an experience Board which given the challenges we face around demand on our services, funding and quality of the hospital assets I believe do a very good job in carrying out their duties.
- good
- Functioning well. High level of appropriate scrutiny. Need to take further assurance without getting into too much detail

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- The quality of discussion, scrutiny, challenge and reporting has generally improved over the year, facilitated by face-to-face meetings, which promote an open, transparent and cohesive context.
- The Board has the appropriate expertise to provide adequate scrutiny and support. The relationship between IMs and Executives is collegiate but with appropriate independence to provide professional scrutiny. While the Board has a credible strategy to provide quality, sustainable services to patients and a robust plan to deliver this, the board has been hostage to fortune financially. Without further funding and a more stable environment, the Board will likely face significant challenges in delivering against its strategy and objectives.
- It is probably a good time for the Board to revisit and confirm current Risk Appetite.
- Strong.

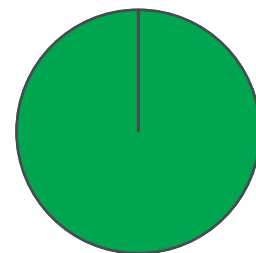
Annual Board Effectiveness Survey

Finance




Responses: 5

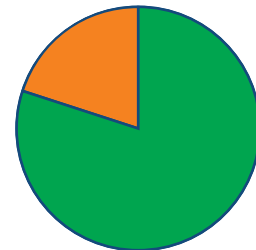
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	5
 Adequate	0
 Needs Improvements	0



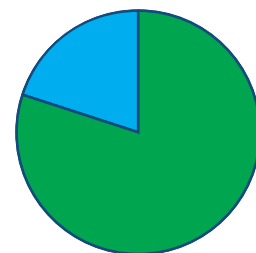
2. The Board was active in its consideration of Committee composition.

 Strong	4
 Adequate	1
 Needs Improvement	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

 Yes	4
 No	0
 Unsure	1



Mohamed Sarah
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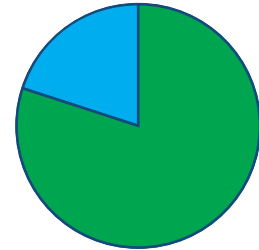


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Cardiff and Vale
University Health Board

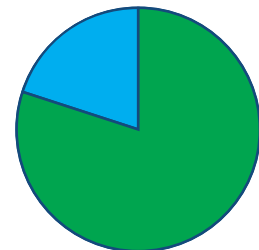
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

 Yes	4
 No	0
 Unsure	1






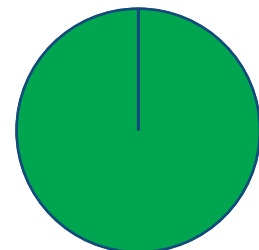
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

 Yes	4
 No	0
 Unsure	1






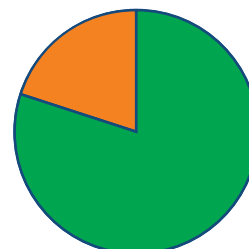
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	5
 Adequate	0
 Needs Improvement	0






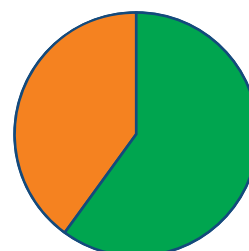
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

 Strong	4
 Adequate	1
 Needs Improvement	0






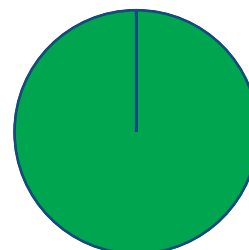
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

 Strong	3
 Adequate	2
 Needs Improvement	0






9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

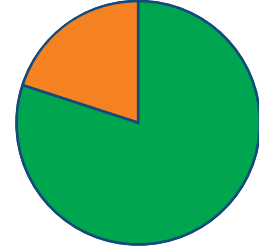
 Strong	5
 Adequate	0
 Needs Improvement	0






Mohamed Sarah
02/05/2023 17:42:26

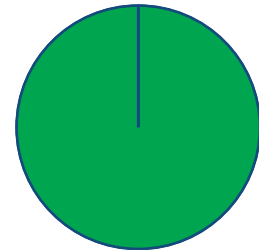
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

 Strong	4
 Adequate	1
 Needs Improvement	0



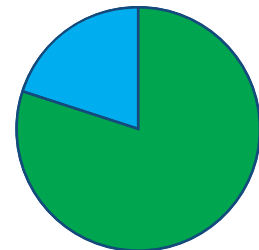
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

 Strong	5
 Adequate	0
 Needs Improvement	0





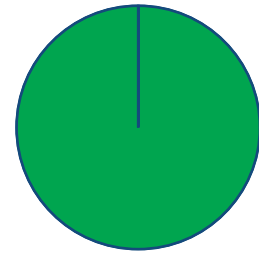
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

 Yes	4
 No	0
 Unsure	1






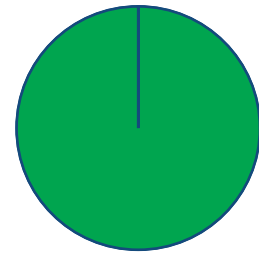
13. Are Committee members independent of the management team?

 Yes	5
 No	0
 Unsure	0



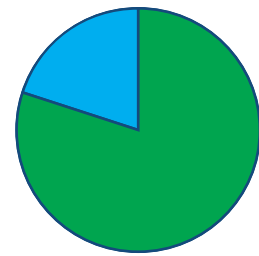
14. The Committee agenda-setting process is thorough and led by the Committee Chair.

 Strong	5
 Adequate	0
 Needs Improvement	0



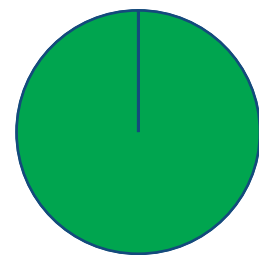
15. Has the Committee established a plan for the conduct of its work across the year?

 Yes	4
 No	0
 Unsure	1



16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

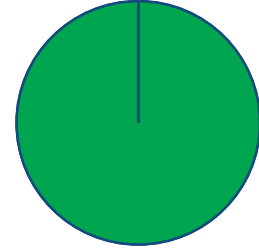
 Yes	5
 No	0
 Unsure	0






Mohamed Salah
02/05/2024 11:42:26

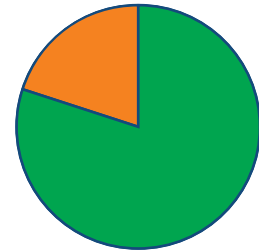
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

 Yes	5
 No	0
 Unsure	0



18. The Committee's self-evaluation process is in place and effective.

 Strong	4
 Adequate	1
 Needs Improvement	0



Mohamed Sarah
02/05/2023 17:42:26

19. The Committee's self-evaluation process is in place and effective

- Strong
- The Finance Committee is well run and meets regularly. It has the required range of experience when the composition of the committee is considered.
- The Committee has the appropriate expertise to provide adequate scrutiny and support. The relationship between IMs and Executives is collegiate but with appropriate independence to provide professional scrutiny.
- Appropriate level of scrutiny achieved. Members independent to management team.
- Is capable of generating good and analytical discussions.




Annual Board Effectiveness Survey

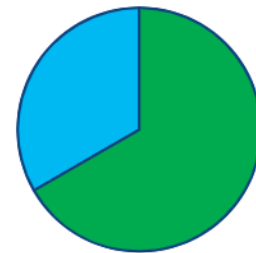
Mental Health and Mental Capacity Act

Appendix 6




Response: 3

1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	2
 Adequate	0
 Needs Improvements	1






2. The Board was active in its consideration of Committee composition.

 Strong	2
 Adequate	1
 Needs Improvements	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

 Strong	2
 Adequate	0
 Needs Improvements	1





Mohamed Sarah
02/05/2023 17:42:26

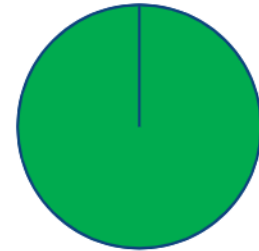


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Caerdydd a'r Fro
Cardiff and Vale
University Health Board

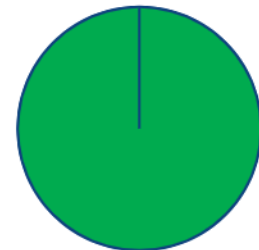
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

 Yes	3
 No	0
 Unsure	0






5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

 Yes	3
 No	0
 Unsure	0






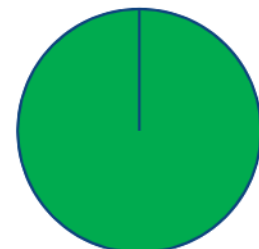
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	2
 Adequate	1
 Needs Improvements	0






7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

 Strong	3
 Adequate	0
 Needs Improvements	0






Mohamed Sarah
02/05/2023 17:42:16

8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

 Strong	2
 Adequate	1
 Needs Improvements	0






9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

 Strong	2
 Adequate	1
 Needs Improvements	0






10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

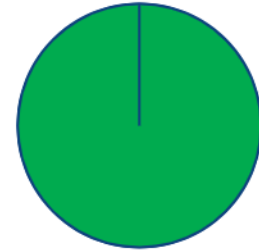
 Strong	2
 Adequate	1
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

 Strong	3
 Adequate	0
 Needs Improvements	0



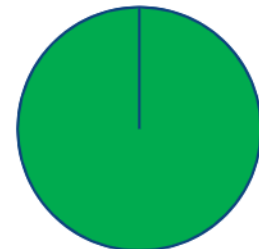
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

 Yes	2
 No	0
 Unsure	1






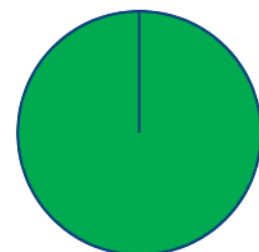
13. Are Committee members independent of the management team?

 Yes	3
 No	0
 Unsure	0






14. The Committee agenda-setting process is thorough and led by the Committee Chair.

 Strong	3
 Adequate	0
 Needs Improvements	0






Mohamed Sarah
02/05/2023 11:42:26

15. Has the Committee established a plan for the conduct of its work across the year?

 Yes	2
 No	0
 Unsure	1





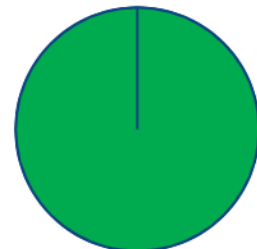
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

 Yes	2
 No	0
 Unsure	1






17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

 Yes	3
 No	0
 Unsure	0



18. The Committee's self-evaluation process is in place and effective.

 Strong	2
 Adequate	1
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

19. What is your overall assessment of the performance of the Committee?

- This committee is very clear about its remit in terms of legislative compliance and habitually refers matters to other committees for consideration when necessary.
- The Committee has benefited considerably from the support and information provided by relevant colleagues within the Mental Health and Children's and Women's Clinical Boards, with the relevant performance metrics clearly explained and trajectories fully analysed and explained.
- Effective committee. Well organised. Assurance provided through appropriate scrutiny

Mohamed Sarah
02/05/2023 17:42:26

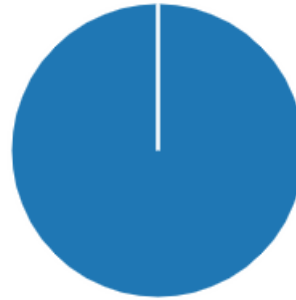
Annual Board Effectiveness Survey - Charitable Funds

3

Responses

1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

● Strong	3
● Adequate	0
● Needs Improvement	0



2. The Board was active in its consideration of Committee composition.

● Strong	2
● Adequate	1
● Needs Improvement	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Mohamed Sarah
02/05/2023 17:42:26

● Yes	3
● No	0
● Unsure	0



4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

● Yes	2
● No	0
● Unsure	1



5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

● Yes	2
● No	0
● Unsure	1



6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

● Strong	3
● Adequate	0
● Needs Improvement	0



Mohamed Sarah
02/05/2023 17:42:26

7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

● Strong	2
● Adequate	1
● Needs Improvement	0



8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

● Strong	1
● Adequate	1
● Needs Improvement	1



9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

● Strong	2
● Adequate	1
● Needs Improvement	0



10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Mohamed Sarah
02/05/2023 17:42:26

- Strong 2
- Adequate 1
- Needs Improvement 0



11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

- Strong 2
- Adequate 1
- Needs Improvement 0



12. Are changes to the Committee's current and future workload discussed and approved at Board level?

- Yes 2
- No 0
- Unsure 1



13. Are Committee members independent of the management team?

- Yes 3
- No 0
- Unsure 0



Mohamed, Sarah
02/05/2023 17:42:36

14. The Committee agenda-setting process is thorough and led by the Committee Chair.

- Strong 2
- Adequate 1
- Needs Improvement 0



15. Has the Committee established a plan for the conduct of its work across the year?

- Yes 3
- No 0
- Unsure 0



16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

- Yes 1
- No 0
- Unsure 2



17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

- Yes 2
- No 0
- Unsure 1



18. The Committee's self-evaluation process is in place and effective.

Mohamed, Sarah
02/05/2023 17:42:26

● Strong	1
● Adequate	2
● Needs Improvement	0



19. What is your overall assessment of the performance of the Committee?

The Committee works very well as a group adhering to the terms of reference and aims of the committee.

works well, good structure timely agenda and papers

There are some items listed here which I have not witnessed in my time on the committee so I have marked as unsure. That would detriment my overall assessment. I am also not clear how this committee links with the other fundraising activities and takes feed back from them so it can hold the overview. I think this committee could do with some targeted work to ensure arrangements are in place for it to oversee all of the CFC activities.




Mohamed Sarah
02/05/2023 17:42:26

Annual Board Effectiveness Survey

Digital Health Intelligence - Appendix 8




Response: 3

1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	2
 Adequate	1
 Needs Improvements	0






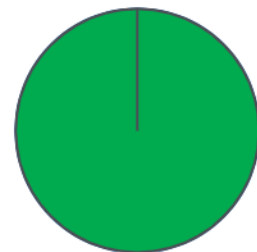
2. The Board was active in its consideration of Committee composition.

 Strong	2
 Adequate	1
 Needs Improvements	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

 Strong	3
 Adequate	0
 Needs Improvements	0




Mohamed Sarah
02/05/2023 17:42:26

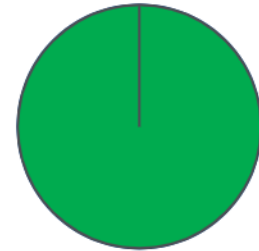


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Cardiff and Vale
University Health Board

4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

 Yes	3
 No	0
 Unsure	0






5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

 Yes	2
 No	1
 Unsure	0






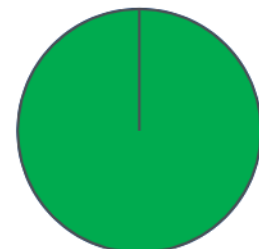
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	2
 Adequate	1
 Needs Improvements	0






7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

 Strong	3
 Adequate	0
 Needs Improvements	0






Mohamed Sarah
02/05/2023 17:42:16

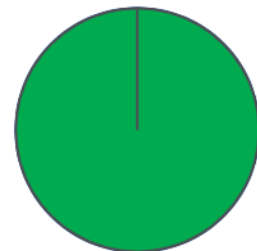
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

 Strong	2
 Adequate	1
 Needs Improvements	0






9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

 Strong	3
 Adequate	0
 Needs Improvements	0






10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

 Strong	1
 Adequate	2
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

 Strong	1
 Adequate	2
 Needs Improvements	0



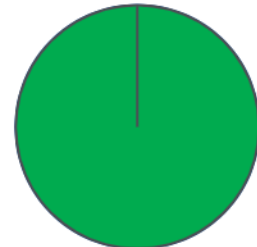
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

 Yes	2
 No	0
 Unsure	1






13. Are Committee members independent of the management team?

 Yes	3
 No	0
 Unsure	0






14. The Committee agenda-setting process is thorough and led by the Committee Chair.

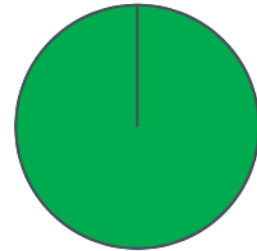
 Strong	2
 Adequate	1
 Needs Improvements	0






Mohamed Sarah
02/05/2023 11:42:26

15. Has the Committee established a plan for the conduct of its work across the year?

 Yes	3
 No	0
 Unsure	0






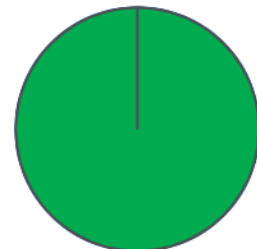
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

 Yes	2
 No	1
 Unsure	0






17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

 Yes	3
 No	0
 Unsure	0



18. The Committee's self-evaluation process is in place and effective.

 Strong	2
 Adequate	1
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

19. What is your overall assessment of the performance of the Committee?

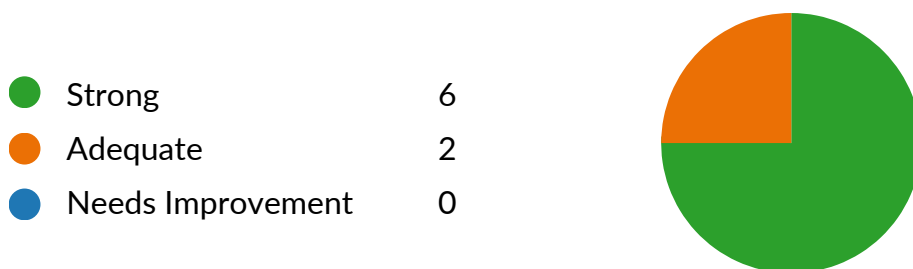
- DHIC maintains a good overview and receives assurance on a wide range of topics under the Digital and Health Intelligence umbrella.
- To the subject matter covered by this committee is crucial to the success of the organization. We are actively considering how to strengthen this.
- The Committee has the appropriate expertise to provide adequate scrutiny and support. The relationship between IMs and Executives is collegiate but with appropriate independence to provide professional scrutiny. Given the increasing importance of digital and IT in operational matters and strategic goals, the committee has identified that digital and IT matters need greater visibility at the Board level.

Mohamed Sarah
02/05/2023 17:42:26

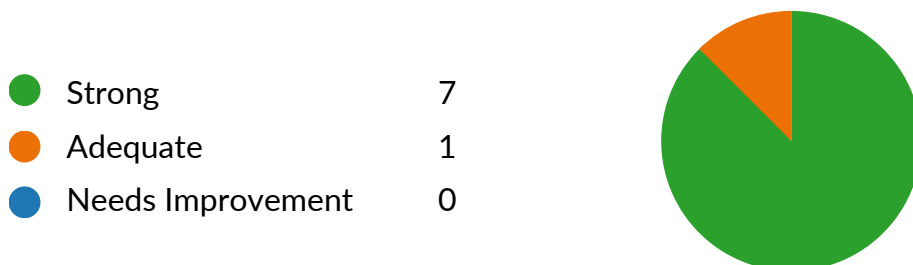
Annual Board Effectiveness Survey - Quality, Safety and Experience

8 Responses

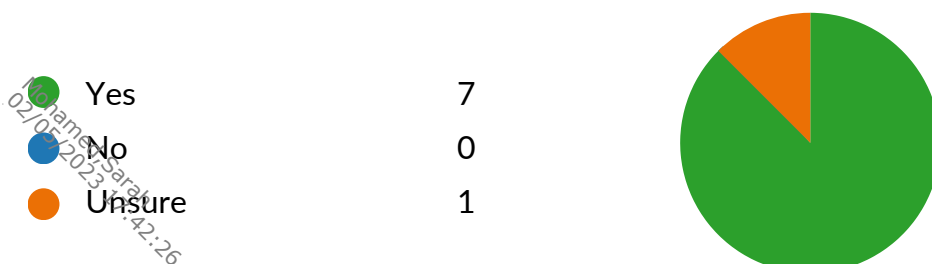
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.



2. The Board was active in its consideration of Committee composition.



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

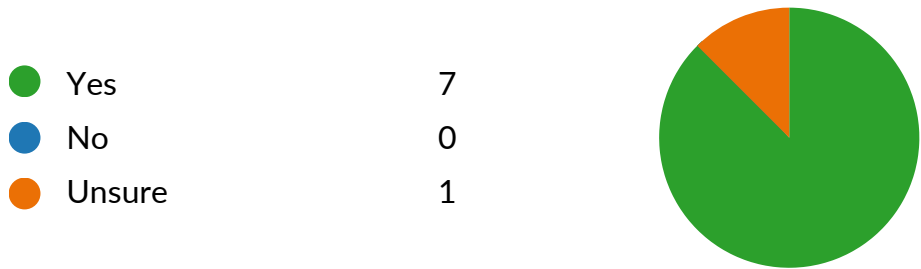


02/05/2023 11:42:26
Mohamed Sarak

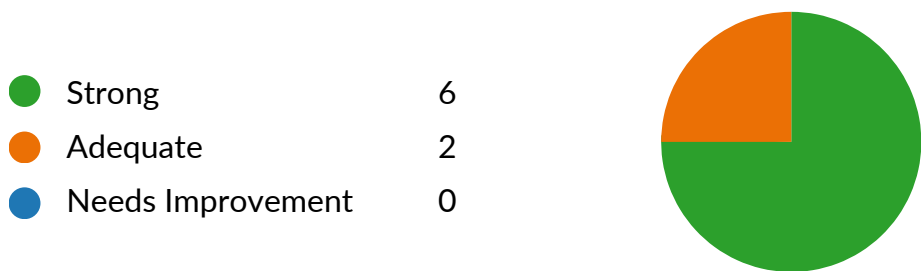
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?



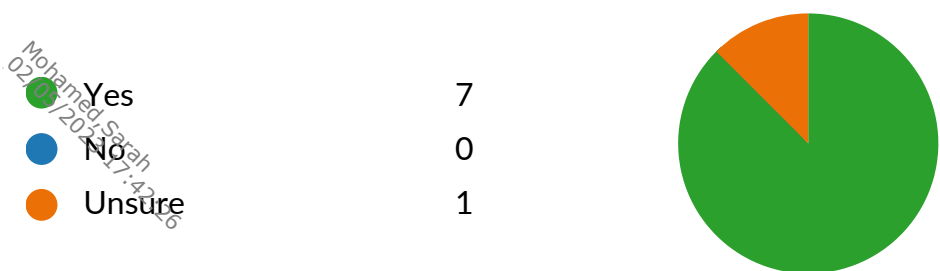
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?



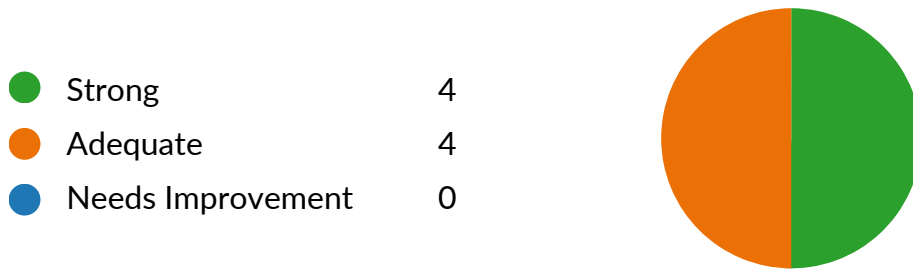
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.



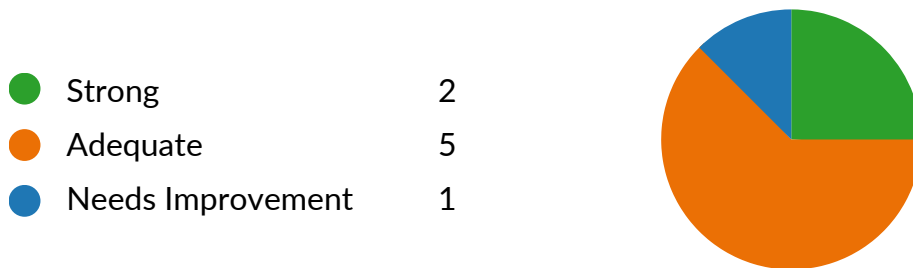
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



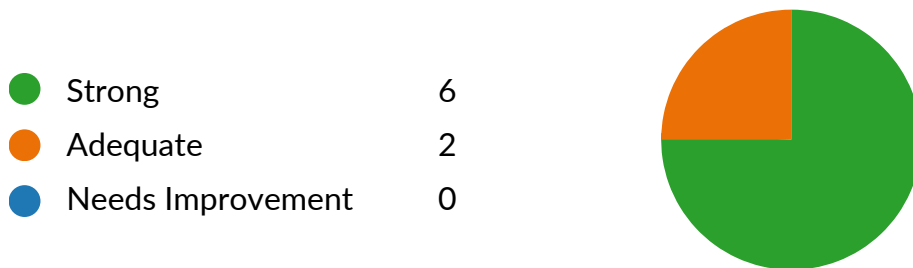
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



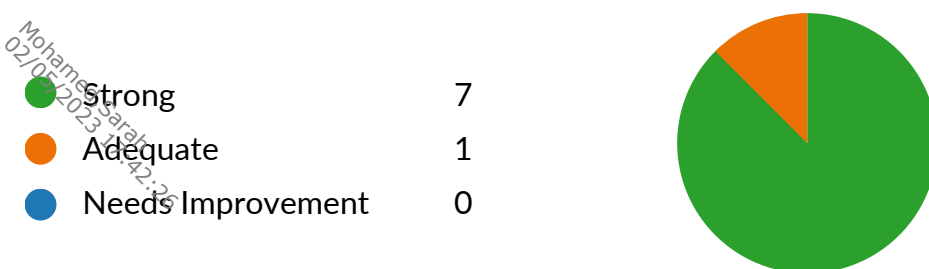
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee’s responsibilities.



10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.



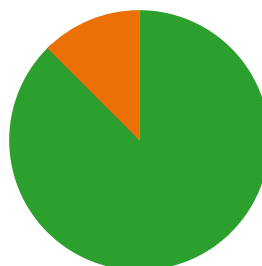
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.



Mohamed Sarah
02/05/2023 17:42:26

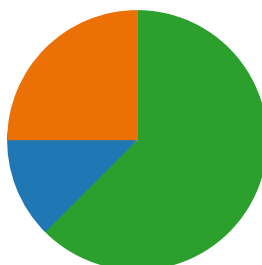
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

● Yes	7
● No	0
● Unsure	1



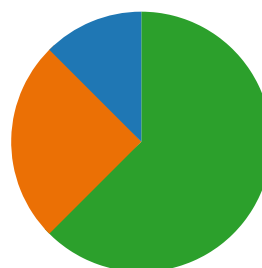
13. Are Committee members independent of the management team?

● Yes	5
● No	1
● Unsure	2



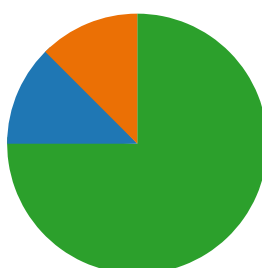
14. The Committee agenda-setting process is thorough and led by the Committee Chair.

● Strong	5
● Adequate	2
● Needs Improvement	1



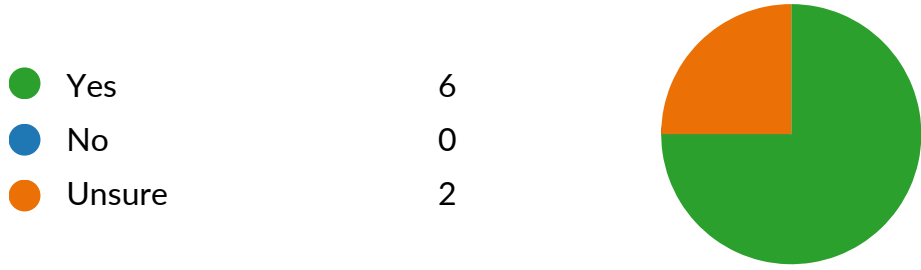
15. Has the Committee established a plan for the conduct of its work across the year?

● Yes	6
● No	1
● Unsure	1

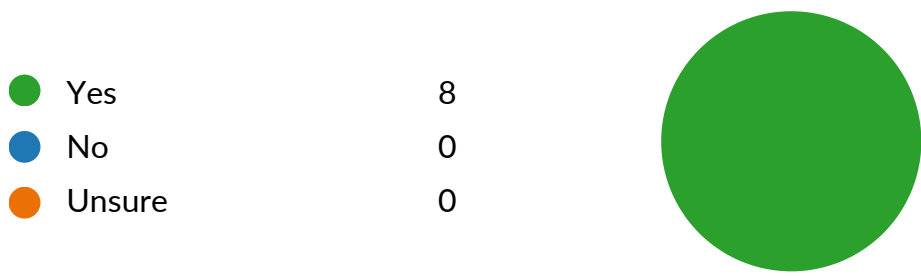


M. Alameddine
02/05/2023 17:42:26

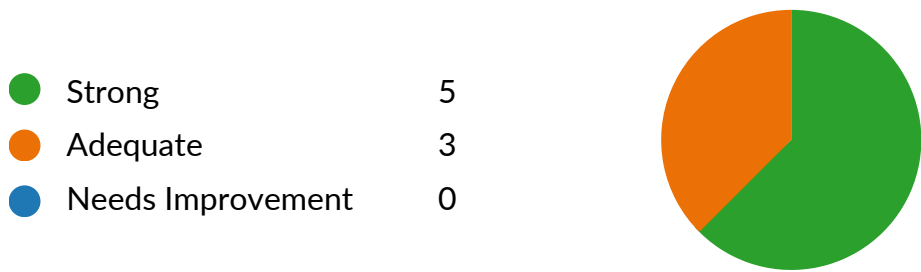
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?



17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?



18. The Committee's self-evaluation process is in place and effective.



Mohamed Sarah
02/05/2023 17:42:26

19. What is your overall assessment of the committee?

- Very good - the format, frequency and papers for routine consideration are under review with an expected improvement in performance and outcome from the Committee
- The committee works extremely well and is very thorough in its work.
- there needs some review regarding frequency, duration and rationalisation of the agenda however the discussion which occur are very in depth and provide useful challenge from the independent members
- adequate
- Agenda often long , chairing struggles to keep to time
- The Committee agendas tends to promote a rather reactive approach, with the loops not always being closed. It would be useful for the Committee to be more proactive and a greater emphasis on improvement aligned to the enhancement of quality and safety.
- Committee performs well, with appropriate independent scrutiny to deliver assurance
- Functions well. Work plan content needs to be revisited to include wider Quality scope in line with our refreshed strategy.




Mohamed Sarah
02/05/2023 17:42:26

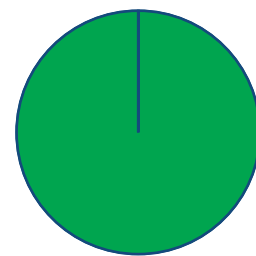
Annual Board Effectiveness Survey

Health & Safety - Appendix 10




Response: 5

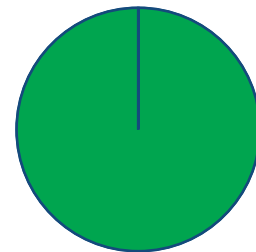
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	5
 Adequate	0
 Needs Improvements	0



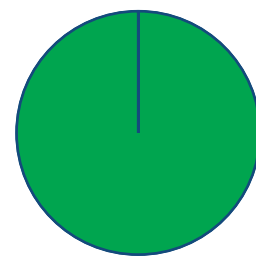
2. The Board was active in its consideration of Committee composition.

 Strong	5
 Adequate	0
 Needs Improvements	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

 Yes	5
 No	0
 Unsure	0



Mohamed Sarah
02/05/2023 17:42:26

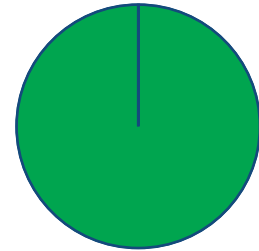


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NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

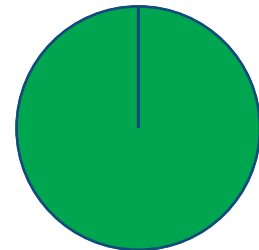
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

 Yes	5
 No	0
 Unsure	0






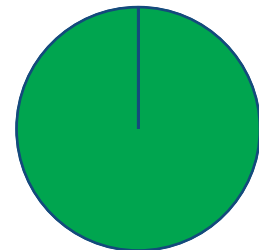
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

 Yes	5
 No	0
 Unsure	0






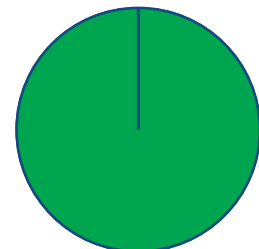
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	5
 Adequate	0
 Needs Improvements	0






7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

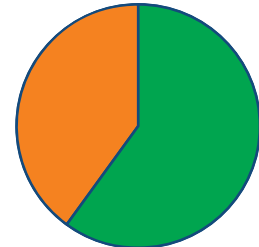
 Strong	5
 Adequate	0
 Needs Improvements	0






Mohamed Salah
02/05/2023 17:02:26

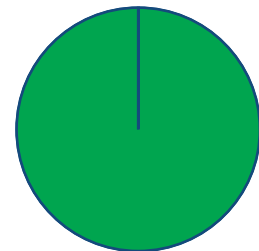
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

 Strong	3
 Adequate	2
 Needs Improvements	0






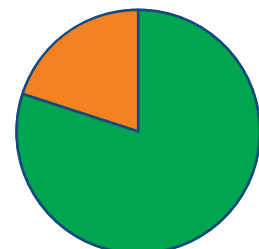
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

 Strong	5
 Adequate	0
 Needs Improvements	0






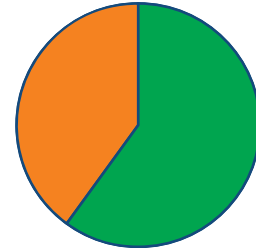
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

 Strong	4
 Adequate	1
 Needs Improvements	0



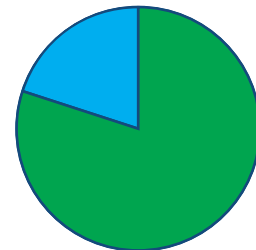
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

 Strong	3
 Adequate	2
 Needs Improvements	0



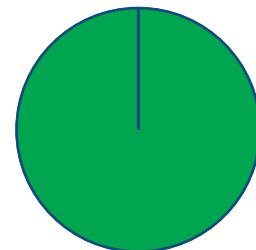
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

 Yes	4
 No	0
 Unsure	1






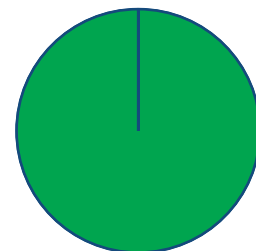
13. Are Committee members independent of the management team?

 Yes	5
 No	0
 Unsure	0




14. The Committee agenda-setting process is thorough and led by the Committee Chair.

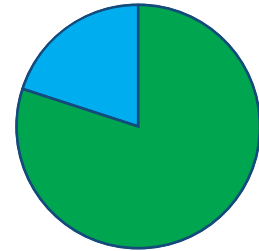
 Strong	5
 Adequate	0
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

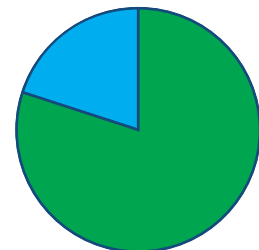
15. Has the Committee established a plan for the conduct of its work across the year?

 Yes	4
 No	0
 Unsure	1



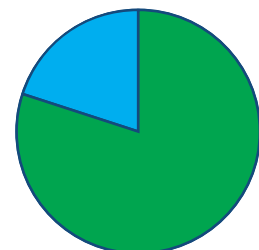
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

 Yes	4
 No	0
 Unsure	1






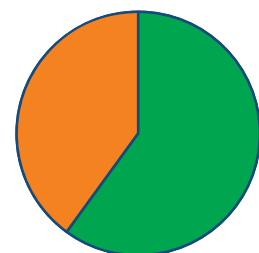
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

 Yes	4
 No	0
 Unsure	1



18. The Committee's self-evaluation process is in place and effective.

 Strong	3
 Adequate	2
 Needs Improvements	0



Mohamed Sarah
02/05/2023 17:42:26

19. What is your overall assessment of the performance of the Committee?

- The Committee works extremely well covering all aspects of Health and Safety. the Committee chair Meets with the Head of Health and safety on regular basis.
- The committee is strengthening and linking in with the Q&S agenda around safety of People. This committee is gaining this clarity and will mature in 2023 with the addition of the People and Culture Committee.
- It might be worth considering how the committee can be promoted - There are senior clinical board directors who have no understanding of H&S despite being responsible for hundreds of staff. It will also be interesting to see how the structure plays out regarding to the new WOD meeting - Is the H&S committee being diluted, also how was this decided? Who was involved in the decision process to implement another committee for the H&S group to report into? Thanks.
- well informed with quality inputs from relevant colleagues
- It functions well.

Mohamed Sarah
02/05/2023 17:42:26

Annual Board Effectiveness Survey - Strategy & Delivery

3

Responses

1. The Committee terms of reference clearly, adequately & realistically set out the Committee’s role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

● Strong	3
● Adequate	0
● Needs Improvement	0



2. The Board was active in its consideration of Committee composition.

● Strong	2
● Adequate	1
● Needs Improvement	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Mohamed Sarah
02/05/2023 17:42:26

● Yes	3
● No	0
● Unsure	0



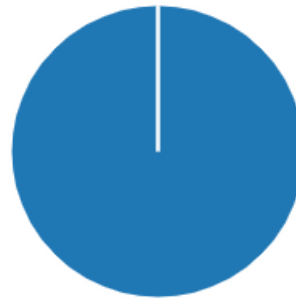
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

● Yes	3
● No	0
● Unsure	0



5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

● Yes	3
● No	0
● Unsure	0



6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

● Strong	3
● Adequate	0
● Needs Improvement	0



Mohamed Sarah
02/05/2023 17:42:26

7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

● Strong	3
● Adequate	0
● Needs Improvement	0



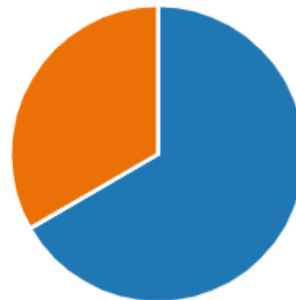
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

● Strong	1
● Adequate	2
● Needs Improvement	0



9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

● Strong	2
● Adequate	1
● Needs Improvement	0



10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Mohamed Sarah
02/05/2023 17:42:26

Strong	3
Adequate	0
Needs Improvement	0



11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	3
Adequate	0
Needs Improvement	0



12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	3
No	0
Unsure	0



13. Are Committee members independent of the management team?

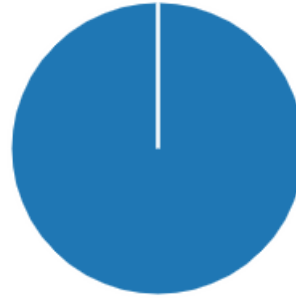
Yes	3
No	0
Unsure	0



14. The Committee agenda-setting process is thorough and led by the Committee Chair.

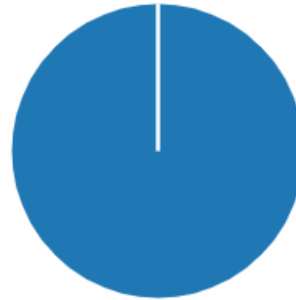
Mohamed Sarah
02/05/2023 17:42:26

Strong	3
Adequate	0
Needs Improvement	0



15. Has the Committee established a plan for the conduct of its work across the year?

Yes	3
No	0
Unsure	0



16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

Yes	2
No	0
Unsure	1



17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

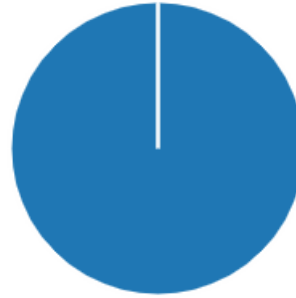
Yes	3
No	0
Unsure	0



18. The Committee's self-evaluation process is in place and effective.

Mohamed Saad
02/05/2023 11:42:26

● Strong	3
● Adequate	0
● Needs Improvement	0



19. What is your overall assessment of the performance of the Committee?

- good
- The Committee's agenda is probably too large and excessive emphasis is on the 'delivery' rather than 'strategy' component. The revised committee structure should provide greater demarcation and clarity.
- Committee performs well and covers both operational and strategic considerations. Scope of committee business is arguably too wide-ranging, potentially impacting agility and sustained focus.

Mohamed Sarah
02/05/2023 17:42:26




Annual Board Effectiveness Survey

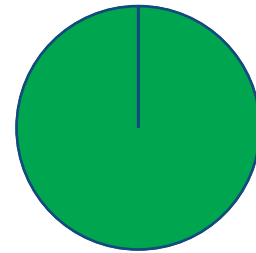
Remuneration and Terms of Service Committee

Appendix 12




Responses: 6

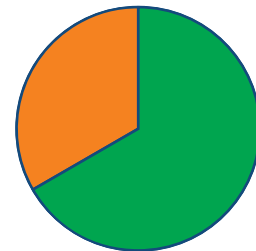
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

 Strong	6
 Adequate	0
 Needs Improvements	0



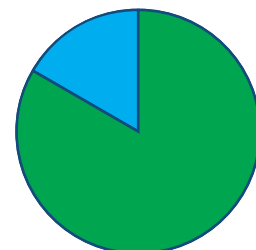
2. The Board was active in its consideration of Committee composition.

 Strong	4
 Adequate	2
 Needs Improvement	0



3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

 Yes	5
 No	0
 Unsure	1



Mohamed Sarah
02/05/2023 17:42:26

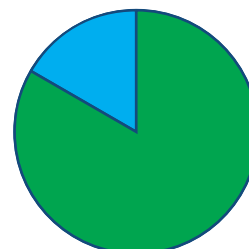


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WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

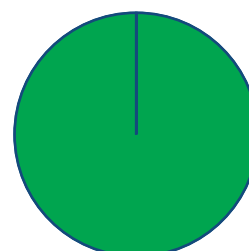
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

 Yes	5
 No	0
 Unsure	1






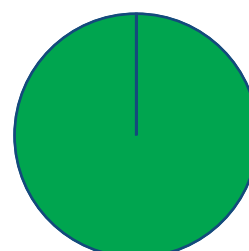
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

 Yes	6
 No	0
 Unsure	0






6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

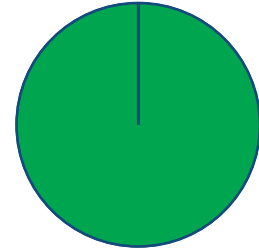
 Strong	6
 Adequate	0
 Needs Improvement	0






Mohamed Sarah
02/05/2023 17:42:26

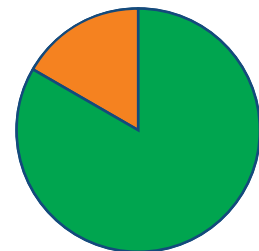
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

 Strong	6
 Adequate	0
 Needs Improvement	0






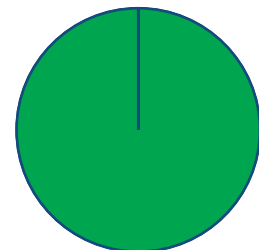
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

 Strong	5
 Adequate	1
 Needs Improvement	0






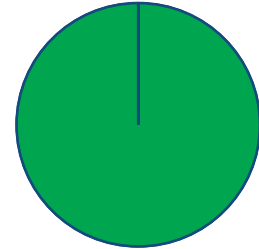
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

 Strong	6
 Adequate	0
 Needs Improvement	0






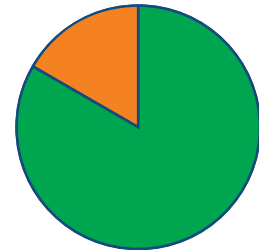
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

 Strong	6
 Adequate	0
 Needs Improvement	0



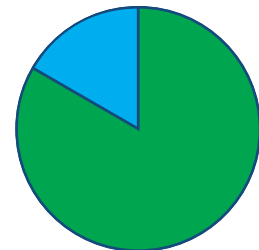
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

 Strong	5
 Adequate	1
 Needs Improvement	0



12. Are changes to the Committee's current and future workload discussed and approved at Board level?

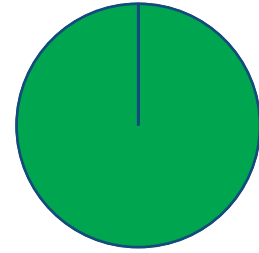
 Yes	5
 No	0
 Unsure	1






Mohamed Sarah
02/05/2023 17:42:26

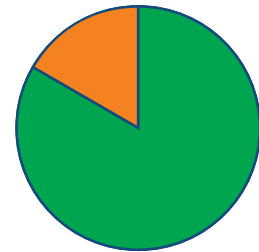
13. Are Committee members independent of the management team?

 Yes	6
 No	0
 Unsure	0



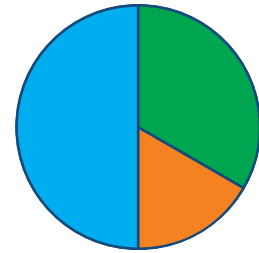
14. The Committee agenda-setting process is thorough and led by the Committee Chair.

 Strong	5
 Adequate	1
 Needs Improvement	0



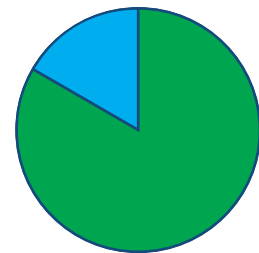
15. Has the Committee established a plan for the conduct of its work across the year?

 Yes	2
 No	1
 Unsure	3



16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

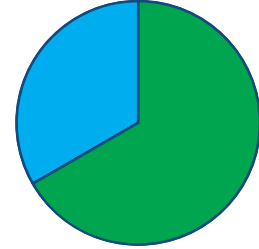
 Yes	5
 No	0
 Unsure	1






Mohamed Salah
02/05/2024 11:42:26

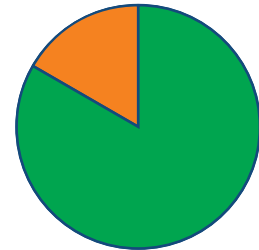
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

 Yes	4
 No	0
 Unsure	2



18. The Committee's self-evaluation process is in place and effective.

 Strong	5
 Adequate	1
 Needs Improvement	0



Mohamed Sarah
02/05/2023 17:42:26

19. What is your overall assessment of the performance of the Committee?

- Good. It's difficult to have a 12 month agenda as items will come adhoc, as well as main agenda points. The committee has the ability to flex.
- Well conducted committee which meets as appropriate to conduct its responsibilities. One area I am unsure is how the RATS committee minutes are reviewed and agreed at (Private) Board. If a process is not in place then this should be done.
- good
- A well organised committee that is flexible and aware of its responsibility to provide assurance to the Board within the scope of its Terms of Reference
- Effective and efficient - well run, timely and highly informed
- Views are shared and discussed thoroughly. Attendance levels would improve if more notice could be given of ad-hoc meetings.

Mohamed Sarah
02/05/2023 17:42:26

Report Title:	Annual Review of the Standing Orders		Agenda Item no.	7.5	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	11 May 2023
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Direcotor of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report

Background and current situation:

NHS Bodies in Wales must agree Standing Orders (“SOs”) that, together with a set of Standing Financial Instructions (“SFIs”) and a scheme of decisions reserved to the Board, a scheme of delegations to officers and others, and a range of other framework documents, set out the arrangements within which Welsh Health Bodies make decisions and carry out their activities.

The SFIs detail the financial responsibilities, policies and procedures adopted by the Health Board. A separate report regarding a review of the SFIs and the Health Board’s accounting policies was taken to the Committee on 4 April 2023 and accordingly this report only addresses the SOs.

The Health Board’s SOs are based upon the Welsh Government issued model Standing Orders. The Model Standing Orders, Reservations and Delegation of Powers (“Model SOs”) were last reviewed by Welsh Government in March 2021 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). On the 7 April 2021 the Welsh Government wrote to the Chair of the Health Board to inform him that the Health Board was required to incorporate and adopt the latest review of the Model SOs into the Health Board’s own SOs. This updated version of the Welsh Government’s Model SOs was incorporated and set out in the Welsh Health Circular (WHC (2021) 010) which was issued on 16 September 2021.

In line with the letter issued by the Welsh Government in April 2021, and following formal Board approval in May 2021, the Health Board incorporated and adopted the Welsh Government’s updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

Since the review undertaken by Welsh Government in March 2021 and the instructions issued to the Health Board in April 2021 to update its SOs, the Welsh Government has not carried out any further reviews of the Model SOs. On 18 April 2023 the Welsh Government wrote to the Health Board, via email, in relation to the proposed temporary variation to Standing Order 7.2.5 (see agenda item 8.3). Save for the proposed variation to Standing Order 7.2.5, no further amendments to the Health Board’s SOs are required by Welsh Government at present.

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

The Health Board’s SOs and SFIs are based upon the model standing orders and model standing financial instructions issued by Welsh Ministers to Local Health Boards. There is a requirement to keep the SOs and SFIs under review to ensure they remain accurate and current, hence the purpose of this report.

It is understood that the Welsh Government plan to undertake a review of the Model SOs in the imminent future. An update report will be brought back to Committee once that review has been carried out.

Recommendation:

The Committee is requested to:

- a) **Note** the update, as set out in the body of this report, with regards to the Health Board’s Standing Orders.

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	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
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	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: No

The Socio-Economic Duty is designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES](#)

(If this has been addressed in the main body of the report, please confirm)

Equality and Health: No

Equality Health Impact Assessments (EHIA) are typically undertaken when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.

Useful guidance on the completion of an EHIA can be found at the following link: [EHIA toolkit - Cardiff and Vale University Health Board \(nhs.wales\)](#)

(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No

Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.

(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Board

25 May 2023

Mohamed Sarah
02/05/2023 17:42:26

Report Title:	Counter Fraud Bribery and Corruption Policy/Procedure Documents		Agenda Item no.	8.2
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date: 11 th May 2023
		Private	<input type="checkbox"/>	
Status <i>(please tick one only):</i>	Assurance	Approval	<input checked="" type="checkbox"/>	Information
Lead Executive:	Catherine Phillips			
Report Author (Title):	Gareth Lavington Counter Fraud Manager			

Main Report

Background and current situation:

The old Counter Fraud Bribery and Corruption Policy and Procedure documents became out of date in December 2022. The existing documents were reviewed and it was deemed necessary to make amendments to them. The amendments made bring the Policy and Procedure up to date in relation to terminology and compliance with the new NHS Requirements introduced by the NHS Counter Fraud Authority in April 2021.

The documents have been submitted to the Corporate Governance team and published accordingly on the staff intranet site for the required timescale in order to invite comment from interested parties.

All comments that have been received have been addressed prior to submission at this meeting.

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

Audit committee members are asked to review and approve the report. Discussion and questioning of the documents is welcomed.

Recommendation:

The Committee is requested to:

- A) Review, discuss and approve (i) the Counter Fraud Bribery and Corruption Policy (UHB 054); and the (ii) Counter Fraud Bribery and Corruption Procedure (UHB 054).

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	<input type="checkbox"/>	6. Have a planned care system where demand and capacity are in balance	<input type="checkbox"/>
2. Deliver outcomes that matter to people	<input checked="" type="checkbox"/>	7. Be a great place to work and learn	<input type="checkbox"/>
3. All take responsibility for improving our health and wellbeing	<input type="checkbox"/>	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	<input type="checkbox"/>
4. Offer services that deliver the population health our citizens are entitled to expect	<input type="checkbox"/>	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	<input checked="" type="checkbox"/>

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	
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Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	✓	Long term	✓	Integration		Collaboration	✓	Involvement	✓
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Loss of public funds which has an effect on patient care

Safety: No

Financial: Yes

Loss of public funds which has an effect on patient care

Workforce: Yes

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes

Use Statutory legislation to conduct investigations

Reputational: Yes

All negative publicity undermines public confidence

Socio Economic: Yes/No

N/A

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Mohamed Sarah
02/05/2023 17:42:26

Reference Number: UHB054 Version Number: 3	Date of Next Review: <i>To be included when document approved</i> Previous Trust/LHB Reference Number: T129
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Counter Fraud Bribery and Corruption Policy

Policy Statement

This policy is designed to promote an anti-fraud and corruption culture and to ensure that there are appropriate measures in place to deter, detect, prevent and investigate fraud. It aims to eliminate fraud and corruption within CAVUHB as far as possible. The policy also provides a framework for responding to suspicions of fraud, together with advice and information on fraud, and the implications and outcome of counter fraud investigations.

This policy is based upon the model policy produced for the NHS by the Local Counter Fraud Specialist and is intended as a guide for all staff on counter fraud work within the NHS. All genuine suspicions of fraud and corruption can be reported to the Local Counter Fraud Specialist or through the NHS Fraud and Corruption Reporting Line.

Policy Commitment

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS are honest and professional. They find fraud committed by a minority wholly unacceptable as it ultimately leads to a reduction in the resources available for the provision of services.

All members of staff have a duty to ensure that public funds are safeguarded and a duty to protect CAVUHB from fraud, corruption or any irregularity. CAVUHB encourages anyone having reasonable suspicions of fraud to report them. If a member of staff has any concerns regarding fraud or corruption, or has seen any suspicious acts or events, they must report the matter to the nominated Local Counter Fraud Specialist, or the National Fraud Reporting Line or the Deputy Chief Executive and Executive Director of Operations & Finance.

CAVUHB is committed to the rigorous investigation of any fraud allegations and to taking appropriate action against the wrong doers. This includes disciplinary action and criminal prosecution when it is necessary.

Supporting Procedures and Written Control Documents

This Policy should be read in conjunction with the supporting **Counter Fraud and Corruption Procedure**, the All Wales Raising Concerns Policy and the All Wales Disciplinary Policy.

Scope

This policy relates to all forms of fraud and corruption and is intended to provide direction and help to members of staff who may identify suspected fraud.

It is intended to provide a framework for responding to suspicions of fraud, advice and

Mohamed Ibrahim
 02/05/2023 17:42:36

Document Title: <i>CFBC POLICY</i>	2 of 2	Approval Date: dd mmm yyyy
Reference Number: UHB054		Next Review Date: dd mmm yyyy
Version Number: 3		Date of Publication: dd mmm yyyy
Approved By:		

information on various aspects of fraud and implications of an investigation.

This policy applies to all CAVUHB staff, including secondees, those with honorary contracts, Non-Executive Directors, those working in bodies hosted by CAVUHB and other parties who may have a business relationship with CAVUHB e.g. consultants, vendors or contractors.

Equality Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact. This policy relies on the generic EHIA for admin type policies.
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Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed as this an administration policy not related to healthcare.
Policy Approved by	Audit Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Audit Committee
Accountable Executive or Clinical Board Director	Catherine Phillips, Executive Director of Finance.

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	24/05/2011	24/05/2011	None
2	03/12/2019	05/12/2019	Minor Amendments made
3	TBC	TBC	Minor Amendments due to changes in NHS CFA requirements.

Mohamed, Sarah
02/05/2023 17:42:26

Reference Number: UHB 054 Version Number: 3	Next Review Date: TBC Previous Trust/LHB Reference Number: T129
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Counter Fraud Bribery and Corruption Procedure

Introduction and Aim

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will be committed to reducing the level of fraud and/or corruption within the NHS to an absolute minimum and keeping it at that level, thereby this will free up public money that can be put to providing better patient care. As one of the basic principles of Public Sector organisations is the proper use of public funds, the Health Board must ensure that its employees act with absolute integrity and honesty as expected and detailed under the various Codes of Conduct.

Objectives

The objective is to ensure that all assets and public funds entrusted to the Health Board are protected against Fraud and/or Loss. The Counter Fraud and Corruption Procedure describes the mechanisms and process that the Health Board will implement and then use to investigate allegations of fraud and fraud related offences, and to develop an Anti-Fraud Culture in accordance with the NHS Counter Fraud Authority's / Cabinet Office required standards.

Scope

This procedure applies to all of our staff in all locations including those with Honorary Contracts.

Equality Impact Assessment

An Equality and Health Impact Assessment (EHIA) **has** been completed and this found there to be no impact. This procedure relies on the generic EHIA for admin type policies.

Documents to read alongside this Procedure

This procedure should be read in conjunction with the UHB Counter Fraud and Corruption Policy, the All Wales Raising Concerns Policy and the All Wales Disciplinary Policy.

Approved by

Audit Committee

Accountable Executive or Clinical Board Director

Executive Director of Finance

Author(s)

Gareth Lavington – Head Counter Fraud

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most to date either by contacting the document author or the [Governance Directorate](#).

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Reference Number: UHB 054		Next Review Date: dd mmm yyyy
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Approved By:		

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Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	24/05/2011	24/05/2011	None
2	03/12/2019	05/12/2019	Updated
3	TBC	TBC	Procedure amended and updated to reflect changes to NHS CFA requirements and to maintain accuracy.

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Mohamed Sarah
02/05/2023 14:22

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Introduction

- 1.1. One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity all such offences are hereafter referred to as “fraud”, except where the context indicates otherwise. This document sets out the Cardiff and Vale University Health Board policy and response plan for detected or suspected fraud.
- 1.2. It is essential that all staff are aware of, and are able to access up-to-date, accurate Cardiff and Vale University Health Board (CAVUHB) policies to ensure they are aware of current approved practices to help reduce risk.
- 1.3. CAVUHB already has procedures in place that reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and a system of risk assessment. In addition, CAVUHB tries to ensure that a risk (and fraud) awareness culture exists throughout the organisation.
- 1.4. This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation.
- 1.5. The three crucial public service values which must underpin the work of the health service: accountability, probity, and openness. CAVUHB is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is therefore committed to the reduction of any fraud occurring within CAVUHB, and to the rigorous investigation of any such cases that do occur.
- 1.6. CAVUHB wishes to encourage anyone having reasonable concern that a fraud has or may be occurring to contact the Counter Fraud service. It is CAVUHB policy that no employee will suffer in any way as a result of reporting reasonably their concerns.
- 1.7. The flowcharts in section 6.2 describe CAVUHB response when a referral is made to the Counter Fraud service. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions.
- 1.8. CAVUHB has a Service Level Agreement with Cardiff & Vale University Health Board for the provision of the Local Counter Fraud service. The Counter Fraud Manager will report directly to the Director of Finance and will produce an agreed work plan to follow, to fulfil the requirements of the role.

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What is Fraud?

1.9. Fraud:

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of a suspect and the intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

Areas where fraud may occur include but are not limited to:

- *Travel and expense claims*
- *Petty cash vouchers*
- *Items of Service claims from independent contractors*
- *Time sheets*
- *Fraudulent use of authorised leave*
- *Overpayment of salary/wages*
- *Fraudulent use of CAVUHB resources*
- *Working whilst on the sick*
- *Handling of cash*
- *Misappropriation of equipment*

This is covered in more detail at section 7.

1.10. Bribery and Corruption:

“The offering, giving, soliciting of an inducement or reward that may influence the actions taken by a body, its members or officers.”

Source: The Code of Audit Practice – Audit Commission

Corruption does not always result in a loss. The corrupt person does not have to benefit directly from their deeds, they may unreasonably use their position to give some advantage to another.

It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

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Corruption prosecutions tend to be most commonly brought using specific pieces of legislation dealing with corruption, i.e. under the The Bribery Act 2010.

1.11. Bribery Act 2010

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 will abolish all existing UK Anti-Bribery Laws and replace them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to “give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad”. It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine. In addition, the Act introduces a ‘corporate offence’ of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The ‘corporate offence’ is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

Public Service Values

Source: WHC (2006) 090 ‘The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006’.

- 1.12.** The codes reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.
- **Accountability:** Everything done by those who work in the NHS in Wales must be able to stand the test of scrutiny by the Welsh Government, public judgments on propriety and professional codes of conduct.
 - **Probity:** There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of the NHS in Wales’s duties.
 - **Openness:** There should be sufficient transparency about the NHS in Wales’s activities to promote confidence between the NHS body and its staff patients and the public.

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02/05/2023 14:12

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CAVUHB Policy Statement

- 1.13.** CAVUHB is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is also committed to the elimination of any fraud within CAVUHB, and to the rigorous investigation of any such cases.
- 1.14.** CAVUHB wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also CAVUHB policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions.
- 1.15.** All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes “reasonably held suspicions” shall mean any suspicions other than those which are raised maliciously and found to be groundless.

Roles and Responsibilities

1.16. Executive Director of Finance

The Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with the Counter Fraud Directions for the organisation.

The Director of Finance will, depending on the outcome of investigations and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The Director of Finance and Local Counter Fraud Specialist (LCFS) will be responsible for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The Director of Finance will inform and consult the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

If an investigation is deemed to be appropriate, the Director of Finance will delegate to the LCFS, who has responsibility for leading the investigation, whilst retaining overall responsibility himself/herself.

The Director of Finance or the LCFS will consult and take advice from the Director of Workforce and OD, if a member of staff is to be interviewed or disciplined.

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The Director of Finance or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation as part of a disciplinary process.

1.17. Local Counter Fraud Specialist

Local Counter Fraud Specialists (LCFS) are located in each NHS organisation. The Lead LCFS is appointed by the Executive Director of Finance and will be responsible for investigating cases of fraud up to a value of £15,000. All investigations involving more than £15,000 and/or Corruption must be referred to the NHS Counter Fraud Service (Wales) Regional Team. Only individuals who are accredited as Counter Fraud Specialists will be responsible for investigating cases of fraud. The LCFS will be responsible for notifying all cases of fraud to NHS CFS (Wales) in the appropriate manner and via the CLUE Case Management System. The LCFS shall:

- Report to Executive Director of Finance.
- Provide a written report at least annually to CAVUHB on counter fraud work within the organisation.
- Be entitled to attend Audit Committee meetings and have a right of access to all Audit Committee members and the Chairman and Chief Officer of CAVUHB.
- Undertake, as agreed with CAVUHB Executive Director of Finance, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall be carried out so as to complement the detection of potential fraud and/or corruption by auditors in the course of routine audits.
- Proactively seek and report to CFS (Wales) opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption.
- Investigate cases of suspected fraud in accordance with the division of work specified in the Directions as amended and replaced from time to time. Refer to CFS (Wales) all cases appropriate to them.
- Inform CFS (Wales) of all cases of suspected fraud investigated by CAVUHB.
- Investigate, report and effect remedy in relation to identified system weaknesses within the organisation that can allow the opportunity for fraud to occur.

1.18. NHS Counter Fraud Service (Wales)

The NHS Counter Fraud Service (CFS) (Wales) will investigate all cases that do not fall within the responsibility of the Local Counter Fraud Specialist.

NHS CFS (Wales) will be responsible for the investigation of cases above £15,000, all corruption cases, and any case at the request of the LCFS,

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where the CFS (Wales) specialist knowledge and resources could assist with the investigation.

Counter Fraud Service Wales will act as the point of contact for the LCFS in relation to liaison with the Crown Prosecution Service.

1.19. NHS Counter Fraud Authority

On the 1st November 2017, an independent special health authority was implemented in England entitled the NHS Counter Fraud Authority (NHSCFA). This was achieved under amendment from the UK Government Secretary of State for Health.

As a result of this, the previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA i.e. NHSBSA/NHS Protect, which was pursuant to section 83 of the Government of Wales Act 2006, which deals with the discharge of certain counter fraud functions in relation to the health service in Wales were reviewed and remained effective with the NHSCFA.

NHSCFA has responsibility for all policy, operational and training matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS.

NHSCFA also provides advice, guidance and risk measurement to NHS Bodies in Wales on all aspects of fraud, bribery and corruption. All instance where fraud is suspected are properly investigated, until their conclusion, by staff who are fully trained and accredited and who are duly nominated by NHSCFA.

1.20. CAVUHB Management

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are followed.

They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

Managers must instil and encourage an anti-fraud, and anti-bribery and corruption culture within their team and ensure that information on

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procedures is made available to all employees. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately to the lead LCFS. If formal investigation is undertaken by the LCFS/CFS managers have a duty to produce any documents or evidence that is required by the investigation team in a timely manner.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.

The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees.

The Response Plan

1.21. Introduction

The flowcharts in section 6.2 describe CAVUHB intended response to reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions. Each situation is different; therefore, the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 6.3 (Commentary on Flowchart Items).

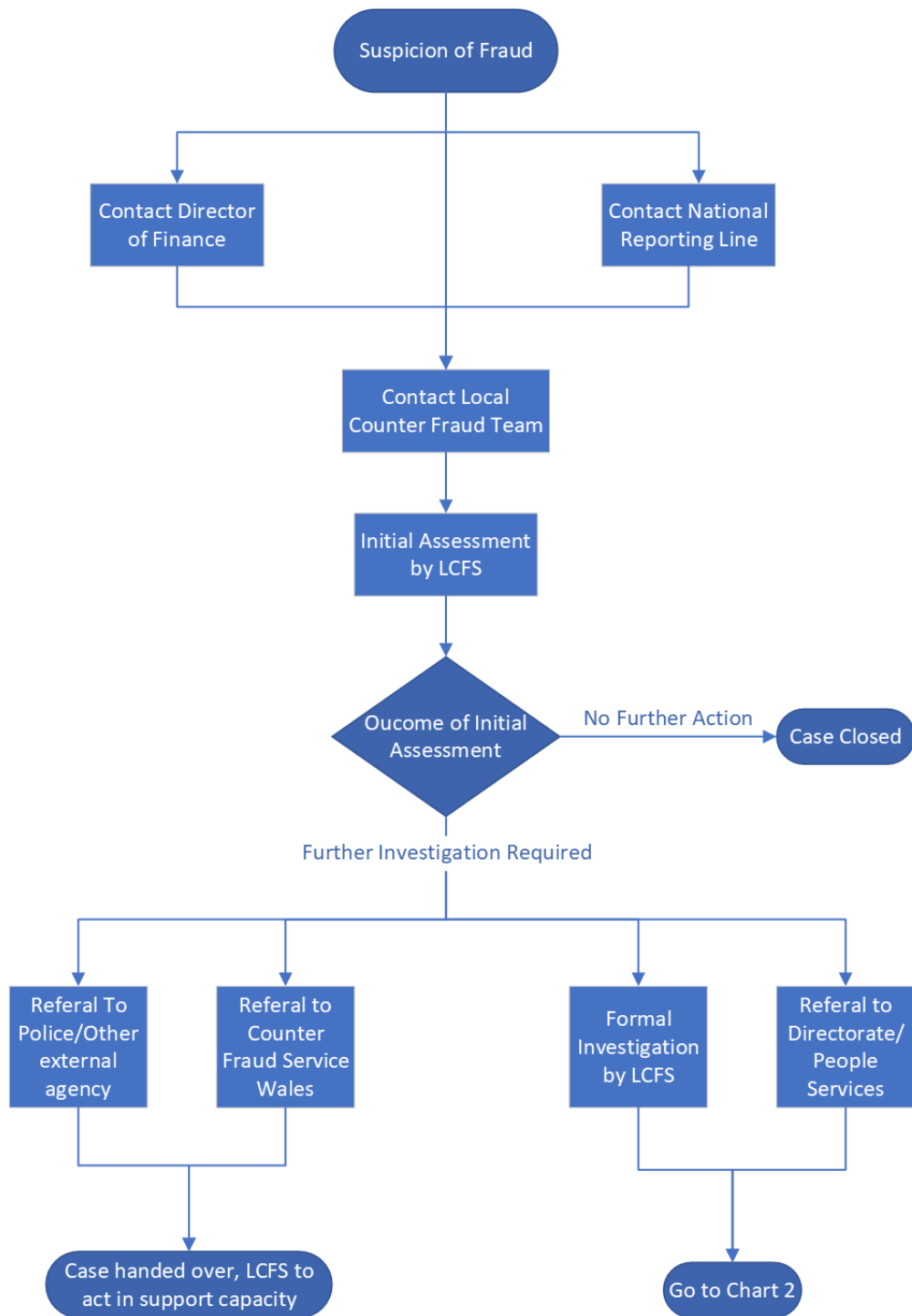
Mohamed Sarah
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1.22. Flowcharts

Chart 1

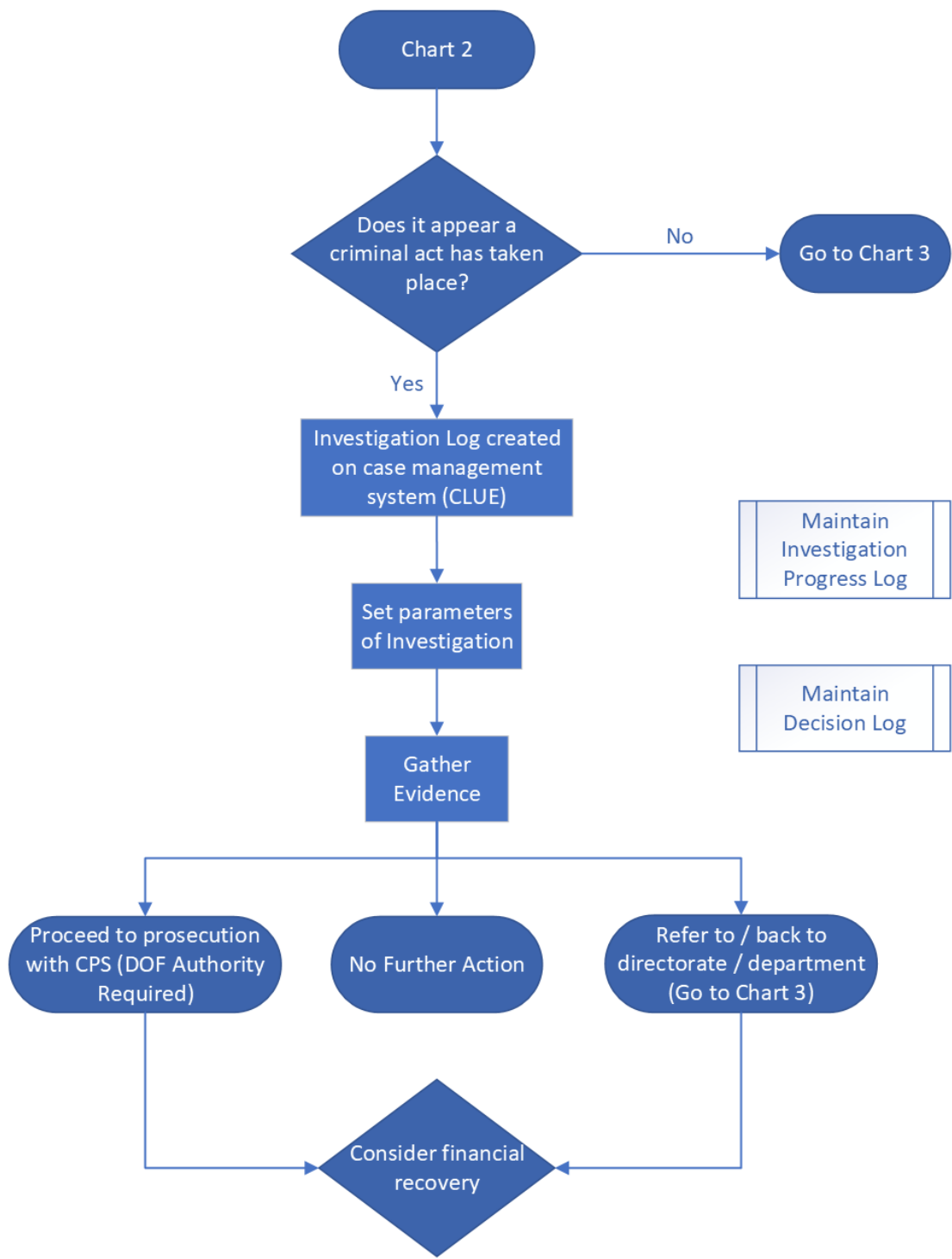


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Chart 2 – Local Counter Fraud Investigation

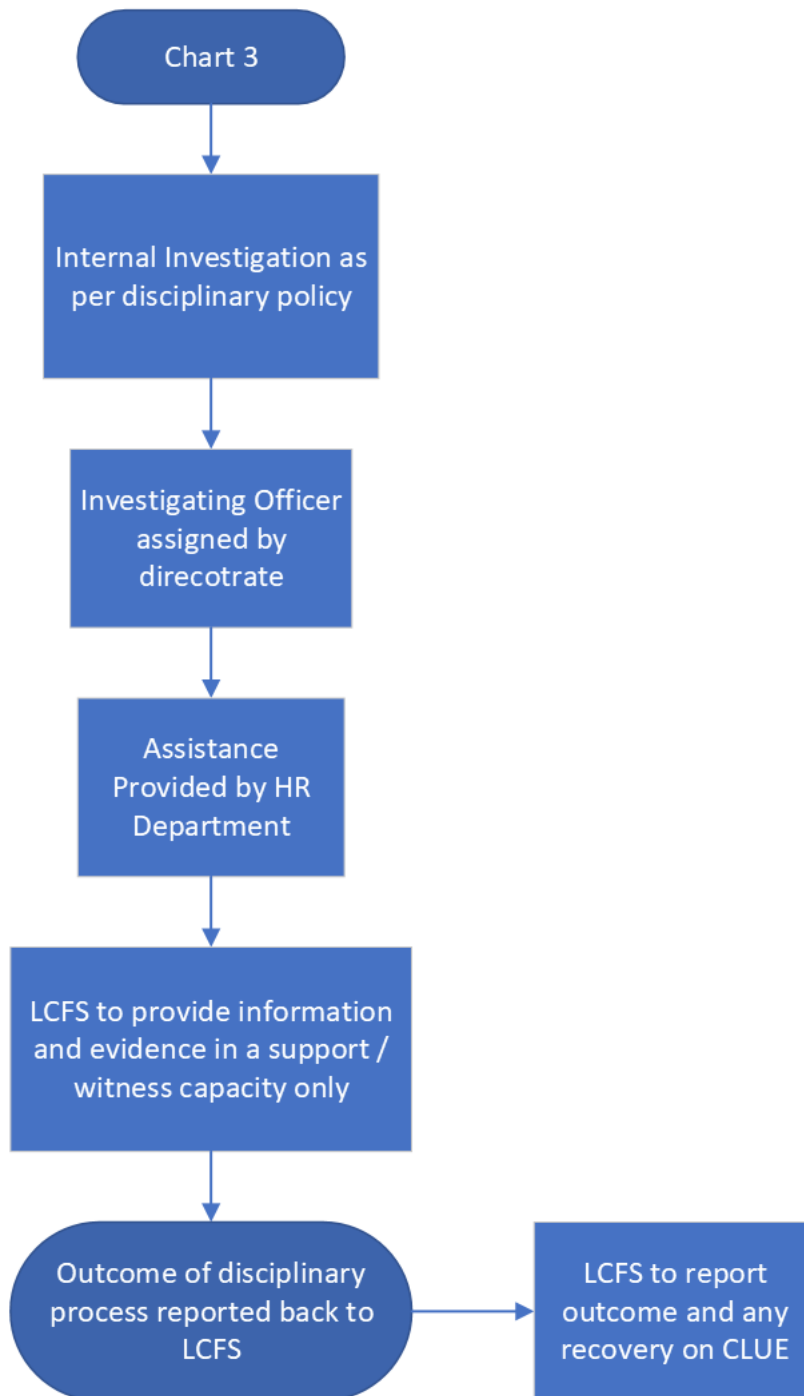


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Chart 3 – Disciplinary Process



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1.23. Commentary on Flowchart Items

Further explanation of many items is also given elsewhere in this document.

Chart 1 – Suspicion of Fraud

1.23.1. The Local Counter Fraud Specialist (LCFS)

The Lead LCFS will be authorised to treat inquiries confidentially and anonymously if so requested by the individual making the referral.

The LCFS will receive appropriate skill-based training leading to professional accreditation and will be able to respond tactfully and appropriately to concerns raised by staff.

LCFS services are currently provided as part of a Service Level Agreement with Cardiff & Vale University Health Board.

1.23.2. Suspicion of Fraud or Any Irregularities/Anomalies

If any CAVUHB employee has any concerns that a fraud has or is taking place, then he/she should discuss any suspicions in the first instance with the Nominated Lead LCFS on 02921 836265.

However, an employee may choose instead to contact the “NHS Fraud & Corruption Reporting Line” on 0800 028 4060.

This contact can be made anonymously.

Time may be of the utmost importance to prevent further loss to CAVUHB.

1.23.3. Upon receipt of a referral LCFS will carry out an initial assessment to understand and identify whether there are reasonable grounds to suspect whether criminal offences have been committed. If not, the case will be concluded with no further action taken. Should there be issues of managerial concern evident then LCFS will liaise with appropriate departmental management and Human Resources department.

LCFS will consider and decide whether the case needs to be referred on to other agencies e.g. Police and Counter Fraud Service Wales. If this is appropriate then LCFS will make the appropriate arrangements. In some instances, a joint investigation may take place.

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CHART 2 – Local Counter Fraud Investigation

1.23.4. Progress of investigation

All investigations carried out by the Counter Fraud Department, will be led by an accredited LCFS and will be overseen by the Head of Counter Fraud. All investigations into fraud will be compliant with the Criminal Procedures and Investigations Act 1990 and the Police and Criminal Evidence Act 1984.

The Local Counter Fraud Specialist in charge of the investigation (OIC) will keep a log of events to record the progress of the investigation. This will commence immediately following referral. If a criminal offence is suspected then the referral will be promoted to formal investigation and recorded upon the NHS CFA case management system (CLUE).

1.23.5. Does it appear a Criminal Act Has Taken Place?

In some cases, this question may be asked more than once during an investigation. The answer to the question obviously determines if there is to be a criminal investigation. In practice it may not be obvious if a criminal act has taken place. If a criminal act is believed to have occurred, the matter will be dealt with by the LCFS/CFS (Wales) as appropriate. If other criminal offences are involved e.g. theft, criminal damage, consideration should be given to reporting the matter, after consultation with the LCFS, to the police

1.23.6. Evidence

For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice.

It is imperative that the collection of evidence must be coordinated if several parties are involved in an investigation, e.g. LCFS and internal audit, police and solicitors. The LCFS will take the lead on this. Evidence gathering requires skill and experience and professional guidance should be sought where necessary. There is a considerable amount of case law concerning the admissibility of evidence and incorrect procedure can lead to a prosecution collapsing.

1.23.7. Witnesses

If a witness to the event is identified, then they will need to give a written statement. The LCFS will take a chronological record using the witness's

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own words. (The witness should be prepared to sign the document as a true record) and advised that the statement may be used as evidence should the matter proceed to court. All witness statements will be completed in accordance with Section 9 Criminal Justice Act 1967 and on the witness statement document provided for this purpose. All witnesses will be provided with ongoing guidance and support throughout the process.

1.23.8. Physical Evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time, date, and place it is taken from and by whom, continuity is essential. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record. It is the responsibility of the LCFS to manage the retrieval, documentation and storage of physical evidence collected during the course of an investigation.

Documentary evidence should be properly recorded, it will need to be numbered and include accurate descriptions of when and where it was obtained and who it was obtained by and from. In criminal actions evidence on or obtained from electronic media needs a document confirming its accuracy.

1.23.9. Interviews

Any interviews carried out with a suspect during the course of a fraud investigation will be carried out only by an accredited LCFS, and will be compliant with the relevant codes and sections of the Police and Criminal Evidence Act 1984.

The subject of the investigation will be written to and advised of the reason for the interview and that he/she is entitled to have a person present at the interview who can act in a legal capacity (i.e. solicitor), but they are not entitled to have a friend, work colleague and/or union representative present at the interview.

The person being interviewed is also to be informed that whilst their attendance at the interview is voluntary, should they not attend, then the matter may be referred to the police which could then result in their subsequent arrest.

Prior to the start of an interview, the interviewee will be assessed with regard to their wellbeing and a decision will be made whether or not it is appropriate to continue with it. If it is not appropriate, then an alternative date in the future will be sought.

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The interview under caution will be tape recorded and once the interview has concluded the interviewee and their legal representative will be provided with a notice informing them of their entitlement to a copy of the recording made. All recordings must be made on a recording device authorised for the purpose.

1.23.10. Investigate Internally

If, after discussion with the LCFS, it appears a criminal act has not taken place, or that the act/s are of a minor nature and it would not be proportionate nor in the public interest to proceed criminally, the next step should be an internal review to determine the facts. The review may recommend various courses of action; instigate an investigation under CAVUHB Disciplinary Policy and Procedure; establish what can be done to recover a loss and what may need to be done to improve internal control to prevent the event happening again. Internal disciplinary investigations are the responsibility of the Directorate/Departmental management in conjunction with the workforce and OD department.

1.23.11. Recovering a Loss

The seeking of financial redress or recovery of losses should always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Service (Wales) where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case. Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

Where recovering a loss is likely to require a civil action, in the absence of established procedures for this recovery, e.g overpayments policy and debt collection agencies, it will be necessary to seek legal advice. Where external legal advisors are required, due to the possible high cost implications, the investigation manager must ensure that the Director of Finance is consulted. The decision of whether to proceed with any civil action will rest with the Director of Finance.

1.23.12. Court Action, Adverse Publicity and/or Police Involvement

Where the investigation reaches a stage where the case is likely to end up in a criminal prosecution via the criminal justice system, then the LCFS must liaise with the Finance Director. Should the investigation or prosecution be

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likely to lead to adverse publicity then LCFS should also liaise with CAVUHB Communications/Press relations Department. Where a fraud is suspected and the need to use the police to carry out an arrest and/or search, then lead LCFS will make the appropriate arrangements and liaise with the relevant organisation directly. The Director of Finance will be appraised accordingly.

No member of staff should contact members of the press without the authority of the Director of Finance and or the Communications/Press Relations team.

1.23.13. Risk Management

At the conclusion/during the course of an investigation it may become clear that system or process weaknesses or failings have provided the opportunity for fraud or loss to occur. In these circumstances LCFS will conduct a risk assessment into the target area and report accordingly upon any weaknesses identified. The CLUE case management system will be used for this purpose. Any weaknesses and recommendation for remedial action will be reported to the relevant directorate or department. Any risks identified during the course of an investigation will be recorded on the local risk register by departmental management in conjunction with the LCFS. This may give rise to future proactive work such as Local Proactive Exercises that will be conducted by the LCFS to test that remedial actions have been undertaken. Where fraud risk assessment/fraud proofing work is required, departmental management must assist in providing all necessary information requested by the LCFS or Internal Audit in relation to the processes or systems under review.

CHART 3 – Disciplinary Process

1.23.14. Disciplinary Procedure

CAVUHB Disciplinary Policy and Procedure has to be followed in any disciplinary action taken by CAVUHB towards an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, the results of the investigation (a formal report) and take appropriate action against the employee.

In the event of a disciplinary investigation taking place where a suspicion of fraud exists, then the appointed investigating officer must liaise with the LCFS to agree a way forward. A decision will be made whether the investigations can run concurrently or whether the internal investigation will need to be put on hold until the completion of the criminal investigation or part of it.

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In some cases where a fraud is suspected it may be deemed by the Lead LCFS that the matter is of a minor nature, or that it would not pass the relevant evidential or public interest threshold tests, and therefore a formal criminal investigation will not progress. In these instances' the LCFS will keep departmental management and HR department apprised that no further action will be taken. A disciplinary investigation can still take place in these circumstances. If a disciplinary investigation only ensues following the report of a fraud or fraud related offence, the internal investigating officer and HR representative will ensure that the LCFS is kept apprised of the process and any resulting action that takes place. The LCFS will act in support of any disciplinary only investigation in the position of a witness only. Any evidence gathered by the LCFS will be shared with management if it assists with the case.

As per national requirements LCFS will report any outcome on the CLUE case management system.

The Law and its Remedies

1.24. Introduction

Section 6 of the NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought.

To summarise, local action can be taken to recover money by using the administrative procedures of the organisation or civil law. In cases of serious fraud, bribery and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s) and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate. This is known as the triple track approach.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002 (POCA)
- recovery sought from ongoing salary payments

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In some cases (taking into consideration all the facts of a case), it may be that CAVUHB under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

1.25. Proceeds of Crime Act

The NHS Counter Fraud Service (Wales) can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

1.26. Fraud Act 2006

The Fraud Act came into force on 15th January 2007. The following offences have been repealed:

- **Theft Act 1968**
 - Obtain property by deception (section 15)
 - Obtain money transfer by deception (section 15A)
 - Obtain pecuniary advantage (section 16)
 - Procure execution of valuable security (section 20)
- **Theft Act 1978**
 - Obtain service by deception (section 1)
 - Evade liability (section 2)

The new Act simplifies the original deception offences. There is no need to prove that any person was deceived. The Act now outlines three ways to commit fraud:

- Fraud by False Representation (section 2)
- Fraud by Failing to Disclose Information (section 3)
- Fraud by Abuse of a Position (section 4)

Many original 'deception' offences will now be covered by section 2 of the Fraud Act 2006 (false representation) which has three main ingredients:

- Dishonesty
- A false representation (no limitations on how this takes place)

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➤ Intention to commit gain or cause loss

Section 3 covers the offence of fraud by failing to disclose information where there is a legal duty to do so.

Section 4 covers the offence of fraud by abuse of position where the defendant is in a privileged position expected to safeguard (not act against) the financial interests of another person.

Section 6 covers the offence of possession of articles for use in fraud. This extends to possession or control of any article, anywhere and includes electronic data.

Section 7 covers the offence of making or supplying articles for use in fraud. It is designed to capture those who supply personal financial details for use in frauds to be carried out by others; or those who manufacture software programmes for generating credit card numbers.

Section 11 of the Fraud Act – Obtain Services Dishonestly replaces ‘obtain services by deception.’ This offence requires the actual obtaining of a service and must include a dishonest act or false representation.

The test for dishonesty that is currently relied upon rests in case law and the cases of *Ivy v Genting Casino 2017* and *Barton and Booth v R 2020*.

1.27. Corruption

The definition (in the context of the Prevention of Corruption Acts) is the offering, giving, soliciting, or acceptance of an inducement or reward, which may influence the action of any person.

References

This policy should be read in conjunction with:

- Standing Orders
- Standing Financial Instructions
- Disciplinary Procedures
- Standards of Business Conduct
- I.T Security Policy
- Public Relations and Communications Strategy
- Whistleblowing Policy
- Dignity at Work Policy

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- CAVUHB policies relating to:
 - Gifts
 - Hospitality
 - Conflicts of Interest
 - Procurement
 - Capital/PFI Contracts

Further Information

Further information and a copy of the fraud policy and response plan may be obtained from the LCFS or CAVUHB intranet.

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NHS Fraud and Corruption: Dos and Don'ts A desktop guide for CAVUHB

FRAUD is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.

CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

<u>DO</u>	<u>DO NOT</u>
<ul style="list-style-type: none"> <li style="margin-bottom: 10px;"> <p>• Note your concerns Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.</p> <li style="margin-bottom: 10px;"> <p>• Retain evidence Retain any evidence that may be destroyed, or make a note and advise your LCFS.</p> <p>• Report your suspicion Confidentiality and anonymity will be respected – delays may lead to further financial loss.</p> 	<ul style="list-style-type: none"> <li style="margin-bottom: 10px;"> <p>• Confront the suspect or convey concerns to anyone other than those authorised, as listed below Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.</p> <li style="margin-bottom: 10px;"> <p>• Try to investigate, or contact the police directly Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.</p> <p>• Be afraid of raising your concerns The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.</p>

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If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- directly contacting the Local Counter Fraud Specialist, or
- telephoning the free phone NHS Fraud and Corruption Reporting Line, or
- contacting the Director of Finance.

[Do you have concerns about a fraud taking place in the NHS?](#)

If so, any information can be passed to the NHS Fraud and Corruption Reporting Line:

0800 028 40 60

All calls will be treated in confidence and investigated by professionally trained staff

Your nominated Local Counter Fraud Specialist are:

Gareth Lavington - Head of Counter Fraud –
Gareth.Lavington2@wales.nhs.uk – 02921836265

Nigel Price - Local Counter Fraud Specialist – Nigel.Price@wales.nhs.uk
02921836481

Henry Bales – Local Counter Fraud Specialist – Henry.Bales@nhs.wales.uk
02921836264

Nicola Tillings – Local Counter Fraud Specialist -Nicola.Tillings@wales.nhs.uk
02921836262

If you would like further information about the NHS Counter Fraud Service, please visit www.nhscfa.co.uk or [Counter Fraud - Home \(sharepoint.com\)](#)

Mohamed Sarah
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Approved By:		

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Report Title:	Standing Orders – Temporary variation (AGM date)		Agenda Item no.	8.3	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	11 May 2023
		Private	<input type="checkbox"/>		
Status (please tick one only):	Assurance <input type="checkbox"/>	Approval <input checked="" type="checkbox"/>	Information <input type="checkbox"/>		
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report

Background and current situation:

Pursuant to Standing Order 7.2.5 the Health Board must hold an Annual General Meeting (AGM) in public no later than the 31 July each year.

In light of the Auditor General's request to delay certification of the accounts to 31 July 2023, the Welsh Government has confirmed that the Health Board's Final Annual Report and Accounts must be submitted to Audit Wales and HSSG Finance by 31 July 2023. Accordingly, the Health Board is unable to hold its AGM by 31 July this year.

The NHS Wales 2022-23 Manual for Accounts, Chapter 3 of the Financial Reporting Manual ("Chapter 3 Guidance") stipulates that "a public meeting must be held no later than 28 September 2023 (date to be confirmed by Welsh Government) at which the Annual Report and audited accounts are presented". It is therefore proposed that Standing Order 7.2.5 is temporarily varied to take account of this year's Chapter 3 Guidance in relation to the date of this year's AGM.

The proposed temporary variation to the Health Board's current Standing Orders (ie to Standing Order 7.2.5) requires consideration and approval by the Audit & Assurance Committee prior to being approved by the Board. In accordance with paragraph xxx) of Section A of its Standing Orders, the Health Board is able to vary or amend its own Standing Orders, provided that the variation is in accordance with the relevant statutory regulations (ie the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009). It has been determined that this section of the Standing Orders can be for local determination.

The Health Board has been given notice of this motion via email from Welsh Government on the 18 April 2023 which formally confirmed and acknowledged, as referred to within the recently revised Chapter 3 of the Financial Reporting Manual, that the Health Board's Annual General Meeting should take place no later than 28 September and not 31 July in 2023.

The purpose of this paper is for the Committee to endorse the variation in the Standing Order 7.2.5 in respect of the temporary arrangements for the AGM in 2023 so that the current wording "*The LHB must hold an AGM in public no later than the 31 July each year*" is temporarily amended to "*The LHB must hold its 2023 AGM in public no later than the 28th September. This variation from the date of July will be reviewed on the 31st March 2024*".

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

This temporary variation will be reviewed on the 31st March 2024 following the publication of the Manual for Accounts containing the Annual Report and Accounting Timetable for 2023-2024.

Mohamed
02/05/2023 17:42

Recommendation:

The Committee is requested to:

- a) **Consider** and **endorse** the proposed variation (as set out in the body of this report) to Standing Order 7.2.5; and
- b) **Recommend to Board** to formally approve the proposed variation to Standing Order 7.2.5.

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	x
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	
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	x	Long term	x	Integration	x	Collaboration	x	Involvement	x
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

The proposed variation to Standing Order 7.2.5 complies with the Standing Orders which permit variation and amendments to the Health Board's Standing Orders (ie paragraph xxx) of Section A to the Standing Orders). Further, as set out in the report Welsh Government has confirmed its agreement to the proposed variation.

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: No

The Socio-Economic Duty is designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: [The Socio-economic Duty: guidance | GOV.WALES](#)

(If this has been addressed in the main body of the report, please confirm)

Equality and Health: No

Equality Health Impact Assessments (EHIA) are typically undertaken when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.

Useful guidance on the completion of an EHIA can be found at the following link: [EHIA toolkit - Cardiff and Vale University Health Board \(nhs.wales\)](#)

(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No

Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.

(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Board

25 May 2023

Mohamed, Sarah
02/05/2023 17:42:26

Report Title:	Internal Audit Reports for Information			Agenda Item no.	9.1
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	11/05/23
		Private			
Status <i>(please tick one only):</i>	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.

The 2022/23 plan was formally approved by the Audit Committee at its April 22 meeting.

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:

Nine audit reports have been finalised since the last meeting of the Committee, with the following assurance ratings:

- Two Substantial Assurance
- Six Reasonable Assurance
- One Limited Assurance

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	x	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	

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

A number of the finalised audits provide assurance around controls and processes relating to patient safety.

Financial: Yes/No

One of the finalised audits provides assurance around financial controls and processes.

Workforce: Yes/No

A number of the finalised audits provide assurance around workforce issues.

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

One of the finalised audits provides assurance around Equality issues.

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Mohamed Sarah
02/05/2023 17:42:26

Individual Patient Funding Requests

Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board



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Review reference:	CVU 2223-38
Report status:	Final Report
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Auditors:	Olubanke Ajayi- Olaoye, Principal Auditor Wendy Wright- Davies, Deputy Head of Internal Audit Ian Virgill, Head of Internal Audit
Executive sign-off:	Abigail Harris, Executive Director of Strategic Planning
Distribution:	Melanie Wilkey, Deputy Director of Commissioning Elinor Mercer, Commissioning 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 Institute of Internal Auditors

Acknowledgement

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Disclaimer notice - please note

This audit 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 and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To establish and review the systems and processes in place to assess, make decisions on, and monitor spend related to Individual Patient Funding Requests (IPFRs).

Overview

We have issued substantial assurance on this area.

The findings of our audit have highlighted that the Health Board processes IPFR applications in line with the requirements of the All-Wales IPFR Policy. The IPFR Panel members were suitably represented at the meetings we reviewed, and decisions made were adequately supported by a decision record. The IPFR team and IPFR panel undertake effective monitoring of the IPFR following approval to ensuring their continued relevance and benefit to the patient. The costs of IPFR are managed as required, either by the Clinical Boards or corporately by the Health Board's Finance team.

The key matter requiring management attention relates to:

- The consistent use of standard documentation and ensuring the timely processing of IPFR applications, as outlined in the IPFR Policy.

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

Report Opinion

Substantial



Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary¹

Objectives	Assurance
1 IPFRs are processed in line with the all-Wales IPFR Policy	Reasonable
2 There is appropriate representation at the Health Board's IPFR panel meetings. Decision-making is in line with guidance in the all-Wales IPFR policy and the decisions and rationale are clearly documented	Substantial
3 Approved IPFRs are regularly monitored and reported to the Health Board's IPFR Panel, to ensure expenditure remains within the funding limit and timeframe	Substantial

¹The 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 IPFR application review	Operation	Medium

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1. Introduction

- 1.1 Our audit review of 'Individual Patient Funding Requests' (CVU 2223-38) was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 When treatments are not routinely available, patients who might get particular benefit can still access the treatment through a process called Individual Patient Funding Requests (IPFR).
- 1.3 Funding applications presented by clinicians are screened by the Health Board, who will refer to WHSSC commissioning criteria to retain the case within Health Board remit or will direct it to WHSSC. Our review focused on the cases which are retained within the Health Board, which will normally be for one of the following reasons:
 - A patient requires a treatment which is new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatment;
 - A patient requires a treatment which is outside of existing clinical policy criteria; or
 - A treatment is required for a patient with a rare or specialist condition and is not eligible for treatment in accordance with the clinical policy criteria.
- 1.4 IPFR requests are considered by the Health Board's IPFR Panel, which will act in accordance with the All-Wales IPFR Policy. The Panel will normally reach its decision based on the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support.
- 1.5 The Executive Director of Strategic Planning is the lead Executive for this review.
- 1.6 The potential risks considered in this review were:
 - Applications of poor quality and/or non-compliant with policy leads to reputational damage due to potential legal challenge;
 - Patient harm due to delays in decisions being reached on IPFRs and thereafter receiving treatment; and
 - Ineffective monitoring of funding limits leads to financial loss.
- 1.7 Limitation to scope

Our review was limited to IPFR processes within the Health Board only and specifically excluded applications referred to and covered by the Welsh Health Specialised Services Committee (WHSSC) commissioning guidance.

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2. Detailed Audit Findings

Objective 1: IPFRs are processed in line with the all-Wales IPFR Policy

- 2.1 There is an All-Wales IPFR Policy in place which highlights how to deal with Individual Patient Funding Requests.
- 2.2 The Health Board has an IPFR page on its internet which includes a number of resources including the IPFR policy, application form, guidance notes, leaflet and IPFR patient's video.
- 2.3 The Commissioning Team provided us with Standard Operating Procedures (SOP) to inform the audit. These cover the treatment and processing of IPFR applications and the processing of Outcomes Data Progress Reports. The SOP are currently in draft and have not yet been taken through any quality assurance or governance process.
- 2.4 A requestor (a Clinician) can submit an application on behalf of their patient via the IPFR database (an All-Wales website) or using the word document form.
- 2.5 As a part of the preliminary checks, the IPFR Team is responsible for requesting the Clinical Board Director and Clinical Director sign off (as budget holders) of the application, so they are aware of the costs which will be taken from their budget. We note that this can be a time-consuming process for the IPFR Team. Velindre Cancer Centre (VCC) specific treatments are monitored by Corporate Finance.
(Matter Arising 1 – Low Priority)
- 2.6 The IPFR team are responsible for the administration of IPFR applications, pre (initial screening checks) and post IPFR panel's decision review. Individual folders are created for each application. There is a checklist / tracker used to log in all received key actions and histories, these include IPFR and other funding requests. There is also a database where all the outcomes of applications following the IPFR panel's review are entered.
- 2.7 Within the IPFR Policy there are expected timelines for the completion of stages/tasks within the IPFR application processing cycle, these are:
- Five working days for initial screening of the application forms by the IPFR team.
 - Review of the application by the panel (Expected timeline determined for each application - Urgently 24-48 hours / 2-3 weeks / Non urgent 4-6 weeks
 - Clinician's Decision letter sent within five working days.
- 2.8 The draft SOPs provide appropriate detail on the IPFR process and reflect the requirements of the All Wales Policy. We undertook testing on a sample of completed IPFR applications to confirm if they had been processed in compliance with the requirements of the All-Wales IPFR policy. The following areas of good practice were observed:

- Initial screening undertaken by the IPFR team for all the sampled applications was done in less than the recommended five working days; and
- All the sampled applications were reviewed, and a decision was reached within the time frames stated within the application form; and

However, a number of exceptions were identified and are noted within Appendix A. **(Matter Arising 2 – Medium Priority)**

2.9 Treating organisations are the Health Organisation's where the patient receiving the IPFR will be treated. In the sample selected for review, treating organisations outside the Health Board were included.

Conclusion:

2.10 The Health Board's compliance to the IPFR Policy is interpreted by the local processes within the draft SOPs which reflect current practice. We were able to evidence that IPFR are being appropriately managed but have identified areas where further work is required to ensure the requirements of the IPFR policy are consistently met. (Reasonable Assurance)

Objective 2: There is appropriate representation at the Health Board's IPFR panel meetings. Decision-making is in line with guidance in the all-Wales IPFR policy and the decisions and rationale are clearly documented

2.11 There is an IPFR panel which acts as a committee of the Health Board. They arrive at decisions by assessing the IPFR application forms, written evidence and any other documentary evidence provided. The Panel has a Terms of Reference (ToR) in place highlighted within the IPFR policy.

2.12 The panel meets at least once a month with additional meetings held as required and agreed by the Panel Chair. For the period of our review, the panel usually meet fortnightly or every three weeks via Microsoft teams.

2.13 As highlighted in the ToR, the IPFR panels are made up of suitably experienced and knowledgeable representatives. A review of the minutes of meetings held between March 2022 and January 2023 was undertaken to confirm the quoracy of meeting attendance and that staff with the required level of expertise were present to allow for adequate review of the IPFR applications. All the IPFR panel meetings which took place within the scope of the sample were quorate as required in the terms of reference.

2.14 Prior to the IPFR panel's meetings, research is undertaken by the Pharmacy team where the application is medicine related. The Health Technology Wales team are expected to undertake further research prior to the IPFR panel's meeting where the IPFR applications are not medicine related.

2.15 A pre-plan checklist is prepared for the IPFR panel. This is a list put together to ensure they have the right information in place for the panel to make an accurate decision.

-
- 2.16 In a situation where an urgent decision is required because of the nature of treatment, and there is no pre-arranged panel meeting taking place within the timeline, the Chair is permitted to provide a decision, as stated in the IPFR Panel's ToR.
- 2.17 Once an application has been approved by the panel it is given an IPFR authorisation number for Finance purposes.
- 2.18 A decision record should be completed for each application considered by the Panel. The record highlights the rationale behind the application decision taken (accepted, rejected or deferred). The decision record has a number of sections relating to statements regarding the patient being clinically different, guidelines and relevant articles, finance and cost details and summary of other ethical consideration. It specifically highlights:
- Evidence of greater clinical benefit;
 - Evidence based considerations;
 - Economic considerations; and
 - Ethical considerations.

All sampled applications reviewed by the IPFR panel had decision records in place highlighting the clinical benefit, economical cost and other ethical considerations. This evidences that the sampled IPFR were subject to appropriate decision making, although we didn't undertake an in-depth review on the contents of the categories within the decision record.

Conclusion:

- 2.19 The IPFR panel were suitably represented at meetings. The decision records completed following every meeting effectively evidence the rationale taken to arrive at the decisions. (Substantial Assurance)

Objective 3: Approved IPFRs are regularly monitored and reported to the Health Board's IPFR Panel, to ensure expenditure remains within the funding limit and timeframe

- 2.20 Following each application approval, there is an authorisation number allocated, this can be likened to a purchase order number. This is included in the letter sent to the clinician following the approval. The Clinical Board Director and Clinical Director are copied into the letter, so they are aware of the decision outcome.
- 2.21 The IPFR team monitors approved IPFRs by periodically checking the Health Board's Clinical Portal to confirm patients should still be receiving treatments.
- 2.22 The IPFR team monitors treatments approved by the IPFR panel by ensuring an outcome form is completed as applicable for prescribed treatment. A Part A

outcome form is used where treatment has stopped, and part B is used where treatment is ongoing.

- 2.23 There is no central IPFR fund, the budgets are devolved to Clinical Board level and IPFR for Cardiff residents are expected to be funded within these existing budgets. As part of the due process within the draft SOP, respective Clinical board Directors and Clinical Directors (budget holders) are informed and involved as part of the application process. They are notified on the cost and need to approve the application before it is considered.
- 2.24 The Finance Contracting and Commissioning team (Corporate team) have the responsibility for monitoring the VCC IPFR fund periodically. VCC IPFR have a separate financial code and spend is monitored as part of monthly reporting. At the end of the financial year, a reconciliation is undertaken between VCC's invoiced amount and monthly payments made by the Health Board.
- 2.25 An SOP has been recently developed to take into consideration expensive requests, the actual table of IPFR scheme of financial delegation has been agreed by key parties. The SOP will be taken to the Strategic Commissioning Group for approval. The panel's delegation limit is £75,000 per year for each application and any amount above this goes to the Executive Director for approval.
- 2.26 An IPFR report is prepared quarterly by the Commissioning Officer in the IPFR team and presented at the Tactical Commissioning Group and Strategic Commissioning Group.
- 2.27 As a form of external monitoring, the All Wales Therapeutic & Toxicology Centre (AWTTC) co-ordinate monitoring of the IPFR information on their database. The IPFR Quality Assurance Group carry out a quarterly review of IPFR applications, where one of the applications are selected at random and an in-depth review is undertaken. AWTTC uses the information and outcome of the review to produce quarterly reports for the various Health Boards including Cardiff and Vale.

Conclusion:

- 2.28 Approved IPFR applications are adequately monitored by the IPFR team and IPFR panel to ensure the treatment being approved is of benefit and added value to the patient. As a part of budget holder's responsibility, applicable Clinical Boards and Corporate Finance monitor the financial aspect of IPFR applications and the IPFR reports are presented to the Tactical and Strategic Commissioning Groups. (Substantial Assurance)

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Appendix A: Management Action Plan

Matter Arising 1: Clinical Board sign-off of IPFR applications (Operation)		Impact	
<p>The Health Board’s internal processes require the IPFR team to seek/chase up the Clinical Board’s Director and Clinical Director for a sign off because the costs for these IPFR applications (with the exception of the Velindre Cancer Centre) normally sit within Clinical Board budgets.</p> <p>The IPFR team’s administration time can be caught up in this process.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Additional time used in the processing of IPFR application 	
Recommendations		Priority	
1	The IPFR team should consider including a permanent signatory field within the application form where the Clinical Board’s Director and Clinical Director can signoff. This would reduce the IPFR team’s overall time consumed in undertaking administrative responsibilities.	Low	
Agreed Management Action		Target Date	Responsible Officer
1	The IPFR Team will aim to include a permanent signatory field that is still editable for the Clinical Board Director and Clinical Director authorisation.	September 2023	IPFR Commissioning Officer

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Matter Arising 2: Review of IPFR Applications (Operation)		Impact
<p>Ten IPFR applications were selected across the four quarters of the 2022/23 financial year for audit review to establish if they were processed in accordance with the requirements of the IPFR Policy. The review considered approved, deferred, and declined IPFR applications.</p> <p>The findings from the review were as follows:</p> <ul style="list-style-type: none"> • One of the IPFR application forms did not have a selected timeline by which a decision should be made or worked towards; • Two decision letters were not issued to the clinicians within the recommended 5 working days; • Two IPFR applications had no decision record as they were approved via chairs action. We do however note that there were copies of email correspondence with key IPFR panel members and the panel chair. • One application did not use the standardised holding letter in conveying the decision/ information to the Clinician; and • One of the applications had no evidence of panel sending a letter to the patient. <p>Monitoring via the income form was undertaken as and when required, however, it was difficult in some instances to identify (at a glance) the full amount approved, the period covered or a requirement for a periodic review using an income questionnaire, within the decision records or letters.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Applications of poor quality and/or non-compliant with policy leads to reputational damage due to potential legal challenge.
Recommendations		Priority
2.1	Management should remind clinicians to complete all sections within the IPFR application.	Medium
2.2	Standard templates including the decision record should be used as required. Where there are exceptions to this practise, this should be updated within the SOP.	
2.3	Management should strive towards timely processing of all documents (as stated in the IPFR Policy) to avoid delay in the IPFR application process.	

2.4	Management should ensure that IPFR applications full amount approved, period covered, and timeline required for completion of an outcome questionnaire (where already determined) is clearly stated within the decision record.		
Agreed Management Action		Target Date	Responsible Officer
2.1	The IPFR Team will remind clinicians to complete all the relevant sections within the IPFR form as detailed in the SOP.	April 2023	IPFR Commissioning Officer
2.2	<p>The SOP will be updated to reflect that standard documents may be tailored to reflect the individual circumstances of the specific applications and associated decisions.</p> <p>The IPFR Team will work with the IPFR Chair to develop a Chair’s Action Decision Record which aligns with the IPFR Panel Decision Record.</p>	<p>June 2023</p> <p>September 2023</p>	IPFR Commissioning Officer
2.3	As per the All Wales IPFR Policy, the initial decision letter will continue to be sent within 5 working days. The IPFR Team will aim to also send the letter containing the decision rationale within 5 working days, once the clinical detail has been ratified by the IPFR Chair.	April 2023	IPFR Commissioning Officer
2.4	<p>We will ensure that duration of the funding is explicit in the decision letter (cycles, annual, excessive toxicity, progression, death or trial period).</p> <p>We will specify how often an outcome data questionnaire is required to be completed by the clinician in the decision letter.</p> <p>We will update the SOP to specify that an Outcome Data Questionnaire is expected every 6 months unless the IPFR Panel specify an alternative period.</p>	June 2023	IPFR Commissioning Officer

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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.
	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.

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Follow-up: Clinical Audit Final Internal Audit Report

April 2023

Cardiff and Vale University Health Board



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Auditors:	Lucy Jugessur, Internal Audit Manager Ian Vigill, Head of Internal Audit
Executive sign-off:	Meriel Jenney, Executive Medical Director
Distribution:	Alexandra Scott, Assistant Director of Quality Safety Angharad Oyler, Head of Patient Safety and Quality Assurance
Committee:	Audit and Assurance Committee



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Executive Summary

Purpose

The overall objective of the audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Clinical Audit (2122-15) review that was reported as part of our 2021/22 work programme.

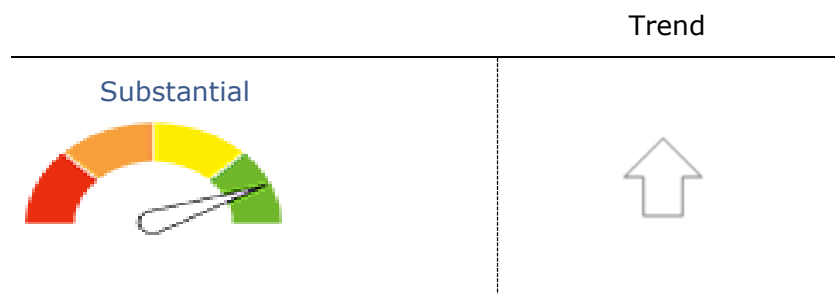
Overview of findings

Management have made significant progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the nine recommendations made, eight of them have been closed including three high priority recommendations. There is only one outstanding high recommendation which has been moved to a low priority as actions have been undertaken to address this recommendation, however, the Clinical Audit Policy has yet to be formally approved by the Quality, Safety and Experience Committee.

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Follow-up Report Classification



Progress Summary

Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1 Absence of a Health Board approved Clinical Audit Strategy	High	Closed
2 Lack of Clinical Audit Policy and Procedures	High	Low
3 Inadequate staff resources for monitoring Clinical Audits	High	Closed
4 Limitations of current systems to monitor clinical audits	High	Closed
5 Absence of a Clinical Audit Training Plan	Medium	Closed
6 Lack of clarity of Local Clinical Audit Plans	Medium	Closed
7 Inadequate registration and oversight of Local Clinical Audits	Medium	Closed
8 Limited scrutiny of Local Clinical Audits	Medium	Closed
9 Risk Management	Low	Closed

1. Introduction

- 1.1 The follow-up review of Clinical Audit was completed in line with the 2022/23 Internal Audit Plan for Cardiff and Vale University Health Board (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 This was a follow-up review of the original report that was issued in October 2021. This identified nine issues and resulted in an overall assurance rating of 'Limited Assurance'.
- 1.3 The Lead Executive Director for this review is the Executive Medical Director.
- 1.4 The potential risks considered in the original review were as follows:
- Resource capacity prohibits the completion of the Clinical Audit Plan;
 - Clinical issues materialise if risks are not identified due to ineffective monitoring and governance arrangements; and
 - Patient harm due to healthcare not meeting quality standards.

2. Findings

- 2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	3	1(R2)	-
Medium	4	4	-	-
Low	1	1	-	-
Total	9	8	1	0

- 2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Checked by Sarah
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Appendix A: Management Action Plan

Previous Matter Arising 2: Lack of Clinical Audit Policy and Procedures		
Original Recommendation		Original Priority
<p>The Health Board should develop a Clinical Audit Policy and subsequent Procedure, which will require formal approval, to provide a mandate to direct staff on a consistent basis.</p> <p>The policy and procedures should be developed in keeping with HQIP guidance, so that national and local clinical audits are carried out consistently and comply with current information governance legislation and guidance.</p>		High
Management Response	Target Date	Responsible Officer
<p>A Health Board specific Clinical Audit policy will be developed and subsequent procedure which will provide a mandate to direct staff in a consistent way. The policy will be approved through the Clinical Effectiveness Committee Meeting.</p> <p>(As with the clinical audit strategy time frames of completing this action will be dependent on the timing of and amount of investment has been agreed which will also influence the approach)</p>	January 2022	Head of Patient Safety and Quality Assurance and Associate Medical Director
Current findings		Residual Risk
<p>It was identified in the previous audit that there was no approved Clinical Audit Policy in place. A Clinical Audit Policy has since been developed in line with HQIP guidance and approved by the Clinical Effectiveness Committee and is due to be approved by the Senior Leadership Board.</p> <p>Conclusion: The previous recommendation has been partially implemented.</p>		Patient harm due to healthcare not meeting quality standards
New Recommendations		Priority


1.1	Management need to ensure that the Clinical Audit Policy is formally approved by the Quality, Safety and Experience Committee. Following approval, the policy should be made available on the Clinical Audit Sharepoint page.	Low	
Management Response		Target Date	Responsible Officer
1.1	The Clinical Audit Policy has been developed and circulated for comment to the Clinical Effectiveness Committee and the Clinical Board Directors. It will be circulated wider through the UHB policy ratification process by Corporate Governance, followed by discussion at the Senior Leadership Board, and finally approval in the Quality Safety and Experience Committee. It will be made available to staff via the Clinical Audit Share point page.	July 2023	Head of Patient Safety and Quality Assurance

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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:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations</p>

Prioritisation of Recommendations

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

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

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



NHS Wales Shared Services Partnership
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Mohamed Sarrah
02/05/2023 17:42:26

Follow-up: Nurse Bank (Temporary Staffing Department)

Final Internal Audit Report

April 2023

Cardiff and Vale University Health Board



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University Health Board



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Committee:	Audit and Assurance 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.

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Executive Summary

Purpose

The overall objective of this audit is to provide the Health Board with assurance regarding the implementation of the agreed management actions from the 'Nurse Bank (Temporary Staffing Department)' review that was reported as part of our 2021/22 work programme.



Overview of findings

Management have made good progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the eight recommendations made, five of them have been closed including one high priority recommendation. Two of the recommendations have been moved to low priority as actions had been undertaken within these areas. One of the high recommendations has moved down to medium and still requires a review to be undertaken of the agencies as no further agencies are currently being utilised by the Health Board.

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Follow-up Report Classification

		Trend
Reasonable 	Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary

Previous Matters Arising	Previous Priority Rating	Current Priority Rating
1 Lack of Temporary Staffing Guidance	Medium	Low
2 Inadequate structure within the Temporary Staffing Department	High	Closed
3 Resilience of the Temporary Staffing Department	High	Low
4 Roles and responsibilities for Bank recruitment	Medium	Closed
5 Lack of engagement with service users	Medium	Closed
6 Operational management of the Temporary Staffing Department	Medium	Closed
7 Range of agency usage	High	Medium
8 Ward verification of agency shifts	Medium	Closed

1. Introduction

- 1.1 The follow-up review of the 'Nurse Bank (Temporary Staffing Department)' was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (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 This was a follow-up review of the original report that was issued in May 2022, which identified eight issues and resulted in an overall assurance rating of 'Limited Assurance'.
- 1.3 The Executive Director of People and Culture is the lead for this review.

Audit Risks

- 1.4 The potential risks considered in this review were as follows:
- Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff;
 - The allocation and completion of bank shifts does not meet the priorities of the Clinical Boards;
 - Financial loss due to unnecessary usage or incorrect payment of bank and agency staff; and
 - Issues relating to bank and agency are not identified or addressed.

2. Findings

- 2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	3	1	2 (R3 & R7)	-
Medium	5	4	1 (R1)	-
Low	-	-	-	-
Total	8	5	3	0

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

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Appendix A: Management Action Plan

Previous Matter Arising 1: Lack of Temporary Staffing Guidance (Design)		
Original Recommendation		Original Priority
<p>Management should review the Temporary Staffing Department's (TSD) procedural guidance to support the Nurse Bank, to ensure the resilience of the team, and to provide clarity of processes.</p> <p>Consideration should be given to the impact of the roll-out of HealthRoster on existing processes.</p>		Medium
Management Response	Target Date	Responsible Officer
<ol style="list-style-type: none"> 1. Identify the full range of processes that will require guidance 2. Develop or improve existing guidance (this will include flowcharts) 3. Communicate all procedures within TSD team 4. Place all processes/flowcharts onto shared folder with hard copies compiled on a file. 	01/09/2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nurse Workforce
Current findings		Residual Risk
<p>Comprehensive guidance has been produced including flowcharts on the processes within the Temporary Staffing Department. However, these have not been shared within the TSD team and a file has not been compiled with them in as they still require some amendments.</p> <p>Conclusion: This recommendation is partially completed</p>		Procedures and guidance are not in place within the Bank to assist the Bank staff to manage the Nurse Bank adequately.
New Recommendations		Priority
1.1	Management should ensure that when all procedures in relation to the TSD are fully completed they are shared with the Temporary Staffing Department team and placed onto a shared folder with hard copies compiled on a file.	Low

Management Response	Target Date	Responsible Officer
1.1 Following completion of all processes and flow charts, this has now been compiled into a lever arch file and uploaded onto a Teams shared folder. This will be promoted and communicated to the wider Team at a meeting scheduled for 11 May 2023.	11/05/23	Jonathan Pritchard

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Previous Matter Arising 3: Resilience of the Temporary Staffing Department (Operation)		
Original Recommendation		Original Priority
Management need to ensure that there is greater resilience within the Temporary Staffing Department, to ensure transactional functions do not come to a stop, due to the absence of one individual.		High
Management Response	Target Date	Responsible Officer
<ol style="list-style-type: none"> The implementation of Allocate/ Health roster and change to incorporate self-billing will resolve the current issue of processing invoices. Provide training to all of the team members to enable them to rotate into each other's roles. This will enable the ability for them to cross-cover when absences arrive and enrich their own roles. 	December 2022	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nurse Workforce
Current findings		Residual Risk
<p>HealthRoster has not been fully implemented as yet and full implementation is due in September 2023 and therefore the processing of invoices is still occurring.</p> <p>Staff are now being rotated on different processes within the TSD.</p> <p>Training was provided to two staff members by the Senior Nurse on the agency invoices report, however, one staff member no longer works in TSD and the other staff member is on long term sick. No other staff members have been trained on the agency invoice reports.</p> <p>Conclusion: This recommendation is partially completed</p>		Issues relating to bank and agency are not identified or addressed.
New Recommendation(s)		Priority
2.1 Management need to ensure that more staff are trained on the agency invoice report so cover can be provided in the event that an employee is absent.		Low
Management Response	Target Date	Responsible Officer

2.1	Two members of the team have now been identified to be trained and assist with the processing of invoices.	19/05/23	Sandra Coles
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Previous Matter Arising 7: Range of agency usage (Operation)		
Original Recommendation		Original Priority
The Temporary Staffing Department is to maximise all available agency options via framework agreements, to ensure a greater fill rate, to support the safer operation of wards		High
Management Response	Target Date	Responsible Officer
Undertake a review of agencies currently not used who are on the Welsh Framework to identify if there are further agencies that could provide appropriate numbers of staff.	31/03/2023	Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce
Current findings		Residual Risk
<p>It was identified in the previous audit that 36 agencies from the 140 agencies recorded on the Agency 2021 Framework were being utilised. We have since been advised that the same number of agencies are currently being used and this is due to a number of agencies detailed on the Framework not covering NHS Wales.</p> <p>It has been agreed that the Senior Nurse will review the current list of utilised agencies and identify how other agencies can be added on. This will be actioned when all wards are using HealthRoster as Rosterpro is still being utilised resulting in invoicing issues needing to be resolved. In addition, from 1st April 2023 the Health Board have agreed that agencies will no longer supply HCSWs.</p> <p>The Assistant Director of Workforce and Senior Nurse met with three agencies to assess whether they could undertake some work for the Health Board, but no response was received.</p> <p>Conclusion: This recommendation is partly completed</p>		Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff.
New Recommendation(s)		Priority
3.1 The Temporary Staffing Department should undertake a review of agencies that are utilised within the Health Board for Nurses to ensure a greater fill rate and to support the safer operation of wards.		Medium
Management Response	Target Date	Responsible Officer


<p>3.1</p>	<p>The number of agencies used by the UHB will have reduced from 1 April 2023 as a result of introducing the workforce sustainability model which ended the use of Agency HCSWs in favour of using the UHB’s own bank HCSWs. This has been possible due to the proactive communication to Agency HCSWs and encouragement to join the Staff Bank. This has resulted in 149 applications being processed and a further 58 applications being received in the last week which will be dealt with soon. As there are a number of agencies who only provided HCSWs this will be the reason why the number of providers will reduce.</p> <p>Meetings have been held with Medacs and Goldstaff Agencies regarding providing their services however, they have not to date been able to provide an update on whether they have been able to recruit to nursing roles to enable them to provide a service.</p> <p>Although many agencies are part of the All Wales contract, most of them do not operate in the South Wales area and so do not have staff available for use.</p> <p>I would suggest that with the benefit of hindsight, increasing the number of agencies used should not be a goal. Instead I feel the UHB should focus on increasing the number of staff employed by the bank so that the staff used have consistent training and the quality and continuity of patient care improves.</p>	<p>December 23</p>	<p>Sandra Coles</p>
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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:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations</p>

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.



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Charitable Funds Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board



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Committee:	Audit & Assurance Committee



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Executive Summary

Purpose

The objective of the audit was to review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Ensuring consistent compliance with the processes for requesting and approving expenditure from Charitable Funds;
- The governance arrangements for the Fundraising Team require reviewing; and
- The governance arrangements for fundraising events require reviewing and enhancement.

Other recommendations / advisory points are 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.

Trend



2020/21

Assurance summary¹

Objectives	Assurance
1 Financial Control Procedure in place	Substantial
2 Charitable Funds Income Received	Substantial
3 Charitable Funds Expenditure	Reasonable
4 Funds held in Trust are monitored	Substantial
5 Role of the Charitable Funds Committee	Substantial
6 Fundraising Team Governance	Limited
7 Appropriate Guidance in Place	Substantial
8 Fundraising Events Governance	Reasonable

¹The 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
3	Charitable Funds Expenditure	3 Operation	Medium
5	Fundraising Team Structure	6 Design	High
7	Effectiveness of Fundraising Events	8 Design	Medium

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2.1 Introduction

- 1.1 Our audit review of Charitable Funds was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 Charitable Funds in the NHS originate from a variety of different sources including donations, grants, legacies and fund raising, which may be for a specific or general purpose. In order to be deemed charitable, funds held on trust must have a purpose which is for the general public good.
- 1.3 The 'Cardiff and Vale Health Board General Purpose Charitable Fund' (Charity Registration Number 1056544) trades under the name Cardiff and Vale Health Charity. The "Charity" is governed by the Declaration of Trust dated 03/06/1996 as amended by supplemental deeds dated 12/07/2001 and 02/12/2010. Under the terms of this deed the Charitable Fund is administered by and managed by the Trustees, the Cardiff & Vale University Health Board as a body corporate. The fund is an umbrella charity with a number of subsidiary charities registered therein and also managed by the Health Board.
- 1.4 For the period 1st April 2021 to 31st March 2022 the charity generated income of £1.761m and spent £2.413m. As of 31st March 2022, the Charity's Investment portfolio position was £6.569m.
- 1.5 The Executive Director of Finance is the lead for this review.
- 1.6 The potential risks considered in this review were as follows:
 - Charitable funds expenditure may be inappropriate, excessive or may be incorrectly recorded;
 - Charitable funds income is not maximised;
 - Monitoring, reporting and oversight arrangements may be inadequate; and
 - Non-compliance with legislation or Charity Commission guidance.

2.2 Detailed Audit Findings

Financial Probity

Objective 1: A Financial Control Procedure is in place which adequately covers receipt of income, expenditure and investments.

- 2.1 A Financial Control Procedure (FCP) is in place which is detailed and comprehensive and adequately covers receipt of income, expenditure and investments.
- 2.2 The document is available to all staff on the Health Board's intranet, on the Finance Department's Documents page.

- 2.3 We did note however that the current version of the document does not detail the 'owner' of the procedure, the date of last review or the date of next review. (Matter Arising 1)

Conclusion:

- 2.4 A Financial Control Procedure is in place which provides comprehensive guidance for Charitable Funds. However, the document needs to be updated to note author and review dates. We have provided Substantial Assurance for this objective.

Objective 2: Charitable Funds income received is appropriate and accounted for correctly (including gift aid).

- 2.5 The coding and crediting of Charitable Funds income is overseen by the Senior Charitable Funds Officer who holds the backing documentation to support donations received by the Health Board.
- 2.6 Testing was undertaken on a sample of thirty income donations to ensure that appropriate documentation was held to support the donations and that the monies received were credited to the correct fund. We noted the following:
- For all thirty samples the fund credited matched the supporting documentation; and
 - For one of the donations there was a delay of five months in banking the donation due to the monies being held by the receiving department and not taken to the Cashiers office. (Matter Arising 2)
- 2.7 The Fundraising Team uses an electronic system 'Harlequin' to record all gift aid income including details of donors and there is a 'local procedure' in place that details the process.
- 2.8 A quarterly claim is submitted to His Majesty Revenue & Customs (HMRC) for gift aid supported by information recorded on the Harlequin system.
- 2.9 A copy of the claim along with supporting details is provided to the Senior Charitable Funds Officer who will credit the individual funds once the claim has been paid and monies credited to the bank account.
- 2.10 Where donations are received without an accompanying gift aid form, if the donor's address is known a form will be sent politely requesting that the form is completed to further benefit the Charitable fund at no additional cost to the donor.

Conclusion:

- 2.11 Our testing found that all income received was appropriate and had been correctly accounted for, however we did note a minor concern regarding the length of time it took to deposit one donation in our sample. We have provided Substantial Assurance for this objective.

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Objective 3: Charitable Funds expenditure is appropriate, authorised and within the terms of the relevant fund.

- 2.12 The processes for applying for charitable funds funding is outlined in the Financial Control Procedure and will vary depending on the amount of monies being applied for.
- 2.13 For applications for funds that exceed £25,000 the bids are coordinated by the Fundraising Department. All bids received are reviewed before being submitted to the Charitable Funds Committee for approval. All applicants will receive notification on the outcome of the applications.
- 2.14 The Fundraising Department also coordinate and review all applications for funds from the Staff Lottery. Once the applications have been considered by the Panel, the Fundraising Department will advise the applicants of the outcome. Details of all applications received and approved by the Staff Lottery Panel are also reported at each meeting of the Charitable Funds Committee.
- 2.15 Testing was also undertaken on a sample of thirty items of expenditure from charitable funds to ensure that the application and authorisation process was in line with guidance and also that all goods or services purchased were appropriate and also in line with guidance issued (Guidance on core and non-core expenditure for charitable funds applications). The following was noted:
- Office furniture was purchased which is contra to the guidance issued;
 - In one case no prior authorisation was received;
 - For four of the items, whilst the expenditure was appropriate there was no supporting documentation to evidence approval. These items related to expenditure from funds overseen by the Fundraising Department; and
 - For one of the sample an accrual is still being held although no invoice has been received.

(Matter arising 3)

Conclusion:

- 2.16 The audit found that effective processes are in place to ensure that Charitable funds expenditure is appropriate, authorised and within the terms of the relevant funds. However, we did identify a number of occasions where the processes were not fully complied with. We have provided Reasonable Assurance for this objective.

Objective 4: Funds held in Trust are appropriately monitored, managed and invested.

- 2.17 The Senior Charitable Funds Office issues monthly statements to designated fundholders/authorised signatories for all 'Funds held in Trust'. However, we do note that this information is not issued to Finance Business Partners. (Matter Arising 4)

-
- 2.18 In accordance with the FCP an exercise is now undertaken annually to identify any funds that are dormant and then contact the fundholders to ensure that expenditure plans are in place to utilise the income available.
- 2.19 A report on the financial position of Charitable Funds is submitted to each meeting of the Charitable Funds Committee. The report is also submitted to the Charitable Funds Trustees meetings which occurs twice a year.
- 2.20 A full year cash forecast is maintained that details the different charitable funds income and expenditure streams. An extract of the cash forecast is included as part of the Charitable Funds Finance Report that is submitted to the Charitable Funds Committee.
- 2.21 An update report on charitable funds investments is provided at each meeting of the Charitable Funds Committee.

Conclusion:

- 2.22 The audit found that funds held in trust are appropriately monitored, managed and invested. However, consideration should be given to providing financial information regarding funds to the Clinical Board Finance Business Partners. We have provided Substantial Assurance for this objective.

Objective 5: The role of the Charitable Funds Committee is appropriately defined and provides adequate oversight for Charitable Funds.

- 2.23 The committee's Terms of Reference are in date and there is an approved annual workplan in place.
- 2.24 A review of records for three meetings that have taken place in 2022/23 found that all meetings were quorate. We found that the meetings were well constructed and with agenda items and supporting papers in line with the Committee's workplans.
- 2.25 As part of the audit we attended the September meeting of the committee and noted that robust discussions took place around the financial position of Charitable Funds as well as applications for funds.

Conclusion:

- 2.26 The Charitable Funds Committee provides appropriate oversight of Charitable Funds. We have provided Substantial Assurance for this objective.

Fundraising

Objective 6: The governance arrangements in place for the structure and financing of the Fundraising Team are appropriate.

- 2.27 The Director of Communications, Arts, Health Charity and Engagement has day to day responsibility for the Fundraising Team and executive responsibility lies with the Director of Finance.

- 2.28 In accordance with the Charitable Funds Committee terms of reference a fundraising report is submitted to each meeting providing details of fundraising events that have taken place since the last meeting. The report will also include updates on the Health Board's appeals.
- 2.29 As part of the audit, we were advised that any changes to the structure of the fundraising Team have to be approved by the Charitable Funds Committee. We compared the Fundraising Structure that was submitted to the March 2022 meeting of the Charitable Funds Committee and the latest structure provided by the Department at the time of our fieldwork in January 2023. We noted a number of changes but were unable to evidence that these changes had been submitted to the Charitable Funds Committee for approval. (Matter Arising 5)

Conclusion:

- 2.30 Whilst responsibilities for Fundraising are clearly defined enhancements are required in approving any changes to the fundraising team. We have provided Limited Assurance for this objective.

Objective 7: Appropriate guidance is in place for fundraising events / appeals.

- 2.31 There is a fundraising policy in place that is available to all staff via the Health Board's intranet but the version of the intranet is currently out of date. The latest version of the policy was submitted to the December 2022 meeting of the Charitable Funds Committee for a review. It was then referred to the January 23 meeting of the Charitable Funds Trustees for formal approval. (Matter Arising 6)
- 2.32 There is a dedicated website for the Health Board's Charity with a link on the Health Board's Intranet and Internet sites.
- 2.33 The website is well designed, easy to navigate and provides guidance to staff and members of the public on how they can fundraise for the Health Board. There are also dedicated pages for Health Board Appeals and the Staff Lottery where detailed information can be found on fundraising events.
- 2.34 There is a dedicated news page on the website where the latest developments are reported. These would include updates regarding fundraising events, both past and future as well as details of projects that have been funded by the Health Board Charity.

Conclusion:

- 2.35 The guidance in place for fundraising is comprehensive and easily accessible. We have provided Substantial Assurance for this objective.

Objective 8: Appropriate governance arrangements are in place for fundraising appeals / events.

- 2.36 The Fundraising Team maintains a list of all major Fundraising Events scheduled for each calendar year. The information is presented at each meeting of the Charitable Funds Committee where discussions take place around Health Board representation/presence at the events.

2.37 Our review of the governance arrangements in place for fundraising events highlighted the following issues:

- There is no formal procedure in place for proposing events. Many of the events that take place arise as a result of discussions that take place within the Fundraising Department and if considered appropriate for one of the Health Board appeals will be discussed and then approved by the Appeal Fundraising Committee;
- When discussing a proposed event whilst estimated costs and income to be raised are discussed no document/template is produced to record these details;
- Whilst records are kept of all costs and income for each event they do not reflect any costs for any time that fundraising staff have contributed to assisting in organising the event; and
- Whilst details of monies raised are included in the fundraising report that is submitted to each meeting of the Charitable Funds Committee there is no formal review of the effectiveness of these events.

Conclusion:

2.38 The governance arrangements for approving and reviewing events require enhancing by implementing a more formal process. We have provided Reasonable Assurance for this objective.

Mohamed Sarah
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Appendix A: Management Action Plan

Matter Arising 1: Financial Control Procedure (Design)		Impact	
<p>There is a Financial Control Procedure (FCP) in place for Charitable Funds that is available to staff via the Finance Department’s pages on the Health Board Intranet.</p> <p>Whilst the review date for the FCP is noted on the intranet the actual document itself does not note the ‘owner’ or the date that it was reviewed and approved.</p>		<p>There is no visible audit trail for the document.</p>	
Recommendations		Priority	
1	<p>Management should ensure that the Financial Control procedure for Charitable Funds is updated to note its author and date of last review.</p>	<p>Low</p>	
Agreed Management Action		Target Date	Responsible Officer
1	<p>Agree, FCP shall be updated with review dates and author assigned.</p> <p>ACTIONED</p>	<p>March 2023</p>	<p>Rebecca Holliday Head of Financial Services</p>

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Matter Arising 2: Delay in banking donations (Operation)		Impact	
<p>For one of the thirty donations tested, we noted that the receipt form indicated that the donation of £514.00 was received at the ward in December 2021 but was not taken to the Cashiers Department for payment into the Health Board’s bank account until five months later in May 2022.</p> <p>Furthermore, discussion with the Head Cashier regarding this indicated that this was not an isolated case and that staff do not always pass on donations received promptly.</p>		<p>Donations received may be mislaid and so may not be paid into the bank.</p> <p>If the delay exceeds six months for a cheque donation, then the cheque is no longer valid and the donation will be lost.</p>	
Recommendations		Priority	
2	<p>Management should issue a general reminder to all staff within the Health Board that any monies received should be passed to Cashiers promptly.</p> <p>Alternatively, if appropriate, staff may advise prospective donors to take monies direct to the hospital’s Cashiers Department personally.</p>	<p>Low</p>	
Agreed Management Action		Target Date	Responsible Officer
2	<p>The Fundraising Department, will engage with Clinical Boards regarding the importance of establishing efficient banking mechanisms to allow charity donations received at ward level to be banked in a timely manner. Colleagues will be reminded to direct donations to the Fundraising Office for processing whenever possible.</p> <p>The Fundraising Team will communicate with cashiers to identify and monitor potential delays in the banking process.</p>	April 2023	Joanne Brandon Director of Communications & Engagement

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Matter Arising 3: Charitable Funds Expenditure (Operation)	Impact
<p>A sample of thirty items of expenditure that covered the period 1st April 2022 to 31st August 2022 was selected to undertake testing on the following:</p> <ul style="list-style-type: none"> • Application process; • Goods or services purchased were in line with purpose of fund or guidance issued; and • Appropriately authorised. <p>The results of our testing were generally satisfactory. However, the following issues were identified:</p> <ul style="list-style-type: none"> • For one of our sample, office furniture for the meeting room at Llandough Childrens Centre costing £2,088 was purchased which is contrary to the guidance issued; • For one of our sample, approval for the £896 course fee expenditure was received retrospectively; • For four of the sample, whilst the £3,360 (Bike Health Check Sessions), £1,200 (Platinum Jubilee Celebrations), £5,289 (Furniture for Staff Haven) and £5,998 (Arts Support for Young People) was appropriate and received, there was no physical evidence to support the decision to incur this expenditure. These items related to expenditure from funds overseen by the Fundraising Department; and • For one of the sample, whilst the goods were received by the Health Board no invoice was received from the supplier. As a result, an unmatched accrual remains on the financial system. (Purchase Order reference 725863146 – December 2019). 	<p>Goods purchased contrary to guidance issued.</p> <p>Expenditure may be incurred which is not approved.</p> <p>Lack of clarity regarding decisions taken.</p> <p>Incorrect entries in the financial ledger.</p>
Recommendations	Priority
<p>3 To ensure charitable funds expenditure is appropriate and accounted for correctly the following action should be undertaken:</p> <ul style="list-style-type: none"> • Fundholders should be reminded regarding the eligibility guidance on items that can be purchased from charitable funds; • All expenditure should be approved prior to it being incurred; • A record should be maintained by the Fundraising Department on decisions made to approve expenditure from funds that they manage. Information should include fund expenditure to be charged to, reason for expenditure, names of approver and date; and 	<p style="text-align: center;">Medium</p>

Matter Arising 4: Engagement with Finance Business Partners (Operation)		Impact	
<p>Whilst individual fundholders receive monthly statements for the charitable funds they are an authorised signatory for, no financial information is issued to the Finance Business Partners.</p> <p>If the Finance Business Partners received this information, they could review the information with the Clinical Board personnel to encourage utilising the funds available when appropriate to avoid the funds being classed as 'dormant' through non-use.</p>		Funds not utilised and become dormant.	
Recommendations		Priority	
4	Management may wish to consider issuing information regarding Charitable Funds to the Finance Business Partners on a quarterly basis.	Low	
Agreed Management Action		Target Date	Responsible Officer
4	<p>The Charity is a separate entity to the Health Board and financial support is outside of duties of the Finance Business Partners also they do not have capacity to support this on an operational level.</p> <p>All nominated Fund Holders receive a summary statement via email on a monthly basis which details fund balances and spend to date. The responsibility to manage and spend fund remains with the fund holders, support is available from the Charitable Fund Officer or they can contact their Finance Business Partners.</p>	N/A	Rebecca Holliday Head of Financial Services

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Matter Arising 5: Approval of the Fundraising Team Structure and Recharges (Design)		Impact	
<p>As part of the audit fieldwork, we were advised by the Fundraising Department that changes to the Fundraising Team’s structure required approval from the Charitable Funds Committee.</p> <p>A comparison between the Fundraising Structure that was reported at the March 2022 meeting of the Charitable Funds Committee and the latest version provided by the department at the time of our fieldwork identified a number of changes, which we were unable to evidence being reported to the Charitable Funds Committee.</p>		<p>Unauthorised changed to the department structure that impact on the costs being charged to the Trust’s Charity.</p>	
Recommendations		Priority	
5	<p>An annual operating plan for the fundraising department should be submitted to the Charitable Funds Committee at the beginning of each financial year. The plan should provide specific details regarding the structure of the department, individual staff costs and also non staff costs. Details should also be provided of an estimate of staff costs that can be recharged to specific appeals and funds that the fundraising staff support noting the net costs that can be expected to be recharged to the ‘general fund’.</p> <p>An update on the plan should be reported at each meeting of the Charitable Funds Committee noting any changes to the structure that will impact on the ‘recharge’ to the general fund.</p>	<p>High</p>	
Agreed Management Action		Target Date	Responsible Officer
5	<p>The Health Charity is currently reviewing its strategy and in line with good practice has been engaging with CFC members and others to review and redevelop it collaboratively. Part of the strategy review entailed a recognition to include an Annual Operational Plan. This will be developed in Quarter 1 of 2023 and will be reviewed agreed via the Charitable Funds Committee and be embedded as part of its annual governance reporting mechanisms.</p> <p>This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding.</p>	Qtr1, 2023	<p>Joanne Brandon Director of Communications & Engagement</p>

	<p>Operational changes to staffing, responding and reacting to workforce or project requirements that do not require additional funding from general reserves, specific funds or have external funding will continue to follow the current reporting mechanisms and sign off via the Day to day operational responsibilities of the Director of Communications and sign off by the lead Executive as identified under section 2.27 above.</p>		
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Matter Arising 6: Fundraising Policy (Operation)		Impact	
<p>The current version of the Fundraising Policy (UHB 238) saved on the Health Board's intranet is out of date. The policy was reviewed and approved at the Charitable Funds Committee held in December 2022 and was then submitted to January 23 meeting of the Board of Trustees for formal approval.</p>		<p>Guidance available to staff is out of date.</p>	
Recommendations		Priority	
6	<p>Management should ensure that the updated and approved Fundraising Policy (UHB238) is uploaded to the intranet and staff are made aware of this.</p>	<p>Low</p>	
Agreed Management Action		Target Date	Responsible Officer
6	<p>All policies are controlled by the Governance Dept. of Cardiff and Vale UHB. Following endorsement by the Board of Trustees, the Governance Dept. has confirmed that the Fundraising Policy (UHB238) has been uploaded to CAVUHB intranet. The Fundraising Team has subsequently uploaded this to the Health Charity website and awaits receipt of a Welsh translation version from CCC. - ACTIONED</p>	<p>March 2023</p>	<p>Joanne Brandon Director of Communications & Engagement</p>

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Matter Arising 7: Effectiveness and viability of Fundraising Events (Design)		Impact	
<p>A sample of 4 fundraising events was selected to determine the arrangements in place for approving and then reporting on the outcome of the events. We acknowledge that some documentation regarding these events such as minutes of meetings and a record of income and expenditure is in place. However, the following observations were made:</p> <ul style="list-style-type: none"> • There is no formal process in place for proposing and approving events. It is acknowledged that for events relating to a specific appeal and where there is a committee in place approval is given by the appeal committee; • Where events are proposed, whilst information is provided regarding costs and potential income to be raised there is no template that allows for consistent recording of this information; • Records are maintained for each event recording costs for the events and all the forms of income received noting the actual amount of monies raised. However, we do note that no costs are included for the time that Health Board Fundraising Staff provide in supporting the organisation of the events; and • Monies raised at the events are reported at each of the Appeals Committees and as part of the Fundraising Report that is submitted to the Charitable Funds Committee. However, there is no formal documented review at the end of each event that assesses the final costs and income and therefore the overall effectiveness of the event. 		<p>The Health Board Charity is unaware of the costs associated with fundraising events.</p>	
Recommendations		Priority	
7	<p>Management should consider developing a formal process for the proposal and approval of fundraising events that includes all associated costs and anticipated income.</p> <p>Once an event has taken place a formal evaluation and review should be undertaken that analysis all costs (including health board fundraising costs) and income received. To aid this management may wish to introduce a template that records all costs and income.</p>	Medium	
Agreed Management Action		Target Date	Responsible Officer
7.1	<p>Health Charity managers will create a reporting template to include planned staff and non-staff costs and projected income for proposed events. The report</p>	<p>Draft template for consideration by the CFC</p>	<p>Joanne Brandon Director of Communications & Engagement</p>

will be submitted to the supporting appeal committees and the Charitable Funds Committee for review and approval, at the beginning of each financial year.

Evaluation reports will inform Health Charity Managers and relevant committee members, to enable a review of the effectiveness of fundraising activities and contribute to forward planning. Findings will be reported to the Charitable Funds Committee.

completed April 2023 and submitted via the CFC governance processes.

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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.
	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.



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Community Patient Appliances (Specialist Services Clinical Board)

Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board



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Review reference:	CVU 2223-33
Report status:	Final Report
Fieldwork commencement:	8 November 2022
Fieldwork completion:	17 February 2023
Debrief meeting:	22 February 2023
Draft report issued:	23 February 2023
Management response received:	26 April 2023
Final report issued:	26 April 2023
Auditors:	Ian Virgill, Head of Internal Audit Wendy Wright-Davies, Deputy Head of Internal Audit Andrea Calise, Principal Auditor
Executive sign-off:	Paul Bostock, Chief Operating Officer
Distribution:	Jessica Castle, Director of Operations (Specialist Services Clinical Board) Paul Rogers, Interim Assistant Director of Therapies & Health Science, and Directorate Manager, ALAS Andrew Lloyd, Quality and Information Manager Linda Hull, Contact Centre Manager Mark Inker, Project Manager Russel Bailey, Technical Officer
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 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.

Disclaimer notice - please note

This audit 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 and Assurance Committee.

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Executive Summary

Purpose

To review the systems in place to monitor and manage the risks of posture and mobility equipment that needs to be repaired or replaced. Including how cases are managed when there are delays to equipment ordering / delivery because of supply chain issues.

Overview

We have issued **Reasonable** assurance overall. Our audit testing was predominantly informed by reviewing data within the BEST patient management system and from system reports, which highlighted the following anomalies:

- Absence of documentation held within the system;
- The timeliness of moving open repairs to complete; and
- The system has the ability to generate a variety of management information reports, which could be better utilised by management.

We reviewed stock management arrangements which appeared ad-hoc at the time of our review.

We noted that the 'Request for Repair' Procedure has been 'draft' since 2019 and requires finalisation.

Whilst the service has a 'Declaration of the Terms and Conditions of Loan of Equipment', there were instances where these were not signed and dated by service users in receipt of equipment.

We make one low priority recommendation which is referred to in section two and Appendix A 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 summary¹

Objectives	Assurance
1 Policies and Procedures	Reasonable
2 Use of the BEST Patient Management System	Reasonable
3 Terms and Conditions of Loan of Equipment	Reasonable
4 Ordering and Supply of Equipment	Reasonable
5 Management Information	Reasonable

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	'Request for Repair' Procedure remains draft	1 Design	Medium
2	Absence and incomplete Repair Worksheet Documentation	2 Operation	Medium
3	Timeliness of updates to the BEST system to close repairs	2 Operation	Medium
5	Terms and Conditions documentation not signed by service users	3 Operation	Medium
6	Ad-hoc monthly stock counts and stock management	4 Operation	High
7	Better use of management information	5 Operation	Medium

1. Introduction

- 1.1 Our review of 'Community Patient Appliances' (CVU 2223-33) was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board'), and at the request of the Specialist Services Clinical Board.
- 1.2 The Artificial Limb and Appliance Services (ALAS) is located within the Specialist Services Clinical Board and provides a range of services to support service users in the community. The ALAS services are provided on a lifetime basis. All items of equipment issued by ALAS are the property of the NHS and must be returned when no longer in use.
- 1.3 The Welsh Health Specialised Services Committee (WHSSC) commission the ALAS on an all-Wales basis. The service is sub-divided between North and South Wales services. The Cardiff ALAS service, hosted by Cardiff and Vale University Health Board, is based out of 2 centres: the Artificial Limb and Appliance Centre on the Rookwood Hospital site and the Posture and Mobility Centre in Treforest.
- 1.4 Cardiff ALAS alone has approximately 10 directly employed staff who work closely as a multi-disciplinary team with sub-contractors and suppliers to deliver a suitable solution and maximise user potential for rehabilitation into their community.
- 1.5 The current audit was limited to review of the Cardiff ALAS.
- 1.6 The Chief Operating Officer is the executive lead for this review.

Audit Risks

- 1.7 The potential audit risks considered in this review were as follows:
 - Service user equipment is not fit for purpose due to equipment requiring repair or replacement, which impacts their ability to rehabilitate or live independently in the community; and
 - Equipment management control procedures fail to adequately direct the management of equipment, which compromises supply.
 - Financial loss to the Health Board due to the loss or misappropriation of posture and mobility equipment;

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2. Detailed Audit Findings

Objective 1: Procedures are in place for the management of posture and mobility equipment, which includes the repair and replacement of equipment

- 2.1 The Business Management System Manual is an overarching document that details all the processes and systems in place for the ALAS service.
- 2.2 Additional "Sub-Procedures" are documented for each operational unit of the service and provide specific step by step guidance to staff. The "Request for Repair" sub-procedure, which applies to the Posture and Mobility Service, is currently still in draft and has been since May 2019. **(Matter Arising 1 - Medium Priority)**
- 2.3 A previous internal audit review of the Service's arrangements (performed by Internal Audit in September 2020) identified that at the time, the quality of the written "Sub-Procedures" varied widely across the operational units within the Service. The report recommended that the Service should work to reviewing and revising all procedural documentation in place to a consistent level. The Service is still in the process of reviewing and updating procedures and aims to save all documentation onto SharePoint so that these are readily available to staff. **(Matter Arising 1 – Medium Priority)**
- 2.4 The Service has published various information about the Posture and Mobility Service on its website including safety guides for the use of wheelchairs, demonstration videos, how to maintain the equipment safely and how to contact the Service to request for a repair or replacement.

Conclusion 1: Currently the Service is still working to ensure that all of its sub-procedures are up to date and have been saved onto SharePoint so they can be easily accessed by staff. The Repairs Request procedures is one of the documents currently still under review. (Reasonable Assurance)

Objective 2: The BEST Patient Management System is utilised to record all relevant patient and equipment information, including requests for repairs or replacements

- 2.5 The BEST Patient Management System has several modules that together document the service users' journey with the Service from the beginning (referral and patient assessment) to the end (ordering and delivery of equipment). Each record holds updated clinical information, outcome of clinical assessment, equipment information and an audit trail of correspondence / contact with the service user. All the information is organised in a standard filing structure so that it can be readily available.
- 2.6 Historical and live data relating to repairs / replacements of equipment reside within the "stock control" module of the system.
- 2.7 We obtained several reports from the BEST system (complete / open repairs) and reviewed the records for a sample of repairs to verify the accuracy of the

information held within the system. Our findings identified several anomalies, which include:

- Absent or incomplete repair worksheet documentation held within the system; and **(Matter Arising 2 – Medium priority)**
- The status of repairs is not always updated correctly, which impacts the reporting of timeliness of repairs. **(Matter Arising 3 – Medium priority)**

2.8 A further review of the BEST system highlighted that the Service is significantly behind schedule with its Preventative Planned Maintenance process, with a large proportion of powered wheelchairs overdue for annual inspection. The inspections inform the service's planned equipment repair programme. **(Matters Arising 4 – Low Priority)**

Conclusion 2: Our testing identified several occasions where the BEST system had not been updated, and with some repair records omitting the service user's signature and date to confirm their satisfaction with work carried out. It was also evident from reviewing the BEST system that the Preventative Planned Maintenance process was behind schedule, which informs the service's repair programme. (Reasonable Assurance)

Objective 3: The 'Terms and Conditions' document issued to service users on receipt of their equipment sets out their responsibilities for notifying the service of required repairs

2.9 Upon delivery/collection of equipment, service users are provided with a pack of documentation which includes the "Terms and Condition" document that sets out key information in relation to the following:

- The conditions of Loan for equipment;
- Responsibility and Ownership;
- Repairs and Maintenance;
- Insurance and Breakdown; and
- Safe use of equipment.

2.10 Service users must sign and date a Handover Certificate declaring that they have read and understood the Terms and Conditions. The documentation is retained by the service and scanned to the BEST system. Sample testing of the BEST system revealed that service users do not always sign and date the Handover Certificates. **(Matters Arising 5 – Medium Priority)**

Conclusion 3: Our sample testing identified that a number of Handover Certificates had not been signed and dated by service users when in receipt of new equipment, to validate their agreement of the loan of equipment. Signed Handover Certificates indemnify the Service and staff against damage that may be caused to service users, third parties or related personal possessions whilst using the equipment and clarifies roles and responsibilities for insuring against these risks. (Reasonable Assurance)

Objective 4: Effective processes are in place for ordering and physically receiving equipment, and any issues encountered are investigated and escalated as appropriate

- 2.11 The stock control team are responsible for overseeing the stock ordering and stock management arrangements at the Treforest unit. New order requisitions are initiated within the BEST system and flow automatically into the procurement module of the Oracle Finance system for approval and processing. Requisitions are approved by the ALAS Project Manager, the ALAS Service Manager and/or the Directorate Manager, ALAS (Interim Assistant Director of Therapies and Health Science).
- 2.12 Supplier deliveries are physically receipted by the stock control team who check and validate the quantities of the orders through the BEST system.
- 2.13 The previous internal audit of the Service's arrangements identified that the reconciliation mechanism between the two systems (BEST and Oracle) was not working effectively and required several manual interventions to ensure that the order number was recorded within BEST. We can confirm that there is now an automatic link that updates order requisition information within the BEST system from Oracle.
- 2.14 The Service holds an inventory of unallocated wheelchairs, powered wheelchairs, and parts within the storeroom of the Posture and Mobility Centre (PMC), Treforest to meet the demands of patients within reasonable timeframes. Bespoke equipment and/or alterations to equipment that is not held in stock is managed in a triage-style process that involves the clinician, stock control team and technical engineers.
- 2.15 Stock levels are recorded within the BEST system and should be verified monthly as part of stock counts, performed by the stock control team. The results of the stock count should be shared with Finance and discrepancies investigated and escalated to senior leads of the Service. It was noted that stock takes and investigation into stock balance issues are not always being performed monthly. A review of the latest available stock take (January 2023) identified instances of stock being misplaced and missing stock. **(Matter Arising 6 – High Priority)**.
- 2.16 As part of the All Wales Wheelchair Supply Contract, the Service has access to several suppliers for sourcing wheelchairs and parts for repairs. The Service re-tendered the contract recently in January 2023 for a period up to 5 years. Discussion with the ALAS Project Manager confirmed that in the past, due to Brexit and the pandemic, the Service's supply chain of wheelchairs and parts was severely impacted, and the issues have been monitored extensively through regular supplier contract management meetings. The Project Manager confirmed that whilst some supply delays are being experienced, the situation is improving overtime as we move away from the pandemic environment.

Conclusion 4: Whilst there are robust arrangements in place for ordering and physically receipting goods from suppliers, the open accessibility of stock to a variety of staff at the PMC without the proper recording within BEST is resulting in stock being misplaced / lost

(as per the latest stock take in January 2023). Whilst stock balance issues are identified and investigated, there is a need to remind staff of the importance to ensure that all equipment / parts moves must be accurately recorded within the BEST system. Inaccurate stock balances and stock locations within the Best system impact on the ability to meet equipment orders and repairs within reasonable timeframes. (Reasonable Assurance)

Objective 5: Management information is available which is accurate, timely and relevant and relates to equipment repairs, replacements, order delays and supply issues

2.17 As part of the Service's KPI Framework arrangements, monthly reports are compiled from the data within BEST and are shared with WHSSC commissioners. The latest available KPI information was completed up to December 2022 and highlighted the following:

- The Service reported 100% compliance with its response to emergency repairs (within 24hr) against a set 90% target.
- The Service reported a 64% compliance with its response to non-emergency repairs (3 days) against a set 90% target.

2.18 Discussion with key leads highlighted that the service is currently operating with a staff capacity shortfall due to sickness and vacancies. This is impacting the operations of the Service and its ability to respond to repairs in a timely manner. We noted that at the time of the review, the Service was operating with 50% capacity of its delivery drivers with only two of the four positions filled and other staff shortages within the stock control team. The Service is in the process of recruiting new staff and is considering overtime and agency staff as a temporary measure to address these issues.

2.19 The Service was able to demonstrate examples of robust processes in place to identify and escalate operational and supplier performance issues, which include:

- The Quality and Information Team have super-user roles within the BEST system and can generate a variety of reports to analyse open orders, orders on hold, orders awaiting parts, orders awaiting planning with the service user and requisitions awaiting approval;
- All staff have access to an operational performance metrics via Dashboard's set up within the BEST system. The data is "live", and metrics are linked to the Service's Key Performance Indicators Framework (see paragraph 2.20);
- Key leads from the service attend the 'All-Wales ALAS Procurement Meeting' which meets once every two months. The scope of the meeting covers several issues that are centred around procurement contracts, re-tendering and contract specifications, supplier performance, supplier orders on hold and spend analysis;
- Regular supplier contract management meetings led by the ALAS Project Manager; and

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- Team Meetings (clinical and operational) that take place every two weeks and discuss referral to treatment performance, long waits, staffing issues, supplier contract management updates (from Project Manager) and other operational issues.

2.20 Whilst we were able to evidence examples of good management information to monitor performance, we also identified areas which could be enhanced:

- Our sample testing captured within Matters Arising 2, 3 and 4 highlight examples where management information from the BEST system could be better utilised to enhance performance of the service. **(Matters Arising 7 – Medium Priority)**

2.21 We were made aware of an incident which occurred in August 2021 where a service user fell from their wheelchair and sustained significant injuries. Prior to the incident, the patient had reported several faults with their wheelchair. An Independent investigation was conducted by the Health Board to identify the root causes and contributing factors. The investigation concluded in March 2022 and the results were shared with the Specialist Services Clinical Board Quality, Safety and Experience Committee which met in April 2022. The Service has developed an Improvement Plan which has been reviewed and approved by the Clinical Board's Director of Nursing. As at February 2023, management have confirmed that the majority of actions in the Improvement Plan have been implemented and the service continues to monitor progress with the remaining actions.

Conclusion 5: We can confirm that the Service has arrangements in place for identifying and escalating issues relating to operational performance and supplier related issues. We have identified opportunities for management to make better use of management information from the BEST system to enhance performance. (Reasonable Assurance)

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Appendix A: Management Action Plan

Matter Arising 1: 'Request for Repair' Procedure remains draft (Design)		Impact
<p>At the time of the audit, the Service were undergoing a review of the policies and procedures in place. The Service is in the progress of revising and updating its procedural documentation and saving these onto SharePoint. The 'Request for Repair' procedure is part of this work in progress, but it was noted that the document had been in 'Draft' since May 2019.</p> <p>Similar issues, in relation to documentation of procedures, were identified in a previous audit of the Service and a recommendation was raised. (Audit reference CVU-2021-18, recommendation 1)</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Equipment management control procedures fail to adequately direct the management of equipment, which compromises supply.
Recommendation		Priority
1	The review of the 'Request for Repair' procedure should be completed and finalised, to provide clarity to staff and service users.	Medium
Agreed Management Action		Responsible Officer
1	Finalisation of the Request for Repair is pending completion of the actions from the recent RCA, described in section 2.21. These actions have been communicated with the ALAS QSE and will be presented to SpS Clinical Board QSE at next scheduled opportunity.	Paul Rogers, Interim Assistant Director of Therapies & Health Science and Directorate Manager, ALAS
		Target Date
		June 2023

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Matter Arising 2: Absence and incomplete Repair Worksheet Documentation (Operation)	Impact
<p>Worksheet repair forms must be signed and dated by a field service engineer and service user to certify that a repair has been executed in accordance with the manufacturer guidelines, and to capture that the service user is satisfied with the outcomes of the repair / replacement. Currently, the Service is using paper forms, which the field service engineers must return to the senior technical officers for review, prior to being passed over to the Stock Control Team who scan the documents and update the records on the BEST system. The system is updated with information on the repair, parts used, and any additional work required to the original repair (if applicable).</p> <p>The Quality and Information Team provided us with a report from the BEST system listing completed repairs without scanned documentation on the system. The date range for the report was of all completed repairs between 1 April 2022 and 13 January 2023. A review of the report found that for 148 (2.4%) completed repairs out of a total of 6,113 the relevant documentation had not been scanned to the system: Two were Emergency repairs (24 hour response target), and 146 were non-emergency repairs (3 day response target).</p> <p>A further review of a sample of 10 completed repairs where the Repairs Worksheets had been scanned to the BEST System found that four forms were not signed and dated by the service user following the repairs. Our sample related to repairs performed in December 2022 and January 2023. There were no notes on the repair worksheets to suggest why these had not been signed by the patients.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> Equipment management control procedures fail to adequately direct the management of equipment repairs.
Recommendation	Priority
<p>2 Following our review of Repair Worksheet documentation, the following should be adhered to for completeness of records:</p> <ul style="list-style-type: none"> Field Service Engineers (FSEs) must ensure that Repair Worksheets for completed repairs are signed and dated by the service user where possible, or a note documented to explain the absence of a signature; and Repair Worksheets are returned to the Senior Technical Officer in a timely manner and the documentation scanned onto the BEST system. 	<p>Medium</p>

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Agreed Management Action	Target Date	Responsible Officer
2 - An additional 'Safety Check' checklist has been added to all FSE paper work. This should be completed at each repair to ensure opportunities are not missed to identify unsafe equipment. Completion of the check list will be reported on at fortnightly Operational meetings and form part of the regular ISO 9001 audit cycle.	June 2023	Russel Bailey, Technical Officer
- Team to review and agree the process which will ensure that the completed forms are always scanned on the system and any non-completed forms are raised with the PMC Technical Manager for investigation.	June 2023	Russel Bailey, Technical Officer
- The MTO team are responsible for the receipt, triage, recording and action of any returned actions from the Field Service Team.	June 2023	Russel Bailey, Technical Officer
- Reports on number of FSE jobs completed, number of those with further work to reported at fortnightly PMS Ops meeting.	June 2023	Russel Bailey, Technical Officer

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Matter Arising 3: Timeliness of updates to the BEST system to close repairs (Operation)		Impact
<p>As at 13 January 2023 there were 553 repairs with an "open" status within the BEST system. We reviewed a sample of 20 repair orders that had been open in the BEST system for the longest period, some of which dated back to September 2021. We identified issues with 14 of the 20 repairs sampled as follows:</p> <ul style="list-style-type: none"> 12 open repairs were complete or no longer required as the service user had been provided with a new wheelchair, however the status of the repair was not closed within the BEST system; One repair was placed on hold by the Clinical Team in July 2022, with no further information on the system to indicate that the repair needed to progress or that the service user had been contacted regarding any delay / cancellation of the repair; and One repair request raised by the Clinical Team had not been correctly allocated and thus had not been tasked for action to the correct Team. There was limited evidence of contact with the service user to confirm any delay/cancellation of the repair. <p>The above findings suggest that limited action is being taken to monitor the number of open repairs and to interrogate the data within the BEST system to ensure records are correct and up to date.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Service user equipment is not fit for purpose due to equipment requiring repair or replacement, which impacts their ability to rehabilitate or live independently in the community; and Equipment management control procedures fail to adequately direct the management of equipment, which compromises supply.
Recommendation		Priority
<p>3 Arrangements should be put in place to ensure that open repairs within the BEST system are regularly reviewed and that once actioned or no longer required, are closed within the system in a timely manner for accuracy of records held.</p>		<p>Medium</p>
Agreed Management Action	Target Date	Responsible Officer
<p>3 Administration Manager to take responsibility for regular checks and validation of open repairs. Administration Manager to present open repairs position at fortnightly operational meetings.</p> <p>Reinstate Daily Ops Meeting [Administration Manager/ Technical Manager/ Stock Team Lead] to address time critical issues. Any themes to be escalated to/ oversight provided at fortnightly PMC Operational Meeting.</p>	<p>April 2023</p> <p>May 2023</p>	<p>Linda Hull, Contact Centre Manager</p> <p>Archie Kaul-Mead, ALAS Service Manager</p>

Matter Arising 4: Constraints to the Preventative Planned Maintenance process (Operation)		Impact	
<p>Field Service Engineers are required to perform annual inspections of powered wheelchairs to assess the overall health of the components and parts of the equipment as part of the Preventative Planned Maintenance process. The outcome of inspections should be documented within the BEST system and used by management to inform the equipment repairs programme.</p> <p>Analysis of the BEST system identified that as at 13th January a total of 2,457 powered wheelchairs (76%) were overdue an annual inspection out of a total of 3,237.</p> <p>Discussions with Management noted that the Service has been aware of this issue however has not been able to carry out inspections in a timely manner due to staff shortages and a rise in service demands.</p> <p>As of December 2022, the Service has started to incorporate annual inspections as part of all repairs undertaken. The inspections are only performed on equipment that is subject to a repair and does not include the rest of the equipment out in the community.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Service user equipment is not fit for purpose due to equipment requiring repair or replacement, which impacts their ability to rehabilitate or live independently in the community; and • Equipment management control procedures fail to adequately direct the management of equipment, which compromises supply. 	
Recommendation		Priority	
4	Consideration should be given to the arrangements in place to undertake annual inspections of all powered wheelchairs to inform the Service's planned repairs programme, given the current limitations on existing resources.	Low	
Agreed Management Action		Target Date	Responsible Officer
4	Service to review approach to Planned Preventative Maintenance (PPMs).	June 2023	Russel Bailey, Technical Officer
	The additional Field Service Engineers check lists now contain a safety check that can be used as a PPM. Service to review how these can be incorporated into PPM cycle to reduce duplication of effort.	June 2023	Russel Bailey, Technical Officer
	Recruitment to full establishment of FSE staff in order to meet demand.	July 2023	Russel Bailey, Technical Officer

Matter Arising 5: Terms and Conditions documentation not signed by service users (Operation)		Impact	
<p>Patients are required to physically sign and date the 'Handover Certificate' as a declaration that they have received the equipment, have been advised how to use this safely and that they agree to the terms and conditions of the loan of equipment provided by the Service.</p> <p>For a sample of 15 completed orders (deliveries of new equipment) we reviewed the BEST system to ensure that the Handover Certificates, which include declaration by the service user that they agree to the 'Terms and Conditions' of the loan of equipment, had been signed, dated, and scanned to the BEST system accordingly.</p> <p>Our testing identified that seven 'Handover Certificates' had not been signed and dated by the service user. Given the number of unsigned certificates from our sample alone, there is reasonable evidence to suggest that there could be more Handover Certificates not signed and dated.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Failure to indemnify the Service against patient injury from the use of equipment 	
Recommendations		Priority	
5	<p>To support adherence to the 'Terms and Conditions' of loaned equipment, the following should be undertaken:</p> <ul style="list-style-type: none"> Handover Certificates must be signed and dated by all service users receiving new equipment. Where a signature cannot be obtained, this must be clearly noted on the certificate by a member of staff responsible for delivering / providing the equipment; and Management should consider reviewing the BEST system to ascertain the scale of instances where service users have not signed and dated Handover Certificates. 	Medium	
Agreed Management Action		Target Date	Responsible Officer
5	<p>5a) Signing of handover sheets was postponed during COVID due to risk of cross contamination. It has now resumed and should be complied with fully. Audit of this action forms part of regular ISO9001 audit process</p> <p>5b) Reporting of the number of FSE job completed and those with appropriately completed worksheets (patient signature and completed FSE check list) at fortnightly PMS Operations Meeting</p>	<p>April 2023</p> <p>June 2023</p>	<p>Archie Kaul-Mead, ALAS Service Manager</p> <p>Archie Kaul-Mead, ALAS Service Manager</p>

	5c) Auditing of correct completion of FSE work sheets to form part of regular ISO 9001 audit schedule.	July 2023	Andrew Lloyd, Quality and Information Manager
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Matter Arising 6: Ad-hoc monthly stock counts and stock management (Operation)		Impact	
<p>The stock control team is responsible for performing monthly stock counts of equipment and parts held in the Treforest Unit stockroom. The results from stocktakes are shared with Finance and senior leads of the Service so that any stock balance issues can be investigated.</p> <p>The latest stock take, performed in January 2023, identified that 85% of stock (1,134 items) were found in the correct place, however the following anomalies were noted:</p> <ul style="list-style-type: none"> 1% of stock (12 items) were missing – the combined value of stock missing amounted to £11.7k compared to a total stock held amounting to £836k; and 14% (191 items amounting to £68.8k) were not in the correct location, but were located elsewhere within the stockroom. <p>The above issues are being looked into by the service. Discussions with the stock control team confirmed that situations can arise where items are moved around the stockroom without the proper recording on the BEST system. Management stated that due to staffing shortages stock takes and investigation into stock balance issues have been performed on an ad-hoc basis.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Financial loss due to missing stock Time delays due to missing parts/equipment 	
Recommendation		Priority	
<p>6 Stock counts of the Treforest Unit Stockroom should be undertaken on a monthly basis, and the results shared with Finance and senior leads from the service to ensure prompt investigation into stock balance issues.</p>		High	
Agreed Management Action		Target Date	Responsible Officer
<p>6 Recruitment underway to support increased staffing in PMC stock, as well as introducing more senior roles to provide greater cover, which in turn will allow regular rolling stock takes across the year culminating in comprehensive annual stock takes at year end.</p> <p>We have also been working closely with the Directorate Accountant who is supporting with our end of year stock take. Full details in the Audit Assurance Tracker: Audit</p>		July 2023	Paul Rogers, Interim Assistant Director of Therapies & Health Science and Directorate Manager, ALAS



Matter Arising 7: Better use of management information (Operation)		Impact
<p>Our sample testing and review of the BEST system has identified examples of issues relating to the completeness and timeliness of repair information being entered into the BEST system. We were able to identify the issues by analysing BEST data / reports generated by the Quality and Information Team. These reports are not currently being utilised by management. The below highlights examples from earlier Matters Arising where management information could be better utilised to enhance the service:</p> <ul style="list-style-type: none"> • The absence of Repair Worksheet documentation held in the system following the completion of a repair; • The status of longstanding open repairs are not currently being routinely reviewed; and • Repairs are not being closed within BEST in a timely manner, even though the repair has been completed. 		<p>Potential risk of:</p> <ul style="list-style-type: none"> • Poor management information to inform timely and effective decision making.
Recommendation		Priority
<p>7 The Service should review the reporting capabilities of the BEST system to improve the level and type of management information being made available to management so that issues are identified and addressed.</p>		<p>Medium</p>
Agreed Management Action	Target Date	Responsible Officer
<p>7 Provide a report of repair status at fortnightly PMS Operational Meetings (as per action 5b)</p> <p>Ensure audit of repair jobs in BEST as part of ISO 9001 audit cycle.</p>	<p>June 2023</p> <p>July 2023</p>	<p>Nigel Davies/ Linda Hull, Contact Centre Manager</p> <p>Andrew Lloyd Quality and Information Manager</p>

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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.
	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.



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Data Warehouse Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board



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Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	Kerry Ashmore, Head of Business Intelligence
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 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.

Disclaimer notice - please note

This audit 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 and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The purpose of the audit was to review the effectiveness of the data warehouse and ensure that it continues to be fit for purpose.

Overview

We have issued reasonable assurance on this area.

The data warehouse has been in place for many years and provides a large amount of useful information. There are good processes in place to define user needs, and develop appropriate information products, with a data quality process in place.

We note security weaknesses with the database, and a lack of documentation regarding feeds in and report products out.

Going forward there is an intent to improve the use of data, however there is no formalised plan for this. the Digital directorate have started working towards more advanced analytics, however there is a lack of staff resource and skills.

The matters requiring management attention include:

- Upgrading the database to a newer, more secure version;
- Defining a structure to fully identify Health Board needs;
- Developing advanced analytical skills; and
- Developing a data strategy and plan.

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 summary¹

Objectives	Assurance
1 Data Feeds	Reasonable
2 Understanding of Business Requirements	Reasonable
3 Information Provision	Reasonable

¹The 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	Manual Feeds	1 Design	Medium
3	Database	1 Operation	High
4	Health Board Needs	2 Design	Medium
5	Report Catalogue	3 Operation	Medium
6	Skills Identification	3 Operation	Medium
7	Data Strategy	3 Operation	Medium

1. Introduction

- 1.1 Our review of the data warehouse was undertaken in line with the 2022/23 Internal Audit Plan for Cardiff & Vale University Health Board (the Health Board).
- 1.2 A data warehouse, also known as an enterprise data warehouse, is a system used for reporting and data analysis and is considered a core component of business intelligence. Data warehouses are central repositories of integrated data from one or more disparate sources.
- 1.3 The risks considered as part of this audit were:
 - IT services and information provided do not suit the needs of the organisation.
 - Inappropriate access to data.

2. Detailed Audit Findings

Objective 1: Processes are in place to feed data into the data warehouse for collation and analysis.

- 2.1 Data comes into the data warehouse from a large variety of sources. These are a mix of old and new, with new feeds being created all the time. All the core Health Board systems are included as feeds, particularly the patient focussed ones. We were informed that there are approximately 160 data feeds in place, however at the time of the audit there was no accurate, up to date record or map of these.

Matter Arising 1

- 2.2 We also note that the lack of a full map or record of feeds increases the risk that a change will be made in a source system without the data warehouse team being notified. This may result in a failure of feed and the requirement for urgent work to be undertaken to resolve.
- 2.3 The frequency of the feeds varies, and is dependent on the original specification and development, with timescales varying from every 10 minutes to weekly. We note that the needs during the Covid pandemic have led to an increased frequency for some feeds.
- 2.4 There is a constraint within the system regarding frequency of feeds, with system resources not being sufficient to provide frequent updates for all sources. Although we note that there has not been any occasion where frequency has not been appropriate for the reporting required, with smaller datasets being extracted more frequently for specific purposes.
- 2.5 Requests for new feeds have historically come into the Digital Directorate via the leadership or via contacts, however we note the new Digital Front Door process is now in place. This has improved the collection of user requirements and the clarity of the assessment and prioritisation process. We further note that there is a backlog of work requests for developing new feeds.

-
- 2.6 The mechanism for the feeds varies, in particular according to age. The older feeds use form extracts or manual data loads, with new ones having automated feeds or SSIS (SQL Server Integration Services) feeds. We also note that the Local Data Resource (LDR) is being created / implemented and this is starting to provide data.
- 2.7 One of the aims of the LDR is to be a single point of truth with upstream, cleansed data, and this will then feed the data warehouse.
- 2.8 We note that the LDR is a work in progress, with the architecture still being defined and a target operating model being developed. There is alignment with the National Data Resource (NDR) with the LDR lead being the C&V representative for the NDR and there are 2 people from the organisation on the NDR team.
- 2.9 Data quality is considered at the development stage and within specifications.
- 2.10 A dashboard and reporting function has been developed that shows the status of feeds, and highlights errors. However as noted above there is no correction of data within the warehouse, any errors are fed back to the source for correction and reloaded. The dashboard focusses on the high risk items and major feeds and has been developed over time to bring in known problems.
- 2.11 Load failures for feeds are identified both by the dashboard and by the provision of automated email notifications for load jobs.
- 2.12 Our audit work included testing a sample of data feeds to ensure that there are appropriate processes in place to enable data quality. We confirmed that specifications considered data quality and included field maps and that checks and quality dashboards are in place for the main feeds. Data quality checks included:
- Dashboard highlighting of high risk items;
 - Reporting on quality and consistency of the data;
 - Checking on the logic running and comparing the data warehouse with the Business Information (BI) system to ensure data is being treated properly;
 - Checking on the data compared to the reference model; and
 - Reconciliation of some items to the source data.
- 2.13 We note that a significant proportion of feeds are manual processes or contain a portion of manual process. There are procedures in place for these, and this work forms part of the planned activity for the department. However, the use of manual processes increases the risk of a missed feed, and of the workload demand within the department. **Matter Arising 2**
- 2.14 The data warehouse is built on an Oracle database and uses IBM Cognos Analytics as a front end for users to access. The warehouse has been in use for a long time and as such the schema / design is old. Support is provided by the original supplier, with additional work commissioned for bringing in new data fields.
- 2.15 The data warehouse is held on physical servers within the Health Board Services Administration Centre (SAC). We note that the warehouse is a significant size,

comprising 840GB, with 540GB being used. It is backed up as a nightly dump, although we note that these aren't tested.

- 2.16 We were informed that there is a test database that can be used to fail over to in the event of a loss of server. However, should a full restore be needed then the recovery time objective (RTO) would be up to a couple of days. The intent is to utilise an Oracle product to enable immediate failover once the upgrade discussed below is complete.
- 2.17 Management of the data warehouse is within the data warehouse team in the Digital Directorate, who control the schema, data feeds and user access.
- 2.18 The database version in use is Oracle 11g (11.2.0.4.2). This is an old version and is out of support, although we note that extended support has been available. This ends in December 2023 with Oracle stating that "...it may cease to function at any time.". We also note that the version contains security vulnerabilities, with the highest being rated as 8.5.
- 2.19 There is no current patch strategy for the database, as it is a single server instance and required 24/7. As such patching is only undertaken should the opportunity arise. **Matter Arising 3**
- 2.20 We note that there is a plan to upgrade the database (along with the PMS database), however this has been delayed due to the need to upgrade forms used in PMS. We also note delays in obtaining funding which have impacted this due to the previous database administrator (DBA) leaving.
- 2.21 Users access the data via IBM Cognos and there is a formal process in place for enabling access to the data. This comprises of an online application form for the user to provide justification, this is approved within the organisation hierarchy and access granted accordingly.
- 2.22 Access to the data warehouse is not linked to the Active Directory, with a separate username being provided. Access is controlled by security groups based on Directorate and role which enables granular data access and ensures users can only access data that they need.

Conclusion:

- 2.23 There are well structured processes for feeding data into the data warehouse. We note that data comes from a wide variety of sources and via varying mechanisms, with all the core Health Board data included. However, there is no full record of these, and there is a proportion of manual work for some feeds. Feeds are developed appropriately and there is consideration of data quality both during the development process and during day to day operation, with a quality dashboard in place. There is a formal process for providing access to data which ensures users access is appropriate, however we note that the warehouse is currently using an out of data Oracle database which contains security vulnerabilities. Accordingly, we have provided reasonable assurance over this objective.

Objective 2: A process to assess and understand the business information requirements of the organisation is in place.

- 2.24 There is a process in place for users across the Health Board to request information products, and we note that this process has recently changed with the introduction of the new service desk system and the "Digital Front Door". These changes have provided greater rigour and clarity over the prioritisation of requests and better enable the team to demonstrate that their work is focussed on the most valuable areas for the organisation.
- 2.25 We also note that funding has been provided from some programmes for analysts who sit within the BI team, and work entirely on the information needs for that specific programme, these cover:
- Corporate Nursing;
 - Pharmacy;
 - Value Based Healthcare; and
 - Mass Vaccination.
- 2.26 This structure enables the sharing of knowledge of how to develop the information products, enables consistency of approach and provides a solid link with the user needs.
- 2.27 The team does not have sufficient resources to enable a full engagement process within the wider organisation, however we note that there are examples of engagement with service areas. In some cases, staff attend workstream project meetings which enables the needs of the workstream to be identified and developed alongside users, and we note that staff do attend Clinical Board meetings when possible.
- 2.28 There is no formal structure within the Health Board for linking leads for data use across Clinical Boards and with the Digital Directorate, although we were informed that the team is trying to provide named analysts linked with Clinical Boards in order to build knowledge and relationships, however staff resource constraints mean this is not possible. **Matter Arising 4**
- 2.29 Development of the information products uses a specification which is completed in conjunction with the data acquisition team. These are adjusted as the process is worked through with the user. We note that the team understands the need to fully define the user's needs, and so work closely with the user.
- 2.30 As noted above some posts are funded and linked to specific service areas and development is also undertaken with stakeholders as part of an iterative, agile process when the digital lead is involved within the relevant project or programme. Both these approaches enable user needs to be accurately defined.
- 2.31 The development process includes documentation that records logic and any calculations, and there is a quality assurance process which ensures the information is accurate and parameters are clear.

-
- 2.32 New information products are subject to a formal release, with notification to the original requestor, issuing of a general email to users and providing accompanying release notes.
- 2.33 There is no structured formal process for asking users for feedback on the products provided, although we note that the original requestor will be consulted.
- 2.34 The use of the information products (cubes and dashboards) is monitored within the team. A bespoke dashboard to enable this has been developed and each products use is monitored on release, although we note that smaller, more specific items are not tracked. The monitoring shows how many times an item has been accessed and by who for every day.
- 2.35 The information from monitoring use is used to iterate and improve the information provided, and in some cases decommission the information provided. This process reduced due to Covid, but it is starting to resume again.

Conclusion:

- 2.36 Needs for specific information products are defined by close working with the user. There are some structures in place to enable Health Board needs to be identified, with funded posts working within the team and with digital staff attending programme and project groups, however we note that a lack of staff resource means that there is no linkage of digital staff with Clinical Boards. The use of information products is monitored in order to assess the uptake and use and that information is used to improve information provided. Accordingly, we have provided reasonable assurance over this objective.

Objective 3: Analytics are provided which enable the Health Board to be a data led organisation.

- 2.37 The information provided to users from the data warehouse via Cognos has varied formats, which are split generally into:
- Cubes, which are similar to powerful pivot tables;
 - Dashboards, which are more up to date data and include some visualisation; and
 - Reports.
- 2.38 In many cases the cube information enables users to drill down into the components that make up the specific data item. E.g. for referral to treatment (RTT) reports the breached patient figure can be drilled into to show the specific patients.
- 2.39 In some cases, data is also linked to other datasets in order to provide meaningful information. As an example, A&E information is linked to inpatient information which shows the state of the hospital in order to assess reasons for delays in admission from A&E.
- 2.40 Filters are also available for users to amend the data being displayed as needed and parameter and filter information is clear on the data displayed.

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- 2.41 We note that there are a large number of information products available for users, however there is no list or catalogue available which sets these out. As such users may not be fully aware of already available information. **Matter Arising 5**
- 2.42 We do note that when new products are released there is communication released accordingly, and that for some roles e.g. directorate managers, when staff are appointed they are automatically provided with the relevant access so they can review and search the information available.
- 2.43 User guides are available for information products, in particular for the main datasets and most commonly used items. We also note that training videos are also available.
- 2.44 We canvassed opinions from information users within the Health Board, and although the response rate was low we note that the feeling was that the data warehouse teams were responsive and that the information provided was useful and influencing decisions made.
- 2.45 There are two teams within the Digital Directorate that deal with information, the data warehouse team, and the BI team. We note that there are vacancies, and there have been difficulties in recruiting. Due to this there is a backlog of requests for data acquisition and information products. The structure has recently been redefined and is currently still "bedding in", partly due to this there is cross working between the teams in order to maximise the use of the skills in place.
- 2.46 There is also an LDR and analytics team in place, although this is relatively new and its full role and remit has not yet been fully defined or embedded. In general, we note that this team is intended to be the core data resource and single point of truth and so pass data to the warehouse and other users.
- 2.47 There is a mix of skills in place across the teams, with requirements identified within individual job descriptions and there has been some identification of courses for staff to undertake as a package for their role, however we note that there is no defined skills framework or matrix that sets out the required skills, with an associated development plan.
- 2.48 There are some advanced skills in place within the analytics team, including in programming languages used in analysis such as Python and R. However overall there is a deficit in advanced analytic skills, with an absence of data scientists, although we note that there has been some collaborative work undertaken with Cardiff University which allows the Health Board to access more advanced skills. As such there is minimal analytics work undertaken within Digital. **Matter Arising 6**
- 2.49 There is a stated aim within the Health Board to have data driven decisions, and as part of that a project is in train to democratise data. The Digital Strategy includes key points relevant to this, with democratising data being included as a principle alongside the concept of transforming data to knowledge and use. In addition, the IMTP has data led decisions running through it, including for service re-design.
-

- 2.50 We note that a data strategy is currently in development, however at present there is no roadmap to get to a data led organisation that sets out how it will coordinate and use its data and no full identification of who will use the data, what they will use and how they will use it. **Matter Arising 7**
- 2.51 As previously noted, the products used are the data warehouse and Cognos Analytics, which can provide an analytics provision using Jupyter workbooks, with some use of python within the analytics team. The Health Board is also implementing Office 365, and as part of that, the use of Power BI is being assessed, both within Digital, and across the organisation. We also note that there is some use of data tools within other areas of the Health Board apart from DHIC, however Digital has limited control or awareness of these.
- 2.52 We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation as per **Matter Arising 7**.
- 2.53 The analytics team has started to develop some more advanced capability, with use of machine learning to predict patients that will fail to attend appointments and using natural language processing (NLP) in order to classify documents. However, the team is small and as such this is at an early stage and as previously noted not within any overarching plan.
- 2.54 We also note that there has been some consideration within the analytics team of user personas.
- 2.55 We note that information provided does not fully examine variances for underlying causes without full use of analytics. Our survey of information users noted a demand for increased analysis and information provision, with an appetite for modelling and machine learning capabilities being expressed, along with greater cross referencing with other data sources.

Conclusion:

- 2.56 The department provides information products that are felt to be useful and that are influencing decisions made within the organisation. There is no catalogue of information products available, however user guides and instruction videos are available. The data warehouse has been in place for a long time and holds and provides a significant amount of information, which would be onerous to replicate. The directorate is establishing an LDR and has started to develop some analytics and there is a stated Health Board aim to make better use of data. However, there is no data strategy and minimal advanced analytical skills within the directorate, which make it hard to fully define the best products to use moving forward. We have provided reasonable assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Feed Record (Operation)		Impact	
<p>Data comes into the data warehouse from a large variety of sources. These are a mix of old and new, with new feeds being created all the time. We were informed that there are approximately 160 data feeds in place, however at the time of the audit there was no accurate, up to date record or map of these.</p> <p>The lack of a full record may lead to feeds not being fully monitored, we also note that the lack of a full map or record of feeds increases the risk that a change will be made in a source system without the data warehouse team being notified. This may result in a failure of feed and the requirement for urgent work to be undertaken to resolve.</p>		<p>Potential risk that:</p> <ul style="list-style-type: none"> IT services and information provided do not suit the needs of the organisation. 	
Recommendations		Priority	
1.1	A map of feeds should be produced.	Low	
Agreed Management Action		Target Date	Responsible Officer
1.1	Documentation of all feeds will be put in place with a routine procedure to maintain and keep up to date.	31/07/2023	Head of Business Intelligence

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Matter Arising 2: Manual Feeds (Design)		Impact	
<p>We note that a significant proportion of feeds are manual processes or contain a portion of manual process. There are procedures in place for these, and this work forms part of the planned activity for the department. However, the use of manual processes increases the risk of a missed feed, and of the workload demand within the department.</p>		<p>Potential risk that:</p> <ul style="list-style-type: none"> IT services and information provided do not suit the needs of the organisation. 	
Recommendations		Priority	
2.1	As the LDR is developed, the department should prioritise the development of replacement feeds from the LDR for those feeds that are currently a manual process.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	An assessment of manual data feeds will be undertaken to identify and document which would be suitable for and benefit from migrating to the LDR. <i>Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.</i>	31/07/23	Head of Business Intelligence

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Matter Arising 3: Database (Operation)		Impact	
<p>The database version in use is Oracle 11g (11.2.0.4.2). This is an old version and is out of support, although we note that extended support has been available. This ends in December 2023 with Oracle stating that "...it may cease to function at any time.". We also note that the version contains security vulnerabilities, with the highest being rated as 8.5.</p> <p>There is no current patch strategy for the database, as it is a single server instance and required 24/7. As such patching is only undertaken should the opportunity arise.</p>		<p>Potential risk that:</p> <ul style="list-style-type: none"> Inappropriate access to information or loss of service. 	
Recommendations		Priority	
3.1	<p>The database should be upgraded.</p> <p>A patch strategy should be defined and implemented.</p>	<p>High</p>	
Agreed Management Action		Target Date	Responsible Officer
3.1	<p>The PMS database is planned for upgrade in September/October 2023. Following the upgrade of PMS, the Data Warehouse database will also be migrated to the latest Oracle database and be included within our new Oracle Goldengate infrastructure.</p> <p>A patching strategy will be implemented for both the PMS and Data Warehouse databases.</p>	31/10/2023	Senior Developer

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Matter Arising 4: Health Board Needs (Design)		Impact	
<p>There is no formal structure within the Health Board for linking leads for data use across clinical boards and with Digital</p> <p>We were informed that the team is trying to provide named analysts linked with Clinical Boards in order to build knowledge and relationships, however staff resource constraints mean this is not possible.</p>		<p>Potential risk that:</p> <ul style="list-style-type: none"> IT services and information provided do not suit the needs of the organisation. 	
Recommendations		Priority	
4.1	<p>Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital.</p> <p>Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.</p>	Medium	
Agreed Management Action		Target Date	Responsible Officer
4.1	List of current digital coordinators in clinical boards will be reviewed and gaps identified. D&HI will work with Clinical Boards who haven't nominated a coordinator to demonstrate the benefits of the approach.	October 2023	Head of Digital Services Management

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Matter Arising 5: Report Catalogue (Operation)		Impact	
<p>We note that there are a large number of information products available for users, however there is no list or catalogue available which sets these out.</p> <p>As such users may not be fully aware of already available information and may therefore not use it, or make unnecessary requests for information.</p>		<p>Potential risk that: IT services and information provided do not suit the needs of the organisation.</p>	
Recommendations		Priority	
5.1	A report / information catalogue should be devised in order to make clear what information is available to staff.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	It is planned to build catalogues as part of the implementation of Power BI and the LDR.	March 2024	Head of Business Intelligence (Power BI) Head of Architecture and Analytics (LDR)

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Matter Arising 6: Skills Identification (Operation)		Impact	
<p>There is a mix of skills in place across the Digital teams, with requirements identified within individual job descriptions and there has been some identification of courses for staff to undertake as a package for their role, however we note that there is no defined skills framework or matrix that sets out the required skills, with an associated development plan.</p> <p>There are some advanced skills in place within the analytics team, including Python and R however overall there is a deficit in advanced analytic skills, with an absence of data scientists, although we note that there has been some collaborative work undertaken with Cardiff University which allows the Health Board to access more advanced skills. As such there is minimal analytics work undertaken within Digital.</p>		<p>Potential risk that: IT services and information provided do not suit the needs of the organisation.</p>	
Recommendations		Priority	
6.1	<p>A skills framework should be developed that identifies the required skills within the department that are needed to deliver a modern information and analytics service.</p> <p>This should be underpinned by a development plan setting out how skills will be brought in, either by development of staff, recruitment, or by partnering with other organisations eg Cardiff University.</p>	<p>Medium</p>	
Agreed Management Action		Target Date	Responsible Officer
6.1	<p>Training plan for existing Informatics and BI staff is in place which will become the departments standard training pack for new starters going forward. Training will be delivered on-line via UDEMY training platform and will run for at least 12 months.</p>	31/03/2024	Head of Business Intelligence

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Matter Arising 7: Data Strategy (Operation)		Impact	
A data strategy is currently in development, however at present there is no roadmap to get to a data led organisation that sets out how it will coordinate and use its data and no full identification of who will use the data, what they will use and how they will use it.		Potential risk that: IT services and information provided do not suit the needs of the organisation.	
Recommendations		Priority	
7.1	A data strategy should be fully defined, along with a supporting roadmap. This should consider the appropriateness of the warehouse for the future. We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation.	Medium	
Agreed Management Action		Target Date	Responsible Officer
7.1	We are committed to and are working to develop a data strategy which will address the warehouse issue raised but also the wider issue of providing data to those that need it.	March 2024	Director of Digital & Health Intelligence

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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.
	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.

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Inclusion and Equality Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board



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Final report issued:	27/04/23
Auditors:	Sharon Edwards, Principal Internal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit Ian Virgil, Head of Internal Audit
Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Claire Whiles, Assistant Director of OD, Wellbeing & Culture Mitchell Jones, Equity and Inclusion Senior 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 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.

Disclaimer notice - please note

This audit 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 and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The overall objective of the audit was to review the structure of the Equity and Inclusion Team and the plans in place to take key actions forward relating to areas such as the Welsh Government’s Anti-Racist Wales Action Plan.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Terms of Reference, membership and remit of the Equality Strategy & Welsh Language Standards Group need to be reviewed to ensure appropriate oversight of all current and future requirements.
- A review is required of the responsibilities of the Equity and Inclusion team and the structures in place within the Health Board to support them in delivery.
- An effective process and structure need to be implemented to enable the development of required action plans to ensure that the Health Board complies with all current and future inclusion and equality requirements.

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

Report Opinion



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives	Assurance
1 Governance arrangements in place	Reasonable
2 Adequately structured and operating effectively	Limited
3 Plans in place ensure adherence to relevant Inclusion and Equality legislation	Reasonable
4 Regular monitoring and reporting	Substantial

¹The 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	ESWLSG Terms of Reference, membership and remit	Design	Medium
2	Workload of the Equity and Inclusion Team	Design	High
3	Development and Delivery of Equality actions	Operation	Medium

1. Introduction

- 1.1 Our review of 'Inclusion and Equality' was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 Equality, diversity and inclusion are at the heart of the operation of the NHS and require any services, interventions or actions to take into account those needs arising from identified protected characteristics.
- 1.3 The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. The Public Sector Equality Duty came into force across Great Britain in 2011, which requires public bodies to consider all individuals when carrying out their day-to-day work in shaping policy, in delivering services and in relation to their own employees.
- 1.4 It also requires that public bodies have due regard to the need to:
 - eliminate discrimination;
 - advance equality of opportunity; and
 - foster good relations between different people when carrying out their activities.
- 1.5 The Health Board's Equality Strategy & Welsh Language Standards Group (the 'Group') "... Advise, embed, and assure the Strategy and Delivery Committee on the development and implementation of the UHB's "Strategy Equality Plan - Caring about Inclusion" (SEP)".
- 1.6 As noted further in the Terms of Reference, the remit of the Group is driven by legislation and compliance. The work of the Equity and Inclusion Team, which is made up of a Equity and Inclusion Senior Manager, and an Inclusion Officer, feeds into the Group.
- 1.7 In October 2022, the Welsh Government published an Anti-Racist Wales Action Plan which outlines their vision for an "equitable whole system approach to health and social care". The Plan covers the expectations of many public sector organisations, with section five directed specifically to Health.
- 1.8 The Executive Director of People and Culture is the lead for this review.

2. Detailed Audit Findings

Objective 1: There are effective governance arrangements in place to oversee the Health Board's adherence to Inclusion and Equality legislation, which is responsive to developments such as the Welsh Government's Anti-Racist Wales Action Plan.

- 2.1 The Equality Strategy & Welsh Language Standards Group (ESWLSG) is responsible for advising, embedding and providing assurance on the development and

implementation of the Health Board's SEP and other key enabling plans including the Anti-Racist Wales action plan.

- 2.2 The ESWLSG reports into the Strategy & Delivery Committee with an update provided at every meeting of the Committee.
- 2.3 It was evident from review of the minutes of the Strategy and Delivery meetings during 2022/23 that the committee also received specific updates relating to reducing health inequalities across the organisation and has been made aware of the draft Welsh Government Race Equality Action Plan.
- 2.4 Review of the agendas of the ESWLSG meetings between February and October 2022 confirmed that the following regular items were included:
 - Presentation of reports on how each Clinical Board is doing in terms of achieving equality and inclusion; and
 - Flash report updates on progress with the SEP.
- 2.5 The introduction of Equality sub-Groups below the ESWLSG is currently being discussed. Due to the growing importance of Equality and Inclusion as a subject area, these groups may become a valuable monitoring and reporting tool.
- 2.6 The Welsh Government Race Equality Action Plan came out in June 2022. The Health Board is currently working on its own action plan and once this has been agreed and signed off, a Steering Group will be formed. Once the Steering Group is in place, a Terms of Reference will be produced identifying the membership and the structure of the Group which will provide an enhanced governance structure.
- 2.7 The ESWLSG's terms of reference are not reviewed on an annual basis as specified, and the governance arrangements have not changed since we completed our Welsh Language Standards Audit 12 months ago. Despite concerns raised at the time about the membership and the remit of the ESWLSG, the group remains the same. **(Matter Arising 1)**

Conclusion 1: The ESWLSG is operating in accordance with its current ToR and effectively reporting into the Strategy and Delivery Committee. However, to ensure upcoming plans and requirements are thoroughly scrutinised and delivered, the remit of the ESWLSG needs to be reviewed and subgroups formed where required. (Reasonable Assurance)

Objective 2: The Equity and Inclusion Team is adequately structured and operating effectively to facilitate the delivery of the inclusion and equality agenda, ensuring compliance with legislation and Welsh Government requirements.

- 2.8 The Equity and Inclusion team consists of the Equity and Inclusion Senior Manager and a band 4 Inclusion Officer. Inclusion and Equality is growing as a subject matter which means that there are areas that are specified within the job descriptions of the team that they may not have the time to focus on due to the demand of the service. **(Matter Arising 2)**

- 2.9 As part of his duties the Equity and Inclusion Senior Manager has been working on the "Equality" and "Gender Pay Gap" Reports, which are due on 31st March 2023. These are detailed annual reports that can take a considerable time to prepare. Due to capacity and timing issues, this year's annual report will be shorter. However, it was acknowledged in October 2022 that work had begun on the first draft of the annual Equality Report. **(Matter Arising 2)**
- 2.10 Where possible, the team are trying to utilise the resources on SharePoint to help with the delivery of inclusion and equality training for the Health Board. They dedicate two months a year to providing face-to-face training as part of mandatory training. However, other face to face training is provided on an ad hoc basis due to limited capacity within the team. **(Matter Arising 2)**
- 2.11 As part of the progression of the "Inclusion Ambassador" program, the Equity and Inclusion Senior Manager has been chasing some Clinical Boards for nominees; he has received nominations from Medicine, Surgery, PCIC, and CD&T. Mental health are training staff via Diverse Cymru who will then hopefully put themselves forward to be Inclusion Ambassadors. Each Clinical Board is at a different stage of the process, the position has been reported to the ESWLSG.
- 2.12 Inclusion Ambassador nominations have been received at Executive and Board level.

Conclusion 2: The team are doing their best to ensure that the inclusion and equality needs of the organisation are met. However, with the demands for the service increasing, there are aspects of the roles that are currently not being delivered. (Limited Assurance)

Objective 3: The Equity and Inclusion Team has plans in place to ensure adherence to relevant Inclusion and Equality legislation and Welsh Government requirements, including the recently published Anti-Racist Wales Action Plan

- 2.13 The Strategic Equality Plan 2020-24 (SEP) should be updated and reported against to demonstrate progress. The SEP is updated on a six-monthly basis and presented to the Strategy and Delivery Committee but is also reported and discussed at the ESWLSG at every meeting. To ensure consistency, the ESWLSG's agenda includes a large proportion on Equality and Inclusion while the rest focuses on Welsh Language Standards.
- 2.14 As part of this update, the Health Board will present the status of the Anti-Racism Wales Action Plan (ArWAP) and LGBTQ+ Action Plan (only released in February 2023).
- 2.15 The Workforce Race Equality Standards (WRES) are currently being scoped by the Welsh Government which will require the Health Board to provide data which they are not currently collating.
- 2.16 Further work is required within the Health Board to ensure that appropriate action plans are developed to enable delivery of the Health Board's objectives and compliance with all required legislation. **(Matter Arising 3)**

Conclusion3: A number of relevant equality plans are already in place and are monitored via the ESWLSG. However, further work is required to ensure all future requirements are covered and that effective structures are in place to support the Inclusion & Equality Team. (Reasonable Assurance)

Objective 4: There is regular monitoring and reporting of inclusion and equality priorities, which ensures issues are escalated where appropriate.

- 2.17 From the minutes and agendas provided, it is evident that the ESWLSG is kept informed of the Health Board's inclusion and equality commitments. The ESWLSG details the progress or delays that are being faced across the organisation.
- 2.18 The ESWLSG ensures that it is fulfilling its responsibilities as set out in the Terms of Reference by providing updates on strategy, delivery and performance as well as providing information on EHIA and staff wellbeing.
- 2.19 The ESWLSG have also been made aware of the newly implemented Anti-racist Wales Action Plan which has been issued by Welsh Government and the group have been given details of how this will affect the organisation.
- 2.20 Progress reports are provided by each clinical board at each ESWSLG. This is so that the Inclusion and Equality team are aware of their progress toward meeting the requirements to treat everyone with dignity and respect.

Conclusion 4: ESWLSG and Strategy and Delivery Committee minutes demonstrate that inclusion and equality priorities are monitored regularly and escalated when necessary. (Substantial Assurance)

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Appendix A: Management Action Plan

Matter Arising 1: ESWLSG Terms of Reference, membership and remit (Design)		Impact	
<p>The Equality Strategy & Welsh Language Standards Group (ESWLSG) reports into the Strategy and Delivery Committee in order to:</p> <p><i>"Advise, embed, and assure the Strategy and Delivery Committee on the development and implementation of the UHB's "Strategy Equality Plan - Caring about Inclusion" (SEP) and the Welsh Language Standards, and key enabling plans"</i></p> <p>The Terms of Reference for the ESWLSG does not specify a date when they were initially approved. It is stated in the narrative within the document that the Terms of Reference will be reviewed annually. There is no evidence that this has happened.</p> <p>When reviewing the Terms of Reference, management may wish to consider a previous finding from the Welsh Language Standards Report that we issued in January 2022. Due to both Equality and Inclusion and Welsh Language Standards growing as subject matter areas, discussions should be undertaken regarding the membership of the ESWLSG. In addition, subgroups should be established where required. This is to ensure that the remit of the group is appropriate and that all action plans and agenda items have the necessary scrutiny at these meetings.</p>		<p>The remit and structure of the ESWLSG may not be appropriate to ensure the Health Board's adherence to Inclusion and Equality legislation.</p>	
Recommendations		Priority	
1	A review of the Terms of Reference along with the membership and remit of the ESWLSG is required by management, along with the formation of subgroups to facilitate decision-making and implementation.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1	The Terms of Reference, including membership and governance requirements of the ESWLSG are currently under review. This review will be informed by the governance surrounding the UHB's Equality, Equity and Experience Framework (currently at consultation), the requirements of the People and Culture Committee and the outcome of this audit. This review will include the	July 2023	Assistant Director of OD, Wellbeing and Culture

	identification of any required sub groups / steering groups / working groups and subsequent membership requirements and TORs.		
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Matter Arising 2: Workload of the Equity and Inclusion Team (Design)		Impact	
<p>The Equity and Inclusion team consists of the Equity and Inclusion Senior Manager and a band 4.</p> <p>When reviewing the job description of the Equity and Inclusion Senior Manager it states that the role “should support equality governance across the UHB by being compliant with legislation and other mandatory requirements including the Equality Act 2021, Human Rights Act 198 and the Welsh Language Standards”.</p> <p>We were informed by the Equity and Inclusion Senior Manager that he spends much of his time writing reports and responding to queries, which can increase his workload.</p> <p>The team prioritises its time considering an ever-increasing workload but there are duties and responsibilities that they do not actively have the time to pursue such as:</p> <ul style="list-style-type: none"> • Attending all strategic groups to have a greater presence in ensuring the agenda is inclusive; • Conducting regular training sessions; • Reviewing the EDI financial budgets; and • Ensuring that staff across the UHB are aware of the need to complete an Equality Health Impact Assessment in accordance with the Equality Act. (Although there are processes in place, not all EHIA's are actively promoted, monitored, or published and they are not regularly reviewed by the team) 		<p>The Equity and Inclusion team may not be able to fully deliver the requirements of their roles.</p>	
Recommendations		Priority	
2	<p>To ensure compliance with the organisation's objectives and legislative requirements, management should undertake a review of the responsibilities of the team members and the structures in place within the Health Board to support the team.</p>	<p>High</p>	
Agreed Management Action		Target Date	Responsible Officer
2	<p>The People and Culture Directorate will commence a benchmarking exercise to assess the effectiveness of current capacity compared to other NHS organisations. This is not restricted to the Equity and Inclusion Team, but also</p>	<p>September 2023</p>	<p>Assistant Director of OD, Wellbeing and Culture</p>

	<p>looking at Welsh Language, and Education, Culture and OD. This is being looked at alongside the UHBs commitment to delivering the SEP, meeting its Socio-Economic Duties, and responding to WG direction, including the Anti-Racist Wales Action Plan; WRES etc. This will be completed, and the UHB will be presented with a paper, outlining the findings, team capacity findings highlighting any areas of risk / any short-falls. This will go to the People and Culture Committee in the first instance.</p>		
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Matter Arising 3: Development and Delivery of Equality actions (Operation)		Impact	
<p>To ensure that the Health Board is able to comply with all current and future inclusion and equality requirements, further work needs to be undertaken to develop and deliver the required action plans. This will include ensuring that the Health Board can identify where there are gaps in information relating to inclusion and equality and the team can then determine what will be required for the upcoming action plans.</p> <p>The Equity and Inclusion team will be leading this work over the next six months which will enable them to identify how this information can be captured and recorded.</p> <p>The Equity and Inclusion Senior Manager also has responsibility for the Welsh Language team and the implementation of the Welsh Language Standards along with the delivery of the newly implemented "More than just words strategy 22-27" which aims to deliver a bilingual service by 2027.</p> <p>We note work is on-going to identify Inclusion Ambassadors within each of the Clinical Boards.</p> <p>The introduction of Equality sub-groups to support the ESWLSG is also currently being discussed.</p>		<p>Actions required to ensure compliance with relevant Equality legislation may not be identified and / or delivered.</p>	
Recommendations		Priority	
3	<p>Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered.</p> <p>This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.</p>	<p>Medium</p>	
Agreed Management Action		Target Date	Responsible Officer
3	<p>The review and refresh of the TORs of the ESWLSG (Action 1), will reinforce the reporting and local accountability against equality actions, while enabling a forum that shapes strategic direction against EDI (and Welsh Language). The reviewed TORs will include reporting accountability for Clinical and Service Boards, along with reporting to the People and Culture Committee, and Board.</p>	July 2023	Assistant Director of OD, Wellbeing and Culture

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.
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	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
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Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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