Public Audit Committee Meeting

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

Agenda

09:00 - 09:10
10 min

1. Welcome and Introductions

John Union

09:10 - 09:10
0 min

2. Apologies for Absence

John Union

09:10 - 09:10
0 min

3. Declarations of Interest

09:10 - 09:10
0 min

4. Minutes of the Committee meeting held on 4th April 2023

John Union

- 04 Draft Public Audit Minutes AprilMD.pdf (15 pages)

09:10 - 09:10
0 min

5. Action log following meeting held on 4th April 2023

John Union

- 05 Draft Public Action Log - MayMD.pdf (2 pages)

09:10 - 09:10
0 min

6. Any other urgent business

09:10 - 10:15
65 min

7. Items for Review and Assurance

7.1. Internal Audit Progress Report

Ian Virgil

- 7.1 Internal Audit Progress Report Cover.pdf (2 pages)
- 7.1a Internal Audit Progress Report May 23.pdf (24 pages)

7.2. Compliance with the UK Corporate Governance Code

James Quance

- 7.2 UK Corporate Governance Code report.pdf (3 pages)
- 7.2a Appendix 1 - Annual Assessment UK Corporate Governance Code 2022-2023.pdf (10 pages)

7.3. Board and Committee Effectiveness Surveys 2022-23

James Quance

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

7.4. Annual Review of the Standing Orders

James Quance

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

7.5. Audit Wales Annual Plan

Wales Audit

- 7.5 Audit Wales Annual Plan 2023.pdf (24 pages)

10:15 - 10:35
20 min

8. Items for Approval / Ratification

8.1. Counter Fraud Annual Report 2022/23

Gareth Lavington

- 8.1 Counter Fraud Annual Report 2022-23 Cover Sheet.pdf (3 pages)
- 8.1a Counter Fraud Annual Report 2022-23.pdf (13 pages)
- 8.1b Annual Counter Fraud Report Appendix 1.pdf (7 pages)

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)

10:35 - 10:45
10 min

9. Items for Information and Noting

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 - Substantial Assurance

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

9.1.2. Follow-up: Clinical Audit - Substantial Assurance

9.1b Clincial Audit Follow up Final Report.pdf (8 pages)

9.1.3. Follow-up: Nurse Bank (Temporary Staffing Department) - Reasonable Assurance

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

9.1.4. Charitable Funds - Reasonable Assurance

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

9.1.5. Community Patient Appliances (Specialist Services CB) - Reasonable Assurance

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

9.1.6. Data Warehouse - Reasonable Assurance

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

9.1.7. Inclusion & Equality - Reasonable Assurance

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

9.1.8. Risk Management - Reasonable Assurance

9.1h Risk Management-Final Internal Audit Report.pdf (15 pages)

9.1.9. Management of Health Board Policies - Limited Assurance

9.1i Management of Health Board Policies Final Internal Audit Report.pdf (25 pages)

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

Ian Virgil

9.2 A&A EQA Report Cover.pdf (2 pages)
9.2a NWSSP Audit Assurance Services - PSIAS EQA -.pdf (15 pages)

10:45 - 10:50
5 min

10. Agenda for Private Audit and Assurance Committee

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)

10:50 - 10:50
0 min

11. Any Other Business

10:50 - 10:50
0 min

12. Review and Final Closure

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

10:50 - 10:50
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].

Unconfirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 4th April 2023 at 9:30am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Ian Virgil	IV	Head of Internal Audit
Lucy Jugessur	WW	Internal Audit Manager
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Claire Salisbury	CS	Head of Procurement
Aaron Fowler	AF	Head of Risk and Regulation
Urvisha Perez	UP	Audit Wales
Mark Jones	MJ	Audit Wales
James Quance	JQ	Interim Director of Corporate Governance
Lianne Morse	LM	Assistant Director of Workforce
David Thomas	DT	Director of Digital & Health Intelligence
Observers:		
Timothy Davies	TD	Head of Corporate Business
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance

Item No	Agenda Item	Action
AAC 4/4/23 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 4/4/23 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 4/4/23 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

AAC 4/4/23 004	**Minutes of the Meeting Held on 7th February 2023** The Minutes were received. Mark Jones (MJ) commented that Anthony Veale (AV) had presented the Audit Wales Report and not Huw Richards. **The Committee resolved that:** a) Pending the above amendments, the draft minutes of the meeting held on 7th February 2023 were held to be a true and accurate record of the meeting.	**MJ**
AAC 4/4/23 005	**Action Log – Following Meeting held on 7th February 2023** The Action Log was received. The Head of internal Audit (HIA) commented that the timing of the Medical Records Tracking report was yet to be agreed and would come to a meeting later on in the year. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 4/4/23 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 4/4/23 007	**Internal Audit Progress Report** The HIA presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> • The Audits planned for the April meeting had not been finalised due to delays. Those would be brought to a future Committee meeting. <u>Section 3</u> • Four reports were finalised in time for today's meeting. • The Cyber Security report would be discussed in the Private meeting. <u>Section 4</u> • There were 38 Audits within the 2022/23 Internal Audit Plan.	

	• 23 Audits had been finalised so far. Of the remaining 15 Audits, 10 were at draft report stage. A number of those Audits would be finalised in time to feed into the end of year opinion. • Appendix C highlighted performance against key performance indicators. The CC queried whether there were concerns that some reports would not be completed in time and would that affect the end of year opinion. The HIA responded that so far only one draft Audit had been awarded limited assurance. Even if that draft Audit remained as limited, only 3 Audits would have limited assurance overall. It was noted that the HIA opinion for the end of year was likely to be reasonable assurance. <u>Section 5</u> • It was agreed with the Assistant Director of Quality & Safety that the QSE Governance advisory review audit would be moved to Q1 23/24 to allow for coverage of developments around the Duty of Quality. • It was proposed that the ChemoCare IT System Follow-up Audit would be deferred into the 23/24 plan due to delays with implementation of the new system. The Independent Member for Capital and Estates (IMCE) queried whether the reasons for the delay in the Audits were typical or should they be concerned and dig deeper into the lack of resources or delays in management responses. The HIA responded that the lack of resources would be addressed going into the new year as Internal Audit were looking into creating a recruitment drive. The engagement from the Health Board was not overly concerning. There had been many pressures and the Winter period had impacted the ability to engage. <u>Section 6 – Final report summaries</u> 1. 6.1 Financial Reporting & Savings Targets • The purpose of the Audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Financial Reporting and Savings Targets'. • Substantial assurance was issued in this area. • The report made three low priority recommendations which included:	

	- The creation of a desktop procedure to support the resilience of completing the Monthly Monitoring Return to Welsh Government and associated Finance Reports; - Greater transparency of the data sources which informed the monthly Finance Report; and - Clarity of the Saving Scheme 'RAG' rating system, used within the publicly available Finance Report. 2. 6.2 Nurse Staffing Levels Act • The purpose of the Audit was to review the processes in place to ensure compliance with the requirements of the Act, with a focus on Paediatric arrangements, which was a new part of the Act. • Reasonable assurance was issued in this area. • The matters which required management attention included: - The Health Board's Nurse Staffing Levels Operating Framework' was not available on the Intranet and also required updating. - The Workforce Planning templates were not all signed off by the Designated Person and the recorded staffing levels were not always reflected within the ward's funded establishments. - The Nurse staffing levels were not always being displayed on the wards or the information was incorrect. 3. 6.3 Decarbonisation • Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change. • Having reviewed all the information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 Audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees. • Accordingly, the decision was taken to affirm common themes to provide an overview of the overarching position across NHS Wales. The details were contained within the report. **The Committee resolved that:** a) The Internal Audit Progress Report was noted.	

AAC 4/4/23 008	**Chemo Care IT System Update** The Director of Digital & Health Intelligence (DDHI) advised the Committee on the following: • This was an update on the management action plan relating to the Chemo Care IT system. • Internal Audit had previously made 8 recommendations. <u>Section 1.1</u> • No breaches had occurred since the Audit had been undertaken. <u>Section 1.2 - 1.3</u> • The Digital Team was awaiting version 6 of the system which was scheduled for April 17th. Paediatrics would be completed in May. <u>Section 2.1 - 2.6</u> • The recommendations were already in place. • The Digital Team was waiting for version 6 to be implemented in April and May 2023. <u>Section 3.1</u> • Training was being undertaken. <u>Section 4</u> • The recommendations had been undertaken and completed. <u>Section 5</u> • The password control recommendation had been completed. <u>Section 6</u> • The Digital Team was waiting for version 6 in April. <u>Section 7.1</u> • The recommendations had been completed. <u>Section 7.2</u> • The back-up schedule was in place.	

	Section 8.1 • This would be completed once version 6 of the system was in place. The HIA advised that a detailed follow up report would be completed in 2023-24. **The Committee resolved that:** a) The Chemo Care IT System Update was noted.	
AAC 4/4/23 009	**Audit Wales Update to include:** MJ advised the Committee that the Financial Audit work had commenced last month. Urvisha Perez (UP) advised the Committee on the following: • The Orthopaedics Services Follow Up Review was published in March 2023. Links to both reports were provided in exhibit 3. • Audit Wales was at the latter stages of the fieldwork for the Unscheduled Care Review. • Audit Wales would begin the follow up review of the Primary Care Services. • Exhibit 3 provided information on other relevant examinations and studies published by the Auditor General in the last six months. The UHB Vice-Chair queried how much of the Unscheduled Care Review would feed into the Six Goals work. UV responded that the review had been completed and a blog was published last year. The current review was looking at the “back door”. Later in the year Audit Wales would look at the “front door”. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 4/4/23 010	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the Declarations of Interest, Gifts and Hospitality Report and highlighted the following:	

	• 417 Declarations of Interests, Gifts, Hospitality and Sponsorship were held on ESR (an increase of 183 from the 234 reported in January 2023). • 2,504 entries were recording 'No Interest' to be declared (an increase of 1,885 from the 619 reported in January 2023). • 97.5% of Declarations received were rated Green (407 Declarations). 2% of Declarations received were rated Orange (8 Declarations). 0.5% of Declarations were rated Red (2 Declarations). • The HRR was in contact with managers of individuals who had declarations rated red. • A meeting with Shared Services would take place shortly to understand whether ESR could be made more functional. The Independent Member for Trade Union (IMTU) commented that it was a massive improvement since last year. He queried how it compared with declarations in other Health Boards. The HRR responded that the Health Board was held as an exemplar in this area. However, he did not have much information available. Other Health Boards were using a purchased package instead of ESR. The CC queried whether responses were completed by banding. The HRR responded that staff on higher bands usually made the declarations. However, his team had targeted the whole Health Board. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The proposals to improve Declaration of Interest reporting across the Health Board was noted.	
AAC 4/4/23 011	**Internal Audit Recommendation Tracking Report** The HRR presented the Internal Audit Tracking Report and highlighted the following: • There were 130 recommendations noted on the Tracker. • Of the 130 recommendations listed within the Tracker, 28 were recorded as completed (3 of which related to the advisory Assurance Strategy Audit), 73 were listed as partially complete and 29 were listed as having no	

	action taken or reported since the last Committee meeting. • The HRR had met with the HIA since the last meeting to discuss recommendations on the tracker. • A full review of all outstanding recommendations had been undertaken since the last meeting of the Committee where the internal audit tracker was presented (February 2023). • Each Executive Lead had been sent the recommendations made by Internal Audit which fall into their remits of work. • The aged entries would be targeted and most would be closed off by the July meeting. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in February 2023 was noted and provided assurance.	
AAC 4/4/23 012	**Audit Wales Recommendation Tracking Report** The HRR presented the Audit Wales Tracking Report and highlighted the following: • The Risk and Regulation team was looking to collaborate with colleagues in Audit Wales to progress recommendations. • The tracker recorded a total of 34 recommendations, 3 of which were reported as complete, 25 had been partially completed. There were also 6 entries where no further action had been reported since the February 2023 Committee meeting. **The Committee resolved that:** a) the progress which had been made in relation to the completion of Audit Wales recommendations had been noted and assurance in relation to the same had been received. b) The continuing development of the Audit Wales Recommendation Tracker had been noted.	
AAC 4/4/23 013	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report and highlighted the following:	

	• The Risk and Regulation team would continue to monitor those areas of compliance whilst working with external regulators. • The tracker highlighted one recommendation which was closed off as being complete. • Significant progress had been made with the trackers. The IMCE queried how the recommendations were prioritised. The HRR responded that each individual recommendation was dealt with as a high priority, especially where there were legal implications. The Executives would lead to push the team to escalate the recommendation. The CC queried timescales for the patient safety alerts. The HRR responded that one patient safety alert was reliant on an all Wales solution. That should be updated in the QSE Committee meetings. **The Committee resolved that:** a) Updates shared were reviewed and assurance was taken from the continuing development and the Legislative and Regulatory Compliance Tracker was reviewed.	
AAC 4/4/23 014	**Scheme of Delegation and Shared Services Governance Structure** The Interim Deputy Director of Finance (Operational) (DDFO) presented the Scheme of Delegation and Shared Services Governance Structure and highlighted the following: • Page 1 detailed an organisation map of Shared Services which was provided for information purposes. • Page 2 listed the services provided by Shared Services. • Page 3 highlighted the leads in Shared Services and their peers in the Health Board. **The Committee resolved that:** a) The Scheme of Delegation and Governance Structure of NHS Wales Shared Services was noted.	
AAC 4/4/23 015	**Review changes to Standing Financial Instructions (SFIs) and Accounting Policies**	

	The DDFO presented the Review changes to Standing Financial Instructions and Accounting Policies and highlighted the following: • The report detailed whether there had been any changes made to SFIs. • The SFIs were periodically revised by WG. • One small amendment had been made and the Finance team was already working to that. • The Finance team was also obliged to report to the Committee any major changes to the Health Board's accounting policies. This year there was the IRFS 16 Leases amendment. • The Finance team had implemented IRFS rules in the 2022/23 accounts. **The Committee resolved that:** a) The update, as set out in the body of the report, with regards to the Health Board's Standing Financial Instructions and Accounting policies was noted.	
AAC 4/4/23 016	**Procurement Compliance Report including Single Tender Actions** The Assistant Director of Procurement Services and Executive Procurement Lead C&V (ADPS) presented the Report and highlighted the following: • The Health Board's Standing Orders & Standing Financi Instructions required that the purchase of all goods and services were subject to competition in accordance with good procurement practice, referred to minimum thresholds for quotes and competitive tendering arrangements. • There were some situations where that was not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) were made in accordance with the Procedure for the Approval of Single Tender Actions. • There were times where individuals acted outside Procurement Regulations and Standing Financials Instructions and that needed to be reported as a non-compliant process, which was a direct breach, and could compromise competition and value for money. The IMCE queried whether they needed to look at the governance processes because the amount of breaches was concerning.	

	The ADPS responded that there was a total of 30 non-compliant activities. Those were mainly due to inexperience or urgency from clinicians. The ADPS added that a letter was issued to the Clinical Boards when there was a breach. The Clinical Board would write back and formally confirm any lessons learnt. There were 31 non-compliant breaches this year which was a drop from last year. The IMCE queried whether there were persistent breaches and if so what would happen. The ADPS responded that the individual was named in the letter and Clinical Director would need to address that.. The Health Board had not had a continuous offender to date. **The Committee resolved that:** a) The contents of the Report were noted and approved.	
AAC 4/4/23 017	**Review of Chair's Actions** The ADPS presented the Review of Chairs Actions Paper. It was noted that there was a concern in relation to the number of Chairs Actions. In 2023, there had been 34 Chairs Action and only 2 Board meeting approvals. The reasons were contained in the paper. A lot of Chairs Actions were due to unforeseen emergency situations. **The Committee resolved that:** a) The contents of the report were noted.	
AAC 4/4/23 018	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented the Counter Fraud Progress Report and highlighted the following: • The Report provided details on activity during Quarter 4. • The Counter Fraud department had been under resourced. • Work had continued to develop better infrastructure. • It had been a busy period for referrals. • The Counter Fraud department had finished the thematic assessment.	

	• Ongoing investigations would be reported in the Private session. **The Committee resolved that:** a) The content of the report was noted.	
AAC 4/4/23 019	**Review Draft UHB Annual Report** The IDCG presented the Review of the Draft UHB Annual Report. It was noted that the Health Board was on track to deliver the Report in May. There was still a lot to be finalised in the draft, in particular in relation to the Health Board's accounts. **The Committee resolved that:** a) The progress made in relation to the drafting of the 2022-23 Annual Report was noted. b) Any comments with regard to the content of the draft report attached as Appendix 2 were provided and reviewed.	
AAC 4/4/23 020	**Audit Committee Effectiveness Survey 2022-23** The IDCG presented the Audit Committee Effectiveness Survey 2022-23 and highlighted the following: • It was noted that 8 responses were good. Overall it was a positive picture. • There were several persistent "ambers" and that could be looked into. • The Corporate Governance team would look at consistent actions that should to be put in place. • It was important to make sure that everyone was supported when moving to the new Committees structure. The IMCE suggested that induction pack should be circulated to all Independent Members (IMs). **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Audit and Assurance Committee were noted.	
	Items for Approval / Ratification	
AAC 4/4/23 021	**Annual Internal Audit Plan 2023/24**	

	The HIA presented the Annual Internal Audit Plan 2023/24 and highlighted the following: The Plan detailed the proposed audits to be undertaken along with the analysis of resources. The Internal Audit Charter was updated in April 2023 and set out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers <u>Section 2</u> • The draft Internal Audit plan for 2023/24 had been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents. • Individual planning discussions were held with each of the Executive Directors, the Chief Executive and Chair to inform development of the plan. • The plan covered the whole of the 2023/24 audit year but would be subject to regular on-going review and adjustment as required to ensure that the audits reflected the Health Board's evolving risks and changing priorities and therefore provided effective assurance. The IMI stated that he had a concern and would discuss this in the Private meeting. **The Committee resolved that:** a) The Internal Audit plan for 2023/24 was approved. b) The Internal Audit Charter as at March 2023 was approved. c) The associated Internal Audit resource requirements and Key Performance Indicators was noted.	
AAC 4/4/23 022	**Audit Wales - Outline 2023 Audit Plan** MJ presented the Audit Wales - Outline 2023 Audit Plan and highlighted the following: • The Plan listed the team. • It also flagged a few conflicts that were being mitigated.	

	• The WG deadline for accounts to be audited had been changed to 31st of July. • There was a link to the Audit Quality Report for 2022. **The Committee resolved that:** a) The Audit Wales - Outline 2023 Audit Plan was noted.	
AAC 4/4/23 023	**Counter Fraud Annual Plan 2023/24** The Lead Local Counter Fraud Specialist presented the Counter Fraud Annual Plan 2023/24 and highlighted the following: • The Counter Fraud Annual Plan 2023/2024 – annual plan outlined the work proposed to be undertaken in order to meet the Counter Fraud requirements for the Health Board for the forthcoming year. • The plan aligned with the NHS Counter Fraud Authority Functional Standard requirements. • Last year had involved developing the infrastructure in Health Board. • This year there was a big push on improving awareness for staff and structure processes for fraud risk assessment. **The Committee resolved that:** a) The Counter Fraud Annual Plan 2023 – 2024 was reviewed, discussed and approved.	
AAC 4/4/23 024	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 7th February 2023 ii. Counter Fraud Progress Update (Confidential – ongoing investigations) iii. Workforce and Organisational Development Compliance Report (Confidential – this report contains sensitive information and/or personal data) iv. Procurement Improvement Plan (confidential discussion) v. Cyber Security – Internal Audit Report (confidential discussion)	
AAC 4/4/23 025	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	

AAC 4/4/23 026	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Thursday 11th May 2023 at 9:00 am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
4 April 2023
(For the Meeting 11 May 2023)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 7/2/23 011	Chemo Care IT System.	An update on the Chemo Care IT System audit recommendations be shared with the Committee.	David Thomas	4/04/2023	Completed Update provided on 4 April 2023
AAC 7/2/23 007	Internal Audit Progress Report	Internal Audit work plan for 2023/24 to be brought to the Committee in April	Ian Virgil	4/04/2023	Completed Update provided on 4 April 2023
AAC 7/2/23 015	Single Tender Actions	The EDF and the EDPC to consider, outside of the Committee meeting, whether the locum amount for Gastroenterology should follow normal HR policy.	Catherine Phillips/Rachel Gidman	4/04/2023	Completed Operational issues driving significant service impact within the Medical Clinical Board led them to procure a locum at a total cost to 31 March 2023 of £149k. That contract will not be extended into 2023/24 as an alternative model has been developed with the team to ensure service continuity and value for money. The locum was supported by the COO, Medical, workforce and finance director.
Actions in Progress					

AAC 7/2/23 007	Internal Audit Progress Report	Follow up audit report in relation to the Medical Records Tracking (CD&T Clinical Board) to be brought to Committee. The IDCG and DM to discuss how best to set up governance arrangements relating to medical record tracking.	Internal Audit James Quance/Sion O Keefe	**September 2023**	**Update in September 2023** To be provided in September meeting.
Actions referred to Board / Committees					
AAC 8/11/22 007	Digital Strategy Audit	Internal Audit re the Health Board's Digital Strategy recommended that it was good practice to have Clinical Board attendance at the DHIC Committee meetings.	James Quance	**4/4/2023**	**Completed**
AAC 7/2/23 014	Assurance Strategy	Audit Committee recommended (i) Assurance Strategy 2021-24 and (ii) Risk Management and Board Assurance Framework Strategy to Board in March for ratification.	James Quance	**30 /03/23**	**Completed**

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

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:

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

Contents

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

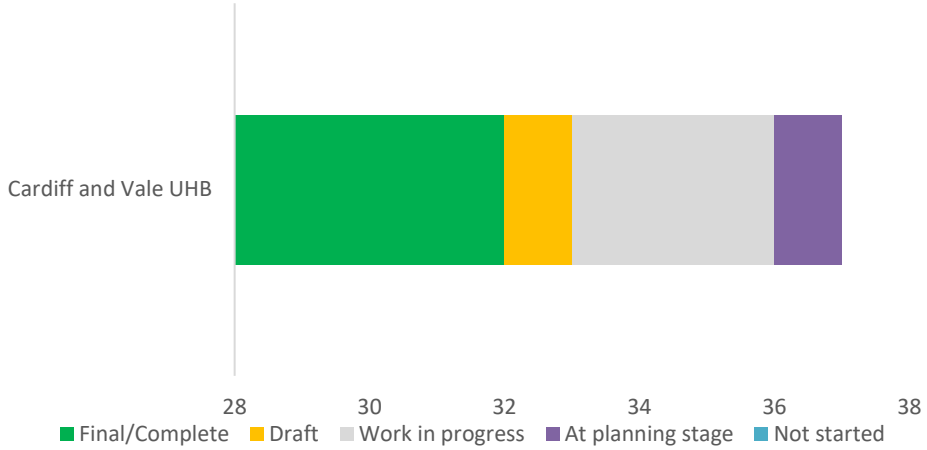
Nine assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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.

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 three audits that are currently work in progress with a further one at the planning stage.

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

Appendix 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.

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 summary[1]

	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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IPFR application review	1	Operation	Medium

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.

Follow-up Report Classification

	Trend
Substantial 	

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.

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

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

Assurance summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
3	Charitable Funds Expenditure	3	Operation	Medium
5	Fundraising Team Structure	6	Design	High
7	Effectiveness of Fundraising Events	8	Design	Medium

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 summary[1]

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

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 summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	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

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

Assurance summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Risk 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

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 summary[1]

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

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	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

6.9 Management of Health Board Policies

Purpose

The overall objective of the audit was to review the arrangements in place for the creation, management and review of Health Board policies and procedures.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- At the time of our review in February 2023, the Health Board had 502 policies and procedures of which 68% were overdue for review including 44% where this was greater than three years overdue.
- The policies and procedures tracker spreadsheet includes 44 entries where no Executive Lead has been identified.
- Staff are not notified when draft policies and procedures are added to the consultation page.
- The most appropriate structure for policies and procedures on the Health Board's website needs to be identified and then implemented.
- Notification of staff and stakeholders regarding policies and procedures is inconsistent.
- The provision of a progress update and revised target completion date to the Audit Committee if the May 2023 deadline for having a fully functioning Policy Management System in place is not met.

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

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 2019/20

Assurance summary[1]

Objectives		Assurance
1	Policy in place for the management of policies	Reasonable
2	Effective processes for managing policies	Limited
3	Plans in place where policy review dates exceeded	Reasonable
4	Staff are notified of new or amended policies	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Policy for the management of policies	1	Operation	Medium
2	Out of date policies and procedures	2	Design	High
3	Tracker spreadsheet	2	Operation	Medium
4	Consultation process	2	Operation	Medium
6	Standing Operating Procedure	2	Operation	Medium
7	Corporate Policies Management System Plan	3	Design	Medium
8	Published policies and procedures	4	Design	Medium
9	Notifying staff and stakeholders	4	Design	Medium

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
Development of Integrated Audit Plans:	*41*	*Strategic Planning*					
• *Development of Genomics Partnership Wales*			*Q3*		*Final*	*Reasonable*	*February*
• *University Hospital Llandough – Endoscopy Expansion*			*Q2*		*Final*	*Reasonable*	*November*
• *University Hospital Llandough – Engineering Infrastructure*			*Q2*		*Final*	*Reasonable*	*February*
• *UHW-Hybrid and Major Trauma Theatres*			*Q4*		*Draft*	*Reasonable*	*July*

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Reviews removed from the plan							
Implementation of People & Culture Plan	*09*	*People & Culture*			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		
Reporting of Covid Deaths	*11*	*Nursing*			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		
Application of Local Choices Framework	*28*	*Chief Executive / COO*			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		
Administration Services (Mental Health CB)	*29*	*Chief Operating Officer*			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		
Regional Planning Arrangements	*39*	*Strategic Planning*			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		
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	Strategic Planning			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		
Capital Systems	*14*	*Finance*			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		
Network & Information Systems (NIS) Directive Follow-up	44	Digital & Health Intelligence			Follow-up of management actions to be covered as part of the Cyber Security audit - Agreed by February 23 AC		
QS&E Governance (Deferred from 21/22 plan)	03	Nursing / Medical			Advisory review to be moved to Q1 23/24 to allow coverage of developments around the Duty of Quality - Agreed by April 23 AC.		
ChemoCare IT System Follow-up	43	Digital & Health Intelligence			Deferred to 23/24 plan due to delay with implementation of new system – Agreed by April 23 AC		
Performance Reporting	19	Digital & Health Intelligence			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
University Hospital Llandough – Endoscopy Expansion	*Reasonable*	*Final*	*13/10/22*	*03/11/22*	*25/10/22*	*26/10/22*	*G*
Development of Genomics Partnership Wales	*Reasonable*	*Final*	*23/11/22*	*14/12/22*	*02/12/22*	*13/12/22*	*G*
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
UHL Engineering Infrastructure	*Reasonable*	*Final*	*14/12/22*	*09/01/23*	*23/01/23*	*23/01/23*	*R*

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
Decarbonisation	*Advisory*	*Final*	*19/12/22*	*12/01/23*	*16/02/23*	*16/02/23*	*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%

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.

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Report Title:	Compliance with the UK Corporate Governance Code			Agenda Item no.	7.2
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	11 May 2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval	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

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 undertaking 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:

Mohamed.Sarah
10/05/2023 15:10:05

Appendix 1

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	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. 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.

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.	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. 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.
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.	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. 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.
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.	The Health Board's Standing Orders (which are based upon the Welsh Government's Model Standing Orders for NHS Wales) stipulate that: **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. **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. **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.
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
"The Board should be balanced, with approximately equal numbers of ministers, senior officials and non-executive Board members. It should comprise: • *the Finance Director, who should be professionally qualified"*	
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.	Board Members received annual performance appraisals. The Annual Committee effectiveness survey was undertaken in during February to April 2023 and the overall findings indicated that the Board was operating effectively. The Chair of the Board and each Committee, review the effectiveness of individual meetings as part of the agenda at each meeting.
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.

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 *de minimis* 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.	• 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 • 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.

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.	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. 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.
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.	The Director of Corporate Governance: • 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,

Requirement of the Code	Evidence of CVUHB Compliance
	• 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.	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. The DOI information is scrutinised by the Corporate Governance Department and the Audit Committee, and the information is included in the Annual Accountability Report. 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.
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.	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. 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.
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.	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. 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'. 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.
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.	The Board receives the BAF at each meeting which provides information on the key risks impacting upon the Strategic Objectives of the Health Board. The Audit and Assurance Committee reviews the Risk Management Strategy prior to Board approval.
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
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.	The draft Annual Governance Statement is presented to the Audit and Assurance Committee for endorsement, prior to submission to the Board. The Audit and Assurance Committee papers are published on the CVUHB website.
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.	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. 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.
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.	The Board and Committees are required to complete an annual committee effectiveness survey. 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.
Chapter 6 Arm's Length Bodies	
Not applicable	

Report Title:	Board and Committee Effectiveness Surveys 2022-23			Agenda Item no.	7.3
Meeting:	Audit and Assurance Committee			Meeting Date:	11 May 2023
Status *(please tick one only):*	Assurance	x	Approval	Information	
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 identifed. 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:

a) **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

b) **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

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 undertaking 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:

Appendix 1

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**	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. The Integrated Performance Report has been developed further to strengthen performance benchmarking and this was discussed at a recent Board Development session (April 2022). **Action** Consider strengthening and developing sharing best practice with/benchmarking against large teaching Health Board across the UK.	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	This work has progressed with strengthened benchmarking against and sharing good practice with other large teaching Health Boards in across the UK. 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.
Board **10. We invite effective feedback and use the lessons learned to develop and improve the**	The Chair of the Board reviews the effectiveness of the Board meeting as part of the agenda at each respective meeting.	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.	**Action** 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.			of the meeting concerned.
Quality, Safety and Experience Committee **Strategy and Delivery Committee** **Shaping our Future Hospitals Committee** **9. Are changes to the Committee's current and future workload discussed and approved at Board level.**	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). 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. 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.	Director of Corporate Governance	March 2023	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. At its meeting on 30 March 2023, the Board also considered and approved the Committees' annual

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				Work Plans and Terms of Reference.
Health & Safety Committee **Strategy and Delivery Committee** **Shaping our Future Hospitals Committee** **12. Has the Committee established a plan for the conduct of its work across the year.**	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).	Director of Corporate Governance	March 2023	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. 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

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.
Health & Safety Committee **Charitable Funds Committee** **Shaping Our Future Hospitals Committee** **13. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?**	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.	Director of Corporate Governance		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. 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

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.
<u>Audit and Assurance Committee</u> **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.**	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. 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.	Director of Corporate Governance	October 2022	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. 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

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
				the Welsh Government and Audit Wales by 31 July 2023. The Audit and Assurance Committee undertook an annual review of the Standing Financial Orders and accounting policies on 4 April 2023.
<u>Audit and Assurance Committee</u> **<u>20.</u> 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.** Mohamed,Sarah 10/05/2023 15:10:05	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:- - 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.	Director of Corporate Governance	March 2023	During 2022/23 Audit and Assurance Committee members have had access to:- Board Development Sessions to support and equip Board Members with the knowledge to undertake their roles effectively; Access to the Director of

Question asked 2021-2022	Response and Action Required	Lead	Timescale to complete	Progress made as at April 2023
	- 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.			Corporate Governance; Access to the auditors without the presence of officials via a pre meeting to the routine Committee meetings.

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
Board **5. The Board scrutinises and challenges performance against delivery of the strategy.**	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. 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. 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.	*Director of Corporate Governance*	*October 2023*

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
<u>Board</u> **8. We identify and share best practice and benchmark.**	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. 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. 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. 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. **Action**	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	*October 2023*

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.**	All Board papers received by the Corporate Governance Team are published at least 10 clear days before the relevant Board meeting. 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.	Director of Corporate Governance	*October 2023*
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.**	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. 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.	Director of Corporate Governance	March 2024

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	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). Independent Members are encouraged to attend other Committees of the Board (ie where they are not appointed members to other Committees).		
<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**	During the year 2022-23, the QSE Committee met bi-monthly. 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. 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	Director of Corporate Governance	March 2024

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	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. 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. This year the agenda included a time allocated per agenda item to assist with managing the meeting in a more timely manner.		
Quality, Safety and Experience Committee **14. The Committee agenda setting process is thorough and led by the Committee Chair** Mohamed,Sarah 10/05/2023 15:10:05	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. 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.	Director of Corporate Governance	March 2024

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	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.		
Charitable Funds Committee **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.**	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. 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. It is acknowledged that there is sometimes a delay in providing draft minutes following the relevant meeting. **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. 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	Director of Corporate Governance	March 2024

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.		
Mental Health Legislation and Mental Capacity Act Committee **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.**	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 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.	Director of Corporate Governance	March 2024
Mental Health Legislation and Mental Capacity Act Committee **3. Are the terms of reference reviewed annually to take account of governance developments and the remit of other committees within the organisation.**	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. 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.	Director of Corporate Governance	March 2024

Question asked 2022-2023	Response and Action Required	Lead	Timescale to complete
	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. 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.		

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.

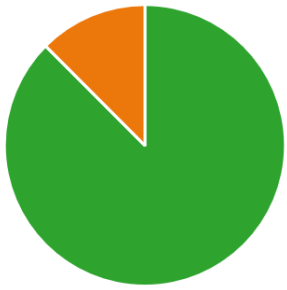
Needs Improvement	0
Adequate	1
Strong	7

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

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

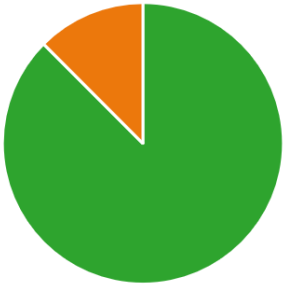


4. There is appropriate consideration of the UHB's financial reporting risks and the related internal controls, which are reflected in the Audit Committee's discussions and agenda items.

Needs Improvement	0
Adequate	2
Strong	6

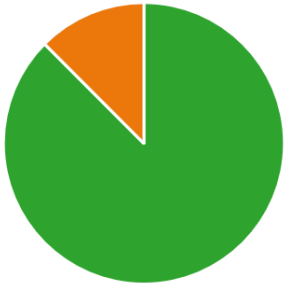
5. Is the Committee's role in the approval of the Annual Accounts clearly defined?

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

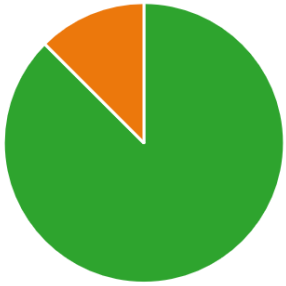


7. Has the Committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?

Yes	6
No	0
Unsure	2

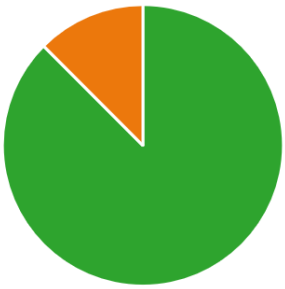
8. Has the Committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Statement of Internal Control, the Assurance Framework, Standards for better Health and the Head of Internal Audit's opinion?

Yes	7
No	0
Unsure	1



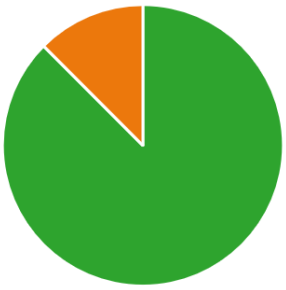
9. Has the Committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged?

Yes	7
No	0
Unsure	1



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.

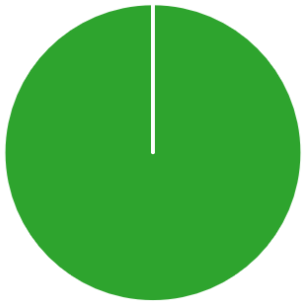
Needs Improvement	0
Adequate	1
Strong	7

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

Needs Improvement	0
Adequate	1
Strong	7

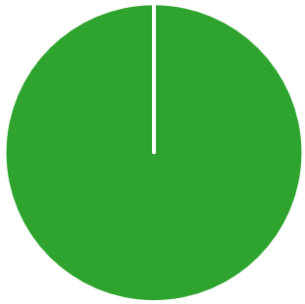
14. Are the terms of reference for Internal Audit approved by the Committee and routinely reviewed?

Yes	8
No	0
Unsure	0



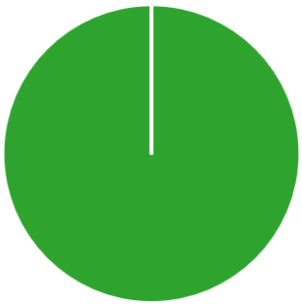
15. Does the Committee review and approve the internal audit plan at the beginning of the financial year?

Yes	8
No	0
Unsure	0



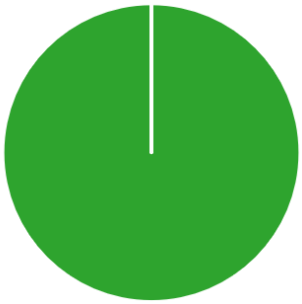
16. Does the Committee approve any material changes to the Internal Audit plan?

Yes	8
No	0
Unsure	0



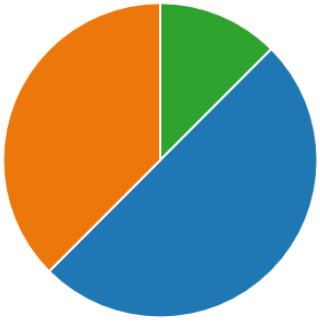
17. Does the Committee effectively monitor the implementation of management actions arising from Internal Audit reports?

Yes	8
No	0
Unsure	0



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?

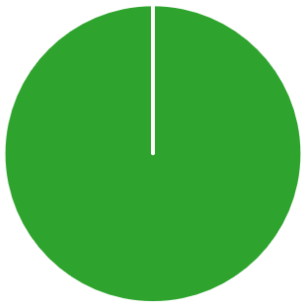
Yes	6
No	0
Unsure	2

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

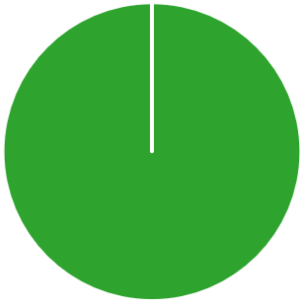
21. Does the Committee receive and monitor actions taken in respect of prior year External Audit plans?

Yes	8
No	0
Unsure	0



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

Yes	8
No	0
Unsure	0

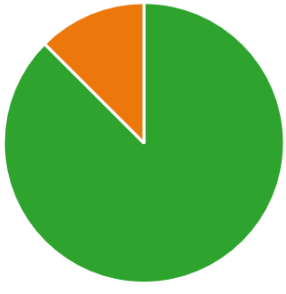


23. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Needs Improvement	0
Adequate	1
Strong	7

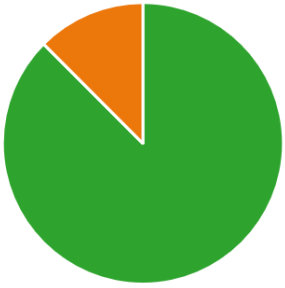
24. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Yes	7
No	0
Unsure	1



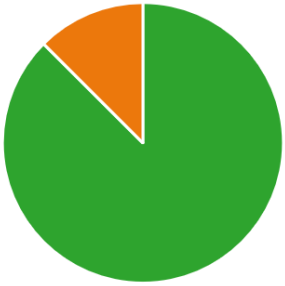
25. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

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

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

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.

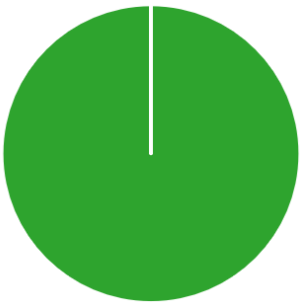
Needs Improvement	0
Adequate	1
Strong	7

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

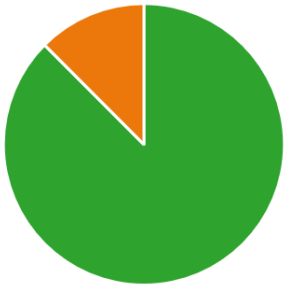


34. The Committee agenda-setting process is thorough and led by the Committee Chair.

Needs Improvement	0
Adequate	1
Strong	7

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

Yes	7
No	0
Unsure	1

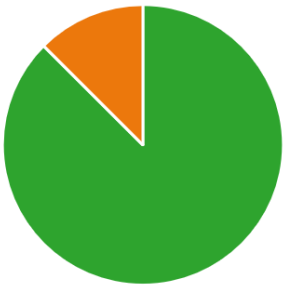


36. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

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



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.

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.

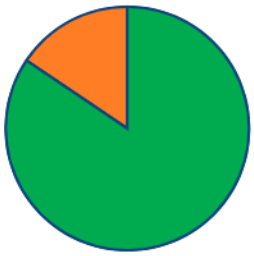
Strong	11
Adequate	2
Needs Improvements	0

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



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.

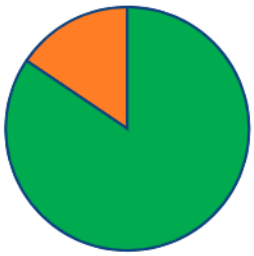
Strong	10
Adequate	2
Needs Improvements	1

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



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

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

- 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

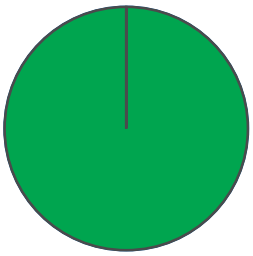
Appendix 5

Finance

Responses: **5**

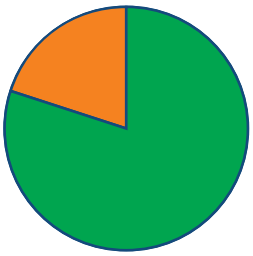
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	5
Adequate	0
Needs Improvements	0



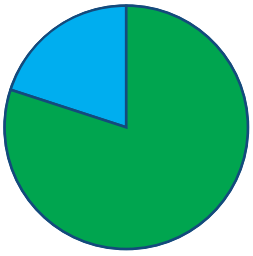
2. The Board was active in its consideration of Committee composition.

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?

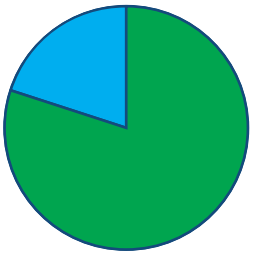
Yes	4
No	0
Unsure	1



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

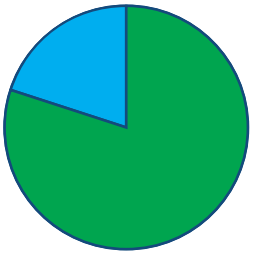
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	4
No	0
Unsure	1



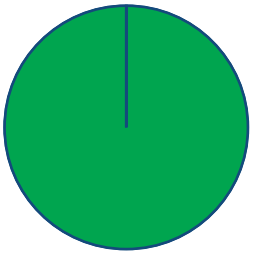
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	4
No	0
Unsure	1



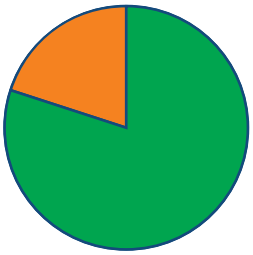
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	5
Adequate	0
Needs Improvement	0



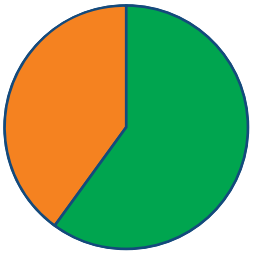
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Strong	4
Adequate	1
Needs Improvement	0



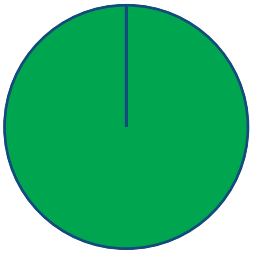
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

Strong	3
Adequate	2
Needs Improvement	0



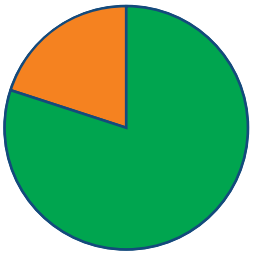
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

Strong	5
Adequate	0
Needs Improvement	0



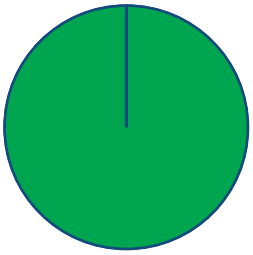
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Strong	4
Adequate	1
Needs Improvement	0



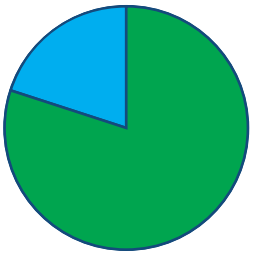
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	5
Adequate	0
Needs Improvement	0



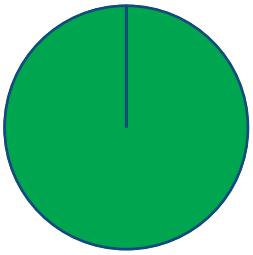
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	4
No	0
Unsure	1



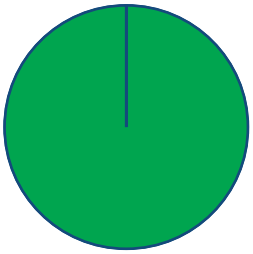
13. Are Committee members independent of the management team?

Yes	5
No	0
Unsure	0



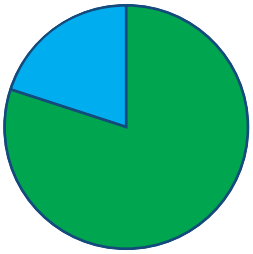
14. The Committee agenda-setting process is thorough and led by the Committee Chair.

Strong	5
Adequate	0
Needs Improvement	0



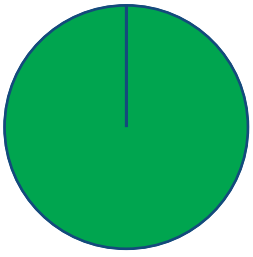
15. Has the Committee established a plan for the conduct of its work across the year?

Yes	4
No	0
Unsure	1



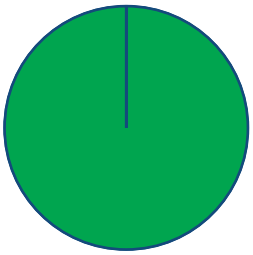
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

Yes	5
No	0
Unsure	0



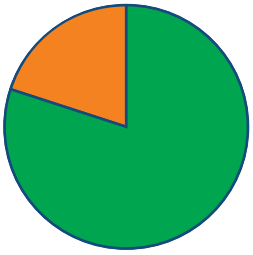
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

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



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.

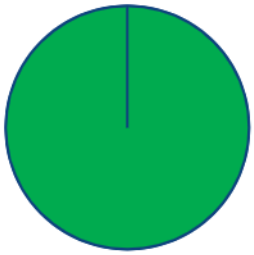
Strong	2
Adequate	1
Needs Improvements	0

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

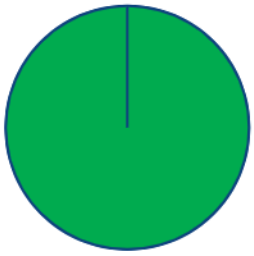
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

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

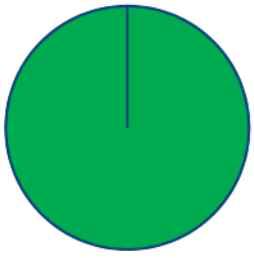


6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

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



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.**

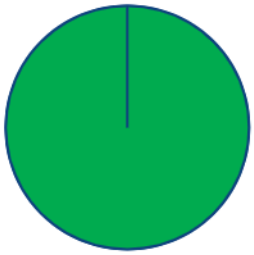
Strong	2
Adequate	1
Needs Improvements	0

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

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

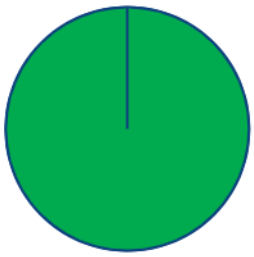


12. **Are changes to the Committee's current and future workload discussed and approved at Board level?**

Yes	2
No	0
Unsure	1

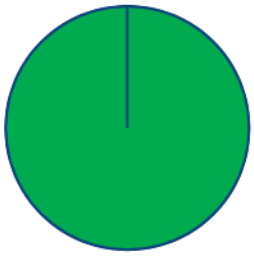
13. **Are Committee members independent of the management team?**

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



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

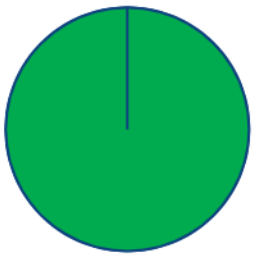
Yes	2
No	0
Unsure	1

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

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 referrs 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 Clincal Boards, with the relevant performance metrics clearly explained and trajectories fully analaysed and explained.
- Effective committee. Well organised. Assurance provided through appropriate scrutiny

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?

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

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.

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

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.

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 fundingraising 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.

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

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

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

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

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

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

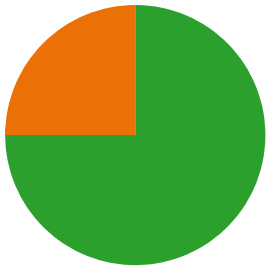
- DHIC maintains a good overview and receives assurance on a wide range of topics under the Digital and Health Intelligence umbrella.
- To the subject matter covered by this committee is crucial to the success of the organization. We are actively considering how to strengthen this.
- The Committee has 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.

Annual Board Effectiveness Survey - Quality, Safety and Experience

8 Responses

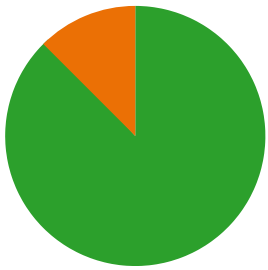
1.The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	2
Needs Improvement	0



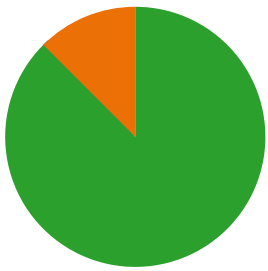
2. The Board was active in its consideration of Committee composition.

Strong	7
Adequate	1
Needs Improvement	0



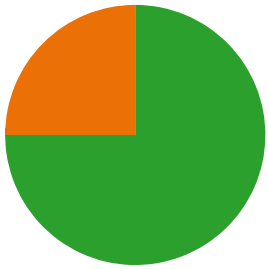
3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Yes	7
No	0
Unsure	1



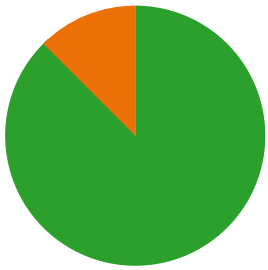
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	7
No	0
Unsure	2



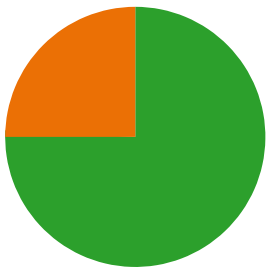
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	7
No	0
Unsure	1



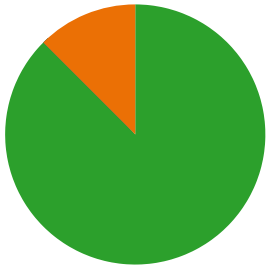
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	2
Needs Improvement	0



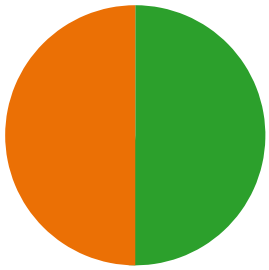
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Yes	7
No	0
Unsure	1



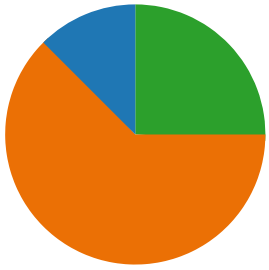
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

Strong	4
Adequate	4
Needs Improvement	0



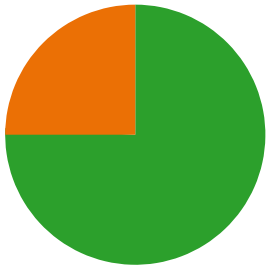
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

Strong	2
Adequate	5
Needs Improvement	1



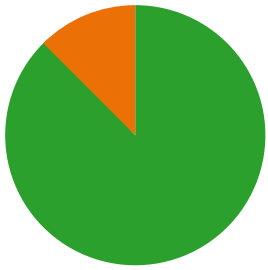
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Strong	6
Adequate	2
Needs Improvement	0



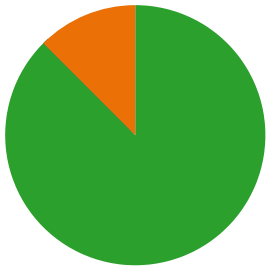
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	7
Adequate	1
Needs Improvement	0



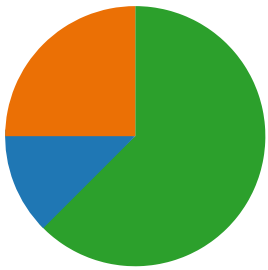
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	7
No	0
Unsure	1



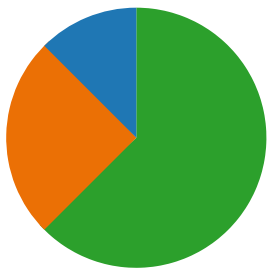
13. Are Committee members independent of the management team?

Yes	5
No	1
Unsure	2



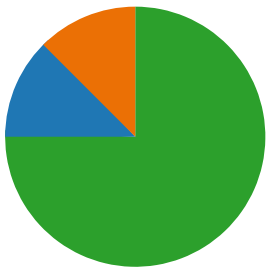
14.The Committee agenda-setting process is thorough and led by the Committee Chair.

Strong	5
Adequate	2
Needs Improvement	1



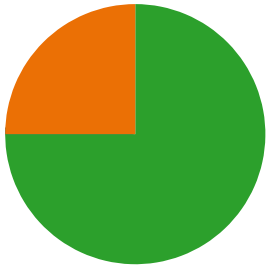
15. Has the Committee established a plan for the conduct of its work across the year?

Yes	6
No	1
Unsure	1



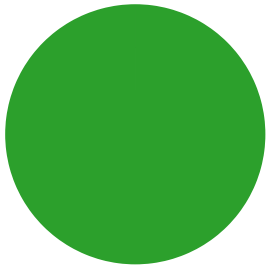
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

Yes	6
No	0
Unsure	2



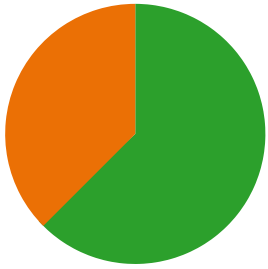
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

Yes	8
No	0
Unsure	0



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

Strong	5
Adequate	3
Needs Improvement	0



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.

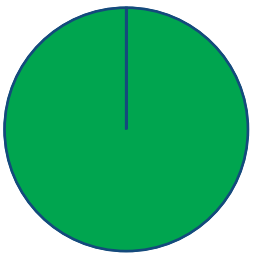
Annual Board Effectiveness Survey

Health & Safety - Appendix 10

Response: **5**

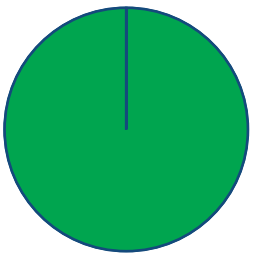
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	5
Adequate	0
Needs Improvements	0



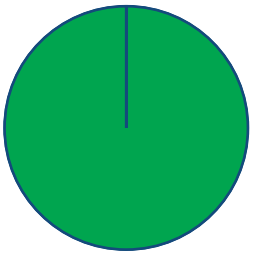
2. The Board was active in its consideration of Committee composition.

Strong	5
Adequate	0
Needs Improvements	0



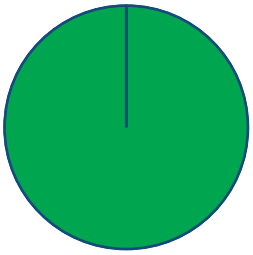
3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Yes	5
No	0
Unsure	0



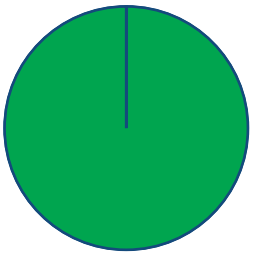
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	5
No	0
Unsure	0



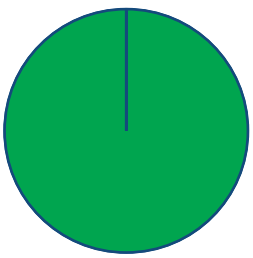
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	5
No	0
Unsure	0



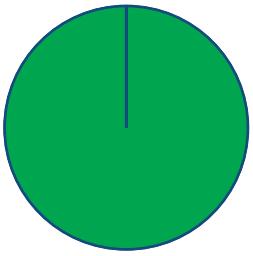
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	5
Adequate	0
Needs Improvements	0



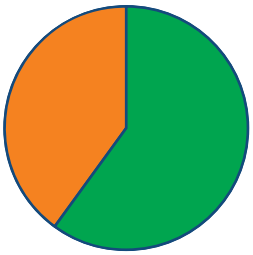
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Strong	5
Adequate	0
Needs Improvements	0



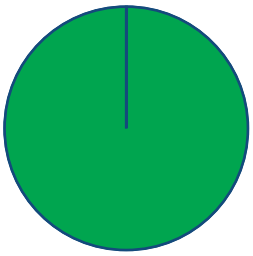
8. **The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.**

Strong	3
Adequate	2
Needs Improvements	0



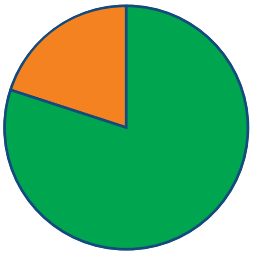
9. **Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.**

Strong	5
Adequate	0
Needs Improvements	0



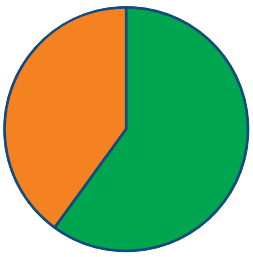
10. **Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.**

Strong	4
Adequate	1
Needs Improvements	0



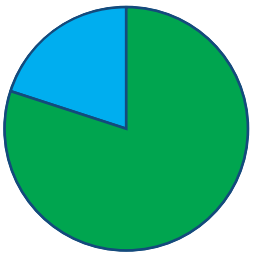
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	3
Adequate	2
Needs Improvements	0



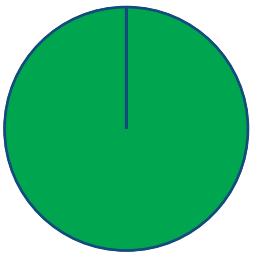
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	4
No	0
Unsure	1



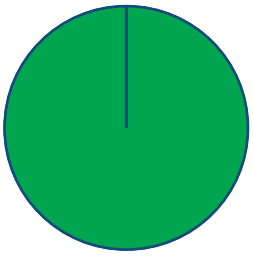
13. Are Committee members independent of the management team?

Yes	5
No	0
Unsure	0



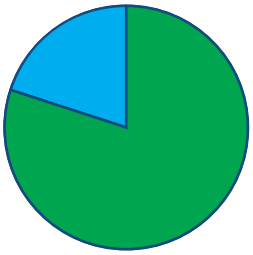
14. The Committee agenda-setting process is thorough and led by the Committee Chair.

Strong	5
Adequate	0
Needs Improvements	0



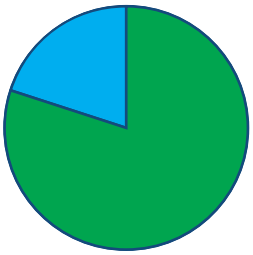
15. Has the Committee established a plan for the conduct of its work across the year?

Yes	4
No	0
Unsure	1



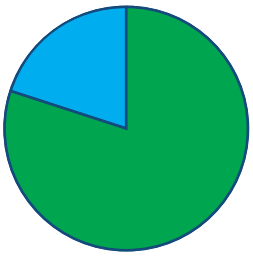
16. **Has the Committee formally considered how its work integrates with wider performance management and standards compliance?**

Yes	4
No	0
Unsure	1



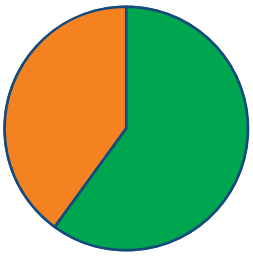
17. **Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?**

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



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.

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?

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

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.

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.

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.

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.

Annual Board Effectiveness Survey

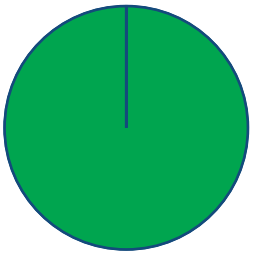
Renumeration and Terms of Service Committee

Appendix 12

Responses: **6**

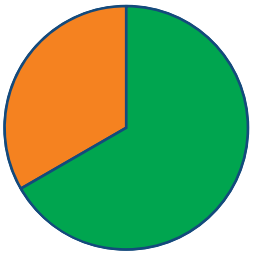
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	0
Needs Improvements	0



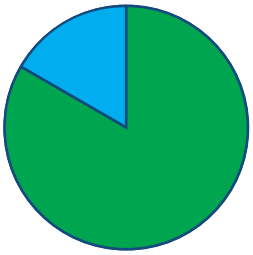
2. The Board was active in its consideration of Committee composition.

Strong	4
Adequate	2
Needs Improvement	0



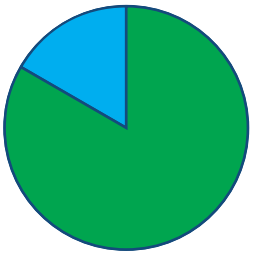
3. Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

Yes	5
No	0
Unsure	1



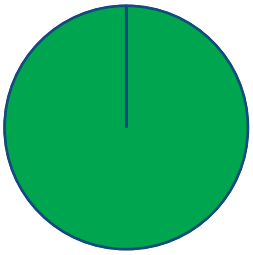
4. Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?

Yes	5
No	0
Unsure	1



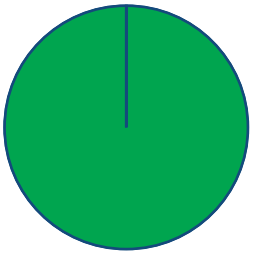
5. Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?

Yes	6
No	0
Unsure	0



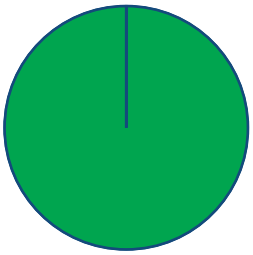
6. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.

Strong	6
Adequate	0
Needs Improvement	0



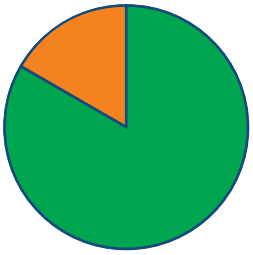
7. The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

Strong	6
Adequate	0
Needs Improvement	0



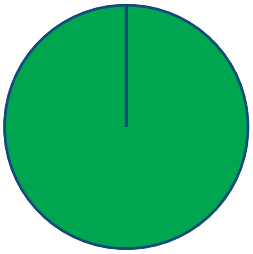
8. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.

Strong	5
Adequate	1
Needs Improvement	0



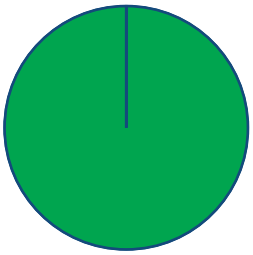
9. Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.

Strong	6
Adequate	0
Needs Improvement	0



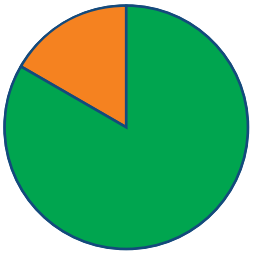
10. Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

Strong	6
Adequate	0
Needs Improvement	0



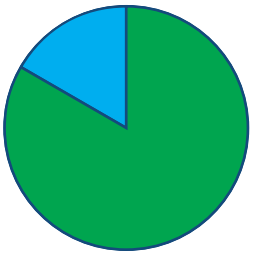
11. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

Strong	5
Adequate	1
Needs Improvement	0



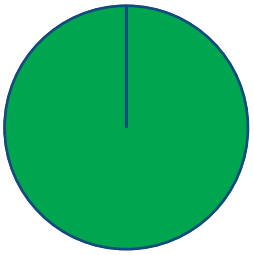
12. Are changes to the Committee's current and future workload discussed and approved at Board level?

Yes	5
No	0
Unsure	1



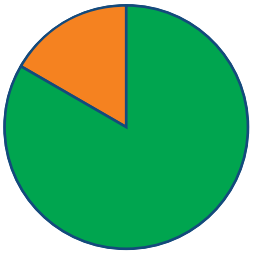
13. Are Committee members independent of the management team?

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

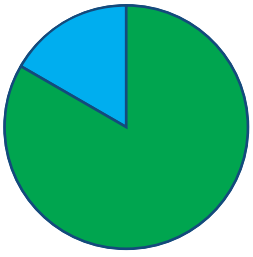


15. Has the Committee established a plan for the conduct of its work across the year?

Yes	2
No	1
Unsure	3

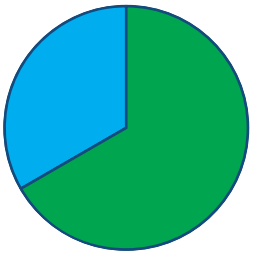
16. Has the Committee formally considered how its work integrates with wider performance management and standards compliance?

Yes	5
No	0
Unsure	1



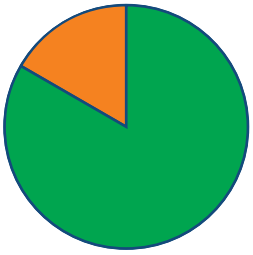
17. Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?

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



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 it responsibilities. One area I am unsure is how the RATS committee minutes are a 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.

Report Title:	Annual Review of the Standing Orders				Agenda Item no.	7.4	
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	11 May 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		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

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 undertaking 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
10/05/2023 15:10:05

Archwilio Cymru
Audit Wales

Cardiff and Vale University Health Board – Detailed Audit Plan 2023

Audit year: 2023

Date issued: April 2023

Document reference: 3532A2023

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Our aims and ambitions

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

I have completed much of my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2023.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', the regularity of the income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the financial statements being misled. The levels at which I judge such misstatements to be material is set out later in this plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

The majority of my performance audit work is conducted using INTOSAI (International Organisation of Supreme Audit Institutions) auditing standards. INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Your audit at a glance

My financial statements audit will concentrate on your risks and other areas of focus

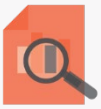
My audit planning has identified the following risks:

The current significant financial statement risks include:

- compliance with the rolling three-year resource limits under the NHS Finance (Wales) Act 2014;
- the valuation of the Health Board's estate;
- the introduction of the new accounting standard (IFRS16)[1] leases;
- the accuracy of the remuneration report disclosures;
- the accuracy and completeness of the related party disclosures; and
- management override of the controls in place.

Other areas of audit focus:

- the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff.



My performance audit will include:

- Structure Assessment – Core
- Structured Assessment – Deep dive review of investment in digital
- All Wales thematic review of planned care service recovery
- Local project work - Examination of the Setting of Well-being Objectives
- Local project work - Follow-up of 2019 Clinical Coding follow-up review

[1] International Financial Reporting Standard 16.

Materiality

Materiality	£17.3 million
Reporting threshold	£865,000

Financial statements materiality

Materiality £17.3 million

My aim is to identify and correct material misstatements, that is, those that might cause the user of the financial statements to be misled.

For planning purposes, I calculate materiality using:

- the 2021-22 gross expenditure of £1.733 billion; and
- a materiality percentage of 1%.

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

There are some areas of the financial statements that may be of more importance to the user of the financial statements, and I therefore set a lower materiality level. These areas are the:

- Remuneration report (including exit packages), £1,000, or lower if a misstatement results in the wrong remuneration-banding being disclosed for an individual;
- Related party disclosures, £10,000; and
- Outturn against the revenue and capital resource limits, £1.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks. My planning to date has identified the following risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
Under the NHS Finance (Wales) Act 2014, health boards moved to a rolling three-year resource limit for both revenue and capital. For 2022-23 and the three years to 31 March 2023, the Health Board forecasts[2] to exceed its revenue resource limit by £26.9 million. This outcome could affect my regularity opinion, as the Health Board has experienced for some of its past financial years.	I monitor the Health Board's financial position for 2022-23 and the cumulative three-year position to 31 March 2023. My review will also consider the impact of any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2022-23 financial statements. I would also expect to place a substantive report on the statements to explain

[2] Based on the Health Board's 'month 11' financial reporting to the Welsh Government.

	the basis of the qualification and the circumstances under which it had arisen.
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date of 31 March 2023.	I will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Welsh Government's Manual for Accounts; and consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.
A new accounting standard, IFRS16[3] Leases, has been introduced from 2022-23. The standard significantly changes how most leased assets are to be accounted for, with leased assets needing to be recognised as assets and liabilities in the Statement of Financial Position (the balance sheet). There are also significant additional disclosure requirements specific to leased assets that need to be reflected in the financial statements.	I will: • consider the completeness of the lease portfolios identified by the Health Board, as needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the new requirements; and • ensure that all material disclosures have been made. As part of my audit planning I have liaised with officers and provided them with the main audit questions to be raised.

[3] International Financial Reporting Standard 16.

I audit some of the disclosures in the remuneration report to a far lower level of materiality, as set out on page 8. The disclosures are therefore more prone to material misstatement. In some of the past audits I have identified material misstatements in the remuneration report, which the Health Board corrected. I therefore judge the 2022-2023 disclosures to be at risk of misstatement. There is also the regularity risk that the Health Board remunerates senior officers above the Welsh Government's pay bands, but without the Welsh Government's formal approval to do so.	I will examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration is at the appropriately approved levels.
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. In some of my past audits I have identified omitted or incorrect disclosures, which were material and required correcting.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.

Other areas of focus

I set out other identified areas of focus, or risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
The ongoing impact if the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff. Last year I qualified my regularity opinion, and I placed a substantive report on the statements to explain the reasons. Principally, that the expenditure relating to the scheme contravenes the requirements of Managing Welsh Public Money.	Last year, I qualified my regularity opinion in respect of clinician's pension tax compensation scheme and placed a substantive report on the financial statements explaining my rationale. For 2022-23, whilst any transactions included in the Health Board's financial statements strictly remain irregular, I am not classifying them as material by their nature. I consider that a further qualification of my regularity opinion would have a diminishing value, particularly against the backdrop of the Chancellor of the Exchequer abolishing the Lifetime Allowance in his March 2023 budget statement".

Financial statements audit timetable

I set out below key dates for delivery of my financial audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	February to March 2023	March 2023
2023 Detailed Audit Plan	February to May 2023	April 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements • Audit of Financial Statements Addendum Report	February to July 2023	July 2023 July 2023 September 2023

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Theme	Approach	Timescales
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2023 structured assessment work will review the following core areas: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2023 with reporting by the end of October 2023.
Structured Assessment - deep dive review of investment in digital	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth.	Fieldwork to commence during the autumn of 2023 and reporting by April 2024.

	This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	
All Wales thematic review of planned care service recovery	I plan to undertake work following on from my national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork to commence between November and December 2023 and reporting by April 2024.
Local project work - Examination of the Setting of Well-being Objectives	My audit team will assess the extent to which the Health Board has acted in accordance with the sustainable development principle when setting its well-being objectives as part of its arrangements for refreshing the organisation's long-term strategy.	Timing of fieldwork to be confirmed, reporting by April 2024.
Local project work – Follow-up of 2019 Clinical Coding follow-up review	My audit team will review the Health Board's progress in addressing the recommendations I made in my 2019 clinical coding follow-up review.	Timing of fieldwork to be confirmed, reporting by April 2024.

Further to the outputs set out in **Exhibits 3 and 4**, we also produced an Annual Audit Report for 2023.

Fee and audit team

In January 2023, I published the fee scheme for the 2023-24 year as approved by the Senedd Finance Committee. My fee rates for 2023-24 have increased by 4.8% for inflationary pressures. In addition, my financial audit fee has a further increase of 10.2% for the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I estimate your total audit fee will be £437,662.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables document sets out the expected working paper requirements to support the financial statements, with timescales and officer responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee[4]

Audit area	Proposed fee for 2023 (£)[5]	Actual fee for 2022 (£)
Audit of Financial Statements	**268,528**	**225,583**[6]
Performance audit work:		
• Structured Assessment	85,622	83,576
• All-Wales thematic review	46,180	43,892
• Local projects	37,332	33,994
Performance work total	**169,134**	**161,462**
Total fee	**437,662**	**387,045**

[4] There will be a separate audit plan for the audit of the 2022-23 charity account.

[5] The fees shown in this document are exclusive of VAT, which is not charged to you.

[6] The 2022 fee estimate was £233,503. The actual fee was £225,583 because there was a rebate of £7,920.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Engagement Director & Audit Director (Performance Audit)	Dave.Thomas@audit.wales 02920 320604
Anthony Veale	Audit Director (Financial Audit)	Anthony.Veale@audit.wales 02920 320585
Mark Jones	Audit Manager (Financial Audit)	Mark.Jones@audit.wales 02920 320631
Darren Griffiths	Audit Manager (Performance Audit)	Darren.Griffiths@audit.wales 02920 320591
Rhodri Davies	Audit Lead (Financial Audit)	Rhodri.Davies@audit.wales 02920 320637
Urvisha Perez	Audit Lead (Performance Audit)	Urvisha.Perez@audit.wales 02920 320610
Natalie Painter	Senior Auditor (Financial Audit)	Natalie.Painter@audit.wales 02920 320500

I can confirm that my team members are all independent of the Health Board and your officers. There are two potential conflicts of interest that we draw to your attention. They relate to Mark Jones, in that his cousin is the Health Board's Counter Fraud Manager (CFM) and the CFM's wife is a Consultant in Paediatric Endocrinology and Diabetes at the Health Board. Arrangements are in place to manage these circumstances. I will update you of any new circumstances that arise during the audits.

Staff secondment

Jessica Cross, one of our apprentice auditors, is currently seconded to the Health Board until 30 June 2023. To safeguard against any potential threats to auditor independence and objectivity, the following restrictions apply in line with the FRC's Revised Ethical Standard 2019:

- the secondee will not undertake any line management or management responsibilities; and
- the secondment is restricted to a set maximum of six months.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2021.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Appendix 1

The key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Report Title:	Counter Fraud Annual Report 2022-23			Agenda Item no.	8.1
Meeting:	Audit and Assurance Committee	Public	✓	Meeting Date:	11th MAY 2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	Information	✓
Lead Executive:	Catherine Phillips				
Report Author (Title):	Gareth Lavington Counter Fraud Manager				

Main Report
Background and current situation:

Counter Fraud Annual Report detailing counter fraud work carried out for the period 01/04/2022 – 31/03/2023. The report sets out the resources deployed and the activities undertaken by the counter fraud department against its annual work plan for the year. It details the costs involved in the provision, the days worked and focusses on key areas of achievement against the NHS Counter Fraud Authority Requirements.

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

Agreed and approved by Executive Director Finance.

At the start of the year 500 days were planned for. Only 362 days have been provided to Cardiff and Vale UHB in this fiscal year. The reduction in these days has been the result of a number of issues: The department was understaffed for a period of time; Cardiff and Vale UHB Counter Fraud Team provides a service to a total of six organisation's (DHCW, HEIW, Velindre, PHW, and NWSSP). Due to the dynamic nature of reactive fraud investigation, and the resulting risk and deterrence activity that follows, resources can be drawn away to a particular organization for a significant amount of time. This will clearly then impact upon the allocation of resources to the other organisations; this was evident this year, when a resource heavy investigation was carried out on behalf of Digital Health and Care Wales, which drew significant resources, and resulted in more provision than was planned for them; a higher than normal volume of fraud referrals received by Health Education and Improvement Wales also drew resources away and resulted in the provision of more days than planned.

Whilst the amount of time available to the CAVUHB Counter Fraud provision has not met that planned for, assurance as to the standard of service provided that has been measured against NHS Counter Fraud functional standards is provided in the main body of the report. A functional standard return will also be provided to the NHS CFA who may choose to quality assess the contents of the report against work undertaken.

The Audit and Assurance Committee are asked to review, discuss and approve this report as it is used along with other documents to inform upon the quality and success of the Counter Fraud provision supplied for the year.

Recommendation:

The Committee is requested to:

a) Review, discuss, question and approve the report as an accurate assessment of the work undertaken during the year and a measure of compliance with the standards set out by the NHS CFA.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: 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:

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

NHS WALES
Cardiff and Vale University Health Board

Annual Counter Fraud Report
01/04/2022 - 31/03/2023

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. INTRODUCTION

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS') to provide a written report at least annually to Cardiff and Vale University Health Board (CAVUHB) on Counter Fraud work undertaken. All NHS organisations, in compliance to their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance to the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of incident reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made.

Further to this at Appendix 1 a comprehensive breakdown of the activities of the Counter Fraud Team for the financial year is provided, along with benchmarking data from the previous year. The aim of this is to provide relevant outcome based metric data to identify areas of strength and areas of need. This data is then used to inform the workplan for the coming year.

This report has been complimented throughout the year with detailed progress reports presented to the Audit Committee and additional briefings being presented to the Executive Director of Finance. Following acceptance and approval by the Audit Committee, this Counter Fraud Annual Report will be distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance and compliance team for review if requested.

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care (DHSC). For more information, the NHSCFA website is www.cfa.nhs.uk. For the purposes of

this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss.

2. SUMMARY OF COMPLIANCE

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales Directors of Finance meeting on 19th February 2021.

The section below highlights how LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects summarised. The NHS CFA measures compliance as follows: Green – fully compliant; Amber – partially compliant; Red – non-compliant. The self-assessment provided below, is monitored and tested by the NHS Counter Fraud Authority by way of compliance visits to the local team.

(A similar breakdown of the actions undertaken by the LCFS team in direct measurement against the Standard requirements for 2021-2022 will be recorded in the NHS CFA Functional Standard Return. This is due for completion by 31st May 2022. This document will be completed by the Counter Fraud Manager and is required to be submitted to the Director of Finance and the Audit Committee Chair for sign-off prior to submission to the NHS CFA.)

- Accountable Individual and Audit Assurance

The LCFS' overall governance is held by the Executive Director of Finance. The LCFS' has ensured to notify her of any referrals received and regular updates are provided throughout the investigation process. Additional to this, the LCFS' have extended this exchange of information to ensure that where appropriate, the senior workforce members have been briefed where aspects of a Counter Fraud investigation may overlap with that of a

disciplinary concern. During the course of the year regular updates and meetings have taken place between the LCFS and DoF, Head of Internal Audit, the Counter Fraud Champion and other senior managers where appropriate.

The LCFS is an invited member of the Audit Committee and as such has presented regular progress reports of Counter Fraud work undertaken throughout the year. All quarterly progress reports have been provided to committee in a timely manner in order that they are appraised prior to the meetings. The Counter Fraud Manager has attended as required any Audit Committee pre-meetings with the Independent Members, Internal Audit and Audit Wales. The Annual Plan has now been completed and has received approval from Director of Finance and Audit Committee. The Govt. Standard 013; NHS Requirements Functional return has been completed and submitted to the NHS Counter Fraud Authority Compliance Team.

GREEN

- Counter Fraud Bribery and Corruption Strategy / Policy and Response Plan

The organisation has a Counter Fraud, Bribery and Corruption Policy. This has been reviewed, updated and amended to ensure that it is fit for purpose and fully aligned to the NHS CFA strategy. The new amended policy requires approval and ratification from Audit Committee. When achieved the policy will be available to staff via the Intranet and will continue to be promoted during fraud awareness work carried out by the team throughout the year. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible. The LCFS team this year has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

AMBER

- Risk Assessment

The LCFS' team have, where appropriate continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy which aims to strengthen the wider practices to reducing the risk of fraud through poor policy or governance controls. Throughout the year the team has carried out risk profiling work in relation to the organisation. Over one hundred and fifty inherent fraud risks to all NHS Organisations have thus far been identified by the NHS Counter Fraud Authority. These are not all relevant to all organisations. Twenty-Seven (27)

Fraud Risks have been identified as being directly relevant to Cardiff and Vale UHB. A report of this Risk Profile has been provided to Audit Committee (February 2023). Work has commenced into carrying out comprehensive fraud risk assessments into these areas. The Organisational Fraud Risk Profile will remain a 'living' document. Further to the inherent risks known, specific risks are also added to the profile as they arise as a result of investigation or external reporting e.g. Thematic Exercise, Fraud Prevention Notice, Local Intelligence Report. (A breakdown of the risk assessments carried out is provided below.) Where local risks have been identified, assessment work has been carried out accordingly.

During the course of the year, work continued to been undertaken in relation to the NHSCFA Thematic Exercise that was delayed due to the Coid Pandemic (Mandate Fraud Risk, Invoice Fraud Risk, Supplier Fraud Risk). A compliance visit was carried out in October by the NHSCFA compliance and accountability team. The result of this visit was positive. The written report in relation to the work carried out by NHS Wales Counter Fraud teams is due but has not yet been received.

In order to comply with the organisational risk management policy a new system of reporting has been introduced. A new Fraud Risk Assessment Document that complies with local procedure has been developed and implemented. All fraud risk work is now reported on the CLUE case management system and each report remains open with a review date placed upon it. This is to ensure that fraud risks remain under constant review. Every fraud risk that is assessed is now reported to relevant stakeholders by way of the new document. Requests are then made for this risk to be added to the local risk register. All fraud risk assessment work is reported to the Audit Committee by way of quarterly progress reports. Further in-house training has been provided to staff to ensure consistency in approach.

This is reported as partially compliant as a result of some risks not being added to the local risk register. All other areas of this work are fully compliant with the NHS CFA requirements.

It is anticipated that the All Wales risk reporting module on Datix will be introduced this year that will add further assurance to this model.

AMBER

- Annual Action Plan

An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document has approval / agreement and sign off from the Director of

Finance and has been submitted to Audit Committee for approval. Progress of the LCFS teams work will be reported periodically at the Audit Committee. Due to the nature of Counter Fraud work the plan remains flexible and subject to change throughout the year as new risks and requirements are identified, and investigation referrals received.

GREEN

- Outcome Based Metrics

Throughout the year new data systems have been developed and implemented with the aim of assisting in recording the work of the LCFS team. These new systems supplement existing systems such as ESR, CLUE case management, NFI, and All Wales Statistical reporting. These are constantly measured and statistics produced as at Appendix 1. This has been carried out in the areas of raising awareness, investigation, risk, awareness, joint working, strategic planning, sanctioning, and financial loss and recovery. The service has been successful in documenting direct results. The collection and review of these figures aims to identify the effectiveness of the team and its activity in all areas of its work with a view to the identification of areas that are proving effective and areas that may require further resource or improvement.

GREEN

- Reporting Routes

Staff and contractors have been made aware throughout the year of the reporting routes available to them. In the last year these included direct contact with the team via email, phone and in person, the use of the online CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers, and an internal reporting interactive form. All instances of fraud reporting have been initially assessed and those that are furthered to formal investigation have been recorded on the case management system (CLUE) and reviewed accordingly. New reporting methods introduced this year involving QR coding, generic email address and Interactive Referral forms have proven effective. They have been publicised by way of the Intranet system, the Counter Fraud Intranet Suite, placement of posters at key venues, Fraud Pop Up stalls, screen saver messaging, all staff News emailing and via awareness sessions. This will continue throughout the upcoming year.

GREEN

- Reporting Identified Loss

The CF team has reported all incidents of suspected fraud, bribery using the CLUE management system that was introduced on 9th April 2021. This reporting tool is used to record all investigations, sanctions, recoveries and losses and also has a mechanism to record system weakness and Local Proactive Exercise work. This system has been supervised by CFS Wales and all information has been used to inform progress reporting to Audit Committee and CFS Wales. All identified loss to fraud is reported in the Annual report. This year for the first time, in compliance with the NHS CFA requirements, figures in relation to prevention have also been recorded and are reported in the body of this document.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators (ACFS) and one fully qualified investigator undertaking accreditation. This accreditation was achieved in July 2022. During the course of the year one full time team member left for another role. This resulted in the team being understaffed by 25% for a period of time totalling one quarter. A recruitment campaign successfully attracted a new team member that commenced in the role in January 2023. This team member is already qualified and accredited. Therefore, at the close of the financial year, the team is made up of four qualified and accredited Counter Fraud Specialist investigators.

GREEN

- Undertake Detection Activity

Where anomalies have been identified through counter fraud work e.g. investigations, the CF team strives to carry out detection activity to assess whether there are any weaknesses present. Where this is the case corrective activity is proactively undertaken to mitigate the identified risk. A PPV programme is undertaken by the organisation and the Counter Fraud Manager attends quarterly meetings in relation to this. Final reports are submitted to counter fraud, and where appropriate an investigation will be started in relation to outlier information. There has been no requirement to commence any investigation as a result of PPV reporting in this year. Regular liaison has taken place with the head of internal audit. Data mining

has also been undertaken within the context of the NFI database and all investigations carried out in relation to the 2020-2021 exercise have now been successfully closed. The new NFI exercise went live on 27th January 2023 and the investigation of high risk matches has begun. All referrals to the team have been fully investigated. All actions taken by the CF team in relation to work in this area have been reported accordingly on CLUE inclusive of any recoveries/preventions made.

GREEN

- Access to and Completion of Training

Due to the aftermath of the COVID situation fraud awareness sessions to staff members continue to be disrupted. However, the team have successfully commenced a program of in person sessions to different staffing cohorts. Remotely delivered sessions have continued in support of this. A new program of remote webinar Fraud Training Sessions and Q and A sessions have been developed and implemented and are open to all members of staff within the organisation. They take place twice a month focussing on General Fraud Awareness and Mandate fraud awareness every other week. It is too early to measure how effective this roll out will be. This requires pre-registration and continues to be advertised throughout the organisation via the communications department.

All wales fraud awareness training has remained available throughout the year via ESR. The report at Appendix 1 shows the uptake of this training module. This module remains non-mandatory training.

A counter fraud newsletter has been published quarterly in order to keep staff appraised. CF team staff have attended all sessions of training provided by CFS Wales and NHS CFA and a number of webinars from NHS CFA have also been undertaken in relation to update training into areas such as risk assessment and CLUE implementation. A full breakdown of Staff CPD undertaken is provided at within the report at Appendix 1.

GREEN

- Policies and Registers for Gifts and Hospitality and Conflicts of Interest

The organisation has in place policies and registers in compliance with this requirement. The register of Conflicts is managed by the Director of Governance and where appropriate liaison with CF can be sought.

GREEN

3. Allocation of Resources

At 31st March 2023 **372** days of Counter Fraud work have been completed against the agreed 500 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year as shown below. The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; interviewing suspects; preparing case files for the Crown Prosecution Service and dev eloping a Fraud Risk Profile for the organisation inclusive of the commencement of formal Fraud Risk related activity. The days provided are less than planned. This has been due to under staffing for a protracted period of time and a higher than normal number of investigations for other organisations. These investigations have been criminal in nature and timeliness is key and therefore they cannot be delayed until a new financial year and will always require immediate attention and take priority.

Strategic Requirements 40 Days

(inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all wales meetings.)

Proactive Work 107 Days

(inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins, detection work including PPV review, system weakness reviews and reporting, Local Proactive work eg pre-employment Risk Assessment. NHSCFA procurement exercise, and National Fraud Initiative work.)

Reactive Work 225 Days

(inclusive of the investigation of all referrals, attendance at court hearings, preparation of reports for disciplinary processes, preparation of reports for professional body investigations.)

4. Summary of Costs

Total Costs	**£ 139,122.00**

5. Breakdown of Investigative work areas

At 1st April 2022 a total of 9 legacy investigations were open and being investigated by the team. These cases are all now complete and closed.

During the course of this financial year a total of 62 new referrals have been received by the team. A total of 27 cases were promoted to formal investigation. A break down of the investigations carried out by the team in this financial year is provided at Appendix 2 (Private Session Only)

6. Sanctions and Recoveries

During the financial year the team has achieved the following sanctions and recoveries.

Disciplinary Sanctions	**5**
Criminal Sanctions	**1**
Professional Sanction	**0**
Financial loss attributed to fraud related activity	**£26,468**
Financial Recoveries	**£26,583 (inc of court costs £115)**
Financial Prevention Figure *	**£18,130**

* as defined by NHS CFA formula.

7. Fraud Awareness

During the period 1st April 2022 – 31st March 2023 a total of (18) awareness sessions were delivered to a total of (310)staff members across the organisation.

8. Fraud Risk Assessments

During the course of the year a Fraud Risk Profile has been developed for the organisation. This has been presented through audit committee. It is intended to be a live document subject to review. As it develops, it will inform future detection and compliance activity via the use of Local Proactive Exercise. The Fraud Risk Profile details the risks identified as inherent to the organisation as identified by the NHS Counter Fraud Authority and the local Counter Fraud Manager. Local/Specific risks will be added to the profile as they arise. These will be informed externally by Fraud Prevention Notices, and intelligence from other agencies and organisations; and, internally, from identified system weakness reporting post/during investigation work.

During this reporting period the following subject areas have been subject to Fraud risk assessment work by the team:

- Mandate Fraud
- Cyber Enabled Mandate Fraud
- Credit Card Terminal Fraud
- Staff Expenses Fraud
- Pre-employment
- Procurement

9. Lines of Reporting

CEO – Suzanne Rankin

Executive Director of Finance – Catherine Phillips

Counter Fraud Manager – Gareth Lavington

LCFS – Nigel Price

LCFS – Nicola Tillings

LCFS – Henry Bales

10. Executive Sign Off / Declaration

I declare that the Counter Fraud work carried out on behalf of Cardiff and Vale Health Board for the year 2021/2022 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Executive Director Finance: Catherine Phillips
Date: 01/04/2023

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

Annual Counter Fraud Report

01/04/2022 - 31/03/2023

APPENDIX 1

Performance Charts

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Contents

Figure 1 – Planned Days vs Actual Days Provided by Counter Fraud Team - 2022-23 (All Organisations)

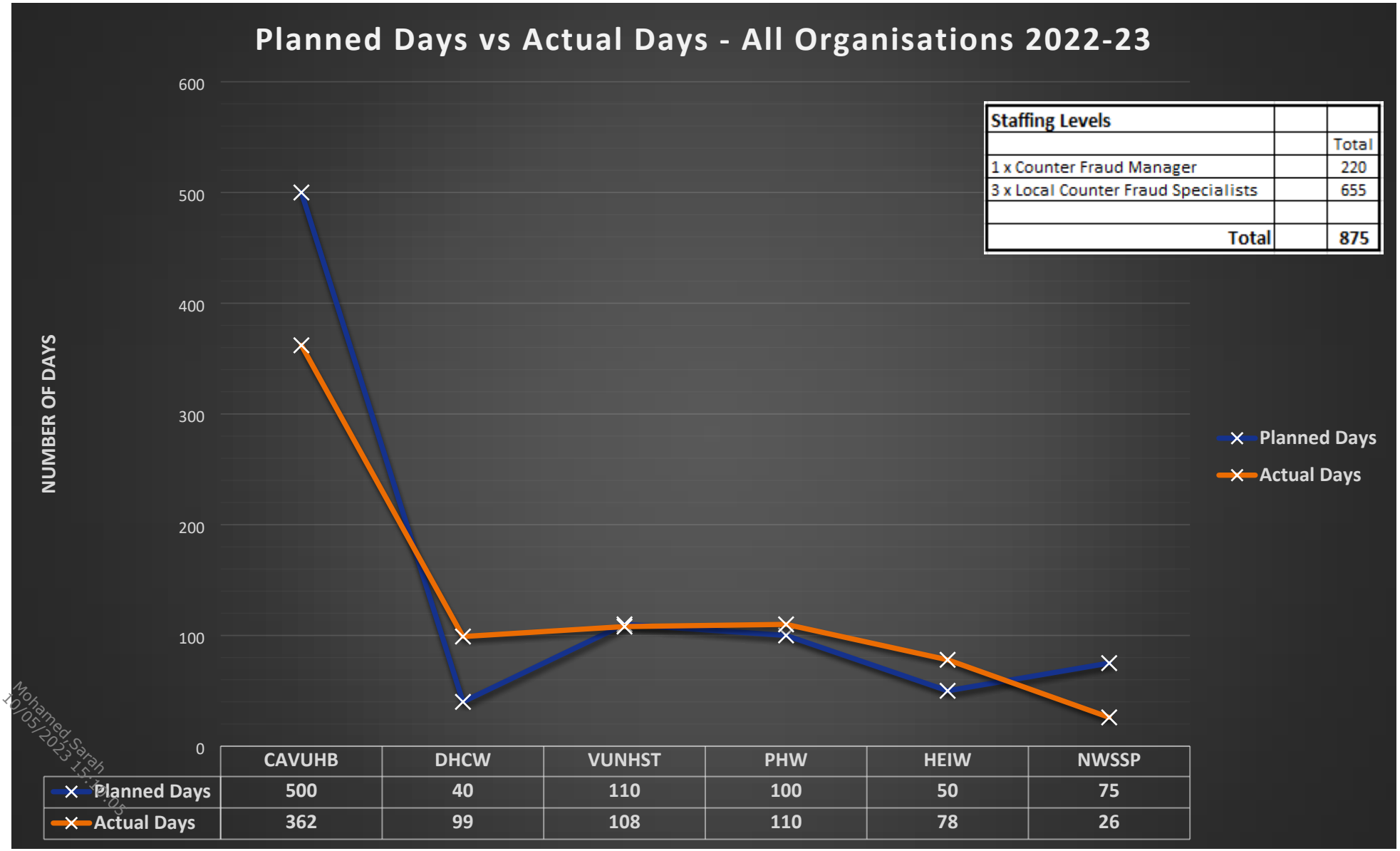


Figure 2 – Referral Forms Submitted to Counter Fraud Team - 2022-2023

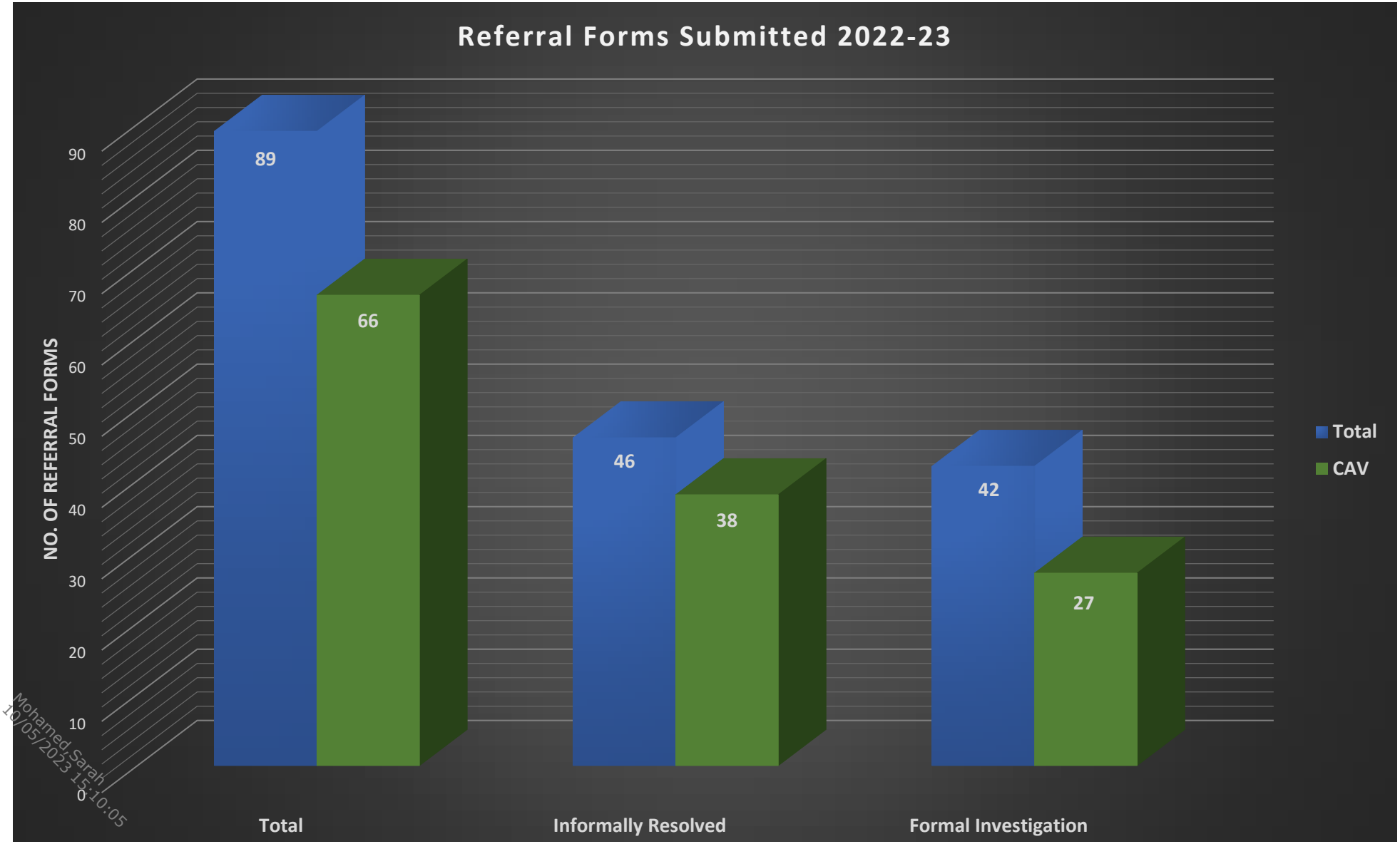
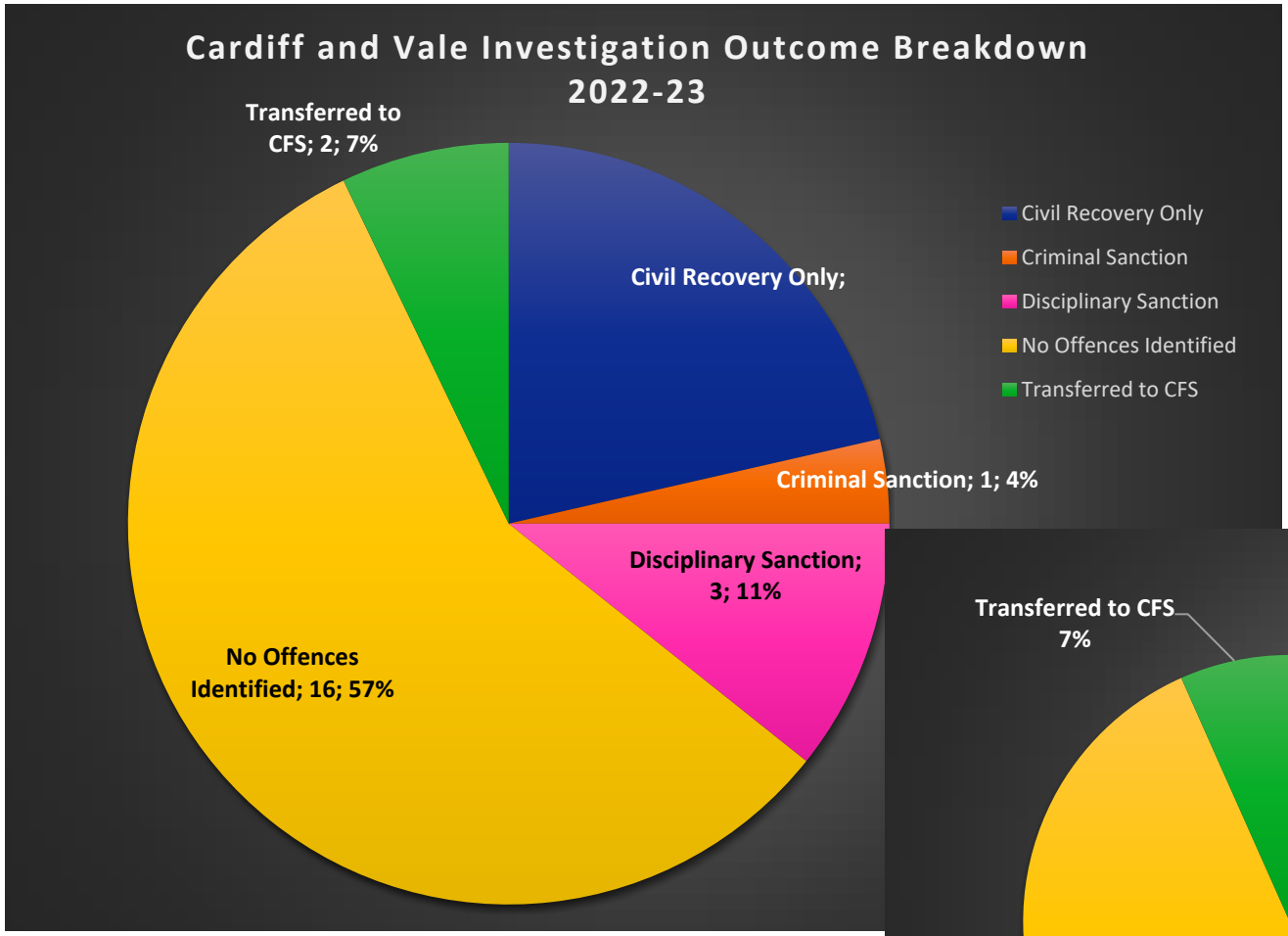


Figure 3 – Investigation Outcome Breakdown – 2022-23



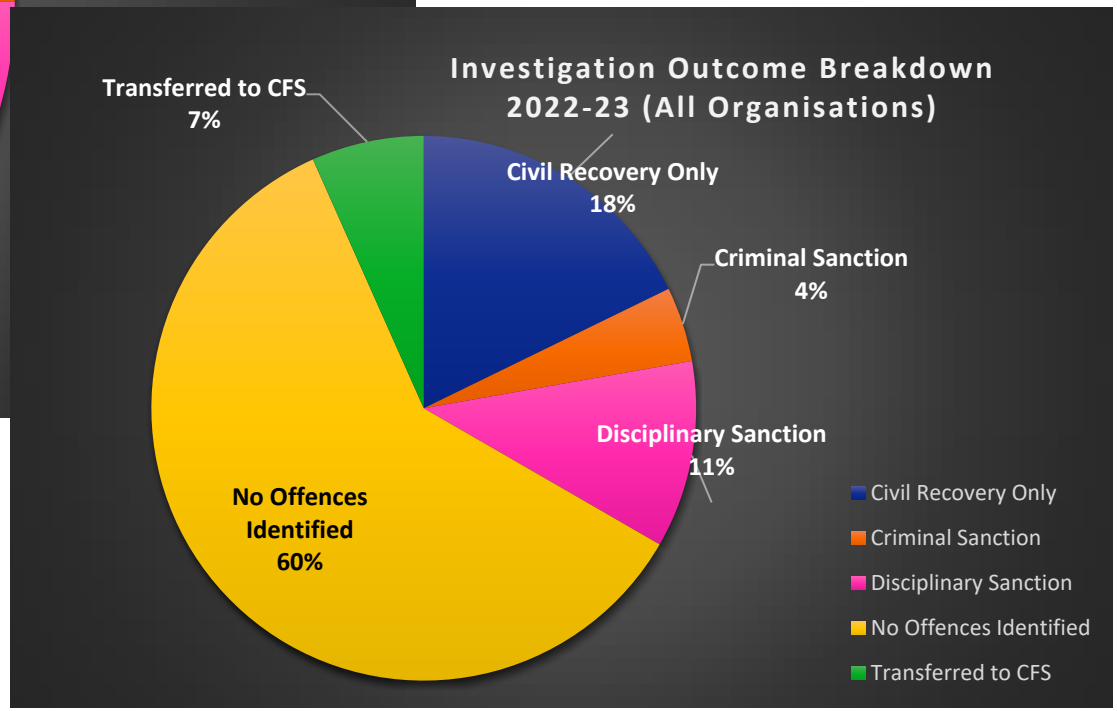


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Figure 4 – Fraud Awareness Sessions by Type – 2022-23

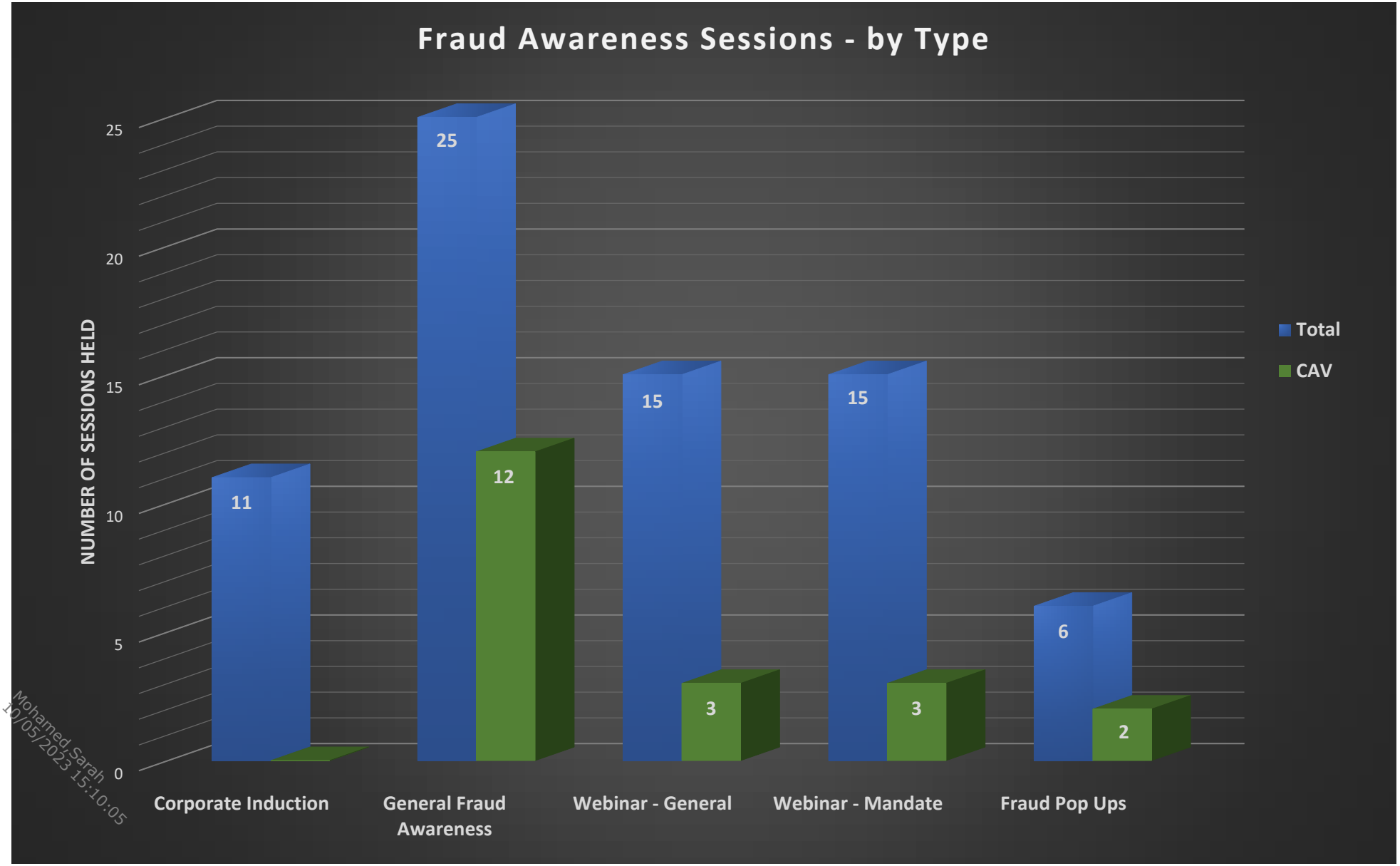
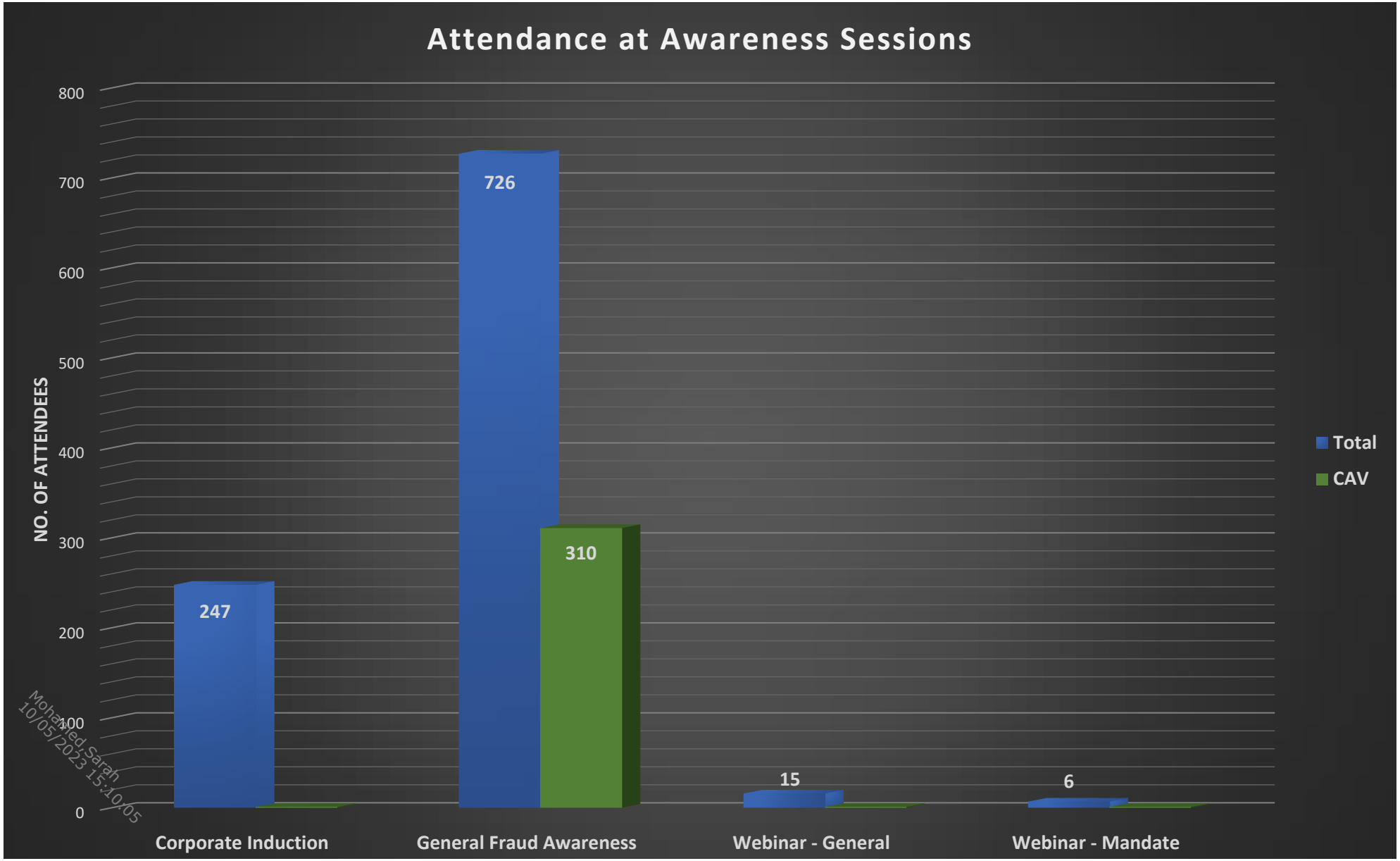


Figure 5 – Attendance at Awareness Sessions – 2022-23



Report Title:	Counter Fraud Bribery and Corruption Policy/Procedure Documents			Agenda Item no.	8.2
Meeting:	Audit and Assurance Committee	Public	✓	Meeting Date:	11th May 2023
		Private			
Status *(please tick one only):*	Assurance		Approval ✓	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		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: 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
10/05/2023 15:10:05

Reference Number: UHB054 **Version Number:** 3	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** T129

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

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.

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.

Reference Number: UHB 054 **Version Number: 3**	**Next Review Date: TBC** **Previous Trust/LHB Reference Number: T129**

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

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.

Table of Contents

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.

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.

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.

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.

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,

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

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).

1.22. Flowcharts

Chart 1

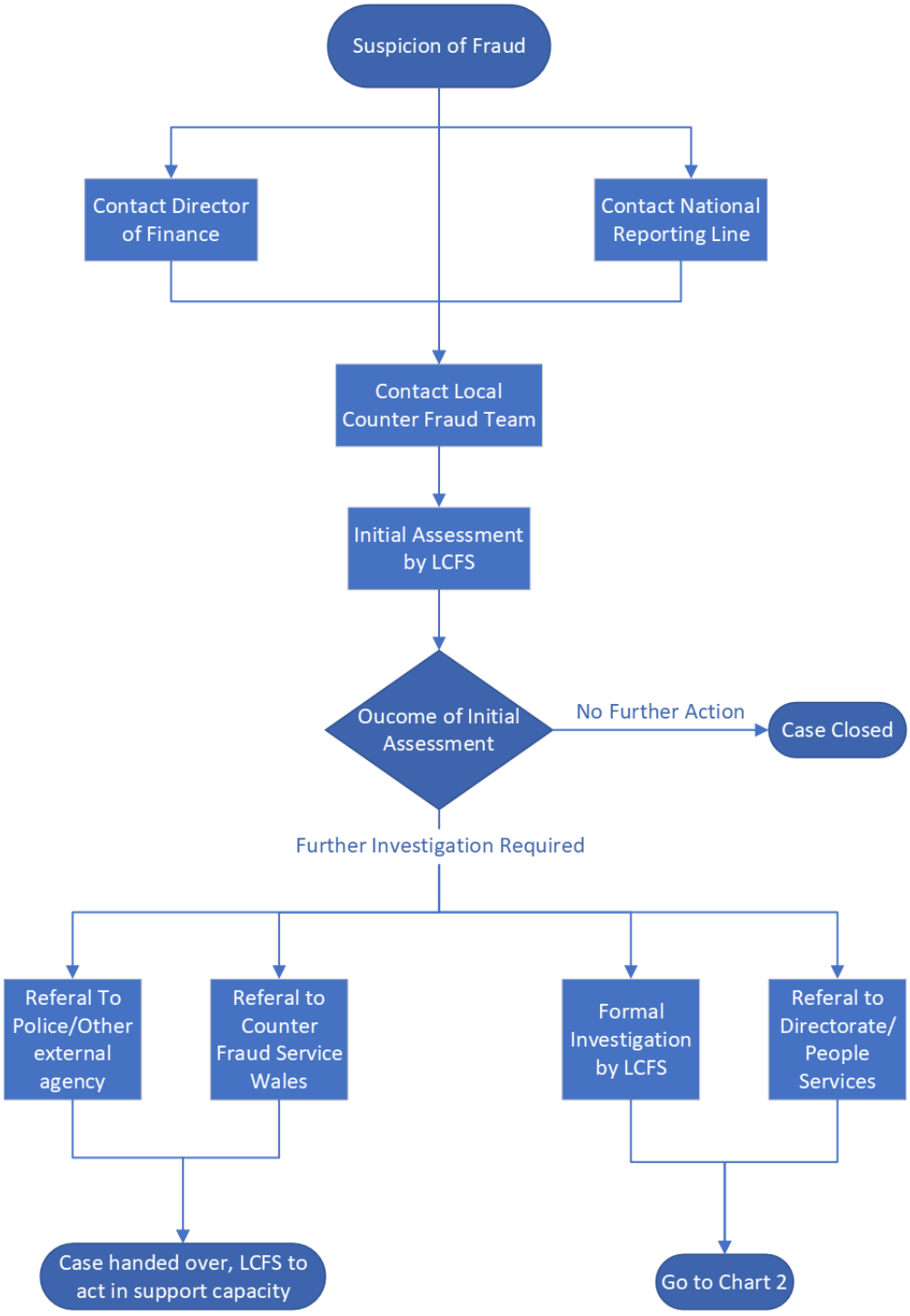


Chart 2 – Local Counter Fraud Investigation

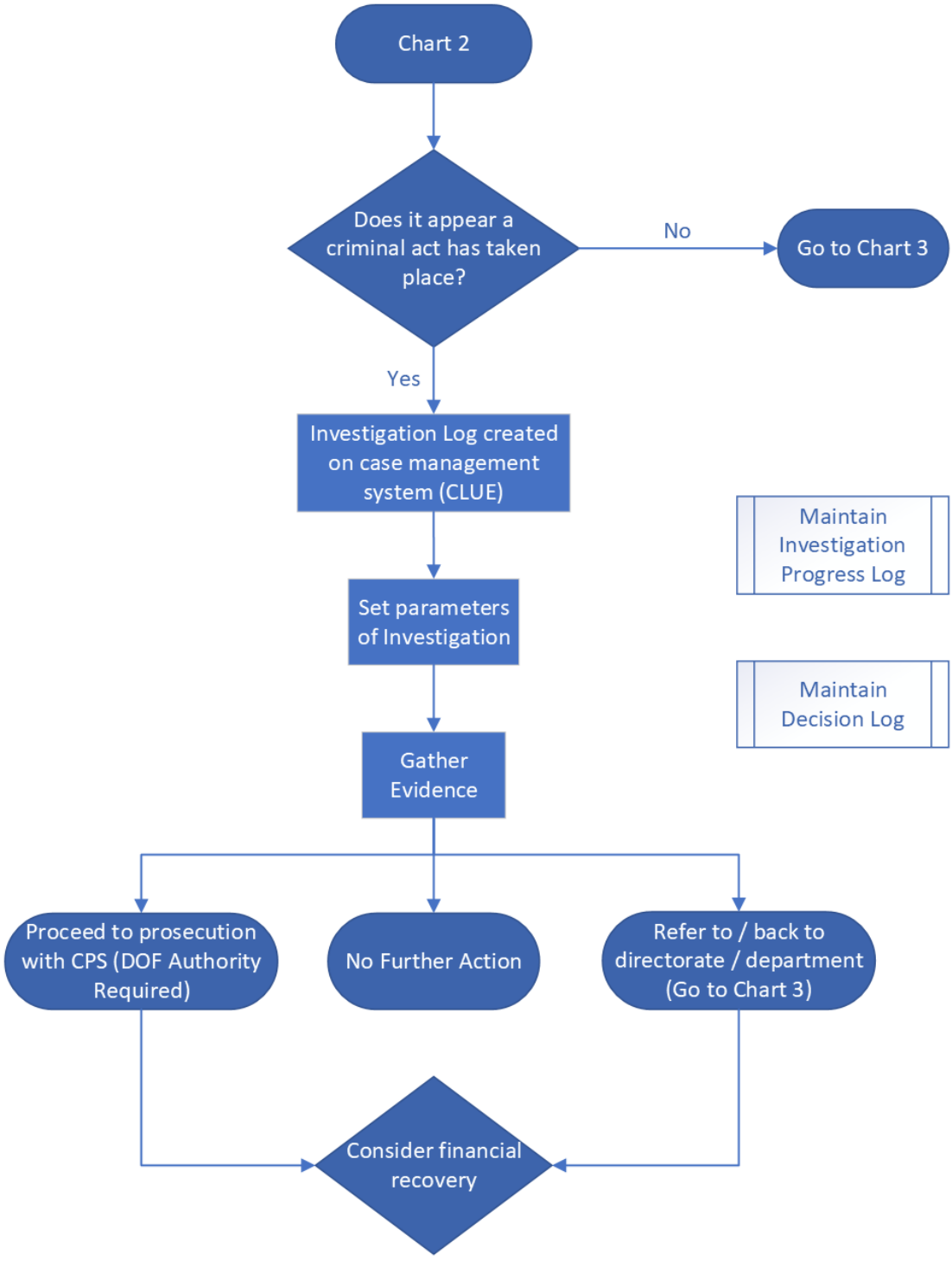
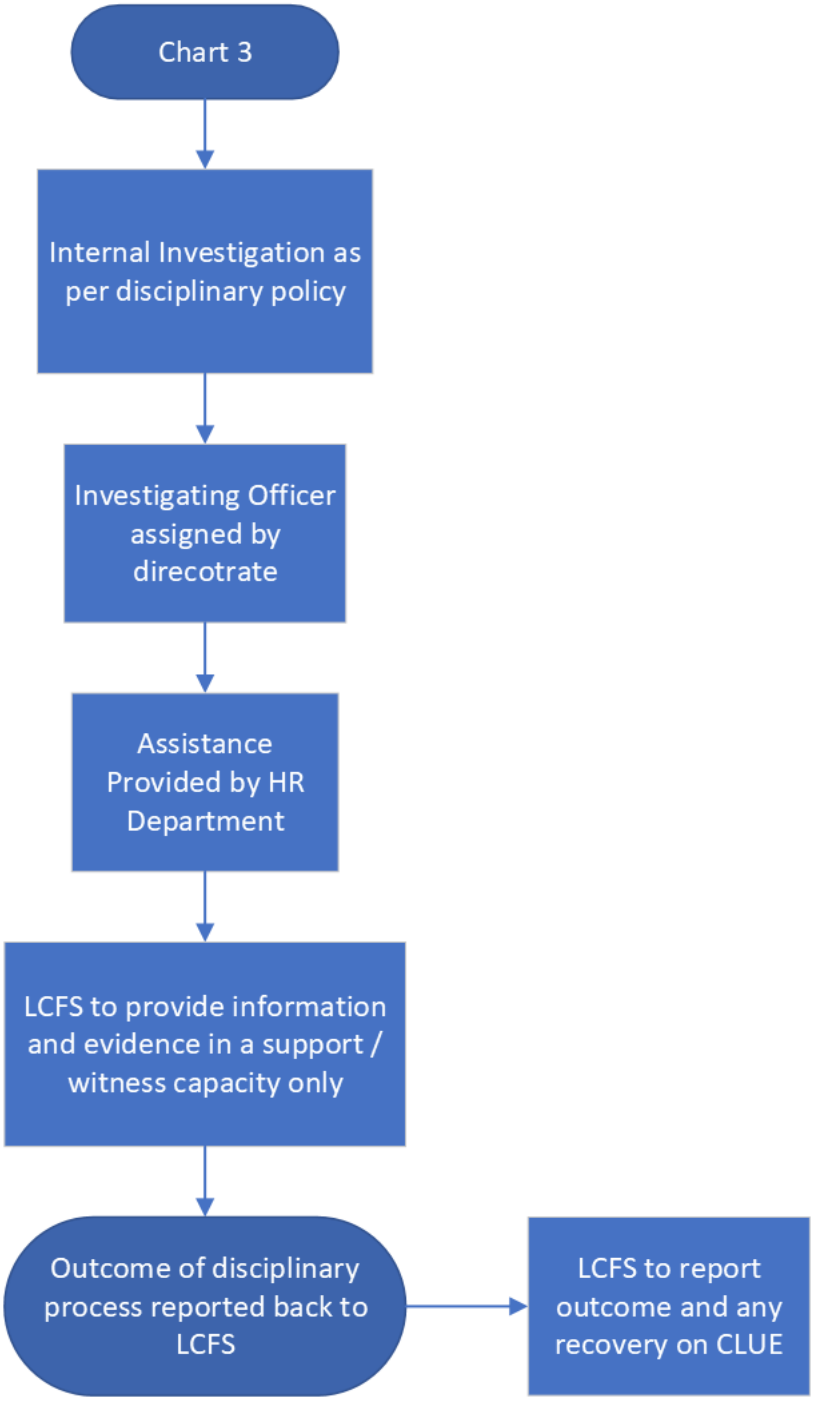


Chart 3 – Disciplinary Process



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.

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

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.

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

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.

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 appraised 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 appraised 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

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 (section1)
  - 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)

- 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

- 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.

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.

DO	DO NOT
• **Note your concerns** **Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**	• **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.**
• **Retain evidence** **Retain any evidence that may be destroyed, or make a note and advise your LCFS.**	• **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.**
• **Report your suspicion** **Confidentiality and anonymity will be respected – delays may lead to further financial loss.**	• **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.**

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)**

Report Title:	Standing Orders – Temporary variation (AGM date)			Agenda Item no.	8.3
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	11 May 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
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.

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

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 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 undertaking 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

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 *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

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

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

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
10/05/2023 15:10:05

Individual Patient Funding Requests

Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board

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

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

Contents

Review reference:	CVU 2223-38
Report status:	Final Report
Fieldwork commencement:	22 February 2023
Fieldwork completion:	25 March 2023
Debrief meeting:	04 April 2023
Draft report issued:	05 April 2023
Management response received:	26 April 2023
Final report issued:	26 April 2023
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
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

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 summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IPFR application review	1	Operation	Medium

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.

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)

Appendix A: Management Action Plan

Matter Arising 1: Clinical Board sign-off of IPFR applications (Operation)			**Impact**
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. The IPFR team's administration time can be caught up in this process.			Potential risk of: • 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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10/05/2023 15:10:05

Matter Arising 2: Review of IPFR Applications (Operation)	**Impact**
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. The findings from the review were as follows: • 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. 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.	Potential risk of: • 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	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. 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.	June 2023 September 2023	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	We will ensure that duration of the funding is explicit in the decision letter (cycles, annual, excessive toxicity, progression, death or trial period). We will specify how often an outcome data questionnaire is required to be completed by the clinician in the decision letter. 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.	June 2023	IPFR Commissioning Officer

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

Follow-up: Clinical Audit
Final Internal Audit Report

April 2023

Cardiff and Vale University Health Board

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

GIG CYMRU NHS WALES
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Contents

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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

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 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 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.

Follow-up Report Classification

	Trend
Substantial 	

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**.

Appendix A: Management Action Plan

Previous Matter Arising 2: Lack of Clinical Audit Policy and Procedures		
Original Recommendation		Original Priority
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. 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.		**High**
Management Response	Target Date	Responsible Officer
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. (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)	January 2022	Head of Patient Safety and Quality Assurance and Associate Medical Director
Current findings		**Residual Risk**
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. **Conclusion:** The previous recommendation has been partially implemented.		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

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	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.
 **Limited assurance**	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.
 **No assurance**	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

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: Nurse Bank (Temporary Staffing Department)

Final Internal Audit Report

April 2023

Cardiff and Vale University Health Board

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

GIG CYMRU NHS WALES
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Cardiff and Vale University Health Board

Contents

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Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Jonathan Pritchard, Assistant Director of Workforce Resourcing Sandra Coles, Senior Nurse, Temporary Staffing & Strategic Nursing Workforce
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.

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

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.

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**.

Appendix A: Management Action Plan

Previous Matter Arising 1: Lack of Temporary Staffing Guidance (Design)		
Original Recommendation		Original Priority
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. Consideration should be given to the impact of the roll-out of HealthRoster on existing processes.		**Medium**
Management Response	Target Date	Responsible Officer
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**
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. **Conclusion:** This recommendation is partially completed		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

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
1. The implementation of Allocate/ Health roster and change to incorporate self-billing will resolve the current issue of processing invoices. 2. 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**
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. Staff are now being rotated on different processes within the TSD. 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. **Conclusion:** This recommendation is partially completed		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

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**
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. 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. 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. **Conclusion:** This recommendation is partly completed		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**

3.1	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. 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. 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. 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.	December 23	Sandra Coles

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	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.
 **Limited assurance**	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.
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Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
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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Charitable Funds
Final Internal Audit Report

April 2023

Cardiff & Vale University Health Board

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Shared Services Partnership
Audit and Assurance Services

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Auditors:	Ian Virgil Head of Internal Audit Wendy Wright-Davies Deputy Head of Internal Audit Jayne Gibbon Audit Manager Geoffrey Woolley Principal Auditor
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Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

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

Assurance summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
3	Charitable Funds Expenditure	3	Operation	Medium
5	Fundraising Team Structure	6	Design	High
7	Effectiveness of Fundraising Events	8	Design	Medium

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.

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.

Appendix A: Management Action Plan

Matter Arising 1: Financial Control Procedure (Design)			**Impact**
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. 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.			There is no visible audit trail for the document.
Recommendations			**Priority**
1	Management should ensure that the Financial Control procedure for Charitable Funds is updated to note its author and date of last review.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	Agree, FCP shall be updated with review dates and author assigned. ACTIONED	March 2023	Rebecca Holliday Head of Financial Services

Matter Arising 2: Delay in banking donations (Operation)			**Impact**
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. 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.			Donations received may be mislaid and so may not be paid into the bank. If the delay exceeds six months for a cheque donation, then the cheque is no longer valid and the donation will be lost.
Recommendations			**Priority**
2	Management should issue a general reminder to all staff within the Health Board that any monies received should be passed to Cashiers promptly. Alternatively, if appropriate, staff may advise prospective donors to take monies direct to the hospital's Cashiers Department personally.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	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. The Fundraising Team will communicate with cashiers to identify and monitor potential delays in the banking process.	April 2023	Joanne Brandon Director of Communications & Engagement

Matter Arising 3: Charitable Funds Expenditure (Operation)	**Impact**
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: • Application process; • Goods or services purchased were in line with purpose of fund or guidance issued; and • Appropriately authorised. The results of our testing were generally satisfactory. However, the following issues were identified: • 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).	Goods purchased contrary to guidance issued. Expenditure may be incurred which is not approved. Lack of clarity regarding decisions taken. Incorrect entries in the financial ledger.

Recommendations		**Priority**
3	To ensure charitable funds expenditure is appropriate and accounted for correctly the following action should be undertaken: • 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	**Medium**

	• With regards to purchase order 725863146 due to the time that has elapsed regarding the accrual management should consider removing the system accrual.	

Agreed Management Action		Target Date	Responsible Officer
3	• The Head of Financial Services shall circulate the eligibility guidance to all fund holders and requistioners, on items that can be purchased from Charitable Funds. • Also Fund holders and requistioners shall be reminded that prior approval is required for all expenditure. • Of the 5 samples selected above, 3 of the sample's expenditure had been approved prior to being incurred. • Order 725863146 – has been cancelled and an annual review shall be completed of all aged system accruals pre-yearend close down. • Funds managed within the fundraising dept., a formal recording process will be implemented to account for decisions made to approve from those funds. Information will include fund expenditure to be charged to, reason for expenditure and names of approvers	April 2023 April 2023	Rebecca Holliday Head of Financial Services Jo Brandon Director of Communications & Engagement

Matter Arising 4: Engagement with Finance Business Partners (Operation)	**Impact**
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. 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.	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	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. 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.	N/A	Rebecca Holliday Head of Financial Services

Matter Arising 5: Approval of the Fundraising Team Structure and Recharges (Design)	**Impact**
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. 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.	Unauthorised changed to the department structure that impact on the costs being charged to the Trust's Charity.

Recommendations		**Priority**
5	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'. 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.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	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. This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding.	Qtr1, 2023	Joanne Brandon Director of Communications & Engagement

	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.		

Matter Arising 6: Fundraising Policy (Operation)			**Impact**
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.			Guidance available to staff is out of date.
Recommendations			**Priority**
6	Management should ensure that the updated and approved Fundraising Policy (UHB238) is uploaded to the intranet and staff are made aware of this.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
6	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	March 2023	Joanne Brandon Director of Communications & Engagement

Matter Arising 7: Effectiveness and viability of Fundraising Events (Design)	**Impact**
A sample of 4 fundraising events was selected to determine the arrangements in pace 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: • 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.	The Health Board Charity us unaware of the costs associated with fundraising events.

Recommendations		**Priority**
7	Management should consider developing a formal process for the proposal and approval of fundraising events that includes all associated costs and anticipated income. 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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Health Charity managers will create a reporting template to included planned staff and non-staff costs and projected income for proposed events. The report	Draft template for consideration by the CFC	Joanne Brandon Director of Communications & Engagement

	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.	

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

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

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

Contents

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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.

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 summary[1]

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;

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

- 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)

Appendix A: Management Action Plan

Matter Arising 1: 'Request for Repair' Procedure remains draft (Design)	**Impact**
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. 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)	Potential risk of: • 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	**Target Date**	**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.	June 2023	Paul Rogers, Interim Assistant Director of Therapies & Health Science and Directorate Manager, ALAS

Matter Arising 2: Absence and incomplete Repair Worksheet Documentation (Operation)	**Impact**
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). 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). 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.	Potential risk of: • Equipment management control procedures fail to adequately direct the management of equipment repairs.

Recommendation		**Priority**
2	Following our review of Repair Worksheet documentation, the following should be adhered to for completeness of records: - 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.	**Medium**

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

Matter Arising 3: Timeliness of updates to the BEST system to close repairs (Operation)	**Impact**
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: • 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. 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.	Potential risk of: • 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**
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.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3	Adminstration Manager to take responsibility for regular checks and validation of open repairs. Administration Manager to present open repairs position at fortnightly operational meetings.	April 2023	Linda Hull, Contact Centre Manager
	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.	May 2023	Archie Kaul-Mead, ALAS Service Manager

Matter Arising 4: Constraints to the Preventative Planned Maintenance process (Operation)	**Impact**
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. 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. 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. 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.	Potential risk of: • 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**
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. 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. 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.	Potential risk of: • Failure to indemnify the Service against patient injury from the use of equipment

Recommendations		**Priority**
5	To support adherence to the 'Terms and Conditions' of loaned equipment, the following should be undertaken: - 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	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	April 2023	Archie Kaul-Mead, ALAS Service Manager
	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	June 2023	Archie Kaul-Mead, ALAS Service Manager

	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

Matter Arising 6: Ad-hoc monthly stock counts and stock management (Operation)	**Impact**
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. 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: • 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. 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.	Potential risk of: • Financial loss due to missing stock • Time delays due to missing parts/equipment

	Recommendation	**Priority**
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.	**High**

	Agreed Management Action	**Target Date**	**Responsible Officer**
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. 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	July 2023	Paul Rogers, Interim Assistant Director of Therapies & Health Science and Directorate Manager, ALAS

	Title: Audit of Accounts Report Addendum, Recommendation: Weakness in stocktaking arrangements. Full update here: Governance: - We will adhere to the Corporate stock take guidance issued by Financial Accounts (including the use of sequential numbered stock-count sheets). Evidence: Comprehensive guidance from Financial Accounts has been distributed to senior management as well as stock leads. This is evidenced through emails as well as F2F and team meetings. There is an exception which should be highlighted in relation to numbered stock-count sheets, whereby this is not possible for wheelchairs due the barcoded system. We do however have another robust procedure planned at month end, which will be implemented in March 2023. - Multiple members of the finance team will be onsite during the 22/23 audit to aid compliance with directions. Evidence: ALAS Directorate Accountant and SpS Clinical Board Accountant will be based at the PMC on 30-31 March 2023. This has been communicated to Justin Saint, Finance Business Partner for PCIC, who is a representative for Cardiff and Vale UHB, who is co-ordinating stock takes with Welsh Audit. Paula Dainton has made provision to be available on other sites during that week for other ALAS services. Team structure: - Stock team lead formally appointed. - COMPLETE (also recruited 2 x Band 3 Senior stock staff). - Joint finance/operational manger appointed to improve understanding of systems/impact upon stock holdings. - COMPLETE. Commenced 31st January 2023 Education and Training: - Enhanced training/education for all stock team members. Evidence: Arrange Requisitioner training for all PMS stock staff	July 2023 April 2023 July 2023	Paula Dainton, Directorate Accountant Paul Rogers, Interim Assistant Director of Therapies & Health Science and Directorate Manager, ALAS Paula Dainton, Directorate Accountant

Matter Arising 7: Better use of management information (Operation)	**Impact**
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: • 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.	Potential risk of: • Poor management information to inform timely and effective decision making.

	Recommendation	**Priority**
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.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
7	Provide a report of repair status at fortnightly PMS Operational Meetings (as per action 5b)	June 2023	Nigel Davies/ Linda Hull, Contact Centre Manager
	Ensure audit of repair jobs in BEST as part of ISO 9001 audit cycle.	July 2023	Andrew Lloyd Quality and Information Manager

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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

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

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

Contents

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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.

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 summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	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.

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**
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. 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.	Potential risk that: • 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

Matter Arising 2: Manual Feeds (Design)			**Impact**
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.			Potential risk that: • 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. *Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.*	31/07/23	Head of Business Intelligence

Matter Arising 3: Database (Operation)	**Impact**
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. 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.	Potential risk that: • Inappropriate access to information or loss of service.

Recommendations		**Priority**
3.1	The database should be upgraded. A patch strategy should be defined and implemented.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	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. A patching strategy will be implemented for both the PMS and Data Warehouse databases.	31/10/2023	Senior Developer

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Matter Arising 4: Health Board Needs (Design)			**Impact**
There is no formal structure within the Health Board for linking leads for data use across clinical boards and with Digital 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.			Potential risk that: • IT services and information provided do not suit the needs of the organisation.
Recommendations			**Priority**
4.1	Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital. Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.		**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

Matter Arising 5: Report Catalogue (Operation)			**Impact**
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 and may therefore not use it, or make unnecessary requests for information.			Potential risk that: IT services and information provided do not suit the needs of the organisation.
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)

Matter Arising 6: Skills Identification (Operation)	**Impact**
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. 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.	Potential risk that: IT services and information provided do not suit the needs of the organisation.

Recommendations		**Priority**
6.1	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. 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.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	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.	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

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

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

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

Contents

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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.

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

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	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

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	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

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)

Appendix A: Management Action Plan

Matter Arising 1: ESWLSG Terms of Reference, membership and remit (Design)	**Impact**
The Equality Strategy & Welsh Language Standards Group (ESWLSG) reports into the Strategy and Delivery Committee in order to: *"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"* 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. 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.	The remit and structure of the ESWLSG may not be appropriate to ensure the Health Board's adherence to Inclusion and Equality legislation.

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.		

Matter Arising 2: Workload of the Equity and Inclusion Team (Design)	**Impact**
The Equity and Inclusion team consists of the Equity and Inclusion Senior Manager and a band 4. 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". 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. 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: • 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)	The Equity and Inclusion team may not be able to fully deliver the requirements of their roles.

Recommendations		**Priority**
2	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.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	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	September 2023	Assistant Director of OD, Wellbeing and Culture

	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.		

Matter Arising 3: Development and Delivery of Equality actions (Operation)	**Impact**
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. 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. 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. We note work is on-going to identify Inclusion Ambassadors within each of the Clinical Boards. The introduction of Equality sub-groups to support the ESWLSG is also currently being discussed.	Actions required to ensure compliance with relevant Equality legislation may not be identified and / or delivered.

Recommendations		**Priority**
3	Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered. This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	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.	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.
	**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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Risk Management
Final Internal Audit Report

May 2023

Cardiff & Vale University Health Board

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

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

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Executive sign-off:	James Quance – Interim Director of Corporate Governance
Distribution:	Aaron Fowler – Head of Risk and Regulation
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.

Executive Summary

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

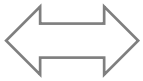
We have issued reasonable assurance on this area.

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

Assurance summary[1]

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

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Risk 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

1. Introduction

1.1 Our review of 'Risk Management' (CVU 2223.01) was completed in line with the 2022/23 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice.

1.3 The Board Assurance Framework provides the Board with the key strategic risks that could impact upon the delivery of the Health Board's Strategy, and the Corporate Risk Register ensures the Board has an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

1.4 The Risk and Regulation Team continue to work alongside Clinical Boards and Corporate Services to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Strategy and Procedure.

1.5 The Director of Corporate Governance is the lead Executive for this review.

Audit Risks

1.6 The potential risks considered in this review are as follows:

- Inconsistent management of risks within clinical boards, corporate services, directorates and departments;
- Failure to achieve strategic, operational, and financial objectives due to a lack of awareness of emerging risks; and
- Exposure to reputational damage due to inadequate identification, assessment, and monitoring of risks.

2. Detailed Audit Findings

Objective 1: The Risk Management and Board Assurance Framework Strategy and associated procedures set out the risk management system. They provide clear guidance to clinical boards, directorates, and departments throughout the Health Board to ensure that the system is robust and working effectively.

2.1 The Health Board has developed a comprehensive Risk Management and Board Assurance Framework Strategy ("the Strategy") which was most recently reviewed and approved by the Audit Committee in February 2023 and by the Board in March 2023.

2.2 The Health Board has also documented the Risk Management Procedures which underpin the Strategy and provide clear guidance to staff within clinical boards, directorates, and departments on the risk management system.

2.3 The Health Board has robust arrangements in place for managing strategic risks. The Board Assurance Framework (BAF) provides key information on the key strategic risks that could impact on the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. The BAF is routinely reviewed by the Executive Team and is a standing agenda item at Board meetings.

2.4 Our review of the Strategy and Risk Management Procedures confirmed that the staff are provided with comprehensive information on the Health Board's risk management system as follows:

- Responsibilities for strategic and operational risk management for the Board and staff throughout the Health Board including at Clinical Board/Corporate Service and directorate/Department level.
- Describes the framework in place for identifying, analyzing, evaluating, and controlling risks to the delivery of strategic objectives.
- Defines the Health Board's approach to risk appetite.
- Sets out the training arrangements with respect to risk management; and
- Incorporates and references latest risk management best practice.

Conclusion: The Health Board is continuing its journey to strengthen and improve the maturity of the risk management system in place. The Strategy and associated Risk Management Procedures are up to date, document the Health Board's current approach to risk management and provide guidance to staff to enable the effective delivery and operation of the risk management system. (Substantial Assurance)

Objective 2: Comprehensive risk registers are in place for clinical boards, through to directorates and departments and appropriate risk owners have been identified.

2.5 To inform this objective, several meetings were held with the nominated risk leads and risk owners for three randomly selected areas of the Health Board:

- Specialist Services Clinical Board;
- Surgery Clinical Board; and
- Capital, Estates and Facilities Corporate Services.

2.6 We were able to obtain copies for most risk registers in place both at Clinical Board and at directorate/department level:

- We obtained the Specialist Services Clinical Board Risk Register and all of the risk registers in place for the directorates;
- We obtained the Capital, Estates and Facilities Corporate Service Risk Register and all of the risk registers in place for the departments;
- We were able to obtain the Surgery Clinical Board Risk Register however this was not up to date. We could not obtain directorate level risk registers

In total we reviewed the information for 13 registers in total. Our testing identified several gaps in risk management information and several instances where the risk scoring was inconsistent. (Matters Arising 1)

2.7 We were unable to obtain directorate/departmental risk registers in place for the Surgery Clinical Board. (See Matters Arising 1)

2.8 We were able to confirm that each area had a nominated risk lead and each risk within the registers provided were assigned to a risk owner. Each individual was deemed to hold appropriate status (roles/responsibility) within the area to manage the corresponding level of risk.

Conclusion: Momentum needs to continue to further enhance the risk management information held at Directorates/Departments level. The findings suggest that further work needs to be undertaken in the form of risk management training/support to ensure that staff understand the importance of Risk Registers and the type of information that needs to be kept up to date. (Reasonable Assurance)

Objective 3: There are clear and consistent processes in place for the identification, classification, scoring and escalation/de-escalation of risks throughout clinical boards down to directorate and departmental level.

2.9 The Risk Management procedures provide detailed guidance to all staff on the risk identification, classification, scoring and escalation/de-escalation process.

2.10 Upon identification of a new risk, staff should complete the Risk Assessment form and provide this to the relevant risk owner and clinical board director for review/approval. Discussions with staff across our sampled areas and a review of risk management information noted that Risk Assessment forms are not always completed to document new/emerging risks. (Matters Arising 2)

2.11 Further testing and review of the risk registers noted that risk scoring is not always accurate. for example, numerous instances were found where residual risk scores were the same as initial risk scores despite the presence of mitigating controls. We

deem these issues to be related to a lack of risk management education/training at directorate/department level. (See Matters Arising 1).

2.12 We can confirm that there are processes in place for the escalation/de-escalation of risks to and from the Clinical Boards and directorates/departments which relies on active engagement and regular submissions between Directorate Managers and Clinical Board Risk Leads. Discussions with staff and a review of submissions in the last 12 months noted that the engagement and flow of information has not always been consistent, leading to inaccurate/out of date risk information within Clinical Board Risk Registers. Risk Leads are aware of these issues and have been working with directorates to improve the situation. (Matters Arising 3)

Conclusion: The Health Board's Risk Management procedures clearly document the process in place for identifying, classifying, and scoring risk however we noted that the current arrangements at directorate/departmental level are informal with a lack of documentation being in place. (Reasonable Assurance)

Objective 4: Risks are actively monitored and scrutinised at an appropriate level within the clinical boards, directorates / departments.

2.13 Discussions with staff and review of documentation confirmed that there are appropriate reporting channels to actively monitor/scrutinise risks identified at an appropriate level within the clinical boards, directorates, and departments. These include one to one meeting between risk owners and line management, weekly/monthly directorate team meetings and clinical board/executive management meetings.

2.14 Whilst appropriate risk management monitoring and scrutiny takes place, actions (to address control gaps) within risk registers are not reviewed/updated in a timely manner. A review of the risk registers identified that several actions were significantly overdue at the time of this review. (Matters Arising 4)

2.15 The Risk and Regulation Team continue to undertake the 'Check and Challenge Process' with all Clinical Board and Corporate Services Risk Leads to ensure that risks are being recorded within the risk registers in line with the Risk Scoring Matrix detailed within the Risk Management Procedures. A review of the check and challenge submissions noted that not all clinical boards and directorates are engaging in a timely manner. (See Matters Arising 3)

Conclusion: Whilst there are appropriate channels in place for the review and scrutiny of risks at appropriate levels within the clinical boards, directorates, and departments our findings indicate that risk management information is not being consistently updated within the risk registers in a timely manner, especially progress of agreed actions to mitigate control gaps/weaknesses. (Reasonable Assurance)

Objective 5: The audit will identify the progress of implementing the internal audit recommendations raised in the 2021/22 audit of Risk Management (CVU 2122.01).

2.16 The Audit Committee is provided with regular updates on the implementation of internal audit recommendations via the 'Internal Audit Tracking' Report.

2.17 The Head of Risk and Regulation also presented a 'Risk Management System' report to the Audit Committee in February 2023, setting out the progress of the three recommendations raised in the Risk Management audit 2021/22.

2.18 We are satisfied that most of the agreed management actions to address the internal audit recommendations raised in the 2021/22 audit of risk management have been implemented. However, we do note that our finding under Matters Arising 1 (stated within this report) is similar in nature to our findings from the 2021/22 audit. Both relate to inconsistencies and gaps of information within Risk Registers. Whilst the Risk and Regulation Team have undertaken risk management training as agreed in 2021/22, our latest findings suggest that further training is required at a directorate/departmental level.

Conclusion: The Health Board has progressed with the implementation of the recommendations raised in the 2021/22 audit of risk management; improvements are noted throughout this report. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Risk Registers Incomplete (Operation)	**Impact**
The Health Board's Strategy and associated risk management procedures require Clinical Boards and Directorates to document risk information within risk registers. We obtained and reviewed a sample of risk registers at directorate/departmental level for two Clinical Boards (Specialist Services and Surgery), and for the Capital, Estates and Facilities Corporate Service. In total, we reviewed 13 risk registers and identified the following: Two directorate risk registers within the Specialist Services Clinical Board were last updated in August 2022 and October 2022. • Risk descriptions within seven registers were found to be inadequate as these referred to events that already occurred and/or referred to controls in place as opposed to risks. • Risks within 5 registers recorded the same Initial and current scoring despite controls being in place. This scoring approach would suggest management is relying on ineffective/inappropriate controls are in place. • We were not able to perform detailed testing of the risk registers within the Surgery Clinical Board directorates as we could not obtain the latest copies. Discussion with the Surgery Clinical Board Risk Lead noted that during the pandemic, it was the Health Board's decision to limit the Surgery CB's risk management arrangements to focus/concentrate on Covid-19 related risks. The Risk Lead has recognised that as we move away from the pandemic, the risk management arrangements need to return to a state of "business as usual". Discussions have started taking place within the Surgery Clinical Board and the Directorates to agree on how to move forward. We recognise that the issues stated above are a result of limited risk management education/training at directorate/departmental level. We also acknowledge that the Risk and Regulation Team have a process in place to provide risk management advice/support for clinical boards and their areas by providing ad-hoc risk management training and by providing feedback on the quality of risk registers as part of the "Check and Challenge process". The above findings suggest that further education/training is required at directorate/departmental level to ensure that risk management principles are understood and are being applied accordingly.	Potential risk of: • Inconsistent management of risks within clinical boards, directorates, and departments; • Failure to achieve strategic, operational, and financial objectives due to a lack of awareness of emerging risks.

Recommendations		Priority
1.1	Further risk management education/training be delivered at directorates/departments level to ensure that risk owners understand their responsibilities in relation to maintaining accurate risk information within risk registers.	**Medium**
1.2	Risk Registers in place for the Surgery Clinical Board and the directorates be reviewed, updated and high-profile risk information be shared on an on-going basis with the Risk and Regulation Team ("Check and Challenge" process).	

Agreed Management Action		Target Date	Responsible Officer
1.1	1.1 - Action agreed – The risk and regulation team will provide further educational support to clinical board and directorate leads to ensure that risk owners understand their responsibilities in relation to maintaining accurate risk information within risk register and have access to relevant supporting documentation and literature.	September 2023	Head of Risk and Regulation.
1.2	1.2 Action Agreed – The Head of Risk and Regulation will remind the Surgery Clinical Board of their obligations in this regard.	May 2023	

Matter Arising 2: Risk Assessment (Operation)	**Impact**
In line with the Health Board's Risk Management Procedures new/emerging risks should be documented within the Risk Assessment Form which should then be approved by the person responsible for managing the risk (Risk Owner) and by the Clinical Board Director. The form captures key information of the risk, such as the description, impact, likelihood and probability, initial and residual risk scoring, mitigating controls, gaps in controls, and actions to be taken. Only following the approval of this form, should the risks be added to the directorate/clinical board risk registers. This process ensures that the information relating to the new risk (description, scoring, controls etc.) are reviewed and approved by the appropriate individual within the Directorate/Clinical Board prior to adding to the Risk Register. Discussions with key risk leads and testing of risk information revealed that Risk Assessment forms are not always being used to document this process and risks are being added to the risk registers without the prior review/approval in line with the Risk Management procedures.	Potential risk of: • Inconsistent management of risks within clinical boards, directorates, and departments; • Failure to achieve strategic, operational, and financial objectives due to a lack of awareness of emerging risks; and • Exposure to reputational damage due to inadequate identification, assessment, and monitoring of risks.

Recommendations		**Priority**
2	Risk owners must ensure that all newly identified risks are properly documented within the Risk Assessment form and for this to be reviewed/approved by the Risk Owners and Clinical Board Directors in line with the Risk Management Procedures.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	Action Agreed – The Head of Risk and Regulation will make clinical colleagues and risk leads aware of this recommendation and their obligations as part of the additional education to be provided, as detailed in response to Recommendation 1.	June 2024	Head of Risk and Regulation

Mohamed Sarah 10/05/2023 13:10:05

Matter Arising 3: Escalation/De-Escalation Engagement (Operation)	**Impact**
Risks should be escalated/de-escalated from and to directorates/departments to clinical boards promptly. The current arrangements rely on active engagement between risk owners and clinical board risk leads. We noted that in the past 12 months the engagement has not been consistent, and this has led to inaccurate/out of date information within the clinical board risk registers. Information within the clinical boards risk registers can also be escalated/de-escalated from and to the Corporate Risk Register as part of the Check and Challenge process led by the Risk and Regulation Team. Similarly, engagement with the Check and Challenge process has also been inconsistent in the past.	Potential risk of: • Failure to achieve strategic, operational, and financial objectives due to a lack of awareness of emerging risks; and • Exposure to reputational damage due to inadequate identification, assessment, and monitoring of risks.

Recommendations		**Priority**
3	Staff within Clinical Boards and Directorates be reminded of their responsibility to actively engage with the escalation/de-escalation process to ensure that risk registers contain risk information that is relevant and up to date.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	Action Agreed – The Corporate Governance Team will regularly remind Clinical Boards and Directorates of their responsibility to actively engage with the escalation/de-escalation process to ensure that risk registers contain risk information that is relevant and up to date. These reminders will take place at monthly Executive Clinical Board Reviews.	June 2024	Director of Corporate Governance/Head of Risk and Regulation

Matter Arising 4: Risk Monitoring (Operation)	**Impact**
Risk monitoring is an integral part of effective risk management and ensures that the system and processes in place are continuously assessed and evaluated in terms of their efficacy to control and mitigate risks and their impacts on objectives. The Risk Registers are used by clinical boards and directorates to capture key risk management information and include actions to address and improve control weaknesses (where applicable). A review of the risk registers within our sampled areas identified several instances whereby actions (to address/improve) control weaknesses had significantly surpassed their target dates (by up to 2 years) with no further information on the progress of these.	Potential risk of: • Inconsistent management of risks within clinical boards, directorates, and departments; • Failure to achieve strategic, operational, and financial objectives due to a lack of awareness of emerging risks; and • Exposure to reputational damage due to inadequate identification, assessment, and monitoring of risks.

Recommendations		**Priority**
4	Risk owners must ensure that actions to address control gaps/weaknesses are frequently monitored and that progress of achieving these is documented and updated within the risk registers in a timely manner.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Action Agreed – The Corporate Governance Team will regularly remind Clinical Boards and Directorates of their responsibilities in this regard. These reminders will take place at monthly Executive Clinical Board Reviews.	June 2024	Head of Risk and Regulation

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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Management of Health Board Policies
Final Internal Audit Report

May 2023

Cardiff & Vale University Health Board

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

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

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Executive sign-off:	James Quance, Interim Director of Corporate Governance
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Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

The overall objective of the audit was to review the arrangements in place for the creation, management and review of Health Board policies and procedures.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- At the time of our review in February 2023, the Health Board had 502 policies and procedures of which 68% were overdue for review including 44% where this was greater than three years overdue.
- The policies and procedures tracker spreadsheet includes 44 entries where no Executive Lead has been identified.
- Staff are not notified when draft policies and procedures are added to the consultation page.
- The most appropriate structure for policies and procedures on the Health Board's website needs to be identified and then implemented.
- Notification of staff and stakeholders regarding policies and procedures is inconsistent.
- The provision of a progress update and revised target completion date to the Audit Committee if the May 2023 deadline for having a fully functioning Policy Management System in place is not met.

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

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	 2019/20

Assurance summary[1]

Objectives		Assurance
1	Policy in place for the management of policies	Reasonable
2	Effective processes for managing policies	Limited
3	Plans in place where policy review dates exceeded	Reasonable
4	Staff are notified of new or amended policies	Limited

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

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	Policy for the management of policies	1	Operation	Medium
2	Out of date policies and procedures	2	Design	High
3	Tracker spreadsheet	2	Operation	Medium
4	Consultation process	2	Operation	Medium
6	Standing Operating Procedure	2	Operation	Medium
7	Corporate Policies Management System Plan	3	Design	Medium
8	Published policies and procedures	4	Design	Medium
9	Notifying staff and stakeholders	4	Design	Medium

1. Introduction

1.1 Our review of 'Management of Health Board Policies' (CVU 2223.04) was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 The Health Board has a responsibility to ensure compliance with legislative, statutory and regulatory requirements. One of the ways it seeks to do this is via the corporate policies, procedures and other written control documents which set out how it should operate and the parameters within which staff are expected to work.

1.3 A similar audit review was undertaken in 2019/20 which made a series of recommendations. In response to these, the Health Board made some changes to procedures and developed a Corporate Policies Management System Plan to address the remainder. The Audit Committee have been updated on progress through updates to the relevant recommendations within the Internal Audit Tracker, and a specific paper was presented to the Audit Committee on 8 November 2022, 'Paper 7.14 - UHB Policies and Procedures Review'.[1]

1.4 The relevant lead for the review was the Director of Corporate Governance.

1.5 The associated risks were:

- There are inadequate process to follow when developing or reviewing policies;
- Policies are developed without relevant input from key staff and stakeholders;
- Out of date policies and procedure fail to adequately direct working practices; and
- Inappropriate decisions or working practices are undertaken due to a lack of awareness about new policies, changes to existing policies and policies that are no longer active.

2. Detailed Audit Findings

Objective 1: The Health Board has a policy in place for the management of policies, procedures and other written control documents.

2.1 Updated versions of UHB 001 'Management of Policies, Procedures and Other Written Control Documents Policy' and UHB 242 'Written Control Documents - Development and Approval Procedure' were presented to and approved by the Audit and Assurance Committee on 5 July 2022.

2.2 The documents were subsequently added to the Health Board's website, although this took five weeks for UHB 242. However, amendable Word versions were added

[1] https://cavuhb.nhs.wales/files/board-and-committees/audit-assurance-committee-2022-23/81122-audit-meeting-book-v3pdf/ (Item 7.14)

rather than fixed PDF versions and the updated versions were not added to Sharepoint. (Matter arising 1)

2.3 UHB 001 was circulated by email to relevant staff following the Audit Committee. However, the more detailed and practical UHB 242 was not. We do however note that UHB 242 is referenced within UHB 001 (Matter arising 1)

2.4 Updating UHB 001 required only relatively minor changes. However, our review of UHB 242 indicated that the changes made were more substantial and that they made the document clearer, stronger and more fit for purpose including:

- A clearer step by step process table;
- The roles and responsibilities of authors, approvers and Corporate Governance being set out more clearly;
- Document format guidance; and
- A key document approval checklist.

2.5 However, the key document approval checklist has not been used since it was approved by the Audit Committee. (Matter arising 1)

Conclusion:

2.6 Updated policy management documents which are clearer, stronger and more fit for purpose were presented to and approved by the Audit and Assurance Committee on 5 July 2022. Following this, the updated documents were disseminated to staff, although aspects of this could be strengthened and the key document approval checklist has not been used since it was approved. We have provided Reasonable Assurance for this objective.

Objective 2: There are effective processes for identifying, updating, consulting and approving new and existing policies and procedures.

2.7 A tracker spreadsheet has been developed by the Head of Corporate Governance to coordinate the work of managing policies and procedures which summarises all that are known to Corporate Governance.

2.8 For each policy or procedure, the tracker includes the document reference and title, date published and when due for review, the Executive Lead, any comments and whether it has been published on the website.

2.9 Ongoing meetings and consultation have been held by the Head of Corporate Governance with each of the Executive Leads within the Health Board to set out the aims of the review, provide them with a copy of the tracker spreadsheet and highlight which policies and procedures appear to be within their area of responsibility.

2.10 The respective responsibilities of the Head of Corporate Governance and Executive Leads are:

- The Head of Corporate Governance provides support and advice to the Executive Leads and acts as pan Health Board co-ordinator.
- The Executive Leads are responsible for coordinating and overseeing the update of policies and procedures within their area of responsibility and at the end of the process providing the completed policies and procedures to the Head of Corporate Governance along with confirmation of the approval process which has been followed, normally the most appropriate committee for that area.

2.11 During development, draft policies and procedures are published for consultation on Sharepoint and are provided to South Glamorgan Community Health Council, the Stakeholder Reference Group and the Local Partnership Forum for comment.

2.12 At the time of our review in February 2023, the Corporate Governance team's tracker spreadsheet had 502 policies and procedures, analysed as follows:

Date to Review	Number of rows	% of rows
Blank	33	7
2012	1	0
2013	8	2
2014	17	3
2015	34	7
2016	18	4
2017	5	1
2018	43	9
2019	56	11
2020	48	10
2021	27	5
2022	51	10
To 2022	341	68
2023	53	11
2024	47	9
2025	58	12
2026	3	1
2023 - 2026	161	32
Total no of rows	502	100

This illustrates that 68% of the Policies and Procedures listed on the tracker were out of date as their Date to Review is 2022 or earlier. (Matter arising 2).

2.13 The Top 5 Executive Leads with Date to Review 2022 or earlier were:

Executive Lead	Number of rows	% of rows
Executive Medical Director	71	14
Executive Director of People & Culture	36	7
Director of Digital & Health Intelligence	29	6
Executive Nurse Director	25	5
Blank - No Executive Lead identified	44	9

Top 5	205	41
Others	136	27
To 2022	341	68

2.14 Going forward, we understand that the Head of Corporate Governance is looking to build in automatic alerts 3 months before documents are due to expire.

2.15 In addition to the overarching management of policies and procedures by Corporate Governance, we also held discussions with identified leads around the procedures in place in two of the Top 5 operational areas listed above.

2.16 Nursing:

- Policies and procedures are not written in isolation but take account of changes in legislation and engagement with interested parties and the Executive Nurse Director is kept informed;
- Completed policies and procedures go to the Quality, Safety and Experience Committee along with a covering paper which summarises the changes proposed. Some go to the Board as well; and
- Updates are provided at the weekly Director of Nursing meetings and are then cascaded downwards from there.

2.17 People & Culture:

- Policies and procedures are developed by People & Culture with close involvement from the Trade Unions and input from key stakeholders and interested parties is also sought;
- Policies and procedures go to the relevant committee / group for approval. This is generally the Employment Policies Sub-Group (EPSG) which comprises representatives of People & Culture and the Trade Unions followed by final approval by the Strategy & Delivery Committee. However, medical policies go via the Local Negotiation Committee (LNC) to the Strategy & Delivery Committee;
- Finally, policies and procedures are emailed to relevant staff including Executive Directors, Trade Unions, Clinical Boards, People & Culture Leads and staff groups.

2.18 We were also informed that much of the coordination work for the Executive Medical Director has been undertaken by the Head of Corporate Governance due to a lack of administration support within that area.

2.19 A number of matters arising were identified during the audit, which covered improvements to the following areas:

- The Tracker spreadsheet. (Matter arising 3)
- Consultation process. (Matter arising 4)
- Standing Operating Procedure. (Matter arising 6)

Conclusion:

2.20 A process is in place for identifying, updating, consulting and approving new and existing policies and procedures. However, at the time of our review, 68% of the Health Board's policies and procedures were overdue for review and matters arising were identified covering improvements to the tracker spreadsheet, consultation process, Standing Operating Procedure and Sharepoint policies and procedures pages. We have provided Limited Assurance for this objective.

Objective 3: In instances where policies and procedures have exceeded their review date there are plans in place to address these.

2.21 A Corporate Policies Management System Plan 2022/23 was presented to the Audit Committee on 8 November 2022 where the proposed actions set out were noted.

2.22 This was a well structured step by step process which comprised 21 actions to be completed in sequential order to address the issues and get the system in place for the management of policies and procedures up to date and operating effectively.

2.23 As at 8 November 2022, 7 of the 21 actions (33%) were marked as complete, 5 were marked as partially complete (24%) and 9 were marked as not complete (43%).

2.24 As at the time of our audit in February 2023, while further work has been undertaken, the nature of the actions meant that the ratings were broadly similar. This was because actions previously rated partially completed would not progress to fully completed until they were true for every policy or procedure and similarly subsequent work planned could also not be undertaken until this has been achieved.

2.25 The date for completion of the final action, having a fully functioning Policy Management System in place, is scheduled as May 2023. However, we would question how realistic this timeframe is given the amount of work still to be completed and the percentage of policies that remain out of date, as highlighted in paragraph 2.22 above. (Matter arising 7)

Conclusion:

2.26 A Corporate Policies Management System Plan 2022/23 was presented to the Audit Committee on 8 November 2022 setting out proposed actions to get the system in place for the management of policies and procedures up to date and operating effectively. However, significant work is still required and so, if this is not achieved by the scheduled May 2023 deadline, then a progress update and revised target completion date should be presented at the next available Audit Committee. We have provided Reasonable Assurance for this objective.

Objective 4: Staff and stakeholders are notified of new or amended policies and procedures, which are published on the Health Board's website.

2.27 The responsibility for this is split between Corporate Governance and the Executive Leads. Corporate Governance is responsible for adding new or amended policies and procedures to the Health Board's website and Sharepoint and Executive Leads are responsible for notifying staff and stakeholders regarding new or amended policies and procedures.

2.28 We selected a sample of nine recently published policies and procedures from the Corporate Governance policies and procedures tracker and checked the information published on the Health Board's website and Sharepoint. Matters arising were identified for all except one. Furthermore, the process for publishing policies and procedures on the Health Board's website and Sharepoint was inconsistent. (Matter arising 8)

2.29 For one of the two operational areas covered by our sample, we were informed that staff notification was covered at weekly leadership meetings and then cascaded downwards to other staff. However, for the other area, we were informed that while various channels may be used, it was an area that could be strengthened further. (Matter arising 9)

Conclusion:

2.30 The processes for notifying staff and stakeholders regarding new or amended policies and procedures, including publishing them on the Health Board's website and Sharepoint, require strengthening. We have provided Limited Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy for the management of policies (Operation)	**Impact**
Updated versions of UHB 001 'Management of Policies, Procedures and Other Written Control Documents Policy' and UHB 242 'Written Control Documents - Development and Approval Procedure' were presented to and approved by the Audit and Assurance Committee on 5 July 2022. UHB 001 required only relatively minor changes. However, the changes to UHB 242 were more substantial and made it clearer, stronger and more fit for purpose than the previous version including: • A clearer step by step process table; • The roles and responsibilities of authors, approvers and Corporate Governance being set out more clearly; • Document format guidance; and • A key document approval checklist. However, we have noted the following issues with the publication and dissemination of the Policy and Procedure: • While both documents were added to the Health Board's website, this took five weeks for UHB 242. Furthermore, the updated versions were not added to Sharepoint; • Amendable Word versions were added to the Health Board's website rather than fixed PDF versions; • While UHB 001 was circulated by email to relevant staff, the more detailed and practical UHB 242 was not. We do however note that UHB 242 is referenced within UHB 001. • The key document approval checklist in UHB 242 has not been used since it was approved by the Audit Committee. • The Document Style links on page 25 of UHB 242 did not work. • Both documents will need to be updated to reflect changes to committee structure which are being implemented.	Inappropriate decisions or working practices may occur.

Recommendations		Priority
1	• Updated Policies and Procedure should be added promptly to the Health Board's website and Sharepoint; • Fixed PDF versions of documents should be added to CVU's website and Sharepoint so that they cannot be amended. However, separate Word versions may also be required where documents need to be completed by users. For example, the key document approval checklist which should be completed by the developer of a policy who is separate from Corporate Governance; • UHB 242 should be circulated by email to all relevant staff who are required to follow it; • The key document approval checklist in UHB 242 should be used and fully completed; • The Document Style links on page 25 of UHB 242 should be amended so that they work correctly; and • UHB 001 and UHB 242 should be updated to reflect changes to committee structure which are being implemented.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1	The Policies and Procedure (UHB 001 and UHB 242) are publicly available on our Website, and are available to staff via Sharepoint. They are now published in a pdf format. As and when staff contact the Corporate Governance department with queries relating to policies and other written controlled documents, copies of the up to date Policy and Procedure (UHB 001 and UHB 242) are sent by email to the member of staff concerned. The Corporate Governance team also send a copy of the Key Document approval checklist (in Word format) for completion and return. The Key Document approval checklist referred to in UHB 242 is now being used by the Corporate Governance team.	Completed Completed	Head of Corporate Governance

	The Policy and Procedure (UHB 001 and UHB 242) will be reviewed following the recent update to the Committee structure and all links enclosed in the same will be updated to ensure they operate. In the meantime, copies of the relevant templates are sent out by the Corporate Governance team, as appropriate, to ensure that new/reviewed policies are updated using the up to date templates.	End of June 2023	

Matter Arising 2: Out of date policies and procedures (Design)			**Impact**
As summarised in the table in paragraph 2.12 of Section 2 Detailed Audit Findings, our review in February 2023 identified that 68% of the Health Board's policies and procedures were out of date.			Inappropriate decisions or working practices may occur.
Recommendations			**Priority**
2	The out of date policies and procedures should be reviewed, updated and published as soon as possible.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	Whilst a detailed plan to address to the previous recommendations made by Internal Audit in 2019/20 was drawn up and presented to the Audit and Assurance Committee in November last year, unfortunately it has been very challenging adhering to the timescales set out in the plan. This has been due to a number of reasons, including limited resource with the Corporate Governance team to undertake this large piece of work. The plan will be updated to reflect the recommendations made (see agreed management action 7 below), but in the meantime the following actions will be undertaken as soon as possible:- a) Head of Corporate Governance to review the current Policies Tracker and ensure that each Policy/other controlled document referenced on the Tracker has an Executive Lead sponsor; b) Produce an updated list of out of date Policies/other controlled documents per Executive Lead and issue to the same for comment with regards to likely timescales to review each policy. c) Executive Leads to work with the Head of Corporate Governance to provide a completed list of all of those out of date policies/other written controlled documents by the end of July 2023.	End of July 2023	Head of Corporate Governance

	The Corporate Policies Management System Plan 2022/23 is to be reviewed by the Head of Corporate Governance, updated and presented to the Audit Committee in early July 2023.		

Matter Arising 3: Tracker spreadsheet (Operation)	**Impact**
A tracker spreadsheet has been developed by the Head of Corporate Governance to coordinate the work of managing policies and procedures which summarises all that are known to Corporate Governance. For each policy or procedure, it includes the document reference and title, date published and when due for review, the Executive Lead, any comments and whether it has been published on the website. However: • There were 44 blank rows, with Date to Review to 2022, where no Executive Lead was identified; • Comments, where included, appeared very brief and often did not include dates so that it was unclear when further action might be required; • There were a large number of gaps in the tracker spreadsheet; • Multiple variants of Executive Lead titles were included e.g. three variants for Director of Capital, Estates and Facilities and two variants for Executive Medical Director; and • In version v1.1 provided at the start of the audit, the conditional shading applied to identify whether policies and procedures were up to date, overdue or about to become overdue gave inaccurate results and was inconsistent with the stated policy. However, this was corrected in version v1.2 subsequently provided during the audit.	Policies and procedures are inadequately managed.

Recommendations		Priority
3	• Further work is required to resolve the 44 blank rows with Date to Review to 2022 where no Executive Lead is identified; • Comments on the tracker should include sufficient information so that the status of policies and procedures can be clearly understood including what further action is required; • The large number of gaps in the tracker spreadsheet should be reviewed and cleared; and • The multiple variants of Executive Lead titles should be reviewed and amended so that there is a consistent approach.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3	The Head of Corporate Governance will undertake a comprehensive review of the policies tracker to address the recommendations made. The Corporate Governance team developed the "tracker" last year as a starting point for this large piece or work in order to record the policies/procedures which were registered on the Corporate Governance team's system and the review dates of the same etc. It is also used by the Corporate Governance team to record the work which the team is and has been undertaking since August last year with regards to putting the Corporate Policies register on a much better footing. For example, it provides the team with a status position of policies/procedures as we work through the tracker list). It is a tool to record the work being undertaken by the Corporate Governance team to produce a fully functioning policy management system.	End of July 2023	Head of Corporate Governance

Matter Arising 4: Consultation process (Operation)			**Impact**
As part of the development of new and updated policies and procedures, draft documents are added to a consultation page on Sharepoint where they can be reviewed and comments can be submitted. However, staff are not notified when documents are added to this Sharepoint page. Furthermore, while draft policies and procedures have been provided to South Glamorgan Community Health Council, the Stakeholder Reference Group and the Local Partnership Forum for comment, the cover emails have not made it clear that the documents are being provided for consultation and the deadline by which any responses must be received.			Beneficial consultation feedback may not be incorporated into new and updated policies and procedures.
Recommendations			**Priority**
4	• Staff should be notified when draft policies and procedures are added to the consultation page on Sharepoint; and • The cover emails accompanying draft policies and procedures provided to South Glamorgan Community Health Council, the Stakeholder Reference Group and the Local Partnership Forum for comment should make it clear that the documents are being provided for consultation and the deadline by which any responses must be received.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	The Corporate Governance team notify the relevant contact/policy author as soon as the policy/procedure document has been published for consultation and a link to the relevant SharePoint link is provided. The relevant policy author should notify relevant members of staff once the document has been published on Sharepoint. Cover emails accompanying draft policies and procedures provided to Llais (formerly the Community Health Council), the Stakeholder Reference Group and the Local Partnership Forum for comment now clearly state that the documents	End of May 2023	Head of Corporate Governance

	are being provided for consultation and the deadline by which any responses must be received		

Matter Arising 5: Policies and Procedures Sharepoint home page (Operation)			**Impact**
The Policies and Procedures Sharepoint home page includes information regarding UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy and UHB 242 Written Control Documents - Development and Approval Procedure but the links to view these documents do not work.			Inappropriate decisions or working practices may occur.
Recommendations			**Priority**
5	The links to UHB 001 Management of Policies, Procedures and Other Written Control Documents Policy and UHB 242 Written Control Documents - Development and Approval Procedure should be amended so that they work correctly.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	Noted. The Policy (UHB 001) and accompanying Procedure (UHB 242) are to be reviewed and all links will be updated to ensure that they operate properly. There is a template section on the Policies page of Sharepoint where staff can access the Health Board's templates for a Policy and (ii) a Procedure. This section will be updated to include the other template documents referred to in Policy UHB 001 and Procedure UHB 242.	End of July 2023 May 2023	Head of Corporate Governance

Matter Arising 6: Standing Operating Procedure (Operation)			**Impact**
Item 2 of the Corporate Policies Management System Plan 2022/23 refers to developing a Standing Operating Procedure which covers the Corporate Governance Team's management of the Corporate Policies. However, while this has been developed, it is very much a work in progress which still needs further review and updating.			Inappropriate decisions or working practices may occur.
Recommendations			**Priority**
6	The Standing Operating Procedure which covers the Corporate Governance Team's management of the Corporate Policies should be reviewed and updated once all work on getting the policy management system fully up to date has been successfully completed.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6	Noted. There are various strands to the Corporate Governance Team's work in relation to putting the management of Corporate policies on a much better footing. This involves working with the Health Board's archivist and IT colleagues to put in place a more efficient policy management system. The SOP will be updated to reflect that work, in addition to any other improvements identified when the policy management system has been fully updated.	September 2023	Head of Corporate Governance

Matter Arising 7: Corporate Policies Management System Plan (Design)	**Impact**
A Corporate Policies Management System Plan 2022/23 was presented to the Audit Committee on 8 November 2022 which set out a step by step process comprising 21 actions to be completed to get the system in place for the management of policies and procedures up to date and operating effectively. The date for completion of the final action within the plan is scheduled as May 2023. The work undertaken as part of our audit and issues we have highlighted, demonstrate that there is still a substantial amount of work to be completed as part of the plan. We would therefore question if the May 2023 deadline is achievable.	Insufficient oversight of progress on getting the system in place for the management of policies and procedures up to date and operating effectively.

Recommendations		**Priority**
7	If all actions in the Corporate Policies Management System Plan 2022/23 have not been completed and scheduled targets have not all been met by the May 2023 deadline, then a progress update and revised target completion dates should be presented at the next available Audit Committee.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
7	The timescales set out in the Policies Management System Plan were ambitious and very challenging. Given the current resource within the Corporate Governance team, it has been very difficult adhering to the timescales set out in the original Plan. The Head of Corporate Governance will review the Corporate Policies Management System Plan 2022/23 with the Director of Corporate Governance. The updated Plan will be presented to the Audit Committee on 4 July 2023.	June 2023	Head of Corporate Governance

Matter Arising 8: Published policies and procedures (Design)	**Impact**
We selected a sample of nine recently published policies and procedures from the Corporate Governance policies and procedures tracker and checked the information published on the Health Board's website and Sharepoint. For all except one, matters arising were identified, which are summarised as follows: • In one case, the document was not on the Health Board's website. This was stated on the policies and procedures tracker. • In two cases, the date of publication on the document on the Health Board's website was earlier than that shown on the tracker; • In one case, the date of publication on the document on Sharepoint was earlier than that shown on the tracker; • In one case, nothing opened when clicking on the document link on Sharepoint; • In six cases, the date approved was not stated on Sharepoint's webpage; and • In two cases, the date of publication was not stated on the document. Furthermore, the Health Board's website splits policies and procedures across the following pages: • Patient Safety and Quality Policies; • Equality and Diversity Policies; • Health and Safety Policies; • Workforce and Organisational Development (Human Resources); and • Corporate Policies. whereas Sharepoint splits policies and procedures across the following pages: • Policies; • Procedures; • Protocols;	Policies and procedures may not be published correctly and locating a policy or procedure may be difficult.

• Strategies and Frameworks; and • Guidelines. This may make finding documents more difficult for staff and may not be applied consistently. We note that the Corporate Policies Management System Plan 2022/23 presented to the Audit Committee on 8 November 2022 indicates that work will be undertaken with the Health Board's Archivist to develop the most appropriate structure going forward for managing policies and procedures.			
Recommendations			**Priority**
8	• The most appropriate structure for managing policies and procedures should be developed and applied consistently on the Health Board's website and Sharepoint. • The policies and procedures published on the Health Board's website and Sharepoint should be checked for accuracy and corrected where necessary.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
8	As highlighted above, the Head of Corporate Governance is working with the Health Board's archivist in order to develop a more appropriate structure (including better categorisation) for the published policies and procedures. It is anticipated that once developed, this structure will be common to both the Health Board's website and SharePoint. Noted. A thorough review of the policies and procedures published on the Health Board's website and SharePoint will be undertaken to ensure accuracy as recommended.	September 2023 July 2023	Head of Corporate Governance

Matter Arising 9: Notifying staff and stakeholders (Design)	**Impact**
For the two operational areas covered by our sample of nine recently published policies and procedures, we enquired whether staff and stakeholders had been notified regarding the new or amended policies and procedures. For Nursing, we were informed that this would be covered at the weekly Director and Nursing meetings and then cascaded downwards to other staff and that, depending on the policy, other channels may also be used. For People & Culture, we were informed that, depending on the policy or procedure, various channels may be used. However, it is an area that could be strengthened. We also note that the Corporate Governance team do not currently retain any information on the processes undertaken for notification.	Staff and stakeholders may not correctly follow the requirements of new or amended policies and procedures.

Recommendations		**Priority**
9	For each new or amended policy or procedure, the Executive Lead should provide Corporate Governance with a statement indicating how staff and stakeholders have been notified and this information should be included in the Corporate Governance policies and procedures tracker.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
9	The Corporate Governance team will strengthen its SOP so that the team routinely notify the Stakeholder Reference Group, the Local Partnership Forum and Llais (formerly the Community Health Council) once a policy/procedure has been approved and/or published.	June 2023	Head of Corporate Governance
	The Corporate Governance team now request a statement from the Executive Lead and/or policy author once the document has been approved and is ready for publication. The Policy Tracker has been updated to include a comment box to capture these statements, and it is already being populated.	May 2023	

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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CF15 7QZ

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

Report Title:	**Audit & Assurance External Quality Assessment of Conformance to the Public Sector Internal Audit Standards**			Agenda Item no.	9.2
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	11/05/23
		Private			
Status *(please tick one only)*:	Assurance		Approval		Information X
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Internal Audit				

Main Report

Background and current situation:

Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS). All public sector internal audit services are required to measure how well they are conforming to the standards.

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service is required to have an external assessment of its conformance to the PSIAS carried out every 5 years.

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

The latest External Quality Assessment (EQA) was undertaken in March 2023 by the Chartered Institute of Public Finance and Accountancy (CIPFA).

CIPFAs final report on the outcome of the EQA was delivered in April 2023 and provided the following opinion:

'It is our opinion that the self-assessment for the NHS Wales Shared Services Partnership's Audit and Assurance Service is accurate, and we therefore conclude that the Audit and Assurance Service FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note'.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Note** the positive outcome of the External Quality Assessment.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	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
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: Yes/~~No~~
Decarbonisation: ~~Yes~~/No

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

Mohamed,Sarah
10/05/2023 15:10:05

External Quality Assessment of Conformance to the Public Sector Internal Audit Standards

NHS Wales Shared Services Partnership's Audit and Assurance Service

Final Report

Lead Associate: Ray Gard, CPFA, FCCA, CFIIA, DMS

Quality Assessment: Diana Melville, FCPFA

8 April 2023

NHS Wales Shared Services Partnership's Audit and Assurance Service

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1. Introduction

1.1 Internal audit within the public sector in the United Kingdom is governed by the Public Sector Internal Audit Standards (PSIAS), which have been in place since 1st April 2013 (revised 2016 and 2017). All public sector internal audit services are required to measure how well they are conforming to the standards. This can be achieved through undertaking periodic self-assessments, external quality assessments (EQA), or a combination of both methods. However, the standards state that an external reviewer must undertake a full assessment or validate the Internal Audit Service's own self-assessment at least once in a five-year period.

2. Background

2.1 The Audit and Assurance Service provides internal audit and consultancy services to the NHS Wales Shared Services Partnership NWSSP), the seven geographic Health Boards, and the five Trusts and Specialist Health Authorities in Wales. The service is managed by the Director of Audit and Assurance and is organised into four regional teams namely Audit North Wales; Audit South East & Swansea; Audit Hywel Dda; Audit South Central; and a fifth team, the Specialist Services Unit (SSU), that provides capital project and specialist estates assurance services for the whole of NHS Wales. As is common with NHS shared services, a single NHS trust takes on responsibility for hosting the shared service. For NWSSP, including the Audit and Assurance Service, the host trust is the Velindre University NHS Trust.

2.2 The Director of Audit and Assurance is supported by seven Heads of Internal Audit (one each for Audit North Wales; Audit Hywel Dda; and the SSU; and two each for the Audit South Central & Swansea; and Audit South Central regions who each have a larger portfolio of clients. Audit and Assurance is a large experienced and well qualified NHS internal audit agency with, at the time of the EQA, a workforce comprising 52 employees. The Director of Audit and Assurance, and the Heads and the Deputy Heads of Internal Audit all hold relevant professional qualifications, being mainly CCAB accountants with four chartered internal auditors. Below this are the Audit Managers and Principal Auditors, the majority of which also hold relevant professional qualifications or are working towards obtaining them.

2.3 From an operational perspective, the Audit and Assurance Service is part of the NWSSP and reports to the Managing Director and the NWSSP's Audit Committee. Regarding Audit and Assurance's other clients, the Heads of Internal Audit report to the respective Board Secretaries and Executive Boards, and their Audit Committees. The Public Sector Internal Audit Standards requires internal audit services to define the roles of 'Senior Management' and 'the Board' in the audit charter. The Board Secretaries and the Executive Boards fulfil the role of 'Senior Management' and the Audit Committees fulfil the role of 'the Board' at each of the Audit and Assurance Service's clients. 'Senior Management' and the 'Board' at each client receive regular reports from the Heads of Internal Audit on their audit plans, progress being made on delivering the plans, details of the completed audit reviews, and the annual opinion and outturn.

2.4 Audit and Assurance has an audit manual that provides the auditors with a comprehensive guide to all aspects of performing an internal audit or consultancy assignment and is cross referenced to the PSIAS. The Service uses standard templates for all engagement working papers, testing schedules, and audit reports, and these are embedded in their TeamMate audit management system. Supervision of the engagements takes place at every stage of the process and is recorded on the appropriate documentation in the TeamMate.

2.5 There is a quality assurance process in place that includes internal and external quality assessments of the Service, reviews of live engagements, and final clearance of all

completed reports by the relevant Head of Internal Audit, or the Director of Audit and Assurance where appropriate, and post audit satisfaction client surveys. In addition, the Director of Audit and Assurance randomly selects a sample of audit reports each year and performs an in-depth quality assurance review, All these processes feed into the Audit and Assurance Service's Quality Assurance and Improvement Programme (QAIP).

2.6 The Audit and Assurance Service has been operating under PSIAS since its launch in 2013, and this is the second external quality assessment (EQA) that they have commissioned.

3. Validation Process

3.1 This validation of the Service's self-assessment comprised a combination of a review of the evidence provided by Audit and Assurance; a review of a sample of completed internal audits for the Service's clients; a survey that was sent to and completed by a range of stakeholders; and interviews with key stakeholders from a sample of the Service's clients, using MS Teams. The interviews focussed on determining the strengths and weaknesses of Audit and Assurance and assessed the Service against the four broad themes of Purpose and Positioning; Structure and Resources; Audit Execution; and Impact.

3.2 The Audit and Assurance Service provided a comprehensive range of documents that they used as evidence to support their self-assessment, and these were available for examination prior to and during this validation review. These documents included the:

- self-assessment against the standards;
- quality assurance and improvement plan (QAIP);
- evidence file to support the self-assessment;
- the audit charters;
- the annual reports and opinions;
- the audit plans and strategies;
- audit procedures manual;
- a range of documents and records relating to the team members;
- progress and other reports to the respective Audit and Standards Committees.

All the above documents were examined during this EQA.

3.3 The main phase of the validation process was carried out during the week commencing 6 March 2023, with further work and interviews undertaken during the following weeks. This phase of the EQA involved a review of a sample of audit files covering the Service's clients, and interviews with a wide sample of key stakeholders from the Service's clients. Overall, the feedback from the interviewees was positive with clients valuing the professional and objective way the Audit and Assurance Service delivered their services.

3.4 A survey was sent to a range of other key stakeholders and the results analysed during the review. Details of the survey findings have been provided to the Internal Audit Manager and a brief summary has been included in this report.

3.5 The assessor reviewed examples of completed audits, to confirm his understanding of the audit process used by the Audit and Assurance Service, and to determine how Audit and Assurance has applied the PSIAS in practice.

4. Opinion

It is our opinion that the self-assessment for the NHS Wales Shared Services Partnership's Audit and Assurance Service is accurate, and we therefore conclude that the Audit and Assurance Service FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.

4.1 The table below shows the Audit and Assurance Service's level of conformance to the individual standards assessed during this external quality assessment:

Standard / Area Assessed	Level of Conformance
Mission Statement	**FULLY Conforms**
Core principles	**FULLY Conforms**
Code of ethics	**FULLY Conforms**
Attribute standard 1000 – Purpose, Authority and Responsibility	**FULLY Conforms**
Attribute standard 1100 – Independence and Objectivity	**FULLY Conforms**
Attribute standard 1200 – Proficiency and Due Professional Care	**FULLY Conforms**
Attribute standard 1300 – Quality Assurance and Improvement Programmes	**FULLY Conforms**
Performance standard 2000 – Managing the Internal Audit Activity	**FULLY Conforms**
Performance standard 2100 – Nature of Work	**FULLY Conforms**
Performance standard 2200 – Engagement Planning	**FULLY Conforms**
Performance standard 2300 – Performing the Engagement	**FULLY Conforms**
Performance standard 2400 – Communicating Results	**FULLY Conforms**
Performance standard 2500 – Monitoring Progress	**FULLY Conforms**
Performance standard 2600 – Communicating the Acceptance of Risk	**FULLY Conforms**

5. Areas of full conformance with the Public Sector Internal Audit Standards

5.1 **Mission Statement and Definition of Internal Audit**

The mission statement and definition of internal audit from the PSIAS are included in the audit charter.

5.2 **Core Principles for the Professional Practice of Internal Auditing**

The Core Principles, taken as a whole, articulate an Internal Audit function's effectiveness, and provide a basis for considering the organisation's level of conformance with the Attribute and Performance standards of the PSIAS.

The clear indication from this EQA is that the Core Principles are embedded in Audit and Assurance's procedures and working methodologies and they are a very competent, experienced, and professional Service that conforms to all ten elements of the Core Principles.

5.3 **Code of Ethics**

The purpose of the Institute of Internal Auditors' Code of Ethics is to promote an ethical culture in the profession of internal auditing, and is necessary and appropriate for the profession, founded as it is on the trust placed in its objective assurance about risk management, control, and governance. The Code of Ethics provides guidance to internal auditors and in essence, it sets out the rules of conduct that describe behavioural norms expected of internal auditors and are intended to guide their ethical conduct. The Code of Ethics applies to both individuals and the entities that provide internal auditing services.

The clear indication from this EQA is that the Audit and Assurance Service conforms to the Code of Ethics, and this is embedded in their procedures, and their audit methodologies. The code of ethics is part of their overarching culture and underpins the way the Service operates.

5.4 **Attribute Standard 1000 – Purpose, Authority and Responsibility**

The purpose, authority and responsibility of the Internal Audit activity must be formally defined in an internal audit charter, consistent with the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards, and the Definition of Internal Auditing). The internal audit charter must be reviewed regularly and presented to senior management and the audit panel for approval.

There is a separate audit charter in place for each of the Service's clients and these are reviewed on an annual basis. We reviewed these documents and found them to be comprehensive and well written. We are satisfied that the Audit and Assurance Service conforms to attribute standard 1000.

5.5 **Attribute Standard 1100 – Independence and Objectivity**

Standard 1100 states that the Internal Audit activity must be independent, and internal auditors must be objective in performing their work.

The need for independence and objectivity is an integral part of the Service's culture. The Service reports in its own name and directly to the Board Secretaries and Executive Boards, and the Audit Committees at all the Service's clients. All employees declare any potential impairment to their independence or objectivity for each audit they undertake.

We have reviewed the Audit and Assurance Service's comprehensive audit manual, procedures, and their standard documentation; their quality assurance and improvement plan; and a sample of completed audit files for all of the Service's clients. We have also reviewed their reporting lines and their positioning within the respective organisations. Neither the Director of Audit and Assurance nor the Heads of Internal Audit have any other roles and responsibilities in addition to Audit and Assurance at NWSSP or any of the Service's other clients. The audit charter confirms that there are no impairments to their independence or the Audit and Assurance Service, although this is not reinforced in the Heads of Internal Audit's annual reports. As the annual report looks back on the year just finished, whereas the audit charter and plan are designed to look forward, it is recognised as good practice to confirm whether there have been any impairments to independence during the year. We have made one advisory suggestion regarding this observation. We are satisfied that the Audit and Assurance Service conforms with attribute standard 1100.

5.6 **Attribute Standard 1200 – Proficiency and Due Professional Care**

Attribute standard 1200 requires the Internal Audit Services' engagements are performed with proficiency and due professional care, having regard to the skills and qualifications of the staff, and how they apply their knowledge in practice.

It is evident from this EQA that the Audit and Assurance Service has a professional and experienced workforce. As mentioned in the background section above, the Director of Audit and Assurance, and the Heads and the Deputy Heads of Internal Audit all hold relevant professional qualifications, being mainly CCAB accountants with four chartered internal auditors. Below this are the Audit Managers and Principal Auditors, the majority of which also hold relevant professional qualifications or are working towards obtaining them.

The Audit and Assurance Service has a specialist IT audit team that undertakes all of the technical IT audits across NHS Wales, although all the team members have sufficient knowledge of the operation of high-level IT controls that they can incorporate these into their testing for the audits they undertake. In addition, the Service also undertakes a regular comprehensive programme of transactional audits for NWSSP who provide all the transactional processing for all of NHS Wales and are currently exploring the potential to expand this by using specialist data analytics software applications.

It is evident from this review that the Audit and Assurance Service's employees are experienced and well qualified and perform their duties with due professional care. We are satisfied that the Audit and Assurance Service complies with attribute standard 1200.

5.7 **Attribute Standard 1300 – Quality Assurance and Improvement Programmes**

This standard requires the Head of Audit to develop and maintain a quality assurance and improvement programme that covers all aspects of the Internal Audit activity.

The Audit and Assurance Service has developed an effective quality assurance process which feeds into their quality assurance and improvement programme that ensures engagements are performed to a high standard. Supervision of audit engagements is carried out at all stages of the audit. Evidence of the supervision of the assignments is recorded throughout the audit process. We have examined the supporting evidence provided by the Audit and Assurance Service during this EQA and are satisfied that they conform to attribute standard 1300.

5.8 **Performance Standard 2000 – Managing the Internal Audit Activity**

The remit of this standard is wide and requires the Chief Audit Executive to manage the Internal Audit activity effectively to ensure it adds value to its clients. Value is added to a client and its stakeholders when Internal Audit considers their strategies, objectives,

and risks; strives to offer ways to enhance their governance, risk management, and control processes; and objectively provides relevant assurance to them. To achieve this, the Chief Audit Executive must produce an audit plan and communicate this and the Service's resource requirements, including the impact of resource limitations, to senior management and the Audit and Risk Committee for their review and approval. The Chief Audit Executive must ensure that Internal Audit's resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.

The standard also requires the Chief Audit Executive to establish policies and procedures to guide the Internal Audit activity, and to share information, co-ordinate activities and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimise duplication of efforts.

Last, but by no means least, the standard requires the Chief Audit Executive to report periodically to senior management and the Audit Committees on Internal Audit's activities, purpose, authority, responsibility, and performance relative to its plan, and on its conformance with the Code of Ethics and the Standards. Reporting must also include significant risk and control issues, including fraud risks, governance issues and other matters that require the attention of senior management and/or the audit panels.

The Audit and Assurance Service has a range of procedures in place that are incorporated in their comprehensive audit manual that is cross-referenced to the PSIAS.

The Service have developed comprehensive planning processes that take into consideration the risks and objectives of each client; their risk management and governance frameworks; any other relevant and reliable sources of assurance that are available; key issues identified by managers at each client; the Service's own risk and audit needs assessments; and any emerging risks identified through horizon scanning and networking with other organisations. The Service produces a risk-based audit plan for each client that is designed to provide them with relevant assurance on their Board Assurance Framework and their governance, risk management and internal controls. The audit plans are reviewed and approved by the Executive Boards and the Audit Committees of the respective clients.

Details of the completed audits, together with regular updates on the progress being made on delivering the audit plans and the performance of the Audit and Assurance Service, are reported to the respective Board Secretaries and Executive Boards and the Audit Committees at each client. Annual reports and opinions are also issued at the end of the year and presented to the respective Executive Boards and Audit Committees.

The clear indication from this EQA is that the Audit and Assurance Service is managed effectively and conforms to standard 2000.

5.9 **Performance Standard 2100 – Nature of Work**

Standard 2100 covers the way the Internal Audit activity evaluates and contributes to the improvement of the organisation's risk management and governance framework and internal control processes, using a systematic, disciplined and risk-based approach.

This is the approach adopted by the Audit and Assurance Service and is embedded in their working methodologies. During this EQA, we reviewed a sample of completed audits and examined them to see if they conformed to standard 2100 and Audit and Assurance's own methodologies. We found that all the sample audit files examined during the EQA complied with all three.

The clear indication from this EQA is that the Audit and Assurance Service conforms to performance standard 2100.

5.10 **Performance Standard 2200 – Engagement Planning**

Performance standard 2200 requires Internal Auditors to develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. The plan must consider the organisation's strategies, objectives, and risks relevant to the engagement.

As mentioned above, the Service have a comprehensive and robust audit manual and supervision processes in place that include engagement planning and meets the requirements of the PSIAS. From the sample of audit files that we examined during the EQA we found that they all conformed to standard 2200 and the Service's own audit procedures, and therefore we conclude that Audit and Assurance conforms to performance standard 2200.

5.11 **Performance Standard 2300 – Performing the Engagement**

Performance standard 2300 seeks to confirm that Internal Auditors analyse, evaluate and document sufficient, reliable, relevant, and useful information to support the engagement results and conclusions, and that all engagements are properly supervised.

As we have mentioned above, the Audit and Assurance Service has a comprehensive audit manual, sound supervision arrangements, and quality assurance processes in place that meet the requirements of the standards. We reviewed the evidence provided in support of the Service's self-assessment, together with a sample of audit files held in the TeamMate audit management system to see if they conformed to the standards, and Audit and Assurance's own working methodologies. We found that all the evidence we examined conformed to the standards and Audit and Assurance's own procedures and methodologies. We therefore conclude that the Audit and Assurance Service conforms to performance standard 2300.

5.12 **Performance Standard 2400 – Communicating Results**

This standard requires Internal Auditors to communicate the results of engagements to clients and sets out what should be included in each audit report, as well as the annual report and opinion. When an overall opinion is issued, it must take into account the strategies, objectives and risks of the clients and the expectations of their senior management, the audit panels and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant, and useful information. Where an internal audit function is deemed to conform to the PSIAS, reports should indicate this by including the phrase "conducted in conformance with the International Standards for the Professional Practice of Internal Auditing".

The Service's audit manual and supervision processes cover the communication of results of individual audits and meet the requirements of the PSIAS. During the EQA we reviewed the evidence provided in support of the Service's self-assessment and the audit reports issued for a sample of audits to establish if they conformed to the standards. All the evidence we examined conformed to the standards and Audit and Assurance's own procedures and methodologies.

We also reviewed the progress and annual reports presented to the respective Audit Committees and found that these also conformed to the standards and the Service's own internal procedures.

We therefore conclude that the Audit and Assurance Service conforms to performance standard 2400.

5.13 **Performance Standard 2500 – Monitoring Progress**

There is a comprehensive follow-up process in place, the objective of which is to monitor the client's progress towards the implementation of agreed actions. The results of the

follow-up reviews are reported to the respective Audit Committees. From this EQA, it is evident that the Audit and Assurance Service conforms to performance standard 2500.

5.14 **Performance Standard 2600 – Communicating the Acceptance of Risk**

Standard 2600 considers the arrangements which should apply if the Director of Audit and Assurance and the relevant Head of Internal Audit has concluded that management have accepted a level of risk that may be unacceptable to the organisation. Situations of this kind are expected to be rare, consequently, we did not see any examples of this during this review. From this EQA, it is evident that the Audit and Assurance Service conforms to performance standard 2600.

6. Areas of partial conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

6.1 There are no areas of partial conformance with the Public Sector Internal Audit Standards.

7. Areas of non-conformance with the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note

7.1 There are no areas of non-conformance with the Public Sector Internal Audit Standards.

8. Survey results

8.1 Overall, the results of the survey of key stakeholders from the Audit and Assurance Service's clients were positive with respondents valuing the services provided by them. The overall number of positive responses were very high with nearly all respondents agreeing or partially agreeing with the survey statements. The detailed findings from the survey have been shared with the Director of Audit and Assurance and a summary of the survey results has been included in this report at page 14.

9. Issues for management action

9.1 We have identified two advisory issues for management to consider, as set out in the table below.

Issues for management action	Priority
The audit charter confirms that there are no impairments to the independence of the Director of Audit and Assurance, the Heads of Internal Audit, or the Audit and Assurance Service although we have noted that this is not reinforced in the respective annual reports. As the annual report looks back on the year just finished, whereas the audit charter and plan are designed to look forward, it is recognised as good practice to confirm whether there have been any impairments to independence during the year.	**Advisory**

Issues for management action	Priority
Management should be mindful of the fact that a consultation on revising the Institute of Internal Auditors global International Professional Practice Framework (IPPF) which is incorporated into the PSIAS, commenced on 1 March 2023. Whilst this will not impact on the Service's current level of conformance, any changes to the Standards arising from the consultation may affect the Service's conformance in the medium term. It is therefore suggested that the Director of Audit and Assurance considers the contents of the consultation document and keeps a watching brief on the developments to the Standards and how this may impact the Service in the medium term.	**Advisory**

10. Definitions

Level of Conformity	Description
FULLY Conforms	The Internal Audit Service complies with the standards with only minor or no deviations. The relevant structures, policies, and procedures of the internal audit service, as well as the processes by which they are applied, at least comply with the requirements of the individual Standard and the Code of Ethics in all material respects. This means that there is conformance to all of the individual Standards and the Code of Ethics.
Partially Conforms	The Internal Audit Service is endeavouring to deliver an effective service however, they are falling short of achieving some of their objectives and/or generally conforming to a majority of the individual Standards and elements of the Code of Ethics and at least partial conformance to the others. There will usually be significant opportunities to improve the delivery of effective internal audit and enhance conformance to the Standards or elements of the Code of Ethics. The Internal Audit Service may be aware of some of these opportunities and the areas they need to develop. Some identified deficiencies may be beyond the control of Internal Audit and may result in actions for Senior Management or the Board of the organisation to address.
Does Not Conform	The Internal Audit Service is not aware of; not making efforts to comply with; or is failing to achieve many/all of the individual Standards or elements of the Code of Ethics. These deficiencies will usually have a significant adverse impact on Internal Audit's effectiveness and its potential to add value and are likely to represent significant opportunities for improvement to Internal Audit. Some identified deficiencies may be beyond the control of Internal Audit and may result in recommendations to Senior Management or the Board of the organisation.

Action Priorities	Criteria
High priority	The Internal Audit Service needs to rectify a significant issue of non-conformance with the standards. Remedial action to resolve the issue should be taken urgently.
Medium priority	The Internal Audit Service needs to rectify a moderate issue of conformance with the standards. Remedial action to resolve the issue should be taken, ideally within a reasonable time scale, for example six months.
Low priority	The Internal Audit Service should consider rectifying a minor issue of conformance with the standards. Remedial action to resolve the issue should be considered but the issue is not urgent.
Advisory	These are issues identified during the course of the EQA that do not adversely impact the service's conformance with the standards. Typically, they include areas of enhancement to existing operations and the adoption of best practice.

The co-operation of the Director of Audit and Assurance, the Heads of Internal Audit, the Business Support Manager, and the Deputy Head of Internal Audit at Audit Hywel Dda in providing the information requested for the EQA, is greatly appreciated. Our thanks also go to the Board Secretaries and chairs of the respective Audit Committees, and the key stakeholders from all the Service's clients that made themselves available for interview during the EQAs and/or completed the survey.

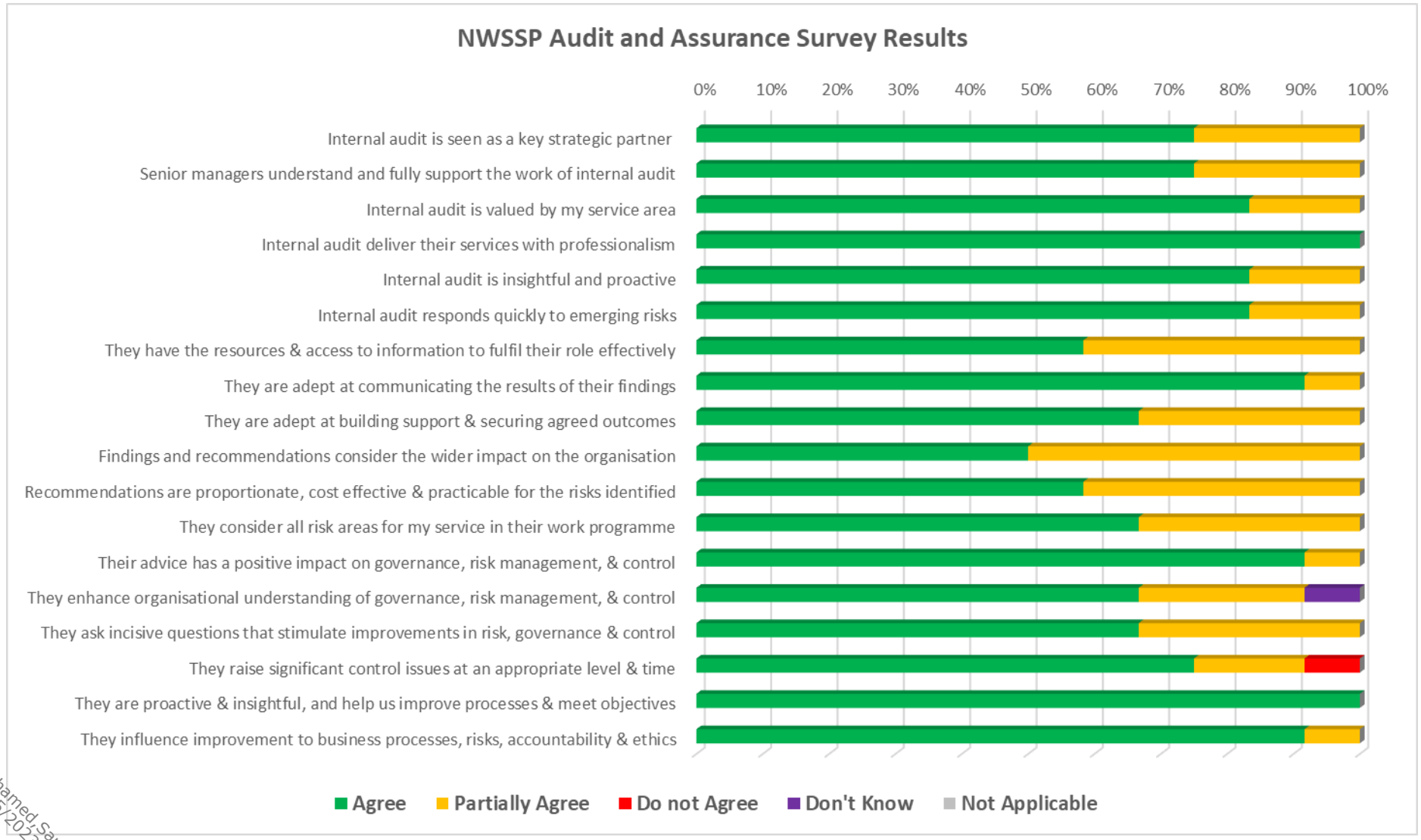
Ray Gard, CPFA, FCCA, FCIIA, DMS

8 April 2023

11. Disclaimer

This report has been prepared by CIPFA at the request of the NHS Wales Shared Services Partnership's Audit and Assurance Service, and the terms for the preparation and scope of the report have been agreed with them. The matters raised are only those that came to our attention during our work. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, we have only been able to base findings on the information and documentation provided to us. Consequently, no complete guarantee can be given that this report is necessarily a comprehensive statement of all the issues that exist with their conformance to the Public Sector Internal Audit Standards that exist, or of all the improvements that may be required.

The report was prepared solely for the use and benefit of NHS Wales Shared Services Partnership's Audit and Assurance Service, including the Executive Boards and Audit Committees of NWSSP and the Service's clients, and to the fullest extent permitted by law, CIPFA accepts no responsibility and disclaims all liability to any other third party who purports to use or rely, for any reason whatsoever on the report, its contents, conclusions, any extract, and/or reinterpretation of its contents. Accordingly, any reliance placed on the report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification by any third party is entirely at their own risk.



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