Public Audit Meeting

Thu 12 May 2022, 09:00 - 10:00

Agenda

09:00 - 09:00
0 min

1.
Welcome and Introductions

John Union

09:00 - 09:00
0 min

2.
Apologies for Absence

John Union

09:00 - 09:00
0 min

3.
Declarations of Interest

John Union

09:00 - 09:00
0 min

4.
Minutes of the Committee meeting held on 5th April 2022

John Union

04 Draft Public Audit Minutes 5.4.22MD.NF.pdf (17 pages)

09:00 - 09:00
0 min

5.
Action log following meeting held on 5th April 2022

John Union

05 Draft Public Action Log - 12.05.22MD.NF.pdf (3 pages)

09:00 - 09:00
0 min

6.
Any other urgent business

John Union

09:00 - 09:00
0 min

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7.
Items for Review and Assurance

7.1.
Compliance with the Corporate Governance Code

Nicola Foreman

- 7.1 Compliance with the UK Corporate Governance Code.pdf (3 pages)
- 7.1a Appendix 1 - Annual Assessment UK Corporate Governance Code 2021-2022.NF(1).pdf (10 pages)

7.2.
Board and Committee Effectiveness Surveys 2021-22

Nicola Foreman

- 7.2 Board and Committee Effectiveness Surveys 2021-22.NF.pdf (3 pages)
- 7.2a Appendix 1 - Board Effectiveness Action Plan 2020-2021 update.NF.pdf (4 pages)
- 7.2b Appendix 2 - Board Effectiveness Action Plan 2021-2022.NF.pdf (4 pages)

7.3.
Counter Fraud Progress Report (Verbal)

Catherine Phillips/Gareth Lavington

7.4.
Internal Audit Progress Report

Ian Virgil

- 7.4 Internal Audit Progress Report Cover Paper.pdf (3 pages)
- 7.4a Internal Audit Progress Report.pdf (23 pages)

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8.
Items for Approval / Ratification

8.1.
Counter Fraud Annual Plan

Catherine Phillips/Gareth Lavington

- 8.1 Counter Fraud Annual Plan Cover Paper.pdf (2 pages)
- 8.1a Counter Fraud Annual Plan.pdf (27 pages)

8.2.
Counter Fraud Annual Report 2021/22

Catherine Phillips /Gareth Lavington

- 8.2 Counter Fraud Annual Report 21-22 Cover Paper.pdf (2 pages)
- 8.2a Counter Fraud Annual Report 21-22.pdf (11 pages)

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0 min

9.
Internal Audit reports for information:

Ian Virgil

9.1.
Internal Audit Reports for Information Cover Paper

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- 9.1 Internal Audit Reports for Information Cover Paper.pdf (2 pages)

9.1.1.
COVID-19 Vaccination Programme - Phase 3 delivery Final Report (Substantial Assurance)

9.1.1 COVID 19 Vaccination Programme (Phase 3) Final Report.pdf (20 pages)

9.1.2.
Health & Safety Final Report

9.1.2 Health & Safety Final Report.pdf (12 pages)

9.1.3.
Wellbeing Hub at Maelfa Final Report

9.1.3 Wellbeing Hub at Maelfa Final Report.pdf (35 pages)

9.1.4.
Development of Genomics Partnership Wales Final Report

9.1.4 Development of Genomics Partnership Wales Final Report.pdf (25 pages)
9.1.4b Genomics_PAQ.pdf (2 pages)

9.1.5.
Network and Information Systems (NIS) Directive Final Report

9.1.5 Network and Information Systems (NIS) Directive Final Report.pdf (13 pages)

9.1.6.
Welsh Risk Pool Claims Final Report

9.1.6 Welsh Risk Pool Claims Final Report.pdf (11 pages)

9.1.7.
Nurse Rostering Children's Hospital for Wales, Children and Women's CB Final Report

9.1.7 Nurse Rostering Children's Hospital for Wales, Children and Women's CB Final Report.pdf (17 pages)

9.1.8.
Nurse Bank Final Report

9.1.8 Nurse Bank Final Report.pdf (20 pages)

9.1.9.
Delivery of Mental Health Services – Advisory Final Report

9.1.9 Delivery of Mental Health Services – Advisory Final Report.pdf (18 pages)

09:00 - 09:00
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10.
Agenda for Private Audit and Assurance Committee

10.1.
Counter Fraud Progress Report

10.2.
Workforce and Organisational Development Compliance Report

09:00 - 09:00
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11.
Any Other Business

09:00 - 09:00
0 min

12.
Review and Final Closure

12.1.
Items to be deferred to Board / Committee

John Union

12.1.1.
To note the date, time and venue of the next Committee meeting:

Tuesday 14th June 2022 (Special Meeting) at 9am

Draft Minutes of the Public Audit & Assurance Committee
Held On 5 April 2022 at 9am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance
Present:		
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Wendy Wright	WW	Deputy Head of Internal Audit
Darren Griffiths	DG	Audit Wales
Mark Jones	MJ	Audit Wales
Aaron Fowler	AF	Head of Risk & Regulation
Nigel Price	NP	Local Counter Fraud Specialist
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Russel Kent	RK	Head of Digital Operations
David Thomas	DT	Director of Digital & Health Intelligence
Marcia Donovan	MD	Head of Corporate Governance
Robert Mahoney	RM	Interim Deputy Director of Finance
Observers:		
Amy Marshall	AM	Audit Wales Graduate Trainee
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair

Item No	Agenda Item	Action
AAC 5/4/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 5/4/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 5/4/22 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

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AAC 5/4/22 004	**Minutes of the Meeting Held on 8th February 2022** **The Committee resolved that:** a) The draft minutes of the meeting held on the 8th February 2022 were a true and accurate record of the meeting.	
AAC 5/4/22 005	**Action Log - Following Meeting Held on 8th February 2022** - AAC 22/02/08/023 – would be scheduled for July 2022 **The Committee resolved that:** a) The Action Log was discussed and noted.	**Action Log**
AAC 5/4/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 5/4/22 007	**Internal Audit Progress Reports** Ian Virgil (IV) presented the IT Service Management Final Report and highlighted the following: • The purpose of the audit was to establish whether the IT service provided by the Health Board was in a sufficient and secure manner which reflected the needs of the organisation. • It was considered against best practice for IT service management as set out in the Information Technology Infrastructure Library (ITIL). • Internal Audit were only able to provide 'limited' assurance. • It was identified that poor controls in relation to the IT service desk function were in place. • It was acknowledged that there were plans to implement a new call handling system, to restructure the service desk department and to introduce new ways of working. • At the time of the audit, eight key matters were identified, four of which were high priority. • Management had provided their agreed actions in response to the audit in Appendix A. The Director of Digital & Health Intelligence (DDHI) advised the Committee on the following: • The audit was completed at a point in time when the Digital Team was supporting the organisation during the pandemic. • The Digital Team had agreed with the recommendations made. • The target date did not reflect the urgency merited by the Health Board.	

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	• Four high priority recommendations were made which included the following: 1. Service design a) To undertake a restructure of the service desk provision which should be based on the ITIL Framework. - The current limited IT support resources would be restructured to provide a skeleton framework of an ITIL service desk structure. - A business case was currently under review to increase staffing within the service desk, to allow for separation of key tasks and provide a single point of knowledge. b) Implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal. - The new service desk implementation would provide a digital front door which would include incident and problem management as well as service requests, change and asset management. - There would also be a user portal on all user devices. - The new service desk tool went live internally in March 2022. It would be going live to the entire organisation by 30 April 2022. c) Existing and new staff should be encouraged to attain ITIL Accreditation. - Staff ITIL training had started in January 2022. - 10 members of the IT support/service desk team had successfully passed the ITIL v4 Foundation course and exams to gain their accreditation. - An additional 6x team members had attended the Advanced ITIL CDS course. The UHB Vice Chair (VC) queried whether the current HEAT system had been replaced by the Ivanti Service Management (ISM), with a target implementation date of the 30th October 2021 as stated in Appendix A of the report. The DDHI responded that it had not yet been implemented due to the ongoing pandemic and how busy the team were in supporting the recovery process. The Windows 10 programme had been completed. A pragmatic decision had been made to roll it forward to the new calendar year. It went live internally in March 2022 and it should be fully live in April 2022. The VC queried if the new system would meet the needs of the organisation. The DDHI responded that it would and that it would be completely ITIL and industry standard aligned.	

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The CC queried if the target date was September 2022.

The DDHI responded that there were components that would be completed in April 2022 but the entire item would be completed by September 2022.

2. Lack of documented guidance

a) Procedures and guidelines should be developed for the Service Desk. These should clarify how to deal with incoming calls, the information to collect, the approval process for proposed resolution actions and the routing of those calls.

- The Health Board had employed the services of a dedicated Ivanti ITSM Implementation Expert.
- As part of the deployment standard operating procedure documents had been created.
- A standalone and dedicated automation server had been set up and the same would provide workflow with approval steps which would provide automation for numerous tasks.

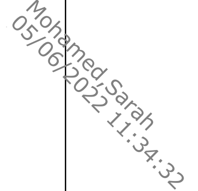
b) As part of those procedures a set of pre-defined calls should be developed for the most common / simple calls and incidents to enable those to be resolved on first contact.

- The ISM implementation also contained an FAQ and Staff Help portal which would continue to be developed and expanded as part of the product use.
- A full set of FAQs would be issued by the end of April 2022.
- There would also be an icon on people's helpdesk which they could click.

3. Call Classification and prioritisation

a) Procedures and guidance on the classification and prioritisation of calls should be drawn up and issued with training provided as appropriate. Staff should be instructed to ensure that calls and incidents were classified and prioritised correctly in accordance with the guidance.

– Automated for call category, call type and priority fields had been implemented as standard.
– Exceptions could be made, although it would require additional approval within the Service Desk management structure.
– That had been populated to ensure prioritisation of calls correctly.



b) The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields.

	– Free Text fields for call category, call type and priority fields had been removed. c) The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu. – Call category, call type and priority fields were now all mandatory when creating incidents and service requests. 4. Call status monitoring a) A formal process to ensure call activity was maintained should be established, and completed calls should be closed appropriately. - A new single digital portal for staff to create, view and close incidents and service desks had been created. - Accurate ISM and call metrics would be available. - Calls and requests for staff would automatically be closed after multiple requests had been ignored. - Cases which had not been progressed within a timely fashion would be reported automatically and flagged. - Staff would also have clear visibility of their case progression via the portal. - The audit found many open calls and this system would help to manage this effectively. The VC queried whether the closing of the call was determined by the requestor or the person dealing with the request. The DDHI responded that the closing of calls would be done in agreement with the user. The call would be closed after the third attempt of trying to reach the user. The VC queried if there would be a follow up to ensure the new systems had been implemented and the extent to which the new systems were shown to be successful. IV responded that a follow up of the limited assurance reports had been built into the Committee's Internal Audit Plan for next year. They would communicate with the DDHI and his team to establish an appropriate date to avoid conducing a follow up too soon. The VC stated that given the language in the report it warranted a more immediate action. The DDHI responded that the majority of actions would be completed by 1st May 2022. Although, the structure of the team would not have been completed, that should not prevent making use of the system in its entirety. It was agreed that the DDHI would provide an update at the Committee's July meeting.	**DDHI**

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Ian Virgil (IV) presented the Internal Audit Progress Report (the Report) and highlighted the following –

Internal Audit

- Seven audits had been delayed and not finalised in time for this meeting. Those would be brought to the next Committee meeting.
- The Capital Scheme Genomics audit and the Estates Assurance Waste Management audit had been issued in draft with a reasonable assurance rating.
- Four audits had been finalised since the last Committee.
- The Advisory Report for Arrangements to Support the Delivery of Mental Health Services provided suggested areas for the Health Board to take forward, as opposed to formal recommendations. The management response to the report had just been received. That would be included in the next Committee meeting papers.

Internal Audit

- There were 34 reviews in the 2021/22 Internal Audit Plan, of which (i) 16 had been finalised and 2 were in the draft stage (ii) 12 were a “work in progress”, and (iii) 2 were in the planning stage ready to be formally agreed.
- The delivery of the 2021/22 Plan had been impacted due to the Covid pressures placed on the Health Board. A total of 10 audits had previously been identified for removal/ deferral from the Plan following discussions with management and the Executive Team. Those had been previously approved by the Committee.
- A further two audits had also been proposed for removal / deferral.

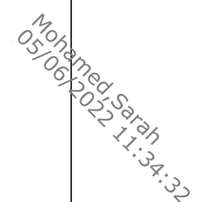
(i) The PCIC CB – Primary Care Vaccinations audit was proposed for removal from the 21/22 plan.

- Elements of the planned scope had been picked up as part of the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery. To avoid duplication, it was agreed that it would be efficient to include it as part of one audit.

(ii) The Digital Strategy Roadmap.

- The audit had been agreed for deferral to the 22/23 plan by the DDHI, due to current pressures on the IT team and the availability of key management. The roadmap would be included in the scope of the 22/23 Digital Strategy audit.

- The remaining 32 audits gave sufficient assurance for Internal Audit to give an opinion on the Health Board for the year.
- The draft 2022/23 plan was subsequently produced and was included separately on the Committee agenda for formal review and approval.



The VC queried whether there would be any consequences of delaying the reports, given the high significance of digitisation within the Health Board.

	IV responded that there would be concern if work was not scheduled early in the plan for 2022/23 to look at the wider strategy of Digital. Wendy Wright (WW) presented the following reports and highlighted the following: 1. Verification of Dialysis Sessions - It was a planned audit taken at the request of the Specialist Services Clinical Services Board. - The outcome was substantial assurance. - The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to raising staff concerns. - Although the review highlighted work in that area, three medium priority recommendations were made which included; (i) providing timely and continued communication around the freedom to speak up campaign, (ii) enhancement to the staff concerns held and (iii) how the governance arrangements required alignment. - A further two low priority recommendations were made. 2. Raising Staff Concerns - The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board. - The review highlighted the progress in the area. - Three low priority recommendations were made which included; (i) providing timely communication around the freedom to speak up campaign, (ii) enhancement to the concerns staff held and (iii) the governance arrangements required an all Wales alignment for staff to raise concerns. - A further two low priority recommendations were made. The Executive Director of Finance (EDF) stated that there was an issue about people raising concerns regarding counter fraud. The organisation should consider undertaking a focused piece of work with regards to how staff could raise concerns across the organisation. The Executive Director of People and Culture (EDPC) commented that following conversation with staff, the awareness was not apparent and it was time to increase the education and awareness around counter fraud. The VC stated that all staff should be made aware of the processes and the degree to which they would be listened to. The Independent Member for Trade Union (IMTU) queried if mandatory training would help raise awareness. The EDPC responded that mandatory training was low at the moment. There should to be different options for different people.	**EDF/EDPC**

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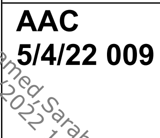
	3. Arrangements to Support the Delivery of Mental Health Services • The review was requested by the Mental Health Clinical Board. • The Advisory Review Report highlighted opportunities and contained no recommendations. • It also included a data collection tool for the Clinical Board to take forward. • The Report highlighted that the Clinical Board had a good understanding of the risks and challenges but there should be a focus on what the solutions were. • Further engagement was planned with the Clinical Board to relay the outcome more widely. The VC stated that it was a key piece of work and would help to manage the demand in a more informed way. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports, was considered. b) The proposed adjustments to the Internal Audit Plan for 2021/22 were approved.	
AAC 5/4/22 008	**Audit Wales Update** Darren Griffiths (DG) presented the Audit Wales Update report and highlighted the following: • Under Exhibit 3, the scope of the 2021 Local Work had now been agreed. • That included a review of the Estates which followed the recommendations made in 2017. The brief had been issued and signed by the relevant Executive Director and the field work was now under way. • In March 2022, the Auditor General had published a consultation inviting views to inform the future Audit work programme for 2022-23. The closing date for responding to the consultation was 8 April 2022. However, the consultation would be kept open to be able to capture as many responses as possible. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 5/4/22 009	**Review changes to Standing Financial Instructions (SFI) and Accounting Policies** The Director of Corporate Governance (DCG) presented the report and highlighted the following:	



	• It was good governance and practice to review Standing Orders and SFIs on an annual basis. • The all Wales SFIs and Standing Orders were adopted last year and there had been no changes since then. • The Standing Orders were brought to the last Committee meeting. **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 was noted.	
AAC 5/4/22 010	**Review System of Assurance** The DCG presented the report and highlighted the following: • It was a quick update on where the Health Board was against the overall system of assurance. • A strategy was brought to the Committee previously, which was then approved by the Board in September 2021. • The purpose of the strategy was to have an overall assurance map across the whole Health Board which would look at areas where there was good or poor assurance. • That would direct regulators in areas where the Health Board had gaps in its assurance. • It was a large piece of work which whilst it was ongoing, it had been delayed due to Covid 19 pressures. • The plan was to present a high- level assurance map to the Board by May 2022. **The Committee resolved that:** a) The proposed development of the Systems of Assurance and the progress made towards a higher level of maturity, were noted.	**DCG**
AAC 5/4/22 011	**Review Draft UHB Annual Report** The DCG stated the Annual Report was made up of 3 parts namely (i) the Performance Report (ii) the Accountability Report and (iii) the Financial Statement. The DCG added that the Accountability Report and Financial Report would be audited. A consistency check would be completed on the Performance Report. The Head of Corporate Governance (HCG) presented the Draft Annual Report and highlighted the following: • The draft Annual Report was a "work in progress" and there were a number of gaps in the current draft. • Some of the information required would not be available until the end of the financial year. There was also some	

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	information to be inserted following last week's Board meeting. • There were gaps in the Accountability Report and the relevant Lead Executives had been chased. • The Committee effectiveness surveys were due to go out that day. It would take another three weeks until the results could be analysed and inserted into the Annual Report. • The draft accounts must be submitted to Welsh Government and Audit Wales by 29 April 2022. • At the end of April 2022, the draft Annual Governance Statement must to be submitted to Internal Audit for their review and comments • On 6 May 2022, the draft Performance Report, the draft Accountability Report and the draft Remuneration Report would go to Welsh Government and Audit Wales. • The Audit Workshop on 12 May 2022, would allow Committee Members to further review the draft document at that stage. • A Special Audit Committee meeting and Special Board meeting were scheduled on 14 June 2022 to sign off the draft Annual Report in readiness for formal submission to Audit Wales and Welsh Government on 15 June 2022. **The Committee resolved that:** a) The progress made in relation to the drafting of the 2021-22 Annual Report was noted; and b) There were no comments with regard to the content of the draft report, attached as Appendix 2.	
AAC 5/4/22 012	**Self-assessment of effectiveness – Verbal** The DCG advised the Committee that self-effectiveness surveys were due to be issued that day and would involve all of the Committees undertaking a self-effectiveness review. The survey response audience had been broadened to improve the response rate and to help improve Committees of the Board. It was noted that the outcome of the survey would firstly be provided to the Audit Committee and then to the relevant Committees. A review against the Code of Governance and the Board Effectiveness Review would be completed for the next Audit Committee meeting. **The Committee resolved that:** a) The Self-assessment of effectiveness verbal update was noted.	**DCG**
AAC 5/4/22 013	**(i) Procurement Compliance Report** The EDF presented the Procurement Compliance Report and highlighted the following:	

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	• The report covered non-compliance and breaches. • There had been extensions to contracts and services due to the Covid pressures. • Those would need to be finalised as the Health Board's Covid response had become more stable. **(ii) Procurement Audit Influenceable Spend Report** The EDF advised the Committee that the report was one of the activities that had come from the breaches and a result of the work completed with regards to Capital governance in the last nine months. The Assistant Director of Procurement Services and Executive Procurement Lead (ADPS) highlighted the following: • The report was a consequence of the work completed in relation to the Capital Governance report phase 1/phase 2 in 2021. • One of the matters that would be looked at was the expenditure that sat outside Procurement influence in that period. • The 2020/21 influenced expenditure of 73.8% had increased significantly to 87.5% for 2021/22, due to the Capital construction expenditure moving to Procurement 's governance management, and the increased influence within medical and surgical consumables expenditure. • Within the currently influenced expenditure of £247,414,470, £102,355,374 manual invoice contracts were identified. • It had been proposed that the expenditure was looked at and popped onto an Oracle catalogue. That should deliver rich data as it would not run through as an Oracle payment but as a contract line. That should give visibility of whether the contracts had been exceeded and if there was additional savings that could be improved. • Examples of the £102,355,374 include CHC placements, laboratory external tests and continence products. • Within the £138,575,257 not influenced amount, a number of expenditure items would remain out of scope for Procurement influence due to the nature of the transactions, e.g., utilities, rates, personal injury, statutory audit fees and clinical negligence. • Removing those out-of-scope items left a figure of £115,310,152.07 which represented the opportunity for increasing Procurement influence for non-pay expenditure. A list of the top 20 categories were included in the report. • A request has been made for Procurement to undertake a "deep dive" analysis on the potential opportunities to increase Procurement influence within non-pay expenditure and return to the Audit Committee in September 2022 with a further update.	**EDF/ADPS**

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	The IMU queried if anything more could be done to reduce the influence on Primary Care. The ADPS responded that all Third Sector spend was managed by Procurement. The contracts had been tendered for a number of years and there was assurance that those contracts were well managed. The Primary Care spend was not services that could be influenced but the Procurement team could look at this. **The Committee resolved that:** a) The contents of the Procurement Compliance report were noted and agreed. b) The contents of the Non Pay Influencable Spend report were approved and agreed.	**ADPS**
AAC 5/4/22 014	**Losses and Special Payments Panel Report** The Interim Deputy Director of Finance (IDDF) presented the Losses and Special Payments Panel Report and highlighted the following: • The Health Board had established a Losses and Special Payments Panel. • That Panel met twice yearly and was tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee. • Service improvements were investigated on a case by case basis to see if there were emerging themes that could be improved. • The losses were also presented in the Annual Accounts and would be presented for full disclosure. The CC queried why the clinical negligence amounts in the report were different to what the Panel were asked to consider. The IDDF responded that the £10.946 clinical negligence amount and the £0.167m for personal injury represented the value of cases finalised and presented for approval of final loss. The table in the report represented the impact of new claims made in the 6-month period of review offset by anticipated income that would eventually be recovered from the Welsh Risk Pool. The £0.658m value was therefore the net I&E impact of new claims in the 6-month period. **The Committee resolved that:** a) The write offs outlined in the report were approved.	
	Items for Approval / Ratification	
AAC 5/4/22 015	**Declarations of Interest and Gifts and Hospitality Tracking Report** The Head of Risk & Regulation (HRR) presented the report and highlighted the following:	

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	• There had been a significant increase in the amount of declarations. • A further 130 declarations had been received since completion of the report. • The analysis of declarations of interest received suggested reasonable success from the recent advertising campaign. There had been an above average increase in the quantity of declarations made, as well as increased use of ESR rather than the more administratively heavy use of hardcopy forms and email returns. • The team would continue to work with the Communications team and hold another "power hour" later in the year. • The team were also working with the Board Members to ensure that their end of year declarations were submitted for end of year reporting purposes. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The Declarations of Interest, Gifts, Hospitality & Sponsorship Register was approved.	
AAC 5/4/22 016	**Regulatory Compliance Tracking Report** The HRR advised the Committee on the following: • The report contained a breakdown of the external regulatory and outstanding recommendations. • A report was shared last Monday in the Management Executive meeting to provide oversight of the Welsh Health Circulars that were outstanding. • Following the meeting, the most recent Welsh Health Circular was shared across the Health Board by email. • An update on Patient Safety Notices (PSN) was shared at the last QSE Committee meeting and would be reported twice a year. • As of 7 March 2022, there were 18 active PSN, 12 of which were overdue. Those were being managed by the Patient Safety Experience team. • 7 recommendations were removed from the Regulatory Tracker as they were complete. A further 2 would be removed that day as they have also been completed. • The team continued to work with the recommendation owners. **The Committee resolved that:** a) The assurance provided by the Regulatory Tracker and the confirmation of progress made against recommendations were approved. b) The continuing development of the Legislative and Regulatory Compliance Tracker was noted.	

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AAC 5/4/22 017	**Audit Wales Recommendation Report** The HRR advised the Committee on the following: • There were 20 entries currently reported. • 9 were added following February's Audit meeting. • All 20 entries were partially complete and 4 were over 6 months overdue. The team would focus on those entries to ensure that they did not stagnate without being progressed. **The Committee resolved that:** a) It noted, and was assured by, the progress which had been made in relation to the completion of Audit Wales recommendations. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 5/4/22 018	**Internal Audit Tracking Report** The HRR advised the Committee on the following: • The Tracker currently recorded 84 entries. • 18 recommendations had been removed and an additional 7 extra reports would be added to the Tracker at the next Committee meeting. • An additional 4 reports would be added to the Tracker following the meeting. • Following discussions with Internal Audit, there was an action plan to move stagnant entries forward. Each Executive Lead had been sent the recommendations, made by Internal Audit, which fell into their respective remits of work. • There was also an action plan on how to record advisory recommendations. IV acknowledged the work that had gone into the Tracker. Internal Audit would continue to meet with HRR before the Audit Committee meetings to review the draft Tracker. IV also added that WW was currently undertaking work to validate a number of recommendations that were recorded as complete over the last year in order to give further assurance to the Committee with regards to the accuracy of the information on the Tracker. That would be reported at the next Committee meeting. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit were noted. b) It noted, and was assured by, the progress which had been made since the previous Audit and Assurance Committee Meeting in February 2022.	**Internal Audit**

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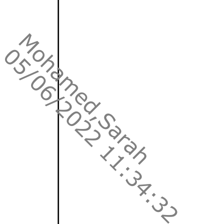
AAC 5/4/22 019	**Internal Audit Annual Plan 22/23** IV presented the Internal Audit Annual Plan 22/23 and highlighted the following: • The Plan detailed the audits to be undertaken in 2022/23. • Section 2 of the report set out that the Plan was being developed in accordance with the Public Sector Internal Audit standards. There was also a risk-based approach to developing the Plan. • Page 5 of the report covered the key elements of the Plan. • Section 2 set out the plan to audit key risk areas within the Health Board. • Section 4 would include any work requested on an all Wales basis by Directors of Finance or Board Secretaries. • Internal Audit met with all the Executives in the Health Board to identify potential audits with risk areas within their individual portfolios. An initial Plan was drafted and discussed with the UHB Chair. • The Plan would be under review in case of changes to risks or priorities within the Health Board and to ensure it gave appropriate assurance. The VC queried whether the previous audits that were postponed were included in the Plan IV responded that the majority of them were still in the Plan following discussions with the relevant Executive Directors. The EDPC stated that the Staff Sickness audit was delayed by the team and requested that it went ahead in May as it was urgently needed. IV responded that the Staff Sickness audit was going to be delivered as part of the 2021/22 plan. **The Committee resolved that:** a) The Internal Audit Plan for 2022/23 was approved. b) The Internal Audit Charter for 2022/23 was approved.	
AAC 5/4/22 020	**Audit Wales Annual Plan** Mark Jones (MJ) advised the Committee on the following: • Under the NHS Finance (Wales) Act 2014, Health Boards ceased to have annual resource limits with effect from 1 April 2014. • Instead, they had moved to a rolling three-year resource limit, with a limit for revenue and another limit for capital. The first three-year period ran to 31 March 2017. • The Health Board had exceeded its rolling three-year revenue limit in the past five years. • For 2021-22 and the three years to 31 March 2022, the Health Board had forecast to operate within its revenue and	



	capital resource limits, subject to anticipated 2021-22 COVID-19 funding of £21.3 million from the Welsh Government. • Covid risks and fraud risks were also included in the Plan. • Exhibit 3 set out the audit fees. The fees had increased by 3.7%. The fee rates had increased for the first time since 2008. • Exhibit 4 set out the Audit team. The Audit Director for Financial Audit had been absent and would not be doing this year's audit. Richard Harris would cover him for this set of accounts. • There were two potential conflict of interests. The new Counter Fraud Manager and MJ were cousins. His wife also worked for the Health Board as a Consultant. DG advised the Committee on the following: • In Anthony Veal's absence, David Thomas would be acting as the Engagement Director for the Health Board. • There were four aspects to the performance audit work. • The Structured Assessment work would be reshaped and refocused this year. Over the last two years there had been a focus on Covid. There would now be a focus on pre-pandemic arrangements. • There was a plan to undertake a piece of work around workforce risks and workforce planning arrangements at each NHS body. Individual reports would be provided to the Health Board. • A locally focused piece of work would also be undertaken. The scope of that had yet to be determined with the Executives. **The Committee resolved that:** a) The Audit Wales Annual Plan Update was noted.	
AAC 5/4/22 021	**Audit Enquiries to those charged with governance and management** The EDF advised the Committee on the following: • A letter had been received from Audit Wales which had detailed audit enquiries to those charged with governance. • A proposed response had been prepared and shared with the relevant colleagues. • Subject to Committee approval, it would be sent as the formal response as part of the audit process. **The Committee resolved that:** a) The response provided to the audit enquiries to those charged with governance and management was endorsed.	
	Items for Information and Noting	

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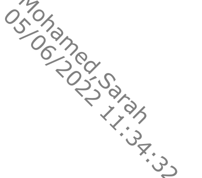
AAC 5/4/22 022	**Internal Audit reports for information:** 1. Verification of Dialysis Sessions Final Report (Substantial Assurance) 2. Raising Staff Concerns Final Report (Reasonable Assurance) 3. IT Service Management Final Report (Limited Assurance) Arrangements to Support the Delivery of Mental Health Services (Advisory)	
	Agenda for Private Audit and Assurance Committee	
AAC 5/4/22 023	i. Counter Fraud progress report ii. Workforce and Organisational Development Compliance Report	
	Any Other Business	
AAC 5/4/22 024	Items to be deferred to Board / Committee	
	Date & time of next Meeting Thursday 12 May 2022 at 9am via MS Teams	



Public Action Log
Following Audit & Assurance Committee Meeting
5th April 2022
(For the Meeting 12th May 2022)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
		Completed Actions			
AAC 22/2/8/022	Annual Audit Wales Plan	Audit Wales Annual Plan to be shared at the next Committee meeting.	Audit Wales	05/04/2022	**Complete** Audit Wales Annual Plan was presented to and noted by the Committee on 5/4/2022 under agenda – item 8.6
AAC 22/5/4/007	Internal Audit Progress Reports	7 Audits were delayed and will be brought to the meeting in May.	Ian Virgil (Internal Audit)	12/5/2022	**Complete** On today's agenda – item 9.1
AAC 22/5/4/007	The Arrangements to support the delivery of Mental Health Services	The management response will be provided at the meeting in May.	Internal Audit	12/5/2022	**Complete** Management response to be shared at May's meeting – on agenda (item 9.1)
AAC 22/5/4 007	Internal Audit Progress Reports: Raising Staff Concerns	Staff education and awareness around counter fraud.	Catherine Phillips/Rachel Gidman	12/5/2022	**Complete** Verbal Update to be provided at May's meeting.
AAC 22/5/4/ 012	Self-assessment of effectiveness – Verbal	A review against the Code of Governance and the Board Effectiveness Review will be completed.	Nicola Foreman	12/5/2022	**Complete** On today's agenda -item 7.2
AAC 22/5/4/ 018	Internal Audit Tracking Report	Internal Audit are validating a number of recommendations that were recorded as complete over the last year to give further	Internal Audit	12/5/2022	**Complete** On today's agenda – item 7.4

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		assurance to the committee on the accuracy of the information on the tracker.			
Actions in Progress					
AAC 22/2/8/023	Meeting with Audit Wales	Independent Members to meet with Audit Wales virtually.	Nicola Foreman	**5/7/2022**	**In progress** Meeting between the Committee IMs and Audit Wales scheduled to take place on or before 5 July 2022.
AAC 22/2/8/009	Audit Wales Report: Taking Care of the Carers' – Management Response	Nicola Foreman to agree timescales with Rachel Gidman and Claire Whiles regarding when to take the recommendations off the Tracker.	Nicola Foreman	**30/09/2022**	**In progress** These will be removed at the end of September after a final check with the EDPC
AAC 22/5/4/007	IT Service Management Report	David Thomas to provide an update on the IT service Management Report actions.	David Thomas	**5/7/2022**	**In progress** Update to be shared at July's meeting.
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	Procurement will complete a deep dive analysis on the potential opportunities to increase procurement influence within non-pay expenditure and return to the Audit Committee in September 2022 with a further update.	Claire Salisbury/Catherine Phillips	**6/9/2022**	**In progress** Update to be provided at the September meeting.
AAC 22/5/4/013	Procurement Audit Influenceable Spend Report	The Procurement team could look at whether the Primary Care spend could be influenced.	Claire Salisbury	**6/9/2022**	**In progress** Update to be provided at the September meeting.
Actions referred to Board / Committees					

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AAC 22/02/08/022	Committee Annual Work Plan - 2022/23	The Committee's Annual Work Plan would be submitted to the Board for formal approval at the end of March 2022.	Nicola Foreman	31/03/2022	**Complete** Approved by full Board at its meeting on 31 March 2022.
AAC 5/4/22 010	Review System of Assurance	A high- level assurance map to be provided to Board.	Nicola Foreman	28/7/2022	**In progress** To be shared at the Board meeting in July 2022 (added to Board Forward Plan).

Report Title:	Compliance with the UK Corporate Governance Code			Agenda Item no.	7.1
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	12 May 2022
		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)[1], 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's 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 2021-March 2022, and to seek the Audit Committee's approval to include the assessment in the Annual Report 2021-2022.

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

- An assessment has been undertaken against the applicable elements of the Code and the findings are presented at ***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 2021-March 2022; and

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[1] https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017

b) **APPROVE** the self-assessment of compliance against the UK Code of Corporate Governance for inclusion in the Accountability Report for 2021-2022.

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	x
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	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes - an EHIA will be undertaken in relation to, and prior to, the publication of the full Annual Report.

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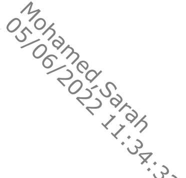
[1] https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017

Decarbonisation: No

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



[1] https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments-2017

Appendix 1

Cardiff and Vale University Health Board (CVUHB) Review Against the UK Corporate Governance in Central Government Departments: Code of Good Practice
2021-2022

This review covers the period April 2021 - March 2022 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), organisational strategy, the clinical services plan, providing leadership which is cascaded throughout the organisation. With regards to the IMTP, and in line with the Welsh Government's direction to return to a three year planning approach, the Health Board has developed a new three year IMTP for 2022 to 2025.
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

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Requirement of the Code	Evidence of CVUHB Compliance
	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.	Traditionally, public Board meetings are held Board bi-monthly, with private Board Development Sessions being held in between. During the Winter period of 2021-2022, the frequency of the public Board meetings increased to monthly in order to focus upon COVID 19 recovery and Winter pressures. The monthly Board meetings ran from December 2021 to February 2022.
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.
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 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	
3.1 The Board should have a balance of skills and experience appropriate to	The Board comprises of Independent Members who are appointed by Welsh

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Requirement of the Code	Evidence of CVUHB Compliance
fulfilling its responsibilities. The membership of the Board should be balanced, diverse and manageable in size.	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 Model standing orders for NHS Wales stipulate that: **Officer Members -** there should be 9 officer members 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 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"*	The job description for the Executive Director of Finance stipulates that they must be a qualified accountant.
3.4 Not applicable	

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Requirement of the Code	Evidence of CVUHB Compliance
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 April 2022 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.
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	

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Requirement of the Code	Evidence of CVUHB Compliance
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:- (i) in the Standing Orders for Board papers to be circulated at least ten days; and (ii) in 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 are not applicable as they are not part of the package.
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 2021-2022 provides the attendance record for Board members.
4.7 Not applicable	
4.8 Not applicable, although principles apply. In short, Board members should	In line with the Health Board's Standing Orders, Board papers are provided to

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Requirement of the Code	Evidence of CVUHB Compliance
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.	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.
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 although it is recognised that this is an area which 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, • 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	Board Members are subject to annual performance appraisal by the Chair and Chief Executive. The Chair and Chief Executive are subject to appraisals

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Requirement of the Code	Evidence of CVUHB Compliance
demonstrates commitment to the role (including commitment of time for Board and committee meetings and other duties).	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 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 are considered by the Board at each of its bi-monthly meeting, and by the Audit and Assurance Committee. The Committees receive regular updates.
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.

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Requirement of the Code	Evidence of CVUHB Compliance
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 also 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'.
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 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 recommendation 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,

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Requirement of the Code	Evidence of CVUHB Compliance
	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 review 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.
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.
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	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

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Requirement of the Code	Evidence of CVUHB Compliance
department's implementation of, corporate governance policy.	CVUHB as part of the annual reporting process.
Chapter 6 Arm's Length Bodies	
Not applicable	

Report Title:	Board and Committee Effectiveness Surveys 2021-22				Agenda Item no.	7.2
Meeting:	Audit and Assurance		Public Private	x	Meeting Date:	12 May 2022
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 in April 2022 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 2021-2022 self-assessment, a survey was disseminated via Survey Monkey 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.

At the time of writing this report, the results for the Committee Effectiveness survey in respect of the Renumeration and Terms of Service (RATS) Committee had not been received. Accordingly, this report does not take account of the RATS Committee Effective survey and the findings of the RATs survey will be presented to the Committee via a separate report.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2021-2022, and to provide an update on the action plan following the survey undertaken in 2020-2021.

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

- Following the survey undertaken in 2020-2021, the Board Effectiveness Action Plan 2020-2021 is presented **within Appendix 1** and outlines the actions completed following the survey undertaken in 2020-2021.

- The survey questionnaires for the annual Board/Committee Effectiveness Surveys 2021-2022 were issued in early April 2021 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 7 areas and a Board Effectiveness Action Plan 2021-2022 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 2021-2022 undertaken in April 2021 are presented **within the supporting documents** for information.

- The findings of the RATS Committee Effectiveness Survey will be presented to the Committee under a separate report.

- 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 March/April 2023 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2022-2023.

Recommendation:

The Committee is requested to:

a) **NOTE** the results of the Annual Board Effectiveness Survey 2021-2022, and the action plan for 2021-2022, to be progressed via Board Development sessions; and

b) **NOTE** the completed actions within the Board Committee Effectiveness Action plan 2020-2021.

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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		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
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

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Appendix 1

Board Effectiveness – Self Assessment 2020-2021 Action Plan

Question asked 2020	Action Required	Lead	Timescale to complete	Progress as at April 2021
Board **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. **Action** Consider strengthening and developing sharing best practice and benchmarking at a future Board Development session.	Executive Nurse Director, Executive Director for Strategic Planning Executive Medical Director, Chief Operating Officer, Executive Director of Workforce and OD.	December 2021	This work has progressed in some areas with strengthened benchmarking against and sharing good practice with other Local Health Boards in Wales. However, there is further work to do. In particular, to consider how the Health Board can benchmark our services across other large teaching hospitals throughout the UK. At the Board Development Session held in April 2022, the Board considered the development of the Integrated Performance Report which includes Key Performance Indicators for Quality and Safety, Finance, Workforce, Performance and Public Health.
Charitable Funds Committee **Health and Safety Committee** **Committee meetings packages are complete,**	All Committee papers are issued in accordance with section 7.4.3 of the Standing Orders, specifically: *"7.4.3 Board members shall be sent an Agenda and a complete*	Director of Corporate Governance	December 2021	All Board papers received by the Corporate Governance Team are published at least 10 clear days before the relevant Board meeting. Committee

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received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting.	*set of supporting papers at least* ***10 calendar days*** *before a formal Board meeting."* *Action* - The Corporate Governance team will continue to adhere to internal performance standards for the review, approval and issuing of minutes, and will ensure that all minutes are issued swiftly. A review of the timeliness of papers being issued against the internal targets set will be undertaken to monitor effectiveness. Agenda planning meetings will confirm that minutes have been approved by the Chair and circulated to Members as required.			papers are published at least 7 clear days prior to the relevant Committee meetings. It is recognised that there are occasions where Board/Committee papers are received by the Corporate Governance Team after the publication date. The Corporate Governance Team's Standing Operating Procedure (SOP) has been updated, in particular to build in further prompts to email reminders to the relevant report authors for outstanding papers. The SOP has also been updated to reflect the required timescales to draft minutes following a Committee meeting, and to send to the relevant Chair for approval in order to ensure that the approved minutes are circulated to the relevant Committee Members in time for the agenda setting meetings.
<u>Health & Safety Committee</u>	The Composition of the Health & Safety Committee is outlined in its	Director of Corporate Governance	December 2021	A review of the Membership for all of the Board's Committees was undertaken by the Chair in

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2. The Board is active in its consideration of the Committee's composition	Terms of Reference which are agreed by the Board. The DCG will liaise with the Chair and review the composition of all Committees and the scheme of delegation within the Standing Orders will be updated.			July last year and the updated Committee Membership was approved by the Board on 29 July 2021.
<u>Quality, Safety, Experience Committee</u> **The Committee agenda setting process is thorough and led by the Committee Chair.**	All Board/Committee meetings are supported through an agenda planning meeting which reviews the agenda, minutes, action log and length of the meeting. The Committee Chair attends the meeting and is involved in setting the agenda with the Director of Corporate Governance. A meeting guidance document will be produced and issued to Officers and Independent Members and all agenda planning meetings will consider the length of the agenda, items for the agenda, time allowed for agenda items, approval of minutes and action logs, terms of reference, quoracy, Chairs report for Board etc	Director of Corporate Governance	May 2021	The Corporate Governance Team's SOP has been further strengthened to ensure the smooth running of Board/Committee meetings and agenda setting meetings. Prior to the agenda setting meeting, the Committee Chair is sent a copy of the draft minutes for review and approval. All relevant individuals (including the Committee Chair and the Executive Lead) are sent a copy of the draft agenda, draft Action Log together with a draft set of minutes before the agenda setting meeting. The Corporate Governance Team has also developed a Forward Plan document to capture additional items of business which are not listed in the Committee's Workplan, in

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				order to streamline the agenda setting business.

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Appendix 2

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
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
Board **10. We invite effective feedback and use the lessons learned to develop and improve the Board's and senior management team's effectiveness.**	The Chair of the Board reviews the effectiveness of the Board meeting as part of the agenda at each respective meeting. **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.	Director of Corporate Governance	July 2022

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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
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

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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	
Audit and Assurance Committee **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
Audit and Assurance Committee **20. Does the Board ensure that the Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters.**	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.	Director of Corporate Governance	March 2023

	- 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. - 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.		

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Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.4
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	12/05/22
			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 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 2021/22 plan was formally approved by the Audit Committee at its April 21 meeting.

The progress report provides the Audit 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 details of proposed postponed / removed audits and 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 Executive summaries for the finalised reports are also included within the progress report and those given Limited or No Assurance are also included separately on the agenda in full. There are two reports that has been given a Limited Assurance rating during the current period.

The plan has been subject to change through the year with 12 audits agreed for removal / deferral. The audits remaining within the plan still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year. On the basis of the outcomes of the audits already completed and the current position of those that are in progress, the draft annual opinion is Reasonable Assurance.

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.

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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/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
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality and Health: Yes/No
Decarbonisation: Yes/No

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

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Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee May 2022

NWSSP Audit and Assurance Services

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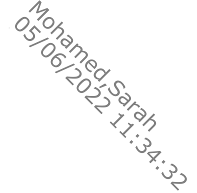
6.Final Report Summaries *6*

Appendix A Assignment Status Schedule

Appendix B Report Response Times

Appendix C Key Performance Indicators

Appendix D Assurance Ratings



1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2021/22 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 2021/22 was agreed by the Audit & Assurance Committee in April 2021 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 April Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
ChemoCare IT System	Draft	Limited	Availability of Management to agree report and provide responses.
Waste Management	Draft	Reasonable	Delay in completion of fieldwork due to availability of Internal Audit resources.
Capital Systems Management	WiP		Delays in receiving information from the Health Board
Post Contract Audit of DHH Costs	WiP		Liaison with Audit Wales to determine work undertaken.

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3. Outcomes from Completed Audit Reviews

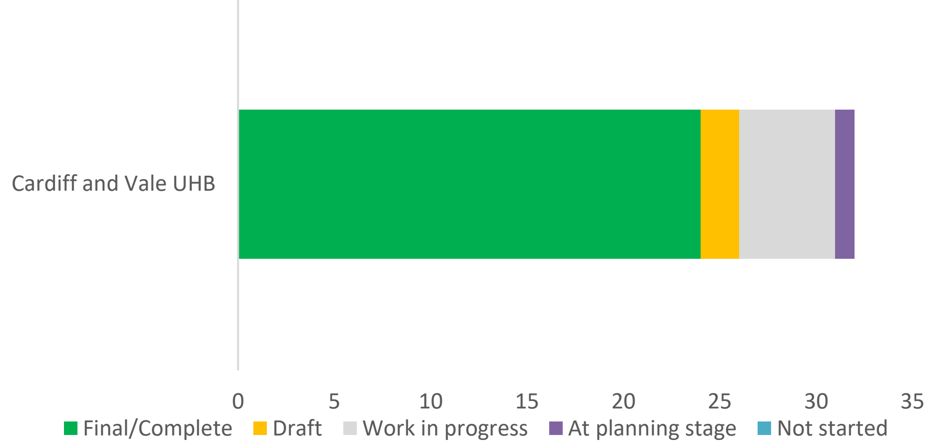
Eight assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

The Executive Summaries from the finalised assignments are reported in Section six. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS	ASSURANCE RATING	
COVID-19 Vaccination Programme - Phase 3 delivery	Substantial	
Welsh Risk Pool Claims		
Health & Safety		
Wellbeing Hub at Maelfa		
Development of Genomics Partnership Wales	Reasonable	
Nurse Rostering: Children's Hospital for Wales (Children and Women's CB)		
Nurse Bank	Limited	
Network and Information Systems (NIS) Directive		

4. Delivery of the 2021/22 Internal Audit Plan

There are a total of 32 reviews included within the updated 2021/22 Internal Audit Plan (including adjustment for the proposed two changes detailed below), and overall progress is summarised below.



From the illustration above it can be seen that twenty four audit outputs have been finalised/completed so far this year with two further audit reports issued in draft.

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

Due to the Covid related pressures faced by the Health Board during the year and resourcing issues within the Internal Audit team, the agreed plan has been subject to ongoing review and adjustment. The Committee has previously agreed the removal / deferral of twelve audits from the 21/22 plan following discussions with management and agreement from the Executive team.

The remaining thirty two audits within the 2021/22 plan still provide sufficient coverage across the Health Board to allow for the provision of a full Head of Internal Audit annual opinion at the end of the year.

On the basis of the outcomes of the audits already completed and the current position of those that are in progress, the draft annual opinion is Reasonable Assurance. This is reflected in the draft Annual Report 2021/22 that has been submitted for the Audit Committee Workshop.

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.

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

5. Assurance on Recommendation Tracking

During 2021/22 the Corporate Governance team have continued to develop the Internal Audit Recommendation Tracking process. The tracker provides the Audit Committee with information on the current progress that has been made towards the implementation of outstanding Internal Audit recommendations. The information within the tracker is based on responses provided by Health Board management confirming the current progress.

We have worked with the Corporate Governance team through the year to review and provide feedback on the tracker prior to its submission to each meeting of the Committee.

We have also commenced a piece of work at the year-end to validate the stated position for a sample of 20/21 recommendations that have been recorded as complete within the tracker, in order to provide additional assurance to the Committee.

This exercise is currently on-going as we are awaiting responses and provision of relevant evidence from a number of managers. The outcome of this work will inform the final Head of Internal Audit opinion for 21/22 and will also be separately reported to a future meeting of the Committee.

6. Final Report Summaries

6.1 COVID-19 Vaccination Programme - Phase 3 delivery

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the delivery of the COVID-19 Vaccination Programme (Phase 3).

Overview

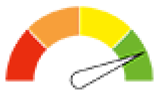
We have issued substantial assurance on this area.

Our report makes the following two low priority recommendations, which are best practice in nature to support the continual improvement of the Health Board's processes:

- To undertake a formal and documented lesson learnt exercise, now that the Health Board has progressed through a number of phases of the COVID-19 Vaccinations Programme; and
- Further progress be made with the accessibility of governance documentation, to support the imminent COVID-19 Inquiry.

Report Classification

Substantial



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

Low impact on residual risk exposure.

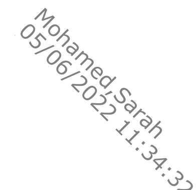
Assurance summary[1]

	Assurance objectives	Assurance
1	An effective plan is in place detailing the delivery of Phase 3 of the vaccination Programme for each workstream.	Substantial
2	There is appropriate governance / oversight over the delivery of the plan.	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.



6.2 Welsh Risk Pool Claims

Purpose

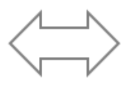
The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Welsh Risk Pool claims.

Overview

We have issued Substantial assurance on this area. The matters requiring management attention include:

- Out of date policy available on the Health Board website.
- Reconciliation between Datix and the financial schedule.

Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2020/21

Assurance summary[1]

	Assurance objectives	Assurance
1	Completed documents within set timescales	Substantial
2	Evidence to support costs incurred	Substantial
3	Appropriate authorisation	Substantial
4	Accurate data within Datix	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Claims Management Policy (UHB 332) requires review	1	Operation	Medium
2	Reconciliation of Invoices	4	Operation	Medium

6.3 Health & Safety

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Health and Safety, in response to an external review undertaken in 2021.

Overview

We have issued substantial assurance on this area.

Our report makes three low priority recommendations, which are best practice in nature and support the improvement journey of Health and Safety arrangements. We note that the draft plans go beyond process and look to reshape the culture within the Health Board, communicated through the Health and Safety Culture Plan 2022-2025.

Given the draft status of the Plan, our recommendations support the Health Board's approach and suggest areas for future consideration, such as formal closure of the recommendations made within the external review of Health and Safety. Further, the assurance mechanisms to be offered to the Health and Safety Committee to facilitate challenge and scrutiny of delivery.

Report Classification

Substantial

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

Low impact on residual risk exposure.

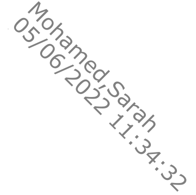
Assurance summary[1]

	Assurance objectives	Assurance
1	Adequate reporting arrangements to the Health and Safety Committee	Substantial
2	There are plans in place to address the recommendations made within the external review of Health and Safety	Substantial
3	Nominated leads and milestones are included within the plans	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.



6.4 Wellbeing Hub at Maelfa

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Maelfa Wellbeing Hub project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

A robust project team structure was operating with supporting workstreams, continued liaison with external advisers and routine reporting to the Project Team and Delivery Group. The construction programme was being effectively managed, and the project was forecast to be delivered on time (complete project: December 2022).

The latest Project Manager's report (March 2022) indicated that a projected underspend of £8,233 was anticipated.

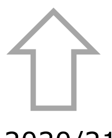
The key matters arising at the project primarily relate to enhancements to the practices of the supporting workstreams, as they gain momentum in the next phases of the project programme, including:

- Evaluation of their operations to ensure deliverables are achieved; and
- Review of the risk management processes applied, to ensure appropriateness of escalation.

There is also a requirement for improved timeliness of contractual payments at the project.

In considering the above, with the otherwise positive time, cost and quality position, **substantial assurance** has been determined at this interim stage of the project.

Report Classification

		Trend
Substantial	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]

	Assurance objectives	Assurance
1	Follow up	Substantial
2	Project Governance	Reasonable
3	Project Management	Reasonable
4	Change Control	Substantial
5	Cost Control & Reporting	Substantial
6	Valuation & Payments	Reasonable

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

Key Matters Arising

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2.2	Monitoring processes within the workstreams require standardisation, including application of target dates	2	Operation	Medium
3.1	The workstreams risk registers require further development to ensure consistency of scoring and escalation.	3	Operation	Medium
7.2	Payments to contractors are required to be paid in line with agreed timescales.	6	Operation	Medium

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6.5 Development of Genomics Partnership Wales

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Genomics Partnership Wales (GPW) capital investment project and is not an audit of the wider strategic programme; and the performance to date against its key delivery objectives i.e. time, cost and quality. The period reviewed included OBC and FBC development, and preparations to commence construction.

Overall Audit Opinion and Overview

A robust project team structure was operating, led by the Project Director and involving key GPW representatives and supporting workstreams, with routine reporting to the Project Team and Capital Management Group. Appropriate engagement with users and stakeholders, and support from appropriate external advisers, was evidenced during the design development process.

An accelerated FBC development approach was agreed at the project - progressing at risk ahead of WG OBC approval; and without a fully developed design at the point of FBC submission.

Despite the accelerated process, targeted FBC dates were not achieved due to slippage in the Welsh Government OBC approval timeline. Contract negotiations, following FBC approval, further delayed the commencement of works on site. Whilst reporting significant risks should further delays materialise, GPW has confirmed it can remain in existing accommodation until the planned completion date.

The FBC target cost has increased, post approval, by £450k following further design development and market testing. At the time of the audit, the increase was being managed within the £1.2m project contingency.

The key matters arising at the project include:

- A need for improved contractual management arrangements at all stages of the project; and
- Weaknesses in the approvals process in relation to the accelerated approach.

Other recommendations are within the detail of the report. Noting the priority ratings of the issues identified at the current report, **reasonable assurance** has been determined at this interim stage of the project.

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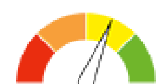
Report Classification

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

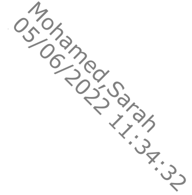
	Assurance objectives	Assurance
1	Governance	Reasonable
2	Approvals	Reasonable
3	Contract Management	Reasonable
4	Design Development	Substantial
5	Project Management	Substantial

[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
3.3	Advice to be sought from NWSSP:SES & Procurement Services on the management of FBC-stage contractual requirements, when progressing the project at risk.	3	Operation	Medium

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	Project acceleration approval (and associated financial risk) to be in accordance with the UHB's scheme of delegation.	2	Operation	Medium
2.2	Deviations from Welsh Government guidance, for business case submission, to be highlighted and endorsed at Board level.	2	Operation	Medium
3.1	Contracts should be in place prior to works / duties commencing.	3	Operation	Medium
3.2	Letters of Intent do not represent good practice and should only be used in exceptional circumstances.	3	Operation	Low

Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken at this project, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report



6.6 Nurse Rostering: Children's Hospital for Wales (Children and Women's CB)

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the rostering arrangements within the Children's Hospital for Wales.

Overview

We have issued reasonable assurance on this area.

The Health Board has acknowledged that there is a need to advance the nurse rostering process with the introduction of a new rostering system, HealthRoster.

A number of the issues that we have identified through this review have the potential to be resolved through the introduction of the new system. We make recommendations which relate to documented approval and dissemination of rosters, which similarly relate to the management of rosters, including the documentation and approval of make up shifts, overtime, and shift changes.

We also identified that the Children's Assessment Unit / Seahorse has no access to a Nurse Practice Educator to oversee skills-mix.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Roles and responsibilities for nurse rostering align with procedure.	Substantial
2	Rosters are produced, signed off and published in advance.	Limited
3	Rosters are produced in accordance with nurse establishment levels.	Reasonable
4	Rosters are fit for purpose with deployment of skills mix.	Reasonable
5	Rosters have been created cognisant of agreed flexible working requests.	Substantial
6	Review and reporting of the effectiveness of the rostering process.	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Evidence of roster approval	2	Operation	Medium
2	Timeliness of Roster Dissemination	2	Operation	Medium
3	Roster dissemination via mobile messaging	2	Operation	High
4	Roster Management	3	Operation	Medium
5	Access to a Nurse Practice Educator (CAU)	4	Operation	Medium

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6.7 Nurse Bank

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the Nurse Bank.

Overview

We have issued limited assurance on this area.

We have made a number of high and medium priority recommendations which require management attention that relate to the structure and operation of the Temporary Staffing Department, which holds the Nurse Bank.

There is a lack of resilience within the current structure, which is impacting the recruitment to the Nurse Bank, payment to agencies, and a general lack of engagement with service users, whether that be ward management or bank staff themselves.

Report Classification

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Policy, procedures and guidance.	Reasonable
2	Structure and operation of the Temporary Staffing Department.	Limited
3	Verification and authorisation of bank and agency shifts.	Limited
4	Accurate and timely reports on bank usage and costs.	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Lack of Temporary Staffing Guidance	1	Design	Medium
2	Inadequate structure within the Temporary Staffing Department	2	Design	High
3	Resilience of the Temporary Staffing Department	2 & 3	Operation	High
4	Roles and responsibilities for Bank recruitment	2	Operation	Medium
5	Lack of engagement with service users	2 & 4	Operation	Medium
6	Operational management of the Temporary Staffing Department	2	Operation	Medium
7	Range of agency usage	3	Operation	High
8	Ward verification of agency shifts	3	Operation	Medium

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6.8 Network and Information Systems (NIS) Directive

Purpose

Review arrangements in place for the implementation of the NIS Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Overview

We have issued limited Assurance on this area. The significant matters which require management attention include:

- the submitted CAF was partially complete resulting an incomplete self-assessed position.
- No retention of supporting information provided to the Cyber Resilience Unit as part of the CAF assessment.
- Improvement actions have not been identified and a plan has not yet been developed.
- Corporate cyber security risk has not been updated to include NIS Regulations.

Report Classification

Limited

More significant matters require management attention.

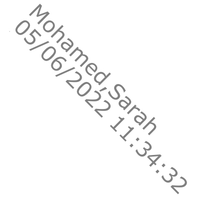
Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	CAF completion and maintenance of evidence	Reasonable
2	Accurate self-assessed position supported by evidence	No
3	Improvement plan implementation	Limited
4	Governance	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Supporting information retention	1	Operation	Medium
2	Self-assessed position	2	Operation	High
3	Improvement plan	3	Design	Medium
4	Cyber security risk	4	Operation	Medium



ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Legislative, Regulatory & Alerts Compliance	06	Corporate Governance	Q1		Final Report Issued August 21	Reasonable	Sept
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	11	Public Health	Q1		Final Report issued August 21	Reasonable	Sept
CD&T CB – Ultrasound Governance	27	COO	Q1		Final Report issued August 21	Limited	Sept
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	29	COO	Q2		Final Report issued August 21	Reasonable	Sept
Clinical Audit	15	Medical	Q2		Final Report issued October 21	Limited	Nov
Five Steps to Safer Surgery	16	Medical	~~Q1~~	Q2	Final Report issued October 21	Limited	Nov
Theatre Utilisation (Surgery Clinical Board)	25	COO	Q1		Final Report issued Jan 22	Reasonable	Feb
Retention of Staff	09	Workforce	Q2		Final Report issued Jan 22	Reasonable	Feb
Core Financial Systems	03	Finance	Q3		Final Report issued Jan 22	Substantial	Feb
Welsh Language Standards	08	Workforce & OD	Q3		Final Report issued Jan 22	Reasonable	Feb
IT Service Management (ITIL)	19	Digital & Health Intelligence	Q2		Final Report issued March 22	Limited	April
Raising Staff Concerns (Whistleblowing)	05	Corporate Governance	~~Q2~~	Q3	Final Report issued March 22	Reasonable	April
Verification of Dialysis Sessions (Specialist Services Clinical Board)	26	COO	Q3		Final Report issued March 22	Substantial	April
Arrangements to Support the Delivery of Mental Health Services (Mental Health Clinical Board)	28	COO	Q4		Final Report issued March 22	N/A Advisory	April

Planned output.	**No**	**Exec Director Lead**	**Plnd Qtr**	**Adj Qtr**	**Current progress**	**Assurance Rating**	**Planned Audit Committee**
Development of Genomics Partnership Wales	*SSU*	*Strategic Planning*	*Q2*		*Final*	*Reasonable*	*May*
Welsh Risk Pool Claims	04	Nursing	Q3		Final	Substantial	May
Nurse Bank	13	Nursing	Q3		Final	Limited	May
Network and Information Systems (NIS) Directive	22	Digital & Health Intelligence	Q3		Final	Limited	May
Nurse Rostering: Children's Hospital for Wales (Children & Women's CB)	30	COO	~~Q4~~	Q3	Final	Reasonable	May
COVID-19 Vaccination Programme - Phase 3 delivery	10	Public Health	Q4		Final	Substantial	May
Health & Safety	18	CEO	~~Q2~~	Q4	Final	Substantial	May
Wellbeing Hub at Maelfa	*SSU*	*Strategic Planning*	*Q4*		Final	*Reasonable*	*May*
ChemoCare IT System	21	Digital & Health Intelligence	Q3		Draft	Limited	July
Waste Management	*SSU*	*Finance*	*Q3*		*Draft*	*Reasonable*	July
Risk Management	01	Corporate Governance	Q4		Work in Progress		July
Recovery of services and Delivery of the Annual Plan 2020/21	31	COO	Q4		Work in Progress		July
Performance Reporting (Data Quality)	32	COO	Q4		Work in Progress		July
Capital Systems Management	*SSU*	*Strategic Planning*	*Q4*		*Work in Progress*		July
Management of staff Sickness Absence	07	Workforce	Q2	Q4	Planning		July
Post Contract Audit of DHH Costs	34	Finance	Q1	Q4	Planning		July

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Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Major Capital Scheme – UHW II	*SSU*	*Strategic Planning*	*Q1-4*		*Complete* *On-going observer role, proactive input, and overview of the progression through the period.*	*n/a*	*n/a*
Development of Integrated Audit Plans	*SSU*	*Strategic Planning*	*Q1-4*		*Complete* *Plans have been developed for inclusion within the respective business case submissions for relevant major projects/ programmes.*	*n/a*	*n/a*
Reviews Deferred / Removed from the plan							
ALNET Act	36		Q2		Director of Therapies and Health Sciences requested Deferral to 22/23 plan as work on-going to embed processes within Health Board. Agreed by June AC.		
Consultant Job Planning Follow-up	17	Medical	Q4		Removed as assurance level increased to Reasonable after 20/21 follow-up – Agreed by June AC		
Clinical Board's QS&E Governance	12	Nursing	~~Q2~~	Q4	Director of Nursing requested deferral to 22/23 plan. QS&E Governance arrangement currently being reviewed by Audit Wales and a new Framework is also being introduced. – Agreed by September AC.		
Estates Assurance - Decarbonisation	*SSU*	*Finance*	*Q3*		*Deferred to 22/23 plan as HB not requirement to publish Action Plan until March 22. Agreed by November AC.*		

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Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
IM&T Control & Risk Assessment	02	Digital & Health Intelligence	Q3		Deferred to 22/23 as the last assessment was only finalised in May 22 and the agreed actions are being monitored through the Health Board's tracker. – Agreed by November AC.		
Medical & Dental Staff Bank	14	Medical	Q3		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Medicine CB – QS&E Governance Framework	23	COO	Q2		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Financial Plan / Reporting	33	Finance	Q3		Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
Delivery of 21/22 Annual Plan	37	Strategic Planning	Q3		Combined with audit of Recovery of Non-Covid services due to potential overlap of scope. Agreed by February AC		
Medical Equipment and Devices	35	Therapies & Health Sciences	~~Q2~~	Q4	Deferred to 22/23 due to pressures on HB. Agreed by Management Executive. Agreed by February AC		
PCIC CB – Primary Care Vaccinations	24	COO	~~Q2~~	Q4	Combined with the wider audit of the Covid 19 Vaccination Programme - Phase 3 delivery. To be agreed by April AC.		

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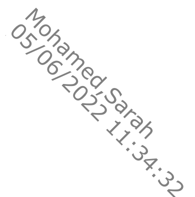
Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Assurance Rating	Planned Audit Committee
Digital Strategy Roadmap	20	Digital & Health Intelligence	Q4		Proposed for Deferral to 22/23 plan and will be included in scope of Digital Strategy audit. Agreed by the Director of Digital. To be agreed by April AC.		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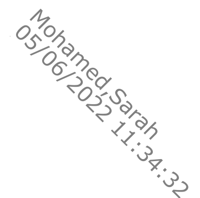
REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued date	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Legislative, Regulatory & Alerts Compliance	Reasonable	Final	20/08/21	14/09/21	25/08/21	25/08/21	G
Healthy Eating Standards - Hospital Restaurant & Retail Outlets	Reasonable	Final	22/07/21	12/08/21	12/08/21	13/08/21	G
CD&T CB – Ultrasound Governance	Limited	Final	27/07/21	12/08/21	24/08/21	25/08/21	R
MH CB – Cancellation of Outpatient Clinics Follow-up	Reasonable	Final	04/08/21	26/08/21	13/08/21	16/08/21	G
Clinical Audit	Limited	Final	17/09/21	11/10/21	07/10/21	15/10/21	G
Five Steps to Safer Surgery	Limited	Final	22/09/21	15/10/21	26/10/21	27/10/21	R
Theatres Utilisation (Surgery Clinical Board)	Reasonable	Final	04/11/21	25/11/21	20/01/22	21/01/22	R
Retention of Staff	Reasonable	Final	14/01/22	04/02/22	24/01/22	24/01/22	G
Core Financial Systems	Substantial	Final	11/01/22	01/02/22	21/01/22	25/01/22	G
Welsh Language Standards	Reasonable	Final	06/01/22	27/01/22	20/01/22	21/01/22	G
Verification of Dialysis Sessions (Spec Serv CB)	Substantial	Final	25/02/22	21/03/22	16/03/22	17/03/22	G
Raising Staff Concerns 9Whistleblowing)	Reasonable	Final	09/02/22	03/03/22	15/03/22	17/03/22	R
IT Service Management (ITIL)	Limited	Final	10/01/22	01/02/22	16/03/22	17/03/22	R
Arrangements to support delivery of MH Services	Advisory	Final	18/03/22	11/04/22	28/03/22	04/04/22	G
Development of Genomics Partnership Wales	Reasonable	Final	18/03/22	11/04/22	25/04/22	25/04/22	R
Welsh Risk Pool Claims	Substantial	Final	26/04/22	19/05/22	27/04/22	27/04/22	G
Nurse Bank	Limited	Final	12/04/22	06/05/22	28/04/22	28/04/22	G
Network and Info Systems (NIS) Directive	Limited	Final	06/04/22	29/04/22	26/04/22	26/04/22	G
Nurse Rostering: Children's Hospital (C&W CB)	Reasonable	Final	06/04/22	29/04/22	28/04/22	28/04/22	G
COVID-19 Vaccination Programme - Phase 3	Substantial	Final	14/04/22	11/05/22	26/04/22	26/04/22	G
Health & Safety	Substantial	Final	22/04/22	17/05/22	25/04/22	25/04/22	G
Wellbeing Hub at Maelfa	Reasonable	Final	25/03/22	20/04/22	20/04/22	25/04/22	G

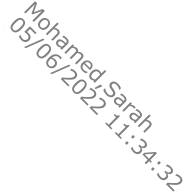
KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2021/22	G	April 2021	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2021/22	A	84% 26 from 31	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 24 from 24	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	73% 16 from 22	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 22 from 22	80%	v>20%	10%<v< 20%	v<10%



Assurance Ratings

Rating	Description
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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Mohamed Sarah
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Report Title:	Counter Fraud Annual Plan 2022 - 2023			Agenda Item no.	8.1	
Meeting:	Audit Committee	Public	✓	Meeting Date:	12th May 2022	
		Private				
Status *(please tick one only)*:	Assurance		Approval	✓	Information	
Lead Executive:	Executive Director of Finance, Catherine Phillips					
Report Author (Title):	Counter Fraud Manager, Gareth Lavington					

Main Report
Background and current situation:

Counter Fraud Annual Plan 2022/2023 – annual plan outlining the proposed work proposed in order to meet the Counter Fraud Provision for Cardiff and Vale UHB for the forthcoming year. This plan aligns with the new NHS Counter Fraud Authority Functional Standard requirements. It is broad in its nature as the provision will need to remain flexible and dynamic throughout the year to meet the needs of the organisation as they arise.

The current process of determining the effectiveness of local counter fraud services is based on an annual return to the NHS Counter Fraud Authority of compliance with the functional standards as detailed in the report. This report is completed in conjunction with the Annual Plan and the Annual Report. Reporting to the CFA in relation to compliance with this plan will be undertaken in May 2023.

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

The plan has already been approved and agreed by Executive Director Finance. Audit committee members are asked to review and approve the report. Discussion and questioning of the plan are welcomed.

Recommendation:

The Committee is requested to:

a) Review, discuss and approve the Counter Fraud Annual Plan 2022 – 2023.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

Objective	Tick	Objective	Tick
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	

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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:

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NHS WALES
CARDIFF AND VALE
UNIVERSITY HEALTH BOARD

COUNTER FRAUD PLAN
2022/2023

Gareth Lavington
Manager Counter Fraud
Cardiff and Vale UHB

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This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Team in order to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Catherine Phillips

Date: 26/04/2022

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WORKPLAN 2022-2023

Background

On 29th 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 DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is 31/05/2023. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. They will provide a grading of compliance in relation to all areas of the functional standards. (Green, Amber or Red)

In order to achieve the standards, set by the NHSCFA Cardiff and Vale University Health Board follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and employs a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS). To ensure that the Health Board's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the Counter Fraud Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided

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below formulates Local Counter Fraud arrangements for Cardiff and Vale University Health Board for 2022-2023. The tasks outlined will be considered and reviewed dynamically throughout the year as the need arises. The effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan for the first time will directly mirror GovS:13 Standard (Counter Fraud) in order to bring the organisations provision into line with the NHSCFA Counter Fraud Bribery and Corruption Strategy. This in turn supports the objectives set by the Welsh Government.

Taking a risk-based approach to planning local counter fraud work

Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the Local Counter fraud Specialist (LCFS).
The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified in the course of investigations, or analysis of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

Meeting key personnel in the health board and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work. Any risks which are identified by the LCFS will be recorded in line with local procedures adopted for such by the organisation, shared with the Internal Audit department and reported to DoF and Audit Committee. This aims to provide another level of assurance that the risk will be **owned** and managed. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices. Information received from external sources will be assessed and any risks locally identified will be targeted as a result.

To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued up to date risk assessment advice and training. This helps the LCFS when assessing the counter fraud arrangements at their own organisation. This provides direction in risk assessment work and provides a basis of measuring local risks using a dedicating risk matrix scoring system and template. Results of all local risk work carried out by the Counter Fraud Team will be reported through the quality

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assurance process to NHS CFA, managed on the CLUE case management system and will be locally reported to the Audit Committee

Outcomes/Results

Accurate records of counter fraud work are crucial. They inform upon the effectiveness of work undertaken, assist in the planning of future work and help to identify strengths and weaknesses within the organisation. Accurate records of all work undertaken by the Counter Fraud team for this upcoming year will be kept and updated. These results will be reflected in the quarterly progress reports and end of year annual report.

The Counter Fraud team are aware of the importance of liaison with External Auditors when planning Local Counter Fraud work in order to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g., Whistle-Blowing arrangements, Declaration of Interests, Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust and the Cardiff and Vale UHB Counter Fraud team will maintain a close working relationship with Wales Audit as required.

Resource Provision

Resource Provision for CAVUHB	Days Planned 22 / 23
Counter Fraud Manager directly employed by Organisation	110
LCFS directly employed by Organisation	330
Total	440

Resource by Activity

Activity	Days Planned 22 / 23
Proactive	220
Reactive	220

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Total	440

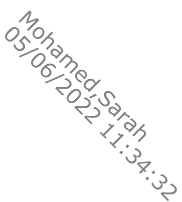
With the move to the GovS:13 taking place and old 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account now obsolete, the methodology to be adopted in breaking down resource time spent by activity area is simplified into Proactive and Reactive areas. Generally *Proactive* work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises involving risk assessment. Reactive work will involve activities such as, investigation into referrals received, carrying out system weakness analysis as a result of investigation findings

Whilst the proactive days allocation is below the suggested total of 325 for an organisation of the size of CAVUHB this is the most suitable balance based on the overall days available. CAVUHB historically receives a relatively high number of referrals that require reactive investigation and these investigations can be very high in resource demand.

NHSCFA states that Proactive work should not be absorbed by Reactive activity or *vice versa* and to this end NHSCFA strongly encourages Proactive work to be 'ring-fenced'. However due to the dynamic nature of the Counter Fraud environment the plan is intended to be flexible to the needs of the service, so may be subject to review and change where service priorities and risk require. If this occurs then careful consideration will be given to any changes made and this will be reported in progress reports to the DoF and the Audit and Assurance Committee. Any changes to the overall days provided or in regard to the areas planned for will be reported in the end of year report.

Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.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Gov s013 / NHS Requirement	Objective	Proposed Delivery
1: Accountable individual NHS Requirement 1A: A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate	Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed. The DoF to act as the link between the Audit and Assurance Committee (AAC) and Risk Management Group to allow key risks to be identified, managed and mitigated. CFM to produce the CAVUHB Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee.	Ongoing throughout the Year Ongoing throughout the year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. N.B. 'Equivalent body' may include, but is not limited to, the board of directors, the board of trustees or the governing body. Oversight of counter fraud, bribery and corruption work should not be delegated to an individual below this level of seniority in the organisation NHS Requirement 1B: The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.	CFM to provide quarterly progress reports to Dof and AAC and to present these quarterly at AAC. Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order. Where necessary and appropriate Counter Fraud Manager (CFM) will seek to hold regular one to one meetings with the Audit Committee Chairperson, Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with non-executive Audit Committee and Board Members. Counter Fraud to remain a standing agenda item at AAC. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year. CFM to report to DoF and AAC any matters arising from NHSCFA in relation to thematic assessment	Q1 As required Ongoing throughout the year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	exercises, matters arising out of Fraud Prevention Notices and national exercises. CFM to liaise regularly with internal partners, such as Internal Audit, HR, Information Governance and Communication Department to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM to carry out annual reporting to NHSCFA in the form of the NHS CFA Functional Standard return and to subsequently address any issues rising from the results of this assessment.	Throughout the year addressing matters arising as necessary Throughout the year (regular 1:1 meetings diarised in advance where possible) Q1

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
2: Counter fraud bribery and corruption strategy NHS Requirement 2: The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks. **(The organisation may have its own counter fraud, bribery and corruption strategy, however, this must be aligned to and referenced to the NHSCFA counter fraud, bribery and corruption strategy)**	CFM to verify that the organisational Counter Fraud Bribery and Corruption Policy is in place and review to check that in date and fit for purpose. CFM to ascertain whether the local policy is properly aligned to the current NHS CFA Strategy. CFM to ensure that work planned for in the Annual Counter Fraud Plan and that work carried out is aligned to the NHS CFA strategy and that the objectives are being met. CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.	Q1 & Q2 Q1 Continual Monitoring
3: Fraud bribery and corruption risk assessment	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk	

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
NHS Requirement 3: The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud	to be recorded in line with the organisations Risk Management Policy and entered on to the appropriate risk registers. All risks identified to be assessed and remedial action identified and reported to key stakeholders. All matters arising to be reported to DoF and AAC by way of counter fraud progress reporting. Counter Fraud department to develop a fraud risk profile upon the CLUE case management system in order to effectively evaluate, evidence and measure the effectiveness of counter fraud risk assessment work with a view to reducing fraud to an absolute minimum. Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year as a result of local identification or if informed by CFA Fraud Prevention Notices and national exercises. All risk analysis work to be subject to timed ongoing review to assess if recommendations acted upon.	Dynamic – throughout the year as the need arises

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
risks within any associated sub company of the NHS organisation.	CF manager to explore with Corporate Governance the preferred method of reporting and recording risk, including the maintenance of a register review. (To compliment the recording upon CLUE) Where resource implications are present priority to be given to those areas identified as higher risk.	Q1& Q2
4: Policy and response plan NHS Requirement 4: The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF Manager to establish/review existing counter fraud bribery and corruption policy, update and amend as appropriate. Counter Fraud team to promote awareness of the policy at presentations and through newsletters. CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.	Q1 Throughout the Year Q3 & Q4

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
5: Annual action plan NHS Requirement 5: The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	CF Manager to complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period. CF Manager to ensure the plan is agreed by DoF, ratified by AAC and is informed by national and local risk and is aligned to organisational objectives and CFA Strategy. CF Manager to ensure that the provision of the CF function is written in to the overall organisation plan. CF manager to provide quarterly reports to AAC. CF manager to provide quarterly statistics to Counter Fraud Service Wales. CF manager to provide annual report measuring the effectiveness of the plan.	Q4 (Due to change of manager 22/23 plan provided Q1 as agreed by AAC) Q1 Throughout the Year Q4
6: Outcome-based metrics	The new contact, enquiry and reporting methods being put into place will benefit from the automatic	

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
NHS Requirement 6: The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team. Where necessary regular review will be used to inform change. Data will be collected in relation to the amount of fraud awareness work is carried out. In turn the effectiveness of these actions will be measured by how many enquiries are generated on a newly developed internal interactive Counter Fraud Enquiry Form. A new local incident reporting form is to be created in order that all enquiries made to the team are recorded an have an audit trail not just those that are logged on the CLUE system. The development of a generic email account will take place in order to assist in the process of this.	Development and Implementation Q1 Data collection throughout the year Development and Implementation Q1 Data collection throughout the year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	Interactive feedback forms will be developed to measure the effectiveness of the service supplied by the CF team throughout the year. Locally and nationally informed risk assessments will be recorded according to local policy and using the CLUE case management system and will and a suitable review date added to check upon progress of recommended remedial action. These items will also be shared automatically with the Internal audit department and reported to the AAC. All investigations will be recorded and Managed on the CLUE case management system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year Throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to AAC via the Audit Committee quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Throughout the Year
7: Reporting routes for staff, contractors and members of the public NHS Requirement 7: The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system.	CF team to undertake a project of assessing the current infrastructure in place for the reporting of concerns and making of general enquiries from all groups. This will involve infrastructure development to include the creation a dedicated Counter Fraud Enquiry email address, the development of interactive referral/awareness request forms available internally to provide a dedicated route of reporting and enquiry to staff (incorporating an anonymised version to provide assurance to the reporter), the updating and upgrading of the CF Intranet Site, and liaison with the	Q1 & Q2 Implementation Q1 & Q2

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	Communications Department in order to ensure that this process and route is promoted in the most effective way in order to give the CF Fraud team have a brand identity and presence. Ongoing review of the effectiveness of the work undertaken and where necessary remedial action to take place dynamically throughout the year. Continuance of promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA. Ongoing events throughout the year such as half-day events at key premises promoting the reporting methods available to all groups. E.g. UHW concourse.	
8: Report identified loss NHS Requirement 8:	CF team to make full use of the CLUE case management system for recording and managing	Ongoing throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises	Investigations, System Weakness reporting, and Local Proactive exercise reporting. CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. H Bales to be added upon accreditation as ACFS. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated . CF manager to oversee live investigations on CLUE. CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting.	Ongoing throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF manager to provide direction to IO concerning case management where necessary. CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and AAC at progress updates and at year end in Annual report.	
9: Access to trained investigators NHS Requirement 9: The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest	The organisation currently employs/has access to provision from, three fully accredited, nominated and qualified LCFS. The team has a further member who is currently undertaking ACFS training course. Target date for accreditation July 2022. Nomination to CFA to follow accreditation and to be actioned by CF manager. All members work on a full-time basis. All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. All staff	Throughout the year Throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.	will keep abreast of changes and updates to legislation and undertake training as necessary. All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. CF team will undertake continuing professional development opportunities associated with role throughout the year as they become available. All staff to maintain full compliance with mandatory training/e learning as measured on the ESR system. CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to	Throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	relevant IT systems, data systems and access to NHS Wales) CF team to continue to have access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and storage of evidential data in line with legal requirements. All training and development to be recorded on ESR and referenced during annual staff appraisals.	
10: Undertake detection activity NHS Requirement 10: The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be	CF team to assess the work already completed in relation to the Thematic Assessment exercise published by the NHS CFA in 2020. Any work left incomplete to be carried out in period stated.	Q1 & Q2

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	CF team to undertake national exercise work as it is published by NHS CFA throughout the year. CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Health Boards and Special Health Authorities. CF team will undertake Local Proactive exercises in response to locally identified risk with a view to identifying if fraud has occurred. Remedial action will be reported as appropriate and any necessary investigative action undertaken. CF Manager to interact with key managers and stakeholder groups such as NWSSP Payroll Services, Corporate Finance, Information Governance, Communications Department and HR to foster relationships improve awareness of CF department and function.	Throughout the Year Throughout the Year Throughout the year (with the aim of scheduling regular quarterly catch ups.)

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF Manager to agree to a joint working protocol with Internal Audit and to meet with Head of IA on a quarterly basis to discuss ongoing areas of mutual concern.	Quarterly and as required
	CF team to foster and maintain a close working relationship with Contractor Services ensuring a flow of intelligence from primary care, PPV, dental and optical teams with the aim of identifying areas of weakness and to assist/incept any investigations as the result of the identification of outlying information.	Throughout the Year
	CF team will engage with investigators from other organisations and agencies where necessary (including police, UKBA, DWP, HMRC, local authorities, regulatory and professional bodies, complying with relevant legislation and organisational policies when countering fraud bribery and corruption.	As required

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF team to make use of NFI database to assist in countering fraud, bribery and corruption within NHS and other organisations.	As required
11: Access to and completion of training NHS Requirement 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard	LCFS team to assess whether Fraud Awareness training is mandatory and a standing item of agenda at all corporate inductions. CF manager to liaise with workforce / education and development directorates accordingly and if this is not the case in order to drive forward. CF team to maintain an up to date e-learning module for staff to undertake.	Q1 Q1 & Q2

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to • Digital banners on organisation intranet site • Regular publishing of Counter Fraud news items via Counter Fraud Newsletter • Regular messaging across available social media systems • All staff email bulletins to advise of fraud alerts • Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation including primary care • The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate in order to provide face to face contact with staff and public promoting the work of the team and its function (Liaison with Comms Dept to discuss)	Development and implementation to take place Q1 Delivery throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF team to fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide and to the general public. CF team to fully participate in National Counter Fraud Week initiative.	Q3
12: Policies and registers for gifts and hospitality and COI. NHS Requirement 12: The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested	CF manager to assess whether a conflicts of interest/business conduct policy is in place and is in date. CF team to assess whether a register for conflicts of interest, gifts and hospitality is in place and in date and being utilised effectively. CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters.	Q1 & Q2 Q1 & Q2 Throughout the Year

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Gov s013 / NHS Requirement	Objective	Proposed Delivery
	CF team to consider use of a local proactive exercise in order to identify if the policy is being followed. CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review.	As required Throughout the Year

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Report Title:	Counter Fraud Annual Report 2021/2022			Agenda Item no.	8.2
Meeting:	Audit Committee – Workshop	Public	✓	Meeting Date:	12th May 2022
		Private			
Status *(please tick one only)*:	Assurance		Approval ✓	Information	✓
Lead Executive:	Executive Direcotor of Finance, Catherine Phillips				
Report Author (Title):	Counter Fraud Manager, Gareth Lavington				

Main Report
Background and current situation:

Counter Fraud Annual Report detailing counter fraud work carried out for the period 01/04/2021 – 31/03/2022. The report sets out the resources deployed and the activities undertaken by the Counter Fraud department against its annual work plan for the year.

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

Agreed and approved by Executive Director Finance. Assurance is provided on the standard of service provided by the self-assessment that is undertaken against NHS Counter Fraud functional standards which are assessed this year as being all Green. 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	✓

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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:

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NHS WALES
Cardiff and Vale University Health Board

Annual Counter Fraud Report
01/04/2021- 31/03/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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9. Executive sign off / Declaration

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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 information reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made

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 is distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance 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.

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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 DoF's meeting on 19th February 2021.

The LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects here emphasised:

(A comprehensive 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. This document will be made available to the Audit and Assurance Committee upon sign -off.)

- 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 IA, the Counter Fraud Champion and other senior managers.

  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. The Annual Report has now been completed and submitted. The Annual Plan has now been completed in draft form and awaits approval from DoF and Audit Committee. The Govt Standard Functional return has not yet been completed but the aim is to do so by 31st May 2022. There has been

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a delay in the reporting of in this end of year period due to the change of management within the counter fraud department.

GREEN

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

The organisation has a Counter Fraud, Bribery and Corruption Policy. This will require review in the oncoming year to ensure that it is in date and fully aligned to the NHS CFA strategy. The policy is available to staff via the Intranet and has been 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.

GREEN

- 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 upcoming year this will be strengthened further with a full review into the relevant policies related to Counter Fraud Work. Where local risks have been identified, assessment work has been carried out accordingly. During the course of the year work has been undertaken also in relation to Mandate Fraud Risk, Invoice Fraud Risk, Supplier Fraud Risk (this has been informed by a Thematic Assessment exercise implemented by the NHS CFA – the work remains partially incomplete and will be completed during the upcoming year.) Work has also been carried out in relation to Pre-employment checks involving the use of agency staff. This work is now complete and has been reported earlier via the counter fraud progress reports. Due to the implementation of a new risk management reporting style adopted by the NHS CFA, a delay in training, and the service being stretched for a significant part of the year not all of this work has been recorded in the new format. All new risk work will now align to this methodology and be reported upon the CLUE case management system and locally through the AAC process, and recorded on the local risk register. Relationships and information sharing has continued throughout the year between LCFS and key contacts in key areas of risk including Workforce and OD, Procurement, and Internal Audit. A review of the joint working

protocols in place between LCFS and these departments will take place throughout the year ahead.

GREEN

- 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 currently awaits agreement and sign off from the DoF and subsequent ratification by the Audit Committee. 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.

  GREEN

- Outcome Based Metrics

  Throughout the year the work of the LCFS team has constantly been measured and statistics produced. 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. Further work is being implemented in Q1 of the year ahead to routinely collect data in relation to further areas that will assist in being able to directly measure the effectiveness of strategies implemented and work carried out. For example, the effectiveness of a new interactive internal Fraud Enquiry / Reporting tool being implemented, promoted and publicised, will be directly measured against a rise or fall in the amount of contact that is made by staff members. Further monitoring of risk work carried out will be implemented to introduce periodic review in order to assess any savings made.

  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 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 are being introduced this year as laid out in the annual plan.

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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.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators that were supported by a full-time administrative support assistant. One of these investigators was off work on sickness leave and remained so throughout the year. The administrative support assistant left in September 2021. The team were joined by a further investigator in January 2022. This team member is at the time of reporting three quarters of the way into an accreditation qualification. This is due to be completed in June 2022. The team have been under staffed for the majority of the year and have provided extra time and been bolstered throughout the year with assistance from the CFS Wales team and members of other NHS Wales teams on an ad hoc basis in order to ensure successful provision of the Counter Fraud Plan for 2021-2022.

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 final reports are submitted to counter fraud and where appropriate an investigation will be started in relation to outlier information. Regular liaison has taken place with the head of internal audit. Data mining has also been undertaken within the context of the NFI database. The majority of matches have now been closed in relation to this years' exercise. Some investigations remain open in

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relation to payroll to payroll matches and these will be finalised prior to Q3 in the coming year. Liaison with payroll services and accounts receivable for overpayment situations have been prevalent this year as a result of the unprecedented uptake of staff due to the COVID situation. This has resulted in a high volume of overpayment referrals being received by the department. Where necessary formal investigation has taken place and suitable action taken. A new all wales policy in relation to overpayments is being developed by NHSWSSP and NHS Organisations throughout Wales. All actions taken by the CF team in relation to work in this area have been reported accordingly on CLUE inclusive of any recoveries made.

GREEN

- Access to and Completion of Training

Due to the COVID situation fraud awareness sessions to staff members have been significantly disrupted. However remotely delivered sessions have been created and delivered where possible. The plan for the year ahead is to get back to in room presenting and making sure that Fraud Awareness is mandatory at corporate induction. All wales fraud awareness training has remained available throughout via ESR. 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.

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

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3. Allocation of Resources

At 31st March 2022 440 days of Counter Fraud work have been completed against the agreed 440 days in the Counter Fraud Annual Work-Plan for the 2021/22 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 carrying out a risk assessment exercise on pre-employment checks conducted by agencies which supply staff to the organisation.

Strategic Requirements 37 Days

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

Proactive Work 146 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 257 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 *(based upon £230 per day)*

Proactive Costs	**£42,100**
Reactive Costs	**£59,100**
Total Costs	**£ 101,200**

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5. Breakdown of Investigative work areas

At 1st April 2021 a total of 18 investigations were open and being investigated by the team. At 31st March 2022 only one of these cases remains open. This relates to an abuse of position investigation from 2020. This case is now going through the Criminal Justice system and the defendant has pleaded guilty. Sentencing is due to take place in the coming weeks.

During the course of this financial year a total of 31 new referrals have been received and investigated by the team. A total of 7 cases remain open as at 31st March 2022. A brief summary of allegations received throughout the year is provided in the table below.

Offence	No. of Referrals	Type
Failing to Disclose information / Theft	16	Overpayment of Salary
False Representations	1	Reporting Sick when not
False Representations	6	Working elsewhere whilst sick
False Representations	1	Prescription fraud
Abuse of Position	1	Nepotism
False Representations	1	Time sheet fraud
False representations	1	Anomalous Pharmacy Claims
False Representations	1	Bogus Injury claim in relation to redundancy
Abuse of Position	1	Improper use of prescriptions
False Representations	1	Job Planning
Theft	1	Theft of Property

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6. Sanctions and Recoveries

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

Disciplinary Sanctions	0
Criminal Sanctions	1
Civil Sanctions	2
Recoveries	**£75,551.57** (inc of 1 x CFS Wales recovery)

7. Fraud Awareness

During the period 1st April 2021 – 31st March 2022 a total of 9 awareness sessions were delivered to staff members across the organisation. A total of 132 staff were presented to. The feedback from these presentations was positive.

8. Lines of Reporting

CEO – Suzanne Rankin

Executive Director of Finance – Catherine Phillips

Counter Fraud Manager – Gareth Lavington

LCFS – Nigel Price

LCFS – Emily Thompson

LCFS (training) – Henry Bales

9. 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.

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Executive Director Finance: Catherine Phillips
Date: 27/04/2022

<table>
<tr><td>Report Title:</td><td colspan="3">Internal Audit Reports for Information</td><td>Agenda Item no.</td><td colspan="2">9.1</td></tr>
<tr><td rowspan="2">Meeting:</td><td rowspan="2" colspan="2">Audit & Assurance Committee</td><td>Public</td><td>X</td><td rowspan="2">Meeting Date:</td><td rowspan="2">12/05/22</td></tr>
<tr><td>Private</td><td></td></tr>
<tr><td>Status
(please tick one only):</td><td>Assurance</td><td>X</td><td>Approval</td><td></td><td>Information</td><td>X</td></tr>
<tr><td>Lead Executive:</td><td colspan="6">Director of Corporate Governance</td></tr>
<tr><td>Report Author (Title):</td><td colspan="6">Head of Internal Audit</td></tr>
</table>

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 2021/22 plan was formally approved by the Audit Committee at its April 21 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:

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

- Three Substantial Assurance
- Three Reasonable Assurance
- Two 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	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	

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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:

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COVID-19 Vaccination Programme - Phase 3 delivery

Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

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Review reference:	CVU-2122-10
Report status:	Final Internal Audit Report
Fieldwork commencement:	7 February 2022
Fieldwork completion:	29 March 2022
Debrief meeting:	12 April 2022
Draft report issued:	14 April 2022
Management response received:	26 April 2022
Final report issued:	26 April 2022
Auditors:	Andrea Calise, Principal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Fiona Kinghorn, Executive Director of Public Health
Distribution:	Lorna Bennett, Consultant Public Health (Immunisation Lead) Suzanne Wood, Consultant Public Health Lisa Dunsford, Director of Operations, PCIC Clinical Board Sara Sturdy, Interim Head of Operations - Mass Immunisations
Committee:	Audit & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed Audit Brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff and 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 review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the delivery of the COVID-19 Vaccination Programme (Phase 3).

Overview

We have issued substantial assurance on this area.

Our report makes the following two low priority recommendations, which are best practice in nature to support the continual improvement of the Health Board's processes:

- To undertake a formal and documented lesson learnt exercise, now that the Health Board has progressed through a number of phases of the COVID-19 Vaccinations Programme; and
- Further progress be made with the accessibility of governance documentation, to support the imminent COVID-19 Inquiry.

Report Classification

Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.

Assurance summary[1]

	Assurance objectives	Assurance
1	An effective plan is in place detailing the delivery of Phase 3 of the vaccination Programme for each workstream.	Substantial
2	There is appropriate governance / oversight over the delivery of the plan.	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.

1. Introduction

1.1 The review of the 'COVID-19 Vaccination Programme - Phase 3 Delivery' was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 The Cardiff and Vale of Glamorgan COVID-19 Prevention and Response Plan, published in September 2020, set out an effective Test, Trace and Protect (TTP) response for the region. A specific Cardiff and Vale COVID vaccination plan was also published in September 2020 and submitted to Welsh Government (WG).

1.3 The overall Prevention and Response Plan[1] was updated for 2021/22, to reflect the rapidly evolving nature of the environment and the changing requirements of an effective response to COVID-19.

1.4 A key part of the plan was to efficiently and effectively deliver a mass vaccination Programme across Cardiff and the Vale of Glamorgan, in accordance with national guidance on priority groups, the COVID-19 Vaccination Strategy for Wales and the developing evidence base.

1.5 The COVID-19 vaccination Programme has been delivered over a number of phases as follows:

1.6 Phase 1

- Milestone 1 - to have offered all adults in groups 1-4 a vaccine by mid-February 2021. This was achieved in February 2021.
- Milestone 2 - to have offered all adults in groups 5-9 a vaccine by mid-April 2021. This was achieved on 19 April 2021.

Phase 2

- Milestone 3 – to have offered a first dose of the vaccine to those in group 10 i.e. the rest of the eligible adult population, with a 75% uptake across all age ranges by the end of June 2021. This milestone was also achieved.

Phase 3

There are 4 workstreams for phase 3 as follows:

- Second dose for those who have only had one;
- Re-offer a vaccine to those who have not had any;
- Booster vaccine for those eligible; and
- Vaccinating young people 12-17 years.

1.7 WG confirmed on 13 December 2021, in response to the Omicron variant, that the booster Programme would be extended so that all eligible adults aged 18+ would be offered a booster by 31 December 2021. On 22 December 2021 the Joint

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[1] https://cavuhb.nhs.wales/news/home-page-news/06836-prevention-and-response-pdf/

Committee on Vaccination and Immunisation made two recommendations to further expand the vaccination Programme for children and young people.

Audit Risks

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

- The plan in place for mass vaccination is not efficient leading to wastage of the vaccine and delays to the delivery of the vaccination Programme.
- Insufficient training for staff, resulting in delays to vaccinations being delivered and / or an increased risk of patient harm.
- Reputational damage as a result of a delayed delivery of vaccinations or insufficient information provided.
- Risk of the public not being vaccinated in a timely manner.
- Insufficient monitoring of the vaccination Programme, resulting in an inefficient delivery.

2. Detailed Audit Findings

Objective 1: An effective plan is in place detailing the delivery of phase 3 of the vaccination Programme for each workstream. *(This objective is broken down into component parts, from 1a through to 1g)*

Objective 1a: Sufficient trained resources are in place to support delivery.

2.1 The national requirements in relation to the groups of people requiring vaccines and the number of vaccines to be administered, have been extended since inception of the vaccine Programme and this in turn has resulted in changing workforce requirements.

2.2 The delivery of Phase 3 has required significant input both in terms of planning and operational management of the Programme during the winter, typically a time which sees additional demand on the workforce.

2.3 On 16th December 2021, the Director of Operations - Primary, Community and Intermediate Care Clinical Board (PCIC CB) presented the Mass Immunisation Workforce Report to the Covid Vaccine Programme Board highlighting the workforce requirements for the continued delivery of Phase 3 of the Programme. The Executive Director of Public Health and Executive Nurse Director subsequently took this paper to the Board. The Board endorsed the report and approved the decision to strengthen the workforce by recruiting additional staff on a permanent basis:

- Admin/Managers 50.5 WTE - Operations, booking coordinators, team leaders, digital/information, primary care, communications (All band 3 to senior manager and excludes band 2 who will be fixed term)

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- Pharmacy 19.7 WTE - Pharmacy Technicians
- Registered Nurses 59.45 WTE - Band 5,6 and 7 and senior nurses.

2.4 Our findings confirm that there is a robust process in place for ensuring that staff are adequately trained, in line with national guidance and clinical best practice, to administer the vaccines. The vaccination training material has been agreed nationally and is circulated to trainee vaccinators by the Health Board through a blended training protocol which consists of e-learning packages, physical shadowing and clinical assessments which must be reviewed and signed off by clinical leads before individuals are rostered as vaccinators.

2.5 In order to confirm the process set out in the paragraph above (2.4) we reviewed a sample of 20 training records for vaccinators that had been working throughout December 2021 and January 2022 across the three Mass Vaccination Centres. No issues were found as evidence was available to confirm full completion of e-learning modules, clinical training and completed and signed off assessments which had been signed off by line management/experienced senior vaccinators.

2.6 The Healthcare Inspectorate Wales (HIW) inspected two of the Health Board's Mass Vaccination Centres in March 2021; Splott and Holm View.[2] One of the findings in the report noted that in some cases, vaccinator competencies had not been assessed prior to them commencing their role. Shortly after the inspection, the Health Board reviewed and improved the process to ensure that newly trained vaccinators are only rostered when they have been assessed by clinical leads/senior vaccinators. We have undertaken testing to confirm this (see paragraph above, 2.5).

Conclusion 1a: We have been able to evidence the Health Board's approach to ensure there are sufficient trained resources to support delivery of the Phase 3 vaccination Programme. There has been continuous oversight on the workforce demands from an operational perspective and additional resources have been put in place when and where these were required in order to mitigate the impacts on the delivery of the Programme. The Health Board has implemented a robust vaccinator training protocol which has and continues to conform with national guidance. (Substantial Assurance)

Objective 1b: All potential individuals are identified within each priority group for vaccination, including individuals not registered with the Health Board.

2.7 In order to identify individuals eligible for a vaccination, in line with the respective priority group, information is extracted from General Practitioner records and uploaded by Digital Health and Care Wales and Public Health Wales (PHW) to the national bespoke Welsh Immunisation System (WIS) that has been developed for the roll-out of the mass vaccination Programme.

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[2] https://hiw.org.uk/sites/default/files/2021-05/20210527CardiffandValeUniversityHealthBoard-MassVaccinationCentresEN.pdf

2.8 The data input capabilities of the system allow for patient data to be refreshed daily which ensures that any changes to patient priority can be quickly actioned in line with ministerial guidance and regulations agreed by WG and by the Joint Committee on Vaccination and Immunisation (JCVI).

2.9 The Health Board has a number of partnership arrangements in place with the local authorities, charities and community groups for capturing information on individuals who are not registered with a GP but effectively live in the area, for example, the homeless and traveller communities. As information is received it is updated to the WIS system by the System Project Lead.

2.10 Throughout the Programme the Health Board has undertaken various initiatives to provide vaccination services to those individuals residing in areas which are far away from vaccination centres or find it difficult to access the Mass Vaccination Centre. Pop-up vaccination clinics have been held at community centres (e.g. Trowbridge and Riverside), religious centres, university/colleges, refugee centres and homeless settings.

2.11 Furthermore, the Health Board has partnered with Well Pharmacy to deliver vaccinations using a mobile unit. This initiative is in addition to the nine community pharmacies across the Cardiff and the Vale of Glamorgan who have been supporting the delivery of the Programme. The Mobile Vaccination Unit has been deployed to the Cowbridge / Western Vale area. The unit has operated on an appointment only basis so patients that live and are registered with a GP in the Western Vale area and are eligible for a booster have received a text message with appointment time and location.

2.12 Appointments at community pharmacies are booked through the central booking line. This criteria for booking appointments is based on an individual's registered GP and residential postcode, and whether there is a community pharmacy delivering the vaccine near where they live.

2.13 In order to accommodate vaccinations for frail older patients residing in the care home setting, the Testing and Mass Immunisation Team have developed a process in-house, in collaboration with PHW. The Interim Head of Operations - Mass Immunisations / Deputy Operations Manager receives information from PHW on the latest outbreaks reported in the care homes within the Cardiff and Vale region. This infection information is reviewed, and the relevant care home is risk assessed prior to booking/scheduling any vaccinations. The care home's risk rating is monitored to ensure that vaccinators only attend the care home if deemed safe to do so. A spreadsheet is maintained on a daily basis to monitor the care home's risk rating and infection dates.

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Conclusion 1b: The capabilities of the Welsh Immunisation System (WIS) and the knowledge and expertise of staff using the system have been fundamental to the Health Board's abilities to maintaining at pace the demands and challenges of delivering Phase 3 of the vaccination Programme. Particularly, the constant change of prioritisation of

eligible patients during Phase 3. The Mass Vaccination and Testing Team has worked closely with Digital Health and Care Wales and PHW to interrogate the NHS patient data and identify eligible individuals in line with ministerial and JCVI guidance. Partnerships and local initiatives have been set up to identify individuals not listed within the Health Board databases / domain, for example the 'Seldom Heard Group'. (Substantial Assurance)

Objective 1c: Effective arrangements are in place to ensure relevant individuals are offered a vaccination as part of the phase 3 Programme and re-scheduled an appointment where appointments are missed.

2.14 Digital Health and Care Wales (DHCW) manage the cohorts (priority groups) data within WIS on behalf of the Health Board based on the requirements and guidance issued by JCVI.

2.15 Daily vaccine offers are informed by supplies, workforce and eligible members of the population area. The decision process considers a number of factors such as vaccine supply, workforce availability, Programme targets and number of patients next due a vaccine.

2.16 The appointment notification process sits outside the Health Board operations. Although the Heath Board operations team notify DHCW of the requirements for the auto-schedule to be actioned on a weekly basis. DHCW use WIS to auto-schedule appointments. This function generates digital appointment letters that get sent to the government notification service for issuing to individuals. In addition to appointment letters the government notification service also sends out a text message (provided that the individual has registered with a valid telephone number).

2.17 Patients who are unable to attend an appointment have the option to suspend their appointment and can do this by either contacting the Health Board or by replying to an automated text messaging service. Any individual that has cancelled and/or has not attended their allocated appointment are provided with the opportunity to re-book again should they wish to do so.

2.18 Currently the Health Board is piloting a digital on-line booking system which is linked to WIS and allows members of the public to amend their appointment and re-book for a more suitable timeslot.

2.19 Patients can suspend their appointment and should complete an online form when they are ready to reschedule their appointment. Individuals that do not attend an appointment without an explanation are recorded on WIS as 'DNA' (Did Not Attend).

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2.20 Daily DNA reports are reviewed by the Booking Team and patients are contacted by phone or text to offer alternative appointment dates. If there is no response or if the patient clearly states that they do not wish to have the vaccine, their status within WIS is changed to 'opted out'. This does not mean that they cannot 'opt

back in' at a later date as the Health Board has a policy to leave nobody behind which is one of the workstreams agreed by JCVI for Phase 3 of the Programme.

Conclusion 1c: The Health Board has effective arrangements for ensuring that eligible individuals are offered a vaccination as part of the third phase of the vaccination Programme. The Health Board has taken steps to ensure that communication lines are open with individuals that have missed an appointment. Individuals can get in touch to re-book through a variety of routes including text messaging, by contacting the booking team and by completing online forms. (Substantial Assurance)

Objective 1d: The use of an appropriate vaccine, taking into consideration storage facilities, patient factors (e.g. allergies) and availability; according to JCVI advise as per National guidance.

2.21 Discussions with the Community Pharmacist Advisor and the Senior Pharmacist Technician noted that for earlier phases (1 and 2) vaccine supply had been one of the significant factors affecting the vaccine rollout. This was a UK-wide issue constrained by pharmaceutical supply and international demand. WG and NHS Wales continue to be informed of vaccine supply around a month in advance, however, this can change at short notice and this can impact on the reliability of projections thus making it difficult to plan supplies over a period longer than two to three weeks. The Senior Pharmacy Technician confirmed that there have not been any supply issues during Phase 3.

2.22 The Health Board has implemented robust controls to ensure the safe storing and effective dissemination of vaccines to its Mass Vaccination Centers, GPs, Pharmacies and Care Homes. It was also noted that a clinic was run in Llandough on a fortnightly basis to administer the vaccine to those patients with allergies and / or immuno-compromised.

2.23 Vaccine supply and stock levels are accessible through WIS and schedules can be exported from the system setting out the vaccine availability allocation to each vaccine delivery unit for any given day for a period up to 2 to 4 weeks. This information is shared with the Booking Team so that they are aware of stock levels when planning appointments for specific individuals for each priority group.

2.24 It was noted that the Health Board has robust processes in place to deliver more than one vaccine type at each MVC. Application of the different vaccines vary, and standard operating procedures have been developed to ensure that the change from one vaccine to another is completed correctly and safely.

2.25 Pharmacy is responsible for ordering and monitoring the temperatures of the vaccine during the logistics process. Throughout its journey and whilst in storage the vaccines are temperature controlled using monitors, which record the temperatures. We visited the Splott MVC and confirmed that visual temperature checks are also made by senior nurses and recorded on daily check forms.

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2.26 The JCVI have advised that a full dose (30 micrograms) of Pfizer BioNTech vaccine or a half dose (25 micrograms) of the Moderna vaccine should be offered as a booster dose. Discussion with the Head of Operation Mass Immunisation and Testing confirmed that the Health Board has relied upon using these two vaccines with equal preference in the COVID-19 booster programme as both vaccines have been shown to substantially increase antibody levels when offered as a booster dose. This is in line with JCVI guidance.

2.27 A half dose of Moderna is advised for the booster dose as it is expected to have a lower rate of side effects (including myocarditis) than a full dose. Where both the Pfizer and Moderna vaccines are clinically contraindicated or if the patient has an allergy to mRNA based vaccine, vaccination with the AstraZeneca vaccine may be considered following a decision by a health professional on a case-by-case basis.

Conclusion 1d: Standard operating procedures have been developed in line with JCVI guidance and have been distributed to the vaccination teams to ensure the safe selection of vaccines when dealing with patients with allergies and/or patients who are immunosuppressed. Arrangements are in place to ensure the safe storage, transportation, and preparation of vaccine doses. (Substantial Assurance)

Objective 1e: Ongoing communication with the population of the Health Board area, to provide information regarding the delivery of the mass vaccination Programme and to answer frequently asked questions, including accessibility.

2.28 The Communications Team have developed a COVID-19 section on the Health Board's website[3] and regularly update the information for the public on COVID-19 and the COVID-19 Mass Vaccination Programme.

2.29 The Head of Communications and the Head of Operations - Mass Immunisation and Testing confirmed that the Health Board has also reached out to the public through the social media platforms, specifically to target the younger audience. Further targeted work in disadvantaged communities took place, based on uptake statistics across Cardiff and Vale. Further, the TTP sub-group and the Seldom Heard Group strengthened the reach to ethnic minority communities.

2.30 The Head of Communications stated that further activity is planned to reach out to those that did not attend appointments, in alignment with the Health Board's approach to 'Leave nobody behind', to ensure that individuals are aware of the continued options available to them. At the time of the review it was anticipated that the approximate number of individuals classed as DNA amounted to ten thousand.

Conclusion 1e: Communication has remained ongoing with the population of the Health Board area through Phase 3 of the Programme, whilst also ensuring that messages are consistent to WG and PHW, reducing the risk of public mixed messaging. The Health

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[3] https://cavuhb.nhs.wales/covid-19/cavuhb-covid-19-mass-vaccination-Programme/

Board's website has been updated regularly to reflect latest government advice and regulations, information on the safety of the vaccine, access to vaccination and updates on the delivery of the vaccination Programme. A range of other mechanisms have been used to reach different sub-groups of the population. (Substantial Assurance)

Objective 1f: Communication with relevant staff and partners to keep them updated of changes that occur (external and internal to the Health Board).

2.31 Various processes are in place to inform key stakeholders as follows:

- Weekly Chief Executive Briefing - Information posted on the website, which provides updates on latest ministerial guidance, decisions from the Executive Team, progress on the mass vaccination Programme and anything important worth sharing. The archive of updates is readily available from the Health Board's website;
- Microsoft Teams Channels - We were provided with access to the Mass Immunisation Group Teams Channel. At the time of the audit there were 75 members and guests who use the channel to share key information and best practice guidance. It was noted that the Teams Channel has been made the central repository for operational documentation for example, training documentation, standard operating procedures, workforce rotas and performance data;
- The Covid Vaccine Programme Board had a local authority representative in the meetings;
- A regular update was provided through the TTP operations meetings, chaired by Cardiff Council's Corporate Director of People & Communities, and to the IMT/TTP Leadership group, chaired by the Chair of Cardiff and Vale UHB, and with membership of the UHB CEO and senior officers, and LA Leaders, Chief Executives, and senior officers;
- We were informed of the COVID-19 Vaccine Stakeholder Group, which has run throughout the duration of the vaccination programme including membership from both Local Authorities, third sector, Police, Military, UHB and other NHS organisations.
- The Website, Newsletters and staff emails – General updates and information on the vaccination Programme are communicated through this channel;
- Operational Team Meetings - throughout the pandemic this team has met twice weekly and has Health Board wide representation;
- One to one sessions between line manager and staff and/or team meetings to communicate new and emerging information;
- Blog posts on the website and staff social media pages; and
- 'Q & A' sessions taken place with staff over Microsoft Teams.

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2.32 It was noted that the Head of Operations – Mass Immunisation and Testing, and the Deputy Head of Operations are both members of the Cardiff and Vale Integrated Health and Social Care Partnership and provide regular updates on the development of the Mass Vaccination Programme. The Partnership is made up of the City of Cardiff Council, Vale of Glamorgan Council, Cardiff & Vale University Health Board, Welsh Ambulance Services NHS Trust, Third & Independent sectors, and carer representatives.

Conclusion 1f: The Health Board have adopted various communication channels internally with staff and externally with partners to reflect and reinforce progress and outlook of the delivery of the mass vaccination Programme. The content of the communication often recognised, praised and celebrated key achievements of the mass vaccination Programme motivating staff and partners alike. (Substantial Assurance)

Objective 1g: Key milestones are documented.

2.33 The 'Wales NHS COVID-19 Vaccination Programme Planning Parameters' details guidance to the Welsh Health Boards on delivering the COVID-19 vaccination Programme. The document provides a live reference and framework for the detailed and granular operational planning at a local level. The document sets out the key milestones agreed by WG and the JCVI for Phase three.

2.34 A review of the Health Board's performance against the milestones for Phase 3 of the Programme were confirmed as follows:

- Second dose – Commitment to offer a second dose to those that have only had one by end of September 2021 – The Health Board offered a first dose vaccine to all eligible by mid-June 2021 and a second dose by September 2021;
- Re-offer the vaccine "No one left behind" - This is an ongoing commitment to leave nobody behind and the Health Board has put in place a number of commitments to progress with this aim. Currently, any individual who has not attended their scheduled appointments can request a call back by completing a "Leave no-one behind" form and the Booking Team will call back offering an appointment. Members of the public do not have to have an appointment and can make use of the "walk-in" sessions at MVCs.
- Boosters - All eligible adults (18+) be offered a booster by the 31st December. This target was met by the Health Board who offered a booster appointment to all eligible individuals (165k) in the Cardiff and Vale Area. Individuals which were not able to attend an appointment in December 2021, were offered another appointment in January 2022 and can still receive their booster by attending "walk in" sessions. As of 9th March 2022, over 80% of eligible adults aged 18+ had received a booster vaccination.
- Vaccinating children and young people – young people aged 16 and 17 to be offered a first dose vaccination by 23rd August 2021 and children aged 12 to

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15 by November 2021. Both milestones had been achieved by the Health Board. As at 9th March 2021, it was noted that 60% of young people aged 12-15 had been vaccinated.

- To have a text service to help citizens rearrange appointments in November 2021. The Health Board achieved this milestone with the system going live on the 30th November 2021.

2.35 Performance data related to the vaccination Programme resides within the WIS database. The system automatically summarises the data by priority group and sets out the total number of individuals identified as requiring the vaccines (within the Health Board demographic remit). Individuals can refuse appointments or opt out for whatever reason, and this is outside of the Health Board's control. Due to the non-mandatory nature of the vaccine, the key milestones set, do not focus on the number/percentage of individuals that have been vaccinated rather the number of people which have been offered the vaccine.

2.36 Whilst the vaccine delivery performance data has suggested that the majority of the Programme has been delivered by MVCs, the contribution of community pharmacies and GPs have played a significant role in increasing the number of vaccinations delivered to the public. As at the 7th April 2022 GPs and community pharmacies had delivered in total 125,000 vaccinations.

2.37 The milestones are set out within the Planning Parameters and updates on the achievements against each one is included as an update to the Operational Team, Programme Board, the Executive Team and the Board. A review of the governance confirmed that frequent updates on the progress against the milestones had been provided in a timely manner at every meeting.

Conclusion 1g: The vaccination Programme's key milestones are set out within the Planning Parameters and updates on the achievements against each one is included as an update to the Operational Team, Programme Board, Executive Management Team and CV Board. (Substantial Assurance)

Objective 2: There is appropriate governance / oversight over the delivery of the plan *(This objective is broken down into component parts, from 2a through to 2c)*

Objective 2a: Regular monitoring and reporting of progress against the plan and the requirements of the Joint Committee for Vaccination and Immunisations (JCVI) recommendations and Welsh Government ministerial priorities.

2.38 The strategic oversight, operational delivery and monitoring of progress against the Mass Vaccination Programme is overseen by a Programme Board, chaired jointly by the Executive Director of Public Health and Executive Nurse Director. The Programme Board has wide representation which includes Public Health, Corporate Nursing, Communications, Pharmacy, Workforce, Patient Experience, Finance,

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local authority councils and members from the Primary, Community and Intermediate Care Clinical Board, who have continued to play a key role in supporting and delivering the Mass Vaccination Programme.

2.39 There is an up to date Terms of Reference (TOR) for the Programme Board, which has met weekly, examples of items considered include but are not limited to:

- National Policy and Strategic Documents - Latest ministerial advice from WG and JCVI;
- Dashboard and Performance Management - Operational review of the Health Board's performance metrics in respect of COVID-19 and the delivery of the Programme;
- Operational highlights, feedback and planning requirements for future stages of delivery of the Programme; and
- In depth examination (deep dives) of issues escalated by Operational Teams.

2.40 A review of the governance papers for the Programme Board did not identify any issues. All meetings were scheduled accordingly in line with meeting cycles, and the standing agenda items reflected the TOR.

2.41 Through the executive leads, the Programme Board reports to the Management Executive Team. It also reports to all pertinent WG groups, including the Wales COVID-19 Vaccine Delivery Programme Board. Executives also report and provide updates to the Regional TTP and Incident Management Team (IMT). It links with local flu vaccination planning groups, which cover Primary Care, healthcare staff, schools, pregnant women and social care. Five of the Health Board's operational workstreams report into the Programme Board and provide updates at every meeting.

2.42 Throughout Phase 3 (Autumn and Winter 2021/22), the governance arrangements of the Programme Board have been regularly reviewed to ensure that appropriate arrangements are in place for timely and effective escalation.

2.43 A full report on the updated governance arrangements was discussed at the COVID-19 Board Governance Group on 27th January 2022. The Audit Committee was also presented with the updated paper, which illustrates the governance structure on page 148 of the published meeting book.[4]

Conclusion 2a: The Health Board has implemented robust governance arrangements to provide effective challenge, support and decision making to the mass vaccination Programme, as it progressed through the delivery of Phase 3. A review of the governance structure confirmed that the configuration holds the operational teams to account and supports transparent decision making. The Programme Board and COVID-19 Board

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[4] https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/audit-080222-final-boardbook-v7-0-pdf/

Governance Group has enabled the Health Board to make decisions quickly and drive progress at a fast pace. (Substantial Assurance)

Objective 2b: lessons learnt are identified and form part of continual improvement.

2.44 Discussion with key leads of the audit noted that whilst lessons from the delivery of the Vaccination Programme are constantly considered and learning has taken place as the Health Board has moved forward into the Programme, there is potential to further formalise and document any learning, for example at the end of each phase of the Programme. *(Matters Arising 1 – Low Priority)*

2.45 Health Boards in Wales, including Cardiff and Vale, are aware that a COVID-19 inquiry is imminent. The Cabinet Office has published A 'COVID-19 Inquiry Terms of Reference' in March 2022, which was out for consultation at the time of audit fieldwork. The Health Board has commenced preparations for a COVID-19 Inquiry, a report was presented to the Board in November 2021, which included a draft plan in response to the Inquiry. The plan sets out fundamental questions likely to be at the centre of focus of the Inquiry and sets out the recommended approach to be taken, to ensure that all decisions and actions have been documented accordingly.

2.46 One of the recommended actions is to have a centralised repository for merging departmental records and governance documentation in chronological order. The Health Board intends to move the central repository into an online system whereby access and privilege levels can be developed and controlled. At the time of the audit this remained work in progress. *(Matter Arising 2 – Low Priority)*

Conclusion 2b: Lessons learnt from the delivery of the Vaccination Programme are constantly considered and addressed on an iterative basis, but the Health Board could formalise any learning at the end of each phase. We make two recommendations under this objective, which are low priority and best practice in nature to support continual improvement within the Health Board. (Substantial Assurance)

Objective 2c: Appropriate approval and monitoring of the plan, including action taken to address shortfalls in delivery or where milestones are not met.

2.47 The Health Board's COVID-19 vaccination plan was submitted to WG in September 2020. The plan includes the composition and governance arrangements for the Programme Board.

2.48 Each decision taken and/or action raised at the Programme Board is documented within an Action and Decision Log spreadsheet. The document details the date the decision/action was taken/raised, description of the decision/action, who is responsible for action to be implemented, target date of actions, an updated status and commentary. At the time of the audit a review of the decision and action log confirmed that all actions had been marked as completed with the exception of one

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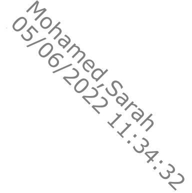
which was due for implementation in September 2021. Comments were added to the action on the reason for why the action was still ongoing.

2.49 The Programme Board and Operational Team continue to monitor the progress against the plan. Action plans to address shortfalls are discussed and presented at governance fora, as demonstrated within objective 2a.

Conclusion 2c: The governance arrangements allow for appropriate approval of key strategic documentation relating to the mass vaccination Programme. Key strategic decisions, and actions to address shortfalls of the delivery of the mass vaccination Programme are logged and monitored on a regular basis. (Substantial Assurance)



Appendix A: Management Action Plan

Matter Arising 1: Lessons Learnt - COVID-19 Vaccinations Programme (Operation)		**Impact**
We note from our review of programme documentation, and discussion with key leads of the audit that lessons from the delivery of the vaccination programme are constantly considered and addressed on an iterative basis. The Health Board is now at a stage where it has progressed through the programme and a number of phases and may benefit from pausing and undertaking a more formal exercise to document and highlight lessons learnt for the future.		Risk of not recognising opportunities for improvement and/or maximising on programme successes.
Recommendation 1		**Priority**
There is scope to undertake a formal lesson learnt exercise, now that the Health Board has progressed through a number of phases of the COVID-19 Vaccinations Programme. The exercise could focus on: • How the Health Board has reacted to mobilise the Programme and subsequent plans; and • How it has achieved objectives and aims with a particular focus on what has gone well across the planning and operational phase including the booking, data entry and logistics and deployment arrangements of the vaccine. The outcome of this exercise should be documented within a Lessons Learnt report with an action plan for improvement.		**Low**
Agreed Management Action 1	**Target Date**	**Responsible Officer**
Whilst there has been review and learning undertaken throughout the delivery of the programme, we agree there would be merit in undertaking a lessons-learned exercise at the end of the current phase (Phase 4) of the programme which could help to inform the planning for future delivery, including the autumn booster programme.	Mid-August 2022	Director of Operations, PCIC Clinical Board

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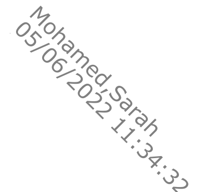
Matter Arising 2: Accessibility of governance documentation (Operation)		**Impact**
At the time of the audit, although we noted progress, it was confirmed that further efforts are required to prepare for the COVID-19 inquiry. Particularly, the arrangements for moving governance and clinical documentation into an online system for ease of access and controlled ownership. Our review was informed by documentation that was provided via email, documentation was still being held on a shared server.		Reputational damage as a result of a delayed or insufficient provision of information.
Recommendation 2		**Priority**
To continue as planned, to ensure that the Health Board progresses further with the action plan to prepare for the COVID-19 Inquiry, particularly the arrangements for moving governance documentation into an online system for accessibility and controlled ownership.		**Low**
Agreed Management Action 2	**Target Date**	**Responsible Officer**
A Teams channel has been established where all core documentation is collated. A lead will be nominated within the Operations team to ensure relevant documentation is saved on a regular basis so it can be accessed, as required, by the inquiry team.	June 2022	Head of Operations – Immunisation



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*

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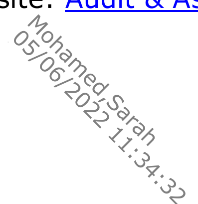
* Unless a more appropriate timescale is identified/agreed at the assignment.



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Health and Safety
Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

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Executive sign-off:	Rachel Gidman, Executive Director of People and Culture
Distribution:	Robert Warren, Head of Health and Safety
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.

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Executive Summary

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Health and Safety, in response to an external review undertaken in 2021.

Overview

We have issued substantial assurance on this area.

Our report makes three low priority recommendations, which are best practice in nature and support the improvement journey of Health and Safety arrangements. We note that the draft plans go beyond process and look to reshape the culture within the Health Board, communicated through the Health and Safety Culture Plan 2022-2025.

Given the draft status of the Plan, our recommendations support the Health Board's approach and suggest areas for future consideration, such as formal closure of the recommendations made within the external review of Health and Safety. Further, the assurance mechanisms to be offered to the Health and Safety Committee to facilitate challenge and scrutiny of delivery.

Report Classification

Substantial

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

Low impact on residual risk exposure.

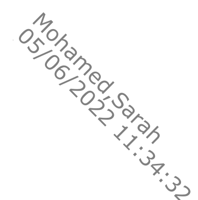
Assurance summary[1]

	Assurance objectives	Assurance
1	Adequate reporting arrangements to the Health and Safety Committee	Substantial
2	There are plans in place to address the recommendations made within the external review of Health and Safety	Substantial
3	Nominated leads and milestones are included within the plans	Substantial

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

Key Matters Arising

There are no key matters arising to report on this occasion.



1. Introduction

1.1 The review of Health and Safety was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 All organisations have a legal duty to put in place suitable arrangements to manage health and safety, as required by the Health and Safety at Work Act 1974. The Health Board has a Health and Safety sub-committee to support the Board to fulfil its responsibilities for health and safety.

1.3 In 2021, the Health Board commissioned an external review of Health and Safety arrangements. The report made 16 high-level recommendations for the Health Board to take forward. The Health and Safety Committee on 12th October 2021 received an overview of the main findings, and the full report was appended to the paper.[1]

1.4 The senior leadership of Health and Safety has been revised through 2021, an external appointment was made for a new Head of Health and Safety, and executive oversight transitioned from the former Chief Executive to the Executive Director of People and Culture, following a permanent appointment.

1.5 The Executive Director of People and Culture was the lead for this review.

Audit Risks:

1.6 The risks considered in the review are as follows:

- Governance structures, roles and responsibilities may not be clear or operating effectively;
- The identification, assessment and escalation of Health & Safety risks may be inconsistent or ineffective; and
- Assurance in respect of health and safety improvements may not be measured effectively or communicated appropriately to the Health and Safety Committee.

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[1] https://cavuhb.nhs.wales/files/board-and-committees/health-and-safety-committee-2021-22/2021-10-12-h-amp-s-final-boardbook-v1-pdf/

2. Detailed Audit Findings

Objective 1: There are adequate reporting arrangements to the Health and Safety Committee, which demonstrates that the recommendations made within the external review of Health and Safety are being taken forward

2.1 In response to the external review, a task and finish working group was established, which was made up of Executive Directors and Senior Health and Safety / Estates and Facilities staff. We were provided with the action and decision notes of the three meetings held, which clearly set out the decisions reached and actions to take forward.

2.2 There is an established Operational Health and Safety Group (OHSG), although it was noted that the group is likely to be reviewed in the context of the external review, and with direction from the new Head of Health and Safety. Minutes of the OHSG meetings are presented to the Health and Safety Committee for information. In July 2021, the Committee received the Group's minutes for the meeting held on 10 March 2021, which highlighted discussion around the external review.[2]

2.3 The Health and Safety Committee were presented with a paper at the October 2021 meeting, '7.1.1 H&S external review update', which included the full report accompanied by an appraisal of progress by the Head of Health and Safety. The appraisal reported that whilst the majority of the 16 recommendations had been accepted, three required further assessment to ensure that the full risk and details of implementation had been considered.[3]

2.4 The most recent meeting of the Committee, held on 19th April 2022 included a refreshed Health and Safety Risk Register, which had incorporated conclusions from the external review of Health and Safety.

2.5 From our review of the papers presented to the Health and Safety Committee, we noted the continued updates by the Head of Health and Safety. Although, a number of these have been offered verbally, accompanied by PowerPoint slides shared with the Committee. Information shared over screens with the Committee does not form part of the meeting book, and therefore is not publicly available information. Consideration will need to be given to the form of the continued updates to the Committee, particularly those that directly relate to the progress of taking forward the external recommendations for challenge and scrutiny.

(Matter Arising 1 – Low Priority)

Conclusion 1: There are clear lines of reporting through to the Health and Safety Committee. We were able to evidence the assurance offered to the Committee, that the recommendations made within the external review of health and safety are being progressed. (Substantial Assurance)

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[2] https://cavuhb.nhs.wales/files/board-and-committees/health-and-safety-committee-2021-22/27-07-2021-h-amp-s-papers-final-pdf/ (page 112 of 120)

[3] https://cavuhb.nhs.wales/files/board-and-committees/health-and-safety-committee-2021-22/2021-10-12-h-amp-s-final-boardbook-v1-pdf/ (page 18 of 220)

Objective 2: In response to the external review of health and safety, the Health Board has plans in place to address the recommendations

2.6 In response to the external review, and as noted in a paper presented to the Health and Safety Committee on 19 April 2022, *"The Health and Safety Culture Plan 2022-2025 has been developed to provide a structured, prioritised approach to underpin Cardiff and Vale University Health Board's H&S aims and objectives. It has been established from the findings of the independent external review conducted in 2021 and a full department workshop session conducted in October 2021."*[4]

2.7 Staff within the Health and Safety department were encouraged to share their ideas on how they thought the recommendations from the external report could be realised. We met with a small number of leads noted within the Plan, which confirmed the inclusive approach. Following the full department workshop the Head of Health and Safety met with key members of staff to collaborate on potential ideas and themes. Subsequently, objectives were identified which incorporate, but are not limited to the recommendations from the external review.

2.8 The objectives frame the Health and Safety Culture Plan 2022 – 2025, and the format aligns with the broader People and Culture Plan, which has received endorsement by the Board in 2022. The template captures the objectives and specific actions to take forward, in addition to how progress of achievement can be determined.

2.9 We observed the Health and Safety Committee on 19 April 2022 and the draft Plan was well received. The Committee were asked to note the draft Plan, which is currently out for consultation, to include input from the Clinical Boards. The intention is to present the Plan to the Management Executive and to the Board for approval. *(Matter Arising 2 – Low Priority)*

2.10 As part of our review we reconciled the recommendations proposed within the external review, to the Draft Health and Safety Culture Plan 2022 – 2025 and noted a couple of anomalies, which were closed following discussion with the Head of Health and Safety. To formally close the external review the Health and Safety Committee should be informed of the minor anomalies, where we identified that there is no intention to take forward the recommendations as proposed.

(Matter Arising 3 – Low Priority)

Conclusion 2: The Health Board has gone beyond the recommendations proposed in the external review of Health and Safety, to develop an approach to reshape the culture and arrangements in place, which are still developing through collaboration and consultation. We note the draft status of the Health and Safety Culture Plan 2022 – 2025 and support the approval of the Plan to address the recommendations proposed in the external review. (Substantial Assurance)

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[4] https://cavuhb.nhs.wales/files/board-and-committees/health-and-safety-committee-2022-23/2022-04-19-health-safety-papers-v2-pdf/

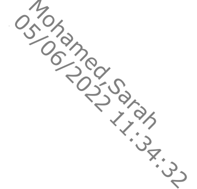
Objective 3: The Health Board's plans to take forward the recommendations include nominated leads with defined milestones

2.1 The Draft Health and Safety Culture Plan 2022 – 2025 has identified a nominated lead for each objective with defined milestones.

2.2 On discussion with three of the nominated leads, the timescales were thought to be realistic and achievable.

2.3 From our review we were able to observe that a small number of recommendations have been realised and there is work underway to progress the objectives and associated actions.

Conclusion 3: The Draft Health and Safety Culture Plan 2022 – 2025 incorporates nominated leads with defined milestones to take forward objectives and associated actions. (Substantial Assurance)



Appendix A: Management Action Plan

Matter Arising 1: Assurance mechanisms to support delivery of the Health and Safety Culture Plan 2022-2025 (Design)	**Impact**
There is a standing agenda item at each Health and Safety Committee, where the Head of Health and Safety provides an update. We have noted that the update tends to be verbal, with key documents included where relevant. Once formalised, consideration will need to be given to the information presented to the Committee against the 'Health and Safety Culture Plan 2022-2025'.	Potential risk of: Assurance in respect of health and safety improvements may not be measured effectively or communicated appropriately to the Health and Safety Committee.

Recommendation 1	**Priority**
Looking ahead and once approved, the form of reporting against the 'Health and Safety Culture Plan 2022-2025' is to be considered, to ensure the Health and Safety Committee is offered assurance of the deliverables, whilst being sufficiently informed to provide challenge and scrutiny.	**Low**

Agreed Management Action 1	**Target Date**	**Responsible Officer**
Recommendation to the Health and Safety Committee from the Head of Health and Safety that an update of the Health and Safety Culture Plan should be added as an ongoing agenda item for the quarterly meetings. This would require the formal submission of a paper outlining the progress of the plan against the proposed time frame. The next agenda setting meeting is 06/06/2022.	06/06/2022	Head of Health and Safety

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Matter Arising 2: Approval of the Health and Safety Culture Plan 2022-2025 (Operation)	Impact
On 19 April 2022 the Health and Safety Committee were asked to note the Draft Health and Safety Culture Plan 2022-2025, and to offer any comments during the phase of consultation. It was noted at the Committee, following a further period of consultation, that the Plan will be presented to the Management Executive for review and then Board for approval. Approval of the Plan is key to formally addressing the recommendations proposed within the external review.	Potential risk of: Governance structures, roles and responsibilities may not be clear or operating effectively

Recommendation 2	Priority
To continue as planned to formalise and seek approval of the Health and Safety Culture Plan 2022-2025, which will address the recommendations proposed within the external review of Health and Safety.	**Low**

Agreed Management Action 2	Target Date	Responsible Officer
Approval of the Health and Safety Culture Plan to be sought. Management Executives approval meeting is 06/06/2022 and the Board approval meeting is July 2022.	29/07/2022	Executive Director for People and Culture.

Matter Arising 3: Closure of the recommendations proposed within the external review of Health and Safety (Design)	**Impact**
We reconciled the recommendations proposed within the external review, to the Draft Health and Safety Culture Plan 2022 – 2025, and noted the following: • Recommendation 9 of the external review refers to creating a Health and Safety Charter, but we found no reference to a Charter in the Draft Plan; and • Recommendation 1 and 4 refer to wellbeing within the context of 'Safety, Health and Wellbeing', but we noted minimal reference to wellbeing within the Draft Plan. Discussions with the Head of Health and Safety confirmed that there are alternative plans or arrangements in place to satisfy the anomalies we identified, for instance the Health Board already has an Employee Health and Wellbeing Service. We also noted that there is no legislative requirement for a Charter and that alterative corporate documents would negate the need for a separate Charter.	Potential risk of: Assurance in respect of health and safety improvements may not be measured effectively or communicated appropriately to the Health and Safety Committee.

Recommendation 3	**Priority**
To formally close the recommendations made within the external review of Health and Safety, the Health and Safety Committee should be informed and note the approach taken in instances where recommendations are not taken forward as proposed.	**Low**

Agreed Management Action 3	**Target Date**	**Responsible Officer**
The Health and Safety Committee to be formally informed of the approach taken not to compile a Health and Safety Charter or include 'Wellbeing' in the title of the department. The earliest opportunity for this will be 19th July 2022.	19/07/2022	Head of Health and Safety

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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:

Rating	Definition
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*

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

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Wellbeing Hub at Maelfa
Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

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Review reference:	CVUHB_SSU_2122_01
Report status:	Final
Fieldwork commencement:	31 January 2022
Fieldwork completion:	11 March 2022
Debrief meeting:	8 March 2022
Draft report issued:	25 March 2022
Draft report meeting:	1 April 2022
Proposed final report issued:	14 April 2022
Management response received:	20 April 2022
Final report issued:	25 April 2022
Auditors:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign-off:	Abigail Harris, Executive Director of Strategy and Planning (Senior Responsible Officer)
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities (Project Director) Owen Rees, Head of Capital Planning, Estates and Facilities Jonathan Aver, Project Officer Robert Wilkinson, Programme Support Manager Catherine Phillips, Executive Director of Finance Nicola Foreman, Director of Corporate Governance
Committee:	Audit & Assurance Committee

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

Acknowledgement

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

Disclaimer notice - please note

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Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Maelfa Wellbeing Hub project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

A robust project team structure was operating with supporting workstreams, continued liaison with external advisers and routine reporting to the Project Team and Delivery Group. The construction programme was being effectively managed, and the project was forecast to be delivered on time (complete project: December 2022).

The latest Project Manager's report (March 2022) indicated that a projected underspend of £8,233 was anticipated.

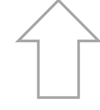
The key matters arising at the project primarily relate to enhancements to the practices of the supporting workstreams, as they gain momentum in the next phases of the project programme, including::

- Evaluation of their operations to ensure deliverables are achieved; and
- Review of the risk management processes applied, , to ensure appropriateness of escalation.

There is also a requirement for improved timeliness of contractual payments at the project.

In considering the above, with the otherwise positive time, cost and quality position, **substantial assurance** has been determined at this interim stage of the project.

Report Classification

		Trend
Substantial	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]

Assurance objectives		Assurance
1	Follow up	Substantial
2	Project Governance	Reasonable
3	Project Management	Reasonable
4	Change Control	Substantial
5	Cost Control & Reporting	Substantial
6	Valuation & Payments	Reasonable

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

Key Matters Arising

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
2.2	Monitoring processes within the workstreams require standardisation, including application of target dates	2	Operation	Medium
3.1	The workstreams risk registers require further development to ensure consistency of scoring and escalation.	3	Operation	Medium
7.2	Payments to contractors are required to be paid in line with agreed timescales.	6	Operation	Medium

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1. Introduction

1.1 The processes, procedures and operational management of Cardiff and Vale University Health Board (the UHB) were assessed in relation to the Wellbeing Hub at Maelfa project ('the project'). This was the third audit undertaken of the project.

1.2 In December 2017, the Welsh Government outlined their plan to build 19 new integrated health and care centres across the country. This £68m programme forms a part of the Welsh Government's commitment to move care closer to home. Included in the listing for the Primary & Community Care pipeline are three schemes for the UHB of which Maelfa is one.

1.3 The project involves the replacement of accommodation at Llanedeyrn Health Centre with modern and flexible primary care and community facilities to deliver Health & Wellbeing Services in conjunction with the Local Authority.

1.4 The phase 1 works (new build) commenced on site on 15 February 2021 and are over a third of the way through the 95-week construction programme, with anticipated completion scheduled in June 2022. The whole programme of works associated with this project (including minor refurbishment work, demolition of the existing surgery and formation of a new car park) are scheduled for completion in December 2022.

1.5 The cost position of the project, as reported by the Project Manager in March 2022 was:

	Forecast costs £	WG approvals £
Works costs	9,234,293	9,234,293
Adjustments (inc. Covid costs)	352,240	-
Anticipated contractor Stage 4 final account	**9,586,533**	**9,234,293**
Stage 2 & 3 design fees	1,026,306	1,004,506
UHB costs (inc. fees, non-works costs & equipment)	1,016,937	1,244,899
Balance of contingency	159,016	308,000
VAT	2,240,720	2,269,655
VAT (COVID 19-Costs)	23,608	0
Project total	**14,053,119**	**14,061,353**
Projected anticipated over / under spend		**8,233**

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

- Failure to address known risks identified at prior audits.

- Failure to achieve key project objectives through poor governance and project management controls.
- Time, cost and/or quality are adversely affected by key decisions that were not subject to appropriate approvals.
- Costs agreed with the contractor did not demonstrate value for money.
- Project costs escalate uncontrollably through an absence of adequate cost monitoring and reporting.

2. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost, and quality) for the period from the date of the previous audit report.

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 At this interim audit of the project, when assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 As reported in the Project Manager's report (March 2022) works are forecast to complete in accordance with the agreed contract construction programme i.e.:

Milestone Event	Contract Completion	Planned Completion
Phase 1 (New Build Complete)	*20 June 2022*	*30 June 2022*
Phase 2 (Demolition & Provision of Car Park)	*1 November 2022*	*1 November 2022*
Anticipated Completion date	*5 December 2022*	*5 December 2022*

Cost

2.4 As per para 4.14, at the current stage of the project, the UHB is reporting a projected underspend of circa £8k which includes £118k, expended on Covid mitigation (and managed within the project's agreed contingency sum).

2.5 The detail of the cost reports produced are evolving, with ongoing discussions between the UHB and the appointed cost adviser, which may have an impact on the way projects costs are presented. Any changes in the reported cost position need to be fully understood by the project team so that appropriate scrutiny can be undertaken.

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Quality

2.6 The project remains set to deliver the objectives of the business case (as per para 1.3). Appropriate project management on the part of the UHB and its partners has ensured the quality of the work delivered to date.

The following sections of the report outline key observations which require management attention, with moderate impact on residual risk exposure until resolved.

Follow Up: Assurance that previously agreed management actions have been implemented.

2.7 The status of actions arising from the previous review (report issued June 2021: *Reasonable Assurance*) was as follows:

	High	Medium	Low	Total
Closed	-	6	3	**8**
Superseded	-	1	2	**3**
Outstanding	-	-	1	**2**
Total	**-**	**7**	**6**	**13**

2.8 The detail in support of the above summary is included in **Appendix B.**

2.9 Whilst noting that three recommendations have been superseded by new issues raised at this report, and that one recommendation remains outstanding, the residual risk is considered low. Therefore, **substantial assurance** has been determined in respect of the actions taken to address previously agreed audit recommendations.

Governance: To ensure that appropriate governance arrangements were in place for the current project phase, including operation of effective reporting and accountability lines; and that appropriate approvals were in place.

2.10 The project operated within a well-defined governance structure, as defined within the Project Execution Plan, updated for the current stage of the project (however, see ***Appendix B, MA1*** for outstanding minor amendments).

2.11 The project continued to be monitored and controlled within the UHB via the overarching Shaping Our Future Wellbeing: In Our Community (SOFW:IOC) Delivery Group and the Project Team.

2.12 These forums had been routinely attended by the Senior Responsible Owner (at the Delivery Group) and the Project Director (at both forums); and other key officers from the defined group memberships (as per the terms of reference), for the period reviewed. However, as previously reported (2019/20 and 2020/21),

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continuing issues were identified in respect of wider membership attendance and the need for the terms of reference to be reviewed (**MA1**).

2.13 Activities to support project delivery were managed at workstream level, with three agreed workstreams in place reporting to the Project Team:

- GP & UHB Relocation & Operational Issues,
- Wellbeing & Social Prescribing Ethos and
- Art Strategy and Communications & Engagement.

2.14 Workstream arrangements have been reviewed and issues associated with attendance and consistency of approach have been highlighted (**MA2**)

2.15 Recognising the above, **reasonable assurance** has been determined in relation to the governance arrangements in place at the project.

Project Management: Appropriate project management controls are applied, including in the management of contractor and adviser performance and project risk.

2.16 A construction risk register was maintained by the external Project Manager; and monitored and reported to the UHB as part of the monthly Project Manager's report. This risk register has been scored, risk owners assigned and costed accordingly.

2.17 The UHB also maintains a separate project risk register which is reviewed by the project team on a regular basis.

2.18 The three workstreams also produce risk registers; with high risks feeding into the project risk register. However, issues were identified with the completeness and escalation of these registers (**MA3**).

2.19 Key Performance Indicators had been completed as required, during the period reviewed, with no performance issues noted to date.

2.20 Recognising the above, **reasonable assurance** has been determined.

Change Control: Appropriate internal and contractual change control mechanisms are applied at the project.

2.21 The Project Execution Plan details the change management process for both client (UHB) proposed changes and SCP proposed changes.

2.22 A sample of four changes (£221k: 81% of total changes applied) were reviewed from the latest change control register. With one exception, each was confirmed to have been reviewed (including time and cost implications) and progressed in a timely manner through both the UHB's internal approval process and by the Cost Adviser (**MA4**).

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2.23 Recognising the above, **substantial assurance** has been determined.

Cost Control and Reporting: Adequate cost control and reporting systems are operated, both internally and by the External Cost adviser.

2.24 Monthly cost reports were provided by the Cost Adviser, with supporting review of information at the monthly commercial meetings held with the Capital Planning Team.

2.25 The 2020/21 internal audit report recommended that the Project Team and Delivery Group should receive formal cost reporting at each meeting (see ***Appendix B – MA4***). It is noted that cost reporting was only implemented in February 2022 with the introduction of a new project reporting template.

2.26 The new reporting template has led to inconsistencies in the way project costs have been reported compared to that included within the Cost Adviser's report (**MA5**). It is acknowledged, however, that the new template needs time to be fully embedded; and there may be a time delay in the extraction of data for each report.

2.27 Reporting on project costs to the Welsh Government is undertaking on a bi-monthly basis via the standardised dashboard reports; with no significant issues being highlighted.

2.28 Whilst recognising the above, effective, and ongoing communication is evident between the UHB, advisers and SCP. Therefore, **substantial assurance** has been determined.

Valuation and Payments: Adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract.

2.29 The interim valuation assessment arrangements were reviewed, including reconciliation to source documentation, confirming the value of work completed prior to passing for approval for payment by the UHB.

2.30 A sample of payments were reviewed to confirm completeness and timeliness:

	Number of invoices sampled	Total sampled
Project Manager	*2*	*£6,601*
Cost Adviser	*2*	*£4,255*
SCP	*2*	*£1,390,313*

2.31 No issues were identified with the adequacy or accuracy of supporting information. However, two of the payments reviewed had been made after the (contractual) due date (**MA6**).

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2.32 Noting the issues with the timeliness of payments, **reasonable assurance** has been determined.

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Appendix A: Management Action Plan

<table>
<tr><th>Matter Arising 1: Governance - Project Team & Delivery Group (Operation)</th><th>Impact</th></tr>
<tr><td>
The role, responsibilities and membership requirements of the Project Team and the Shaping Our Future Wellbeing: In Our Community (SOFW:IOC) Delivery Group had been appropriately defined, in the current terms of reference (reviewed in September 2021 and June 2018 respectively).
Attendance was assessed against the nominated membership, to ensure project members were appropriately represented:

At the three project team meetings reviewed (September, October and November 2021) the percentage of nominated members attending varied from 48% to 57%. The project Director (Director of Capital, Estates and Facilities) attended all the meetings. Attendance was not evidenced for the Assistant Head of Finance or the representatives for Mental Health or East Cardiff Cluster.
At the three Delivery Group meetings reviewed (June, September and October 2021) the percentage of nominated members varied from 44% to 56% Attendance again. The Executive Director of Strategy and Planning & Director of Capital, Estates and Facilities attended all the meetings. Attendance was not evidenced for the following: Primary, Community and Intermediate Care (PCIC) Clinical Board's Clinical Director; Community Director - Vale Locality; Community Director North and West Locality; and Community Director South and East locality.

Noting that poor attendance was also identified at the prior audit of the project, this recommendation supersedes the previous recommendation (Appendix B – MA2). It should be ensured that key parties are committed to their role of members of these forums to allow them to operate as intended as the project progresses.
Further, it was noted that quorum requirements were not detailed in either set of terms of reference.
</td><td>
Potential risk of:
Reduced ability to make the right decision for all parties.
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Recommendations		Priority
1.1a	The terms of reference for both the Project Team and Delivery Group should be reviewed to identify a smaller number of key individuals to form the core membership; with individuals invited to attend as appropriate.	**Low**
1.1b	Quorum requirements should be documented within the terms of reference.	

Agreed Management Action		Target Date	Responsible Officer
1.1a	Agreed. The terms of reference will be reviewed by both the Programme Board and the Project Team and will be changed to reflect the positions of its members and not individuals by name. Whilst other individuals may be invited for specific discussions or input this approach should reduce the numbers. There will also be opportunity to send deputies if not available.	May 2022	Head of Capital Planning, Estates & Facilities
1.1b	Agreed. The above approach will enable the identification of quorum as it will be an agreed number from the core group.		

Matter Arising 2: Governance – Workstreams (Operation)	Impact
Activities to support project delivery were managed through the following workstreams, with updates provided to the Project Team: 1. GP & UHB Relocation & Operational Issues; 2. Wellbeing & Social Prescribing Ethos; and 3. Art Strategy and Communications & Engagement. A project structure is in place (updated October 2021) and sets out the high-level objectives and membership for each. However, the frequency of meetings per workstream was not stated. A review of the operational processes of the three workstreams noted the following: • Attendance of members at workstream meetings varied significantly; • Actions arising from meetings were being tracked in an inconsistent manner. Only the GP & UHB Relocation and Operational Issues workstream maintained a detailed tracker which was reviewed at each meeting; • The workplans for all the workstreams did not have target dates for the completion of tasks. For example, the GP & UHB Relocation & Operational Issues workstream had an identified task of coordinating the booking systems and use of shared rooms. This task would need to be established and tested prior to implementation - but there was no evidence of when this would occur; and • The ownership of individual tasks within the workplans should be refined to ensure clear accountability.	Potential risk of: • Inability to make decisions in a timely manner.

Recommendations		Priority
2.1	The governance structure of the workstreams should be reviewed to ensure meetings are held as required and attendance of members is improved.	Low

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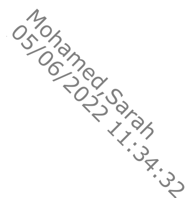
2.2	Standard processes within the workstreams should be established that highlights clear accountability for tasks; and that the individual tasks are SMART (Specific, Measurable, Agreed, Realistic and Timely).		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. It is accepted that attendance at the workstream meetings was better in some than others; and the Project Director has relayed this view to o workstream group Chairs at the last project team meeting and asked that membership be reviewed to ensure attendance is improved.	May 2022	Director of Capital, Estates & Facilities; and Programme Support Manager
2.2	Agreed. Chairs of workstreams will be asked to provide verbal reports of progress against the tasks agreed which will be SMART.	June 2022	



Matter Arising 3: Project Management - Workstream Risk Registers (Operation)	**Impact**
It was noted that workstream risks were assessed in a consistent manner; and that there was an expectation that any high-scored risks should be escalated to the project risk register (reviewed monthly at the project team meeting). A review of the risk management processes operating at the workstreams identified the following: • The impact and likelihood sections of both the GP & UHB Relocation & Operational Issues and Wellbeing & Social Prescribing Ethos workstreams risk registers had not been scored. They were only RAG rated (High, Medium, Low). • An oversight was noted within the scoring applied to the risk registers e.g., the overall risk was rated as medium when the actual scoring indicated high. This led to delays in escalating the risk to the project team. • Mitigating actions were not clearly reviewed. Whilst there was a section on the risk register for 'notes and action taken', in most cases this was left blank. • Whilst the ownership of risks had been assigned, it was noted that those within the GP & UHB Relocation & Operational Issues workstream had been assigned to one individual. It was unclear how this would be effectively managed	Potential risk of: • The project team is not able to effectively manage the key risks to the project.

Recommendations		**Priority**
3.1	The risk management processes operating at workstream level require review, to ensure risks are appropriately scored, managed and escalated (where applicable).	**Medium**

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Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed. Workstream Chair's have been requested to prepare risk registers for their respective areas and ensure that any high risks are brought forward at project team meetings for inclusion on the overarching risk register as appropriate	June 2022	Director of Capital, Estates & Facilities; and Programme Support Manager

Matter Arising 4: Change Management - Timeliness of process (Operation)			**Impact**
The project's change management process was documented at the Project Execution Plan, as follows: *"Following the Cost Adviser's assessment of the Supply Chain Partner's quotation, the Project Manager is to seek UHB approval via the Project Issues Form; and on approval of the Project Issues Form, the formal Project Manager's Instruction can then be issued."* Whilst the process does not detail the delegated limits to be applied to approvals, it was expected that the project team adhere to the UHB's scheme of delegation. A sample of four changes (£221k: 81% of the total at December 2021) were reviewed. For one change (CE05A: £88k), a delay of 20 days was noted from when the project issue form had been signed, to the issue of a Project Manager Instruction. It is acknowledged that governance and approval arrangements within the UHB have been revised since the date of the above-mentioned change (May 2021).			Potential risk of: • An informed, and timely, decision cannot be taken by relevant parties.
Recommendations			**Priority**
4.1	The UHB should ensure delays in issuing Project Manager's Instructions are minimised.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Noted and this will be monitored. However, where there is delay this needs to be reported on the project team highlight report with the mitigation.	April 2022 and ongoing	Director of Capital, Estates & Facilities; and Project Manager

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Matter Arising 5: Cost Control and Reporting - Consistency (Operation)	**Impact**
As previously recommended (see ***Appendix B- MA4***), the monthly Project Progress Reports that were submitted to the project team had recently been revised (February 2022); and provided a more detailed cost review including budget, projected outturn costs, spend profiles etc., than previous reported. However, review of the monthly project progress report for February 2022 and the Project Manager's report, for the same, period, noted a small number of inconsistencies:	Potential risk of: • Project time and cost is not appropriately reported, to ensure informed decision making.

Item	*Project Manager Report*	*Monthly Highlight Progress Report*	*Difference*
Approved Budget	*£14,061,353*	*£14,060,662*	*£473*
Projected Outturn Cost	*£14,099,145*	*14,060,662*	*£38,483*

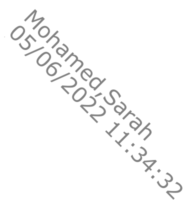
Differences in reporting have meant that an on-budget position is being presented to the Project Team, whereas an overspend position is being forecast by the Project Manager. It was acknowledged, however, that there may be timing differences that contribute to the discrepancies within the figures.

The March 2022 PM report confirms WG approval figure of £ *£14,061,*353 and an improved projected outrun cost of £14,053,119. Noting the above inconsistencies in the previous reports, confirmation that the monthly highlight report accurately reflects the same is required.

The cost reporting mechanism was still evolving, with ongoing discussions between the UHB and Cost Adviser with changes proposed from March 2022, which may have an impact on the way projects costs are presented. These changes need to be fully understood by the project team and delivery group, to allow for appropriate challenge / scrutiny.

Recommendations		**Priority**
5.1	Further explanation on changes to the cost position should be included within the Monthly Highlight Reports.	**Low**

Agreed Management Action		Target Date	Responsible Officer
5.1	Actioned since audit fieldwork.	N/A	Head of Capital Planning, Estates & Facilities



Matter Arising 6: Valuation and Payments – Payments (Operation)	**Impact**
The Late Payment of Commercial Debts (Interest) Act 1998, as amended by the Late Payment of Commercial Debts Regulations 2002 requires public bodies to pay within 30 days or potentially be liable for interest. This is applicable to the External PM and CA invoices reviewed during the course of fieldwork The SCP timeframes for payments fall under the NEC contract, which states, in respect of payment timeframes: *(51.2) "Each certified payment is made within three weeks of the assessment date. If a certified payment is late, or if a payment is late because the Project Manager does not issue a certificate which he should issue, interest is paid on the late payment."* A sample of six invoices (SCP, Project Manager and Cost Adviser) were reviewed for timeliness of payment: • One invoice from the Project Manager, dated 10 December 2021 had not been paid at the date of fieldwork (1 month late); and • One invoice from the SCP noted payment delays of 19 days past the contractual timescales. Management confirmed that the wrong purchase order number had been originally placed on the invoice, which could have accounted for an element of the delay accounts for some of the delay. Noting that poor payment practices were also identified at the prior audit of the project, this recommendation supersedes the previous recommendation (see ***Appendix B – MA10***).	Potential risk of: • The UHB may incur increased costs because of inefficient payment practices.

Recommendations		**Priority**
6.1	Payments should be made in accordance with contractual or legislative requirements.	**Medium**

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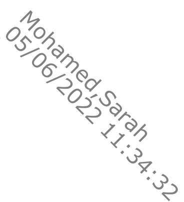
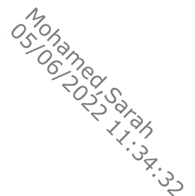
Agreed Management Action		Target Date	Responsible Officer
6.1	Noted and with the PBC now set up this should address this matter.	April 2022 and ongoing	Director of Capital, Estates & Facilities; and Project Manager

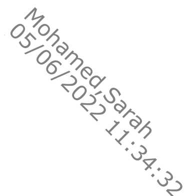


Appendix B: Follow up of previously agreed management actions

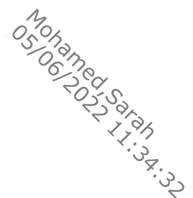
Previous matter arising 1: Project Execution Plan (PEP)		
Original recommendation and management response		Original priority
The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference).		**Low**
Current findings		**Residual risk**
Updated PEP received and dated January 2022. However, accuracy issues in terms of Project Board members are still noted. **Conclusion:** Outstanding.		Inaccuracy of key governance document
Recommendation		**Priority**
The PEP should be updated accordingly and resonate with other supporting documentation.		**Low**
Management response	**Target Date**	**Responsible Officer**
Agreed. The PEP will be re-reviewed with updates made where applicable.	May 2022	Head of Capital Planning, Estates & Facilities



Previous matter arising 2: Project management – Delivery Group and Project Team	
Original recommendation and management response	Original priority
Attendances at Project Team and Delivery Group should be reviewed, to ensure key parties are reminded of their responsibilities as members of these forums and are present where possible at relevant stages. **Management response:** Agreed. Attendances will be reviewed to ensure they are sufficient for the current stage and members reminded of their responsibilities. Whilst noting attendance issues by some parties, it is not considered to have impacted to date on critical decision making at key project development stages.	**Low**
Current findings	**Residual risk**
Attendance of members at the Project Team and Delivery Group remain an ongoing issue. **Conclusion:** Superseded (see **MA1, Appendix A**).	See **MA1, Appendix A**

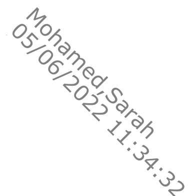


Previous matter arising 3: Project Management – Delivery Group and Project Team	
Original recommendation and management response	Original priority
It should be ensured that all parties reference the most up to date terms of reference for the Project Team and Delivery Group. **Management response:** Agreed. It will be ensured the relevant documents are up to date.	**Low**
Current findings	**Residual risk**
The terms of reference for the Project Team were updated (September 2021) to reflect the new membership. However, there was no quorum requirement detailed. The Delivery Group terms of reference remain the same as previously reported. Noting the change in UHB personnel responsible for the project a review is required. **Conclusion:** Superseded (see **MA1, Appendix A**).	See **MA1, Appendix A**

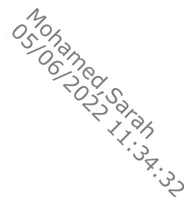


Previous matter arising 4: Project Management - Reporting	
Original recommendation and management response	Original priority
The Project Team and Delivery Group should receive formal cost reporting at each meeting, including any over/underspend, and the balance of contingency funds. **Management response:** Agreed. Financial information would normally be included; however we have been awaiting closure of year end and receiving the ledgers. These have now been received and, going forward, the highlight reports prepared will include spend profile and surplus / deficit.	**Medium**
Current findings	**Residual risk**
Updated cost reporting has been established as of February 2022 that incorporates over/underspends and the balance on contingencies. It is recognised that this new reporting requires time to be embedded; and audit have provided informal comments on improvement areas. **Conclusion:** Closed.	N/A

Previous matter arising 5: Project Management - Reporting	
Original recommendation and management response	Original priority
Welsh Government Project Progress Reports should be shared with an appropriate forum. **Management response:** Agreed. The inclusion of the Welsh Government Project Progress Reports on the Project Team agenda is not considered appropriate, recognising the quantum of information currently being presented. However, inclusion of the reports within the papers submitted to the Capital Management Group would enable improved scrutiny and challenge.	**Medium**
Current findings	**Residual risk**
Review of the Capital Management Group papers for October 2021 and December 2021, confirmed that the dashboard reports had been included (in line with the bi-monthly submission to Welsh Government). However, a further enhancement would be to include reference to papers as a standing agenda item; or reference as 'further information for discussion' within the minutes of the meetings. **Conclusion:** Closed	N/A



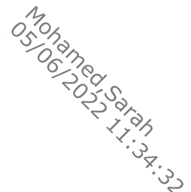
Previous matter arising 6: Contract Documentation – Confirmation Notice Number 2	
Original recommendation and management response	Original priority
The risk register should be updated to reflect the current contractual issues. **Management response:** Agreed. The risk register will be updated to reflect the contractual issues.	**Low**
Current findings	**Residual risk**
Whilst the risk register had not been updated to reflect the contractual issues; at the date of fieldwork all contracts had been signed and sealed. **Conclusion:** Closed.	N/A



Previous matter arising 7: Contract Documentation – Confirmation Notice Number 2	
Original recommendation and management response	Original priority
Confirmation Notice no. 2 for the SCP should be finalised and executed as soon as possible. **Management response:** Agreed. We are in possession of the SCP's Confirmation Notice Nr 2, Signed and Sealed on behalf of the SC. The delay is due to one issue that based on the advice from NWSSP SES and the Framework Lawyers could be accepted if proven to be a requirement of the SCP's Insurers. Given the UHB holds signed copies of the Confirmation Notice Nr 2, the risk to the UHB could be considered low. Further, noting the update received from the SCP regarding withdrawal of their requirement for the additional clause, we will now be able to progress the execution of the contract documents.	**Medium**
Current findings	**Residual risk**
Confirmation Notice Number 2 has been signed and sealed **Conclusion:** Closed.	N/A

Previous matter arising 8: Contract Documentation – Confirmation Notice Number 2	
Original recommendation and management response	Original priority
Management should continue to seek the early resolution of the Project Bank Account provision. **Management response:** Agreed. The Project Bank Account will be entered into upon completion of engrossment of Confirmation Notice Nr 2 and resolution of wider issues in relation to implementation of the account.	**Low**
Current findings	**Residual risk**
Management confirmed that the project bank account is live; with the first payment due in March 2022. **Conclusion:** Closed.	N/A

Previous matter arising 9: Contract Documentation - Advisers	
Original recommendation and management response	Original priority
Adviser agreements should be executed in a timely manner prior to duties commencing. **Management response:** Agreed. The contract will be executed as a matter of priority. The Cost Adviser Confirmation Notice Nr 2, signed and sealed by the CA is with the UHB and will be engrossed by the UHB shortly. The PMs Confirmation Notice Nr 2 is expected to be provided shortly; and no further payments will be made until this has been resolved.	**Medium**
Current findings	**Residual risk**
At the date of fieldwork, the adviser contracts had been signed. However, it is noted that the Project Manager contract had only recently been signed (January/February 2022). This represents a significant time delay from the original target date of July 2021. Signing of contracts remains an issue at other capital schemes operating within the UHB and has been raised accordingly through the relevant internal audit reports **Conclusion:** Closed.	N/A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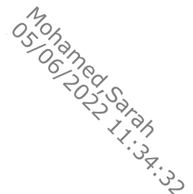
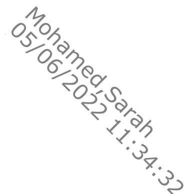
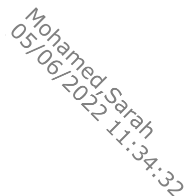
Previous matter arising 10: Cost Monitoring and Reporting - Payments	
Original recommendation and management response	Original priority
Payments should be made in accordance with the terms of the contract. **Management response:** Agreed. The delay in payment after sign off and approval of invoices is largely due to the process of having to uplift the order value for CEs issued on the contract, specifically during OBC & FBC production. This has been recognised and an updated process approved for the inclusion of monies in order values to allow for UHB risk/contingency. This will reduce the time required to secure additional authorisations at key junctures of the project and improve the timeliness of payments.	**Medium**
Current findings	**Residual risk**
Although improvements have been made since the previous review; two of the six payments reviewed were delayed beyond the contractual timescales. **Conclusion:** Superseded (see **MA7, Appendix A**).	(see **MA4, Appendix A**).



Previous matter arising 11: Change Management	
Original recommendation and management response	Original priority
The UHB should implement improved monitoring and control arrangements to ensure Project Issue Forms are prepared and authorised in a timely manner following Cost Adviser's assessment. **Management response:** Agreed. As noted additional information and appropriate evidence is sought for PIF's, this can often cause delay in sign off by the UHB. The timescale can be further extended due to the value of the PIF being greater than £25,000. Regarding PIF 29 – this is suspected not to have been received by email as there had been known issues of not receiving emails from the external PM's organisation. Moving forward we will more closely monitor the timeliness of these authorisations and raise any issues with the external PM.	**Medium**
Current findings	**Residual risk**
A review of a sample of Project Issue Forms noted improvements in the timeliness of completion. **Conclusion:** Closed	N/A



Previous matter arising 12: Covid 19 – Funding Risk	
Original recommendation and management response	Original priority
The management of risks and contingency, including Covid-19 and other costs, should be consistently reported. **Management response:** Agreed. It will be ensured the Project Manager's report aligns with the presentation in the CA's report, and that the risk register is updated to reflect the Covid risk and Early Warning Notices as they arise.	**Low**
Current findings	**Residual risk**
The revised cost reporting to the project team, established in February 2022 has details surrounding risk and contingency. **Conclusion:** Closed	N/A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Previous matter arising 13: Covid 19 – Funding Risk	
Original recommendation and management response	Original priority
Specific Covid funding risks, and its impact on project funding (as per Welsh Government requirements) will be highlighted and regularly reported to relevant forums **Management response:** Agreed. It will be ensured the Project Manager's report aligns with the presentation in the CA's report, and that the risk register is updated to reflect the Covid risk and Early Warning Notices as they arise.	**Medium**
Current findings	**Residual risk**
Since the date of the previous report, the compensation event specific to Covid costs has been substantiated and agreed with the Cost Adviser. At the date of audit fieldwork, there were no further Covid funding risks identified for reporting to the Project Team or Delivery Group. As per ***previous matter arising 12*** an updated cost reporting template has been implemented which will allow for clarity of such reporting if/when applicable. **Conclusion:** Closed	N/A

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Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

Rating	Definition
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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Development of Genomics Partnership Wales

Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

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Report status:	Final
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Fieldwork completion:	28 February 2022
Debrief meeting:	10 February 2022 and 1 March 2022
Draft report issued:	4 March 2022
Draft report meeting:	9 March 2022
Proposed final report issued:	18 March 2022
Management response received:	25 April 2022
Final report issued:	25 April 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit (SSu)
Executive sign-off:	Abigail Harris, Executive Director of Strategy and Planning (Senior Responsible Officer)
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities (Project Director) Clive Morgan, Managing Director, Genomics Partnership Wales Michaela John, Genomics Partnership Wales Programme Manager Owen Rees, Head of Capital Planning Alex Morris, Senior Capital Project Officer Catherine Philips, Executive Director of Finance Nicola Foreman, Director of Corporate Governance
Committee:	Audit Committee

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

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

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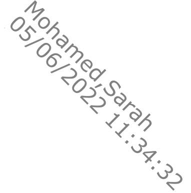

Executive Summary

Purpose

The audit was undertaken to review the delivery and management arrangements in place to progress the Genomics Partnership Wales (GPW) capital investment project and is not an audit of the wider strategic programme; and the performance to date against its key delivery objectives i.e. time, cost and quality. The period reviewed included OBC and FBC development, and preparations to commence construction.

Overall Audit Opinion and Overview

A robust project team structure was operating, led by the Project Director and involving key GPW representatives and supporting workstreams, with routine reporting to the Project Team and Capital Management Group. Appropriate engagement with users and stakeholders, and support from appropriate external advisers, was evidenced during the design development process.

An accelerated FBC development approach was agreed at the project - progressing at risk ahead of WG OBC approval; and without a fully developed design at the point of FBC submission.

Despite the accelerated process, targeted FBC dates were not achieved due to slippage in the Welsh Government OBC approval timeline. Contract negotiations, following FBC approval, further delayed the commencement of works on site. Whilst reporting significant risks should further delays materialise, GPW has confirmed it can remain in existing accommodation until the planned completion date.

The FBC target cost has increased, post approval, by £450k following further design development and market testing. At the time of the audit, the increase was being managed within the £1.2m project contingency.

The key matters arising at the project include:

- A need for improved contractual management arrangements at all stages of the project; and
- Weaknesses in the approvals process in relation to the accelerated approach.

Other recommendations are within the detail of the report. Noting the priority ratings of the issues identified at the current report, **reasonable assurance** has been determined at this interim stage of the project.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

	Assurance objectives	Assurance
1	Governance	Reasonable
2	Approvals	Reasonable
3	Contract Management	Reasonable
4	Design Development	Substantial
5	Project Management	Substantial

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

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Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
3.3	Advice to be sought from NWSSP:SES & Procurement Services on the management of FBC-stage contractual requirements, when progressing the project at risk.	3	Operation	Medium

Future Assurance Matters[2]		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	Project acceleration approval (and associated financial risk) to be in accordance with the UHB's scheme of delegation.	2	Operation	Medium
2.2	Deviations from Welsh Government guidance, for business case submission, to be highlighted and endorsed at Board level.	2	Operation	Medium
3.1	Contracts should be in place prior to works / duties commencing.	3	Operation	Medium
3.2	Letters of Intent do not represent good practice and should only be used in exceptional circumstances.	3	Operation	Low

[2] Future assurance matters are for management action at future (appropriate) projects. Noting current action cannot be taken at this project, the Audit Committee is requested to exclude from the audit tracker and the matters arising included in this report for management information. They have, however, been taken into consideration when determining the assurance rating at this report

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1. Introduction

1.1 The audit reviewed the delivery and management arrangements in place to progress the Genomics Partnership Wales (GPW) capital investment project (the project). This audit is limited to a review of the refurbishment of the building to accommodate GPW and not the wider GPW strategy.

1.2 The Full Business Case (FBC) sought the approval for a capital investment of £15.3m (for the preferred option i.e. the partial refurbishment of the existing CD1 building on the GE site). It also permits further development of the Genomics for Precision Medicine Strategy to enable Cardiff and Vale University Health Board (the UHB) to provide increased delivery for the following Genomics Partnership Wales organisations:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

1.3 The construction has been procured through the NWSSP:SES established Designed for Life: Building for Wales Framework (DfL Framework). The Supply Chain Partner (SCP) has been appointed under the framework to develop both the design and construction of the proposed facility.

1.4 The FBC was approved by Welsh Government (WG) in September 2021, with construction commencing on site in January 2022. At the time of review, completion was forecast for February 2023.

1.5 This was the first audit undertaken of the project, and has reviewed the period of business case development and approval (both outline business case (OBC) and FBC and preparations to commence construction (including contractual arrangements).

1.6 An Integrated Audit & Assurance Plan was included within the approved FBC and includes a further review (construction stage) to be undertaken during 2022/23.

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

- Failure to achieve key project objectives (e.g. delivery to time, cost and quality);
- The project may not be effectively managed;
- Poor business case development processes;
- Appropriate approvals not in place to progress through key development stages;
- The appointed supply chain partner and advisers do not represent value for money or the appointments do not follow best practice;

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- The interests of the UHB are not protected under contract; and
- Adequate monitoring and reporting may not be demonstrated.

1.8 A Capital Systems Management audit is currently being undertaken at the UHB following identification of issues associated with the procurement, governance and financial monitoring arrangements applied within the Capital & Estates function. Revised working practices have been implemented and where matters arising, at this review, are impacted by the same, it has been acknowledged as such.

2. Detailed Audit Findings

Project Performance: Summary of the achievement of the project's key delivery objectives (time, cost and quality) for the period reviewed.

2.1 At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives and that governance, risk management and internal control within the area under review are suitably designed and applied effectively.

2.2 This initial audit of the project covered the period of OBC and FBC development to pre-construction (January 2022). When assessing progress against the original delivery objectives, the following was evidenced:

Time

2.3 Following commencement of OBC development, the project was temporarily stood down (in March 2020) with the emergence of Covid.

2.4 However, noting the significant risks to the GPW of remaining in the existing (not fit for purpose) accommodation longer than the originally agreed project completion date, a decision was taken to accelerate project development arrangements. The FBC submission to WG was targeted for January 2021; with the aim of securing approval ahead of the 2021 summer election period.

2.5 Acceleration was achieved by taking the following measures during the FBC development process (see further detail at the ***Approvals*** section):

- Development of the FBC at risk, ahead of WG approval of the OBC (with the UHB carrying the financial risk of OBC/FBC fees expended should the business cases not be approved); and
- Development of the target cost, for inclusion within the FBC, at Royal Institute of British Architects (RIBA) Stage 3 design, and not Stage 4 as usually required (which was completed at a later stage).

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2.6 Delays in the anticipated WG scrutiny and approval process for the OBC, and the need for further clarity around revenue costs, resulted in FBC submission in May 2021, with approval granted in September 2021. Subsequent delays in contract

negotiations have further impacted the start date on site and consequently the expected completion date has moved from October 2022 (as per OBC) to February 2023.

Cost

2.7 The FBC was submitted with costs developed and market tested to RIBA Stage 3 design. The continuation of design development and market testing post-FBC submission, coupled with extra-ordinary market conditions during the period (including higher than average inflation), led to a subsequent increase in the target cost of circa £451k.

2.8 Noting the cost increase was identified post-FBC submission, it was not included in the WG approved funding envelope; and, therefore, is currently being managed within the project contingency (representing a 38% commitment against the total contingency allowance of £1.2m, prior to commencement of construction).

2.9 Whilst the UHB has indicated potential WG support for additional funding of 50% of the cost increase, approval of the same had not yet been confirmed.

2.10 The UHB returned £1.6m from the 2021/22 Capital Resource Limit (to WG) in respect of slippage at the project, noting the delayed start on site.

Quality

2.11 A robust design development process has been evidenced, with engagement from key stakeholders and appropriate technical advice obtained. Key Performance Indicators completed by the UHB to the current stage have not highlighted any performance issues with the SCP or advisers.

The following sections of the report further outline the key observations that have contributed to the above – matters which require management attention, with low to moderate impact on residual risk exposure until resolved.

Governance: To ensure that appropriate governance arrangements were in place for the period reviewed, including operation of effective reporting and accountability lines.

2.12 The project governance structure had been formally defined within the FBC and the Project Execution Plan.

2.13 The Executive Director of Planning fulfilled the role of Senior Responsible Owner (SRO), with appropriate engagement demonstrated at the project through membership of the Capital Management Group (CMG) and regular liaison with the Project Director.

2.14 The Director of Capital, Estates & Facilities fulfilled the role of Project Director, chairing the Project Team and reporting to the Genomics Partnership Wales Governance Board and CMG.

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2.15 No separate Project Board has been established. Rather, project updates are presented to the Genomics Partnership Wales Governance Board which, whilst not a UHB forum, is chaired by the C&V UHB Chief Executive in their capacity as SRO of the GPW Strategy. Monthly meetings have been held, with routine attendance from either the Project Director or the Managing Director (All Wales Medical Genomics Service) to present a verbal project update.

2.16 Formal written reporting to this forum has not been evidenced. The verbal updates shared, as minuted, included limited information on project performance (excluding, for example, project costs and risks).

2.17 At other UHB projects reviewed, the forum with Project Board responsibilities receives a Flash Report, or similar, providing an overview of project performance in key areas, including an overarching 'RAG' (red/amber/green) rating. Whilst recognising at this project the Governance Board is not a UHB forum, and may not be deemed the appropriate platform for discussion and approval of UHB matters (such as project financials), the absence of formal reporting may reduce the Governance Board's ability to fulfil the scrutiny and approval role expected of a Project Board. (**MA1**).

2.18 A Project Team was established with appropriate terms of reference and chaired by the Project Director. Monthly meetings have been held to facilitate coordination of project management activities, including those undertaken by supporting working groups. Capital Highlight Reports were presented to each meeting providing an appropriate level of project information to facilitate the role of the team.

2.19 Recognising the above, **reasonable assurance** has been determined.

Approvals: To ensure that the business case development process was robust, including approval at key junctures; and that appropriate approvals were sought and obtained at key stages in the project life cycle.

2.20 In an attempt to maintain the required completion date, the project did not progress in accordance with the WG Infrastructure Investment Guidance (see **para 2.4**). In October 2020, the Management Executive granted approval to commence development of the FBC at risk, ahead of OBC approval by WG. Recognising the financial quantum of the risk involved (referenced as circa £800k), this decision should have been taken at Board level (**MA2**).

2.21 The OBC was approved by the UHB Board in November 2020 and submitted to WG in December 2020; subsequently undergoing both OBC scrutiny and a Gateway review. Comments / recommendations arising were appropriately factored into the FBC prior to submission.

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2.22 Formal written approval of the OBC, by WG, was not evidenced. However, management advised that verbal approval was received in March 2021, with subsequent email communication confirming the approval.

2.23 The FBC was presented to the Board in March 2021 and subsequently approved, for submission to WG, via Chair's Action in May 2021. Board approval was also sought in August 2021 to enter into contract with the SCP to deliver the construction works, pending WG approval of the FBC.

2.24 Noting the above, **reasonable assurance** has been determined in respect of the approvals processed applied.

Contract Management: To ensure that contractual costs (including the target cost) have been robustly agreed and that appropriate contractual documentation is in place for the main contractor and the UHB's advisers.

Target Cost

2.25 As referenced in **para 2.4**, noting time pressures at the project, the FBC target cost was developed to RIBA Stage 3 design, as opposed to Stage 4 detailed design as usually required. Two potential methodologies were developed, in consultation with NWSSP:SES, for the agreement of the target cost. Both options were presented to the Management Executive, with the lowest risk option approved.

2.26 The approved FBC target cost was £8,782,274. In October 2021, after the FBC and project funding envelope had been approved by WG, the Cost Adviser reported an increase of this cost to £9,233,697: a movement of £451,423 (5.1%). This has been attributed to:

- inclusion of Covid working measures (£170k);
- review of tendered packages in light of the timescale (from agreement of the target cost to the forecast start on site) and current market conditions (£159k); and
- review of preliminaries and project resourcing (£122k).

2.27 At the time of reporting, the increase was being managed within the project's contingency provision of £1.2m. The potential for support from WG for partial funding has been indicated in project reports; but not yet confirmed.

Contract Documentation

2.28 This being the first audit of the project, the overall contract position as at the time of audit fieldwork, was reviewed as follows:

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	SCP	Cost Adviser	Project Manager
Call off contract *To cover the period of Strategic Outline Case (SOC) to Outline Business Case (OBC)*	✓ But executed 2 months late	✓ But undated	✓ But undated
Confirmation Notice 1 *To cover the period of approval of OBC to FBC*	*X* *para 2.30*	*X*	*X*
Confirmation Notice 2 *To cover the period of design completion, construction, commissioning, handover (Stage 4), operational commissioning (Stage 5) and Project Closure (stage 6)*	*X* *para 2.31*	*X*	*X*

2.29 Noting the FBC was developed at risk during the period November 2020 to June 2021, management advised that the SCP was unwilling to enter into contract ahead of OBC approval, perceiving this to be outside the required DfL Framework procedure. Formal guidance, to this effect, has not been identified. The UHB progressed without appropriate contractual protection; and there is no evidence to demonstrate that the Management Executive were advised of this issue when granting approval to accelerate the FBC development (see **MA2**).

2.30 The issuing and execution of Confirmation Notice No. 2 was delayed whilst the inclusion of additional clauses, at the request of the SCP, was assessed and negotiated. Noting the desire to maintain the project programme timeline and achieve the targeted completion date, construction works were instructed to commence under a Letter of Intent, with details as follows:

- The Letter was authorised by the Chief Executive and issued on 20 December 2021;
- The Letter instructed the SCP to progress with mobilisation, design and early sub-contract procurement up to the value of £500k;
- Works commenced on site on 10 January 2022;
- Confirmation Notice No. 2 was subsequently executed w/c 21 February 2022.

(See **MA4** for all contractual issues).

2.31 At the date of reporting, it has been confirmed that all outstanding contract documents were executed by 25 February 2022.

2.32 Management have expressed the view that, in the absence of timely stage contract execution, the UHB is protected by the wider D4L Framework arrangements. Audit & Assurance (SSu) has subsequently sought advice from NWSSP:SES and the DfL Framework legal advisers. The response provided notes that whilst mitigating controls are provided by the overarching Framework arrangements,

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the signing of contracts post-commencement of works should be kept to a minimum.. Noting the period of delay in this instance, **reasonable assurance** has therefore been determined.

Design Development: To ensure that the design was sufficiently progressed and signed off by users in accordance with the development programme. That users were adequately supported with professional advice.

2.33 As referenced at **para 2.26** the design was only developed to RIBA Stage 3 for the FBC submission, with Stage 4 design progressing post-FBC submission. The approval process to progress in this manner has been assessed in the ***Approvals*** section (see **MA2**).

2.34 Notwithstanding the non-standard timeline and associated impact on development of the target cost, robust design development processes were applied, with effective engagement of key stakeholders throughout, and user sign off at key stages.

2.35 The Genomics Partnership Wales has managed a number of supporting workstreams, developing service and workforce models, and operational policies, alongside design development.

2.36 A clearly defined change control process operated during the design stages, with some changes made to designs / room data sheets, post sign-off. The challenges of working remotely (due to Covid restrictions) when developing and agreeing these designs, particularly for non-expert service users, are recognised. The changes made were formally assessed and agreed in accordance with the defined procedure.

2.37 Derogations have been captured on a central register and signed off by the UHB, for submission with the FBC.

2.38 Whilst recognising the design development process did not progress in the standard manner, the alternative approach was appropriately considered including associated risks. **Substantial assurance** has therefore been determined.

Project Management: To ensure that effective arrangements are in place to administer and manage the project, including change management, risk management and programme management.

2.39 A range of project management tools have been appropriately applied at the project, for the period reviewed, including:

- A comprehensive Project Execution Plan, including change management procedures, updated in readiness for the construction stage.

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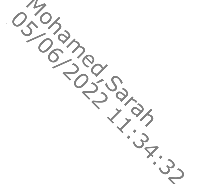
- Robust reporting arrangements, including monthly progress and cost reporting from the external advisers, highlight reporting to the Project Team and exception reporting to the CMG.

  The Capital Highlight report format has recently been enhanced to provide more detailed financial information. This will be applied at this project from February 2022 onwards, through the construction stage. However, as per **MA1**, improved reporting arrangements are required to the Project Board.
- An agreed design-stage programme, coordinating design development activities.
- The External Project Manager's and UHB/Genomics Partnership Wales' risk registers, reported to the Project Team for monthly discussion. The former was appropriately costed and, noting the early pressures on project budget, it is recommended that the UHB/GPW risk register is also costed to aid contingency management as the project progresses (**MA5**).
- Key Performance Indicators, which have been completed to the current stage with no significant performance issues noted to date.

2.40 Recognising the above, **substantial assurance** has been determined.



Appendix A: Management Action Plan

Matter Arising 1: Governance – Project Board (Design)	**Impact**
The Capital Investment Manual recommends the establishment of a Project Board at large or complex schemes, to "*represent the wider ownership interests of the project to maintain coordination in the delivery of the development programme*". The Project Board should comprise senior staff from within the organisation/s who have an interest in the project, including representatives from clinical areas, Estates, IT, Finance, Workforce etc. A dedicated Project Board has not been established within this project's governance structure. Instead, the FBC states that the Genomics Partnership Wales (GPW) Governance Board will act as the Project Board, with the Project Director also reporting to the UHB's Capital Management Group (with Executive representation) on all projects by exception. The expected responsibilities are outlined in section 6.2.2.5 of the FBC. The GPW Governance Board is chaired by the UHB's Chief Executive in their capacity as Senior Responsible Officer supporting the delivery of the Genomics for Precision Medicine Strategy in Wales, and shares membership with the Genomics Project Team via the Managing Director (All Wales Genomics Service) and the GPW Programme Manager. Whilst updates have been verbally presented on a monthly basis to the Governance Board, by either the Project Director or the Managing Director (All Wales Genomics Service), written reporting was not evidenced. Such would ensure members were appropriately sighted on the key project performance objectives of time, cost and quality, and would facilitate scrutiny and challenge in line with the expected role of the nominated Project Board.	Potential risk of: • Insufficient oversight and scrutiny of project activities and performance; • The Project Team is not effectively held to account.

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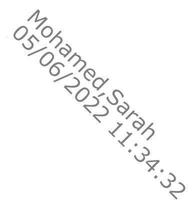
Recommendations		Priority
1.1 The Project Director should provide written reports to the GPW Governance Board.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 Agreed. Project monthly progress reports will be issued to GPW Governance Board as an appended paper for information.	May 2022	Project Director



Matter Arising 2: UHB Approval to Accelerate FBC development (Operation)	**Impact**
The UHB's Standing Orders & Delegation of Powers states: *"All financial commitments above £0.5m must be approved by the Board."* Recognising significant time pressures at the project, and the plan to submit the FBC ahead of the Welsh Government election period in 2021, a briefing paper was submitted to the Management Executive (October 2020) requesting approval to commence development of the FBC at risk utilising discretionary capital funds, ahead of WG approval of the OBC. Whilst not stated in the paper itself, the associated minutes referenced circa £800k in FBC development costs. The Interim Director of Finance confirmed in the minutes that slippage monies were available to cover the costs, and the recommendation to accelerate FBC development at risk was approved. Noting the potential financial quantum of the approval sought, the decision should have been taken at Board level (in accordance with the Standing Orders and Delegation of Powers). Further, the briefing paper did not highlight associated benefits and/or risks with progressing in this manner. When the OBC was submitted to the Board for approval, in November 2020 (i.e. post-dating the above decision taken by Management Executives), the covering paper did not outline the earlier decision taken to accelerate the development of the FBC, ahead of receipt of OBC approval from WG – missing an opportunity to ensure the Board were fully informed of the approach being taken. Whilst noting the above, we acknowledge that the issues arising at this project pre-date the internal reporting undertaken on procurement, governance and financial monitoring arrangements applied within the Capital & Estates function. Improved arrangements have been introduced, since November 2021, and are subject to a separate internal audit review (Capital Systems Management).	Potential risk of: • Non-compliance with Standing Orders; • Decisions are not appropriately informed.

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Recommendations		Priority
2.1a ***Future Assurance*** The financial implications of approvals should be taken into account when determining from which UHB forum the approval should be sought, ensuring compliance with the UHB's Standing Orders and Delegation of Powers. 2.1b ***Future Assurance*** When briefing papers are prepared to seek approvals, it should be ensured that associated benefits and/or risks are highlighted to the relevant decision-making forum.		**Medium**
2.2 ***Future Assurance*** Whilst recognising that nothing can be done in this instance, when submitting future business cases for Board approval, members should be made aware of any deviations from the Welsh Government Infrastructure Investment Guidance, or increased risks to the UHB, in the approach being taken.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1a Agreed. Approvals shall be directed to the appropriate forum in terms of financial delegated limits. 2.1b Agreed. Impact Assessment section within Template Report to Board and Committee to be populated with appropriate detail.	At future projects	Project Director
2.2 Agreed. See 2.1b	At future projects	Project Director

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Matter Arising 3: Contract Management (Operation)	**Impact**
The status of the DfL Framework call-off contract, Confirmation Notice No. 1 and Confirmation Notice No. 2 was reviewed for the Supply Chain Partner, Project Manager and Cost Adviser. A number of issues were identified in the execution of the contracts:	Potential risk of: • The project progresses at risk without appropriate contractual cover in place. • Non-compliance with the UHB's Standing Orders.

Contract party	Contract	Period of duties	Contract status	Delay in execution
Supply Chain Partner	Framework call-off & OBC stage	6 January 2020 – 11 May 2020-	Executed 1 March 2020	2 months
	Confirmation Notice No. 1 (FBC stage)	2 November 2020 – 21 June 2021	Executed w/c 21/2/22	Over 1 year
	Confirmation Notice No. 2 (Construction stage)	10 January 2022 – 27/3/23	Executed w/c 21/2/22	Approx. 6 weeks
Project Manager	Framework call-off & OBC stage	6 January 2020 – 11 May 2020	Signed by both parties but not dated	Cannot be confirmed
	Confirmation Notice No. 1 (FBC stage)	2 November 2020 – 21 June 2021	Executed w/c 21/2/22 but not dated	Over 1 year
	Confirmation Notice No. 2 (Construction stage)	10 January 2022 – 27/3/24	Executed w/c 21/2/22 but not dated	Approx. 6 weeks
Cost Adviser	Framework call-off & OBC stage	6 January 2020 – 11 May 2020	Signed by both parties but not dated	Cannot be confirmed
	Confirmation Notice No. 1 (FBC stage)	2 November 2020 – 21 June 2021	Executed w/c 21/2/22 but not dated	Over 1 year
	Confirmation Notice No. 2 (Construction stage)	10 January 2022 – 27/3/24	Executed w/c 21/2/22 but not dated	Approx. 6 weeks

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Confirmation Notice No.1

The issuing of these notices (covering FBC-stage works for the SCP and advisers), was intentionally delayed by the UHB, until Welsh Government approval of the OBC was received. Management advised that whilst they would have preferred to have these contract documents in place, the SCP was of the view that contracts could not be entered into, in accordance with the DfL Framework procedure, until WG approval of the prior stage was in place; and was therefore unwilling to sign any documents before this point.

However, noting OBC approval was granted in March 2021, there was still a significant delay in issuing the notices after this point.

It is noted that the inability to enter into FBC stage contracts in a timely manner was not highlighted to the Management Executive when the briefing paper was submitted requesting approval to proceed at risk with FBC development (see **MA2**).

Whilst recognising the intention to comply with the DfL Framework procedure, formal guidance from NWSSP: SES to this effect is not currently available. Confirmation Notices No. 1 should have been executed prior to commencement of FBC duties; ensuring compliance with Standing Orders, and providing fullest legal protection for the UHB.

Noting the above, Audit & Assurance (SSu) sought advice from NWSSP:SES and the D4L Framework legal advisers, as to the level of risk the UHB would be exposed to, in the event of any dispute arising prior to stage-based contracts being executed. It has been advised that, whilst the Framework provides some protection, the signing of contracts post-commencement of works should be kept to a minimum.

Confirmation Notice No.2

The issuing of these notices (covering the construction period) was delayed due to negotiations between the UHB (and its advisers) and the SCP over the inclusion of a clause in respect of inflation. Recognising the time pressures at the project, the UHB issued a Letter of Intent (signed by the Chief Executive, 20 December 2021), capped at £500k to enable commencement on site while contract negotiations were

finalised. As has been previously reported to the UHB, the use of these letters does not represent best practice – noting that they do not afford the same legal protections as a contract.

It is also noted that two versions of the signed Letter of Intent have been provided to Audit. It should be ensured that key documents, particularly those with contractual implications, are subject to appropriate document control to enable the extant document to be identifiable/securely retained.

It has been confirmed that all outstanding contract documents (Confirmation Notices 1 & 2 for the SCP and advisers) were executed by 25 February 2022.

Project Bank Account

The NHS Wales Infrastructure Investment Guidance requires all projects over £2m in value to have a Project Bank Account. This has been delayed at the project whilst the above contractual issues were resolved and administration requirements with the bank finalised.

Recommendations	Priority
3.1 ***Future Assurance*** Contracts should be in place before duties/works commence.	**Medium**
3.2 ***Future Assurance*** Letters of Intent do not represent good practice and should only be used in exceptional circumstances.	**Low**
3.3 ***Future Assurance*** Contracts should be dated at the time of execution.	**Low**
3.4 Appropriate document control arrangements should be implemented for key documents such as those with contractual implications.	**Low**

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3.5 Management should continue to seek the early resolution of the Project Bank Account provision.		Low
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 Recognising the legal advice received via NWSSP:SES, the UHB will seek to minimise the period between commencement of works and contract signature..	At future projects	Project Director
3.2 It can be noted in this particular instance, the issued LOI makes specific reference to the provisions of the Contract under which it would be executed, providing a defined scope of works and a cap on total payment under the LOI further mitigating the risk to the Health Board.	At future projects	Project Director
3.3 Agreed. Contracts to be dated at point of execution.	At future projects	Project Director
3.4 Agreed. Major Capital Project folder structure has been reviewed for implementation on existing and future projects.	At future projects	Project Director
3.5 Agreed. Risk and Assurance are currently agreeing approach to execution of PBA joining deed.	Ongoing	Risk and Assurance

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Matter Arising 4: Risk & Contingency Management (Operation)	**Impact**
The Welsh Government Infrastructure Investment Guidance (2018) states: *"Risk registers for each individual project/programme must be completed, shared and monitored, with reference not only to time, cost and quality but also operational/service impacts, functionality and benefits realisation. It is therefore important that NHS bodies not only consider construction risks, but wider operational/implementation risks which have to be managed and mitigated over the lifespan of a scheme."* Good practice was evidenced through the maintenance of two risk registers at the project: 1. a costed construction risk register managed by the external Project Manager; and 2. a UHB / Genomics Partnership's risk register, for wider project-related risks. Monitoring of the costed construction risks against the contingency balance are evidenced as taking place; and reported in the external Project Manager's monthly progress report. As reported at the December 2021 report (reviewed at the date of fieldwork), *"additional cost since RIBA Stage 3 are to be covered by the risk contingency, this does not leave sufficient contingency to cover the other risks that have been identified within the risk register which will need to be regularly monitored."* The wider project risks were captured at the project risk register, with appropriate detail noted including scoring of likelihood and impact, assignment of an appropriate risk owner, and regular updates demonstrating frequency of review. Whilst reported at the monthly Project Team meetings; they are not costed. Noting there are some risks captured which may also impact on project contingency (for example, availability of WG capital funding and capital relocation costs), the costing of these risks where possible would better facilitate management of the contingency budget – particularly in light of the current pressures as reported by the Project Manager. It is also noted there may be some duplication between financial risks on both risk registers (i.e. cost increase of materials), and clarity would be improved by cross-referencing these points (if, for example, the costing has been undertaken at the construction register).	Potential risk of: • The potential financial impact of project risks may not be accurately determined. • The potential financial impact of identified project risks may not be sufficiently taking into account when managing project contingency funds.

Recommendations		Priority
4.1 The UHB / Genomics Partnership's project risk register should be costed where appropriate.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 Whilst it is common practice to cost the construction risk register under the NEC form of contract this approach does not necessarily translate across to operational and service risks.	Ongoing, where appropriate	Project Director

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

Rating	Definition
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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Client Organisation	Cardiff & Vale University Health Board
Audit title	Development of Genomics Partnership Wales
Audit reference	SSU_CVUHB_2122_02
Final Report Date	25 April 2022
Auditor(s)	Melanie Goodman / Felicity Quance

I would be very grateful if you would please take a moment to complete the below questionnaire which will enable us to ensure that we provide a high quality service. Feedback will also be also reflected within our key performance information reported to the Audit Committee.

	QUERY (enter "X" alongside)	**Yes**	**No**	**Partially**	**n/a**	**Any further comments**
1	**Engagement & Communication** Were you satisfied with the way the audit team engaged with you and colleagues?					
2	**Professionalism** Was the audit conducted in a positive, professional manner and respectful of your work commitments?					
3	**Report** Was the work reported in a clear, constructive way?					
4	**Impact** Was the audit beneficial eg providing assurance regarding current arrangements, or supporting improvements?					

What words would you use to describe the audit service you have received? Please feel free to enter up to six words into the boxes below:		

If you have any additional comments or suggestions, please add them below:

Form Completed by	
Date	

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Thank you very much for taking time to complete this questionnaire. Please return by email: **huw.richards@wales.nhs.uk** or post :**Huw Richards, Deputy Director (SSU), NWSSP Audit & Assurance, Floor 3, Companies House, Crown Way, Cardiff, CF14 3UB**
Alternatively, please feel free to call me on: **029 2090 5312**

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Network & Information Systems (NIS) Directive

Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

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Review reference:	C&VUHB-2122-22
Report status:	Final
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Fieldwork completion:	01 April 2022
Debrief meeting:	25 April 2022
Draft report issued:	06 April 2022
Management response received:	26 April 2022
Final report issued:	26 April 2022
Auditors:	Sian Harries (IM&T Audit Manager)
Executive sign-off:	David Thomas (Director of Digital & Health Intelligence)
Distribution:	Russell Kent (Head of Digital Operations), Nigel Lewis (Assistant Director of IT), James Webb (Information Governance Manager)
Committee:	Audit & Assurance Committee

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

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

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff and 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.

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Executive Summary

Purpose

Review arrangements in place for the implementation of the NIS Directive in the Health Board, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.

Overview

We have issued limited Assurance on this area. The significant matters which require management attention include:

- the submitted CAF was partially complete resulting an incomplete self-assessed position.
- No retention of supporting information provided to the Cyber Resilience Unit as part of the CAF assessment.
- Improvement actions have not been identified and a plan has not yet been developed.
- Corporate cyber security risk has not been updated to include NIS Regulations.

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	CAF completion and maintenance of evidence	Reasonable
2	Accurate self-assessed position supported by evidence	No
3	Improvement plan implementation	Limited
4	Governance	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Supporting information retention	1	Operation	Medium
2	Self-assessed position	2	Operation	High
3	Improvement plan	3	Design	Medium
4	Cyber security risk	4	Operation	Medium

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1. Introduction

1.1 In line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the Health Board or organisation) a review of Network and Information Systems (NIS) regulation arrangements was undertaken.

Cyber Security and Resilience is the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

A core piece of legislation relating to Cyber Security are the Network and Information Systems Regulations of 2018 (NIS Regulations), transposed into UK law in May 2018 from the EU Security of Networks & Information Systems (NIS) Directive, with the intention to raise levels of cyber security and resilience of key systems across the EU.

At the core of this piece of legislation is the aim to drive improvement in the protection of the network and information systems which are critical for the delivery of digital services and essential services in the UK. These regulations require bodies to have processes in place to protect themselves from attack, detect potential intrusions and react appropriately when intrusions occur.

Although cyber security is not a devolved matter, Welsh Government (WG) is the competent authority for the NIS in the case of essential health services in Wales.

Within NHS Wales Digital Health and Care Wales (DHCW) takes a leading and coordinating role for the maintenance and improvement of cyber security on behalf of WG, they are responsible for establishing the compliance framework for operators of essential services, which includes defining the scope of the regulations, reporting thresholds, and processes for reporting and dealing with cyber incidents. The Individual Trusts and Health Boards which fall within scope must adopt and comply with these arrangements.

1.2 The potential risks considered in the review are as follows:

- poor or non-existent stewardship in relation to cyber security;
- failure to comply with regulations; and
- loss of data or services and inappropriate access to information.

1.3 We note that the purpose of the audit is to provide assurance on the processes within the Health Board for assessing its current position in relation to cyber security and developing an improvement plan that will address the key identified weaknesses. This internal report does not assess the current state of cyber security within the organisation and this function is the responsibility of the Cyber Resilience Unit (CRU) within DHCW.

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2. Detailed Audit Findings

Objective 1: a process exists for completion of the self-assessment and maintenance of appropriate evidence.

2.1 As part of the initial process, the Digital and Health Intelligence (D&HI) team was required to identify all services deemed critical, which excluded national services provided by DHCW and was limited to the OES. Following clarification received from the CRU regarding the definition of a 'critical system', all Health Board systems that process digital data were to be listed. Over 300 clinical systems and over 1,000 non-clinical systems were identified as part of the scoping exercise.

2.2 The list of systems was reviewed by the Director of Digital and Health Intelligence, Head of Operations, Information Governance Manager, and system owners. As advised by the CRU, one critical system was to be selected to complete this iteration of the Cyber Assessment Framework (CAF) and the Patient Management System (PMS) was unanimously decided upon.

2.3 The CAF was completed by the Information Governance Manager and Director of Digital and Health Intelligence with input from the Head of Operations, developers, and system owners. Prior to submitting the completed CAF to the CRU, it was reviewed and signed-off by the Information Governance Manager and Director of Digital and Health Intelligence.

2.4 We were informed by the Information Governance Manager that information to support each CAF objective was provided through discussions with the CRU via Microsoft Teams calls. The CRU did not specifically request evidence in the form of documentation as part of the assessment, however, we noted that records of the discussions and information provided have not been retained. As the self-assessment will be repeated annually, the lack of recorded information and clarifications sought from the CRU may hinder the timeliness and efficiency of future iterations. **See Matter Arising 1 at Appendix A.**

Conclusion:

2.5 Our review highlighted the work undertaken by the Cyber Security Team to prepare for and complete the self-assessment. However, records of discussions have not been appropriately retained for future iterations of the CAF. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 2: the self-assessed position is accurate and supported by evidence.

2.6 As noted above, there was no retention of information provided to the CRU in support of the statements against the CAF objectives, therefore, we were unable to appropriately evaluate the Health Board's self-assessed position. Furthermore, we noted that a third of the CAF objective results were not fully complete and had the status of 'not assessed' as opposed to 'achieved', 'partially achieved' or 'not achieved', despite assessments being made against each objective's indicators of good practice (IGP). Several IGP's had 'yes' or 'no' recorded against them in terms

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of achievement, however, they lacked the required justification and supporting comments. **See Matter Arising 2 at Appendix A.**

Conclusion:

2.7 As the submitted CAF assessment results are partially complete and no supporting information was retained, we are unable to determine the self-assessed position. Consequently, we have concluded **No** assurance for this objective.

Objective 3: an improvement plan is in place to improve the cyber security position within the organisation, is being implemented appropriately and monitored.

2.8 We understand from our interview with the Information Governance Manager that there is no dedicated cyber security resource within the Health Board but that a process is underway to address this. We can confirm this matter has been addressed in Digital and Health Intelligence Committee papers (DHIC) and recorded on the Digital and Health Intelligence corporate risk register (*A4/0023 Cyber Security - The Cyber Security threats to service continuity*).

2.9 Work to develop an improvement plan has yet to be started due to insufficient capacity within the current IMT team to dedicate to the task, however, we were informed that the task had been added to the Information Governance workplan to progress shortly. **See Matter Arising 3 at Appendix A.**

Conclusion:

2.10 Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement, and it will be for the CRU and Welsh Ministers to determine their sufficiency. Whilst the task has been added to the directorate's workplan, it has not yet been progressed. Consequently, we have concluded **Limited** assurance for this objective.

Objective 4: there is monitoring and reporting of the progress of the improvement plan and gaps in compliance to an appropriate governance group.

2.11 Our review highlighted that DHIC is a statutory committee of the Board and comprehensive cyber security updates are appropriately received under the standing agenda item for its private sessions.

2.12 We further noted that the Board was apprised of the NIS Regulations through the DHIC update report and 2021/22 Annual Report presented at its public meeting on 31 March 2022. The Board is regularly apprised of wider IMT and cyber security matters as evidenced by comprehensive update reports provided by DHIC.

2.13 As noted earlier in the report, there is a dedicated risk around cyber security on the corporate risk register, however, it has not been updated to include compliance with the NIS Regulations. This matter requires attention, particularly due to the potential to receive Revenue / Budget fines for non-compliance. **See Matter Arising 4 at Appendix A.**

Conclusion:

2.14 Whilst there are appropriate governance arrangements to oversee cyber security matters, an improvement plan has not yet been developed due to reasons noted under objective 3, therefore, has not been reported to an appropriate governance group. Consequently, we have concluded **Reasonable** assurance for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Supporting information retention (Operation)		**Impact**
Our review highlighted that records of discussions and supporting information provided to the CRU have not been captured and maintained throughout the self-assessment process.		Potential risk of: • poor or non-existent stewardship in relation to cyber security.
Recommendations		**Priority**
1.1 Management should ensure that for all future annual self-assessments, records of discussions and information provided to and from the CRU are captured and retained.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 We recognise and appreciate the importance of recording adequate evidence to support any self-assessment process and will where possible ensure that future assessments include further context which justifies the answers provided.	December 2022	Head of Information Governance and Cyber Security

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Matter Arising 2: Self-assessed position (Operation)		**Impact**
We noted that a third of the CAF objective results were not fully complete and had the status of 'not assessed' as opposed to 'achieved', 'partially achieved' or 'not achieved', despite assessments being made against each objective's indicators of good practice (IGP). Several IGP's had 'yes' or 'no' recorded against them in terms of achievement, however, they lacked the required justification and supporting comments.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations; and • loss of data or services and inappropriate access to information.
Recommendations		**Priority**
2.1 Management should ensure that the CAF is reviewed and accurately completed to include assessed status and justifications for each IGP and objective.		High
Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 This was an oversight on one of the questions that has now been amended.	Complete	Head of Information Governance and Cyber Security

Matter Arising 3: Improvement Plan (Design)		**Impact**
Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement, however, we noted that improvement objectives have not been identified following the completion of the self-assessment.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations; and • loss of data or services and inappropriate access to information.
Recommendations		**Priority**
3.1 Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 The competition of our improvement action plan and adherence to this will be one of the first duties undertaken by the dedicated cyber resource, which we are currently recruiting to. We have the information required to develop this plan and the work needs to be appropriately scheduled/prioritise.	Q3 2022/2023	Head of Information Governance and Cyber Security

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Matter Arising 4: Cyber security risk (Operation)		**Impact**
Whilst we established that a general risk relating to cyber security is included on the Corporate Risk Register, it has not been updated to include the NIS Regulations. This matter requires attention, particularly due to the potential to receive Revenue/Budget fines for non-compliance.		Potential risk of: • poor or non-existent stewardship in relation to cyber security; • failure to comply with regulations; and • loss of data or services and inappropriate access to information.
Recommendations		**Priority**
4.1 Management should ensure that the current cyber security risk (A4/0023) included within the Corporate Risk Register is reframed to reflect the high-level risks identified from the self-assessment process.		Medium
Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 Risk register updated to reflect NIS and the international situation, both of which elevate the cyber risk.	Complete	Head of Information Governance and Cyber Security

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*

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

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Welsh Risk Pool Claims
Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

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Review reference:	CVU-2122-04
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Draft report issued:	26 April 2022 v1.0 27 April 2022 v1.1
Management response received:	27 April 2022
Final report issued:	28 April 2022
Auditors:	Liz Vincent, Principal Internal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Ruth Walker, Executive Nurse Director
Distribution:	Angela Hughes, Assistant Director of Patient Experience Vicky Stuart, Head of Concerns Suzanne Wicks, Head of Clinical Negligence Claims Karen Lewis, Head of Personal Injury Claims
Committee:	Audit & Assurance Committee

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

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

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Executive Summary

Purpose

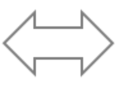
The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Welsh Risk Pool claims.

Overview

We have issued Substantial assurance on this area. The matters requiring management attention include:

- Out of date policy available on the Health Board website.
- Reconciliation between Datix and the financial schedule.

Report Classification

		Trend
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.	 2020/21

Assurance summary[1]

	Assurance objectives	Assurance
1	Completed documents within set timescales	Substantial
2	Evidence to support costs incurred	Substantial
3	Appropriate authorisation	Substantial
4	Accurate data within Datix	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Claims Management Policy (UHB 332) requires review	1	Operation	Medium
2	Recovery of all relevant costs	4	Operation	Medium

1. Introduction

1.1 Our audit review of Welsh Risk Pool concerns and compensation claims was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments; this gives rise to a potential for mistakes to occur. Welsh Risk Pool Services (WRPS) require claims for reimbursement and repayment to be made within specific timescales. Reimbursement of settled claims are either under NHS indemnity, or from April 2018, redress cases.

1.3 In 2020 WRPS issued an updated standard: The Compensation Claims Management Standard, to ensure that NHS bodies:

- Have an effective process for managing concerns raised but patients and staff;
- Have an effective process for managing legal claims for financial compensation; and
- Ensure that there is good organisational learning from all events.

1.4 Area for Assessment 3 of the standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement, made on Welsh Risk Pool Services.

1.5 The relevant lead for this review is the Executive Nurse Director.

Audit Risks

1.6 The potential risk considered in this review is that claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

2. Detailed Audit Findings

Objective 1: An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales

2.1 A sample of 25 cases across the three areas of Clinical Negligence, Personal Injury and Redress was reviewed to ensure that an appropriately completed Learning from Events (LFE) report, Case Management Report (CMR), a Finance Case Record checklist (U1/U2) and a Financial Schedule of costs had been completed. We can confirm that in all instances the required documentation was produced and found within the Datix system.

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2.2 Under the new standard, claims management teams must complete a LFE Report within 60 days of the decision to settle date. This requirement came into effect for claims received after 1 January 2019. All the claims in our review pre-date this requirement. However, a separate requirement to submit LFE Reports for historic cases by the deadline of 31/01/22 was confirmed as having been met for the cases we reviewed.

2.3 Claims Management are also expected to complete and submit a CMR, checklist and financial schedule to WRPS within 4 months of the final payment date. The Health Board had achieved this target for all case within our sample.

2.4 We compared the key dates on the LFE report, the CMR, and the checklist U1. Inconsistencies were found in the 'Final Payment' date recorded in two of the 14 Clinical Negligence cases. Discrepancies between the 'final payment' date will not have an impact on the monitoring of the 4-month target date. The Finance Department manages these dates and provide regular reports to the Claims Leads of their target dates for each of the cases.

2.5 Late invoices have been known to be received after the CMR has been authorised and converted into a PDF format. The Finance Department is therefore unable to amend the 'final payment' date shown on the CMR so that it corresponds with the checklist U1 before sending to WRPS.

2.6 We reviewed the Health Board's Claims (Clinical Negligence, Personal Injury and redress) Management Policy[1] (UHB 332 v1) that is available on the Health Board's website and found it was past its review date of 13 September 2019. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: We found that all cases sample tested had the relevant documents required and had been submitted to WRPS within the required timeframe. Although there were differences between the final payment dates, this did not have an impact on the monitoring of the 4-month target dates. (Substantial Assurance)

* We did note on review of the Health Board processes that the Claims Management Policy (UHB 332 v1) is a number of years past its scheduled review date and requires review. Although, this has not impacted the completion and submission of the required documentation and has not therefore been taken into account in determining the overall assurance rating for this objective. We also note that several processes are currently under review, both by the Health Board and Welsh Risk Pool, which will impact the Policy.

Objective 2: There is appropriate evidence to support the costs incurred

2.7 From our sample of 25 cases, we reviewed seven cases across the three areas to ensure that there was sufficient evidence obtained within Datix to support the costs incurred. We also referred to the U1 checklist and the financial schedule of costs for each case to ensure that they also reconciled to the amounts reimbursed from

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[1] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/corporate-policy/c-corporate-policy/cand-v-claims-final-use-2-copy-pdf/ (accessed 12.04.2022)

WRPS. In all cases analysed there was source documentation within Datix to substantiate that the costs cited on the forms was accurate.

Conclusion 2: We confirmed that all cases that we tested against had evidence to support the costs incurred. (Substantial Assurance)

Objective 3: Forms have been appropriately authorised aligning with the delegated limits of the organisation

2.8 The claims within the sample that we tested had an appropriate governance and case manager declaration and had been appropriately authorised prior to submitting to WRPS.

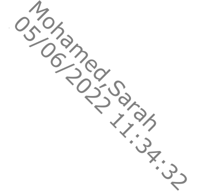
Conclusion 3: We confirmed that all the cases that we tested had been appropriately authorised. (Substantial Assurance)

Objective 4: Claims submitted are accurately entered onto the Datix risk management database

2.9 For all 25 cases reviewed the amount reimbursed from the Welsh Risk Pool reconciled to the U1 checklist and the Financial Schedule of Costs.

2.10 We did identify however, discrepancies when comparing the invoices shown within the relevant Payment Summary within Datix to what is shown on the U1 Checklist and the Financial Schedule of Costs. *(Matter Arising 2 – Medium Priority)*

Conclusion 4: Whilst we could confirm that all the cases had been appropriately reimbursed by WRPS, our testing identified an issue when comparing the invoices recorded within Datix to the U1 checklist and the financial schedule of costs. (Reasonable Assurance)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Appendix A: Management Action Plan

Matter Arising 1: Claims Management Policy (UHB 332) requires review		Impact
The Health Board's Claims (Clinical Negligence, Personal Injury and redress) Management Policy (UHB 332 v1), which is available on the Health Boards website has surpassed its review date (13 September 2019). A review of the policy is underway, the Assistant Director of Patient Experience commenced a review in December 2020; but acknowledges that further adjustments and the finalised forms from Welsh Risk Pool are to be included.		Potential risk of: • Claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Trust's senior management, as directed by Health Board Policy.
Recommendation 1		**Priority**
Following the review of current processes, management need to ensure that the Concerns and Claims Management Policy (UHB 332) is updated and approved.		**Medium**
Agreed Management Action 1	**Target Date**	**Responsible Officer**
The above policy is in draft to include awaited confirmation of the updated national guidance.	31st October2022	Angela Hughes, Assistant Director of Patient Experience

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<table>
<tr><th colspan="2">Matter Arising 2: Recovery of all relevant costs (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">As part of our testing we sampled 14 clinical negligence cases and attempted to reconcile the relevant Payment Summary held within Datix, to the U1 checklist and Finance Schedule produced by the Finance Department. We identified discrepancies for four of 14 cases reviewed, which identified that:
• Three cases were impacted by the late receipt of invoices, which had not been submitted for reimbursement to the Welsh Risk Pool: Case 3191, £647; Case 3627, £1,000; and Case 3652, £420. We were advised that a process is in place to seek reimbursement for late invoices.
• A further anomaly identified was due to a miscoded invoice, which as a result had not been claimed, Case 3627 for £1,750. The invoice was noted on the Payment Summary within Datix but not on the Financial Schedule, and was only identified because of our testing exercise. We were advised that the introduction of ‘No Purchase Order, No Payment’ would prevent future occurrences of this nature.</td><td>Potential risk of:
• Claims costs are not fully reimbursed from the Welsh Risk Pool.</td></tr>
<tr><th colspan="2">Recommendation 2</th><th>Priority</th></tr>
<tr><td colspan="2">To continue as planned to seek reimbursement from the Welsh Risk Pool for the late invoices identified (Cases 3191, 3627, and 3652); and
Consideration should be given to current reconciliation arrangements to ensure all relevant costs have been identified and captured.</td><td>Medium</td></tr>
<tr><th>Agreed Management Action 2</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>The financial accountant will seek reimbursement for the late invoices captured during this audit. With immediate effect, the claims team will send a payments schedule captured on Datix to financial accounts when cases are concluded to assist cross reference purposes</td><td>31/05/22</td><td>Steve Monk, Losses and Taxation Accountant
Suzanne Wicks, Head of Clinical Negligence Claims</td></tr>
</table>

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The matter of late payment fees/invoices has been brought to attention of the Legal & Risk lead and thereafter to agree a process in respect of avoiding further late payment fees	Complete	Suzanne Wicks, Head of Clinical Negligence Claims

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:

Rating	Definition
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*

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

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Nurse Rostering: Children's Hospital for Wales (Children & Women's Clinical Board)

Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

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Review reference:	CVU-2122-30
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Final report issued:	28 April 2022
Auditors:	Stuart Bodman, Principal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Caroline Bird, Interim Chief Operating Officer
Distribution:	Catherine Wood, Director of Operations, Children and Women's Clinical Board Andy Jones, Interim Director of Nursing, Children and Women's Clinical Board Kerenza Moulton, Lead Nurse, CHfW Tina Freeman, Senior Nurse, CHfW
Committee:	Audit & Assurance Committee

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

Acknowledgement

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Executive Summary

Purpose

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place for the rostering arrangements within the Children's Hospital for Wales.

Overview

We have issued reasonable assurance on this area.

The Health Board has acknowledged that there is a need to advance the nurse rostering process with the introduction of a new rostering system, HealthRoster.

A number of the issues that we have identified through this review have the potential to be resolved through the introduction of the new system. We make recommendations which relate to documented approval and dissemination of rosters, which similarly relate to the management of rosters, including the documentation and approval of make up shifts, overtime, and shift changes.

We also identified that the Children's Assessment Unit / Seahorse has no access to a Nurse Practice Educator to oversee skills-mix.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Roles and responsibilities for nurse rostering align with procedure.	Substantial
2	Rosters are produced, signed off and published in advance.	Limited
3	Rosters are produced in accordance with nurse establishment levels.	Reasonable
4	Rosters are fit for purpose with deployment of skills mix.	Reasonable
5	Rosters have been created cognisant of agreed flexible working requests.	Substantial
6	Review and reporting of the effectiveness of the rostering process.	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Evidence of roster approval	2	Operation	Medium
2	Timeliness of Roster Dissemination	2	Operation	Medium
3	Roster dissemination via mobile messaging	2	Operation	High
4	Roster Management	3	Operation	Medium
5	Evidence of training records to support the nursing 'skills-mix'.	4	Operation	Medium

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1. Introduction

1.1 The review of the arrangements for Nurse Rostering within the Children's Hospital for Wales (CHfW) was undertaken in accordance with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board'). This review was undertaken at the request of the Children and Women's Clinical Board.

1.2 The Health Board's rostering arrangements are directed by the 'Rostering Procedure for Nurses and Midwives (UHB 339 v2)', which is published on the Health Board's website[1]. The Procedure highlights the value of staff, "the health board is committed to the delivery of high quality services. The UHB recognises that its' staff are its' greatest asset and therefore the deployment of this resource is vital in optimising service delivery."

1.3 The Health Board currently uses RosterPro to facilitate nurse rostering. A live project is in place to move the Health Board to an alternative e-rostering system, HealthRoster (Allocate), which will require a change in culture and practices. In conjunction with the forthcoming changes we understand that the Nurse Rostering Procedure is currently under review.

1.4 The Interim Chief Operating Officer is the executive lead for this review.

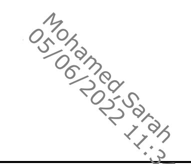
Audit Risks

1.5 The potential risks considered in this review were as follows:

- Roster patterns to do not reflect agreed staffing establishments, resulting in increased financial cost;
- Late preparation and agreement of rosters may impact the work life balance of staff;
- Ineffective rostering arrangements may impact high quality standards of care and exposure to greater clinical risks; and
- Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increased financial burden on the Health Board.

Limitations to scope

1.6 It should be noted that the scope of this audit did not cover the appropriateness of the funded nurse establishment levels in each of the areas reviewed.



[1] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/workforce-and-od-policies/r-workforce-and-od/rostering-procdeure-for-nurses-and-mdiwves-final-v2-pdf/

2. Detailed Audit Findings

2.1 The basis of our review was informed by sampling undertaken within the following areas:

- Neonatal Intensive Care Unit (NICU), C2, University Hospital for Wales;
- Children's Assessment Unit (CAU)/Seahorse, CHfW; and
- Island Ward, CHfW.

Objective 1: Roles and responsibilities for nurse rostering align with the Health Board's Rostering Procedure for Nurses and Midwives.

2.2 The Health Board's 'Rostering Procedure for Nurses and Midwives (UHB 339 v2)' requires review, the date of next review contained within the Procedure refers to 3rd November 2019. We were advised that the procedure is under review and consultation but is yet to receive formal approval through the Committee structure. A key component of the updated procedure reflects the implementation of the Health Board's new rostering system HealthRoster, the rollout had commenced while audit fieldwork was progressing, but the roll out is not scheduled to impact the audit sampled areas until May 2022 onwards.

2.3 For the basis of this review, we referred to the published version of the Procedure (v2), which outlines key rostering principles and processes to be undertaken by ward management. Audit testing identified that all three areas have assigned responsibilities within the wards to implement the key processes that underpin roster management.

2.4 At the time of our review Island Ward demonstrated that they have a local rostering procedure to supplement the Health Board approved procedure, to clarify the arrangements locally. We did not identify any local procedures within NICU and CAU/Seahorse.

Conclusion 1: Roles and responsibilities within the three areas align with the current Health Board Rostering Procedure. (Substantial Assurance)

** We do note that the Health Board Rostering Procedure, approved in June 2017, is over two years past its intended review date. However, given that it is currently under review and acknowledging the imminent move to HealthRoster and the known impact on the Procedure, we make no recommendations on this occasion.*

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Objective 2: Rosters are produced, signed off and published in advance by the appropriate staff and in accordance with the timescales set out in the Procedure (a minimum of 6 weeks in advance). Any changes to the published roster must be approved by the nominated person.

2.5 All three wards have processes in place which ensure that off-duty rotas are compiled at least six weeks prior to shift commencement. The process in each ward also ensures the inclusion of all planned absences to provide appropriate shift allocation to nursing staff.

2.6 We were unable to evidence the sign-off of finalised off-duty rotas by NICU ward management, prior to issue to nursing staff. The ward systems were predominantly paper based. *(Matter Arising 1 – Medium Priority)*

2.7 We also considered the dissemination of rosters to staff and we could not evidence their actual dates of issue to NICU ward staff. We found that the further two wards are utilising mobile messaging via WhatsApp to disseminate their rosters. Although CAU/Seahorse was unable to provide evidence of dissemination of off-duty rotas via their WhatsApp Group, for two of the three months sampled (*Matter Arising 2 - Medium Priority*).

2.8 Through the COVID-19 pandemic we understand there has been an increasing use of mobile messaging, such as WhatsApp for communicating ward rosters. We were unable to identify any Health Board approved policy or procedures to direct the use of, and to provide the parameters within which the forum is acceptable. We sought advice from the Digital & Health Intelligence Directorate, and we were advised by the Health Board's Information Governance Manager that WhatsApp is not a permitted platform, unless it has been approved on a case-by-case basis that a clinical need out ways the risk for its use. The recommended platform is Microsoft Teams, although we note that not all nurses have access to the application.

2.9 For the purposes of this review, we were reliant on staff providing screenshots from their personal devices in order to obtain audit evidence of dissemination of the rosters, which highlighted that WhatsApp is being used for purposes beyond roster dissemination, although we found no parameters in place for its use.

(Matter Arising 3 – High Priority)

2.10 We have been advised that the introduction of HealthRoster will provide a shift change in the technology used to support the roster process, which will be linked to a mobile application that staff will be able to access on their personal device. The new application will be solely for professional use.

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Conclusion 2: Whilst there are processes in place to facilitate accurate and timely production of off-duty rotas, action is needed to ensure visible sign-off and dissemination in a timely manner. We acknowledge that a move to HealthRoster will remove some of the issues currently identified, but our assurance rating for this objective reflects the use of platforms currently not permitted by the Health Board. (Limited Assurance)

Objective 3: Rosters are produced in accordance with funded nurse establishment levels, ensuring the effective utilisation of existing staff and that contracted hours are met, including make up shifts, in advance of seeking support from bank and agency nurses.

2.11 All three wards have funded nursing establishments that incorporate specialities which are reflected within the off-duty rotas. It is, however, noted that CAU/Seahorse at the commencement of the audit was in a position of revising its staffing establishment due to historical shortfalls in its composition but these have now been rectified and approved by senior nurse management.

2.12 We reviewed the three sampled areas, over a three month period, August to October 2021, and selected a sample of staff. We identified some instances of non-compliance with expected roster management processes, for example:

- To ascertain if contracted hours are met, we reviewed the monitoring arrangements for make up shifts, which account for the 1.5 hours per week that are paid (salaried) but not actually worked, and is either worked back as a 6 hour shift per month, or a 12 hour shift every other month. We were unable to evidence the complete monitoring of make up shifts by ward management in any of the three areas. The recording of make up shifts on the off-duty rotas was inconsistent, and within NICU the information was not available at the time of the review.
- We also gave consideration to enhanced overtime, our testing identified a small number of instances where we could not locate documentation to confirm approval.
- We reviewed changes to the rosters once approved and disseminated, but there was a lack of clarity to support some of the changes made or the evidence of written authorisation.

(Matter Arising 4 – Medium Priority)

2.13 As noted previously, the move to HealthRoster has the potential to address the issues highlighted and enhance the transparency of roster management. Current paper based systems do not facilitate efficient or effective roster management practices.

Conclusion 3: Whilst off-duty rotas are built upon and reflect nurse staffing establishments, ward management attention is required to ensure the effective recording and monitoring of 'make up' shifts, reinforcing existing processes in respect of recording and authorising overtime, and shift-changes. (Reasonable Assurance)

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Objective 4: Rosters are fit for purpose with deployment of appropriate skills mix to ensure safe, high-quality standards of care.

2.14 Off-duty rotas in the three wards reflect the skills-mix of nursing staff allocated to shifts worked.

2.15 NICU and Island Ward hold current training records to ensure that 'skills mix' levels are maintained, and these are updated by their respective Nurse Practice Educators.

2.16 Within the CAU/Seahorse there is no evidence of training records to support the oversight, updating and maintenance of nursing 'skills-mix' provision *(Matter Arising 5 - Medium Priority).*

Conclusion 4: We were able to evidence the deployment of skills mix within the rostering process for NICU and Island wards. The CAU/Seahorse should ensure that evidence of training for their staff is retained. (Reasonable Assurance)

Objective 5: There is appropriate evidence to demonstrate that rosters have been created cognisant of agreed flexible working requests.

2.17 All staff have the opportunity to request flexible work arrangements, for consideration and approval by ward management.

2.18 Audit testing identified that only staff within the Island Ward have formalised flexible working arrangements in place. For those sighted, the requests had been appropriately recorded, signed off by ward management and the shifts requested formed part of the off-duty rota compilation process.

2.19 We have been advised that the Health Board's ability to better support the balance of clinical needs with the work life balance needs of staff can be managed with greater transparency to ward management, through both formal and informal requests within HealthRoster.

Conclusion 5: There is documented evidence to support formal flexible working requests and their inclusion within the off-duty rotas. (Substantial Assurance)

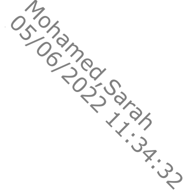
Objective 6: There are appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process.

2.20 All three areas have processes in place in respect of the monitoring of off-duty rotas and that of risk and incident reporting, and an escalation process to Clinical Board management if appropriate. Testing identified that only one area (Island Ward) had an example of a rota management issue that required recording on Datix, which was effectively managed and reported to the senior nursing team accordingly.

2.21 Given the current reliance on paper based systems to support the rostering process, management are hampered to effectively review and report on the

rostering process. The move to HealthRoster will provide greater management information to review the effectiveness of staff utilisation, and the equity and fairness for staff.

Conclusion 6: Whilst we make no recommendations in this area, with the reliance on paper based systems we are unable to provide substantial assurance of the appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process, due to the limitations associated with current systems. (Reasonable Assurance)



Appendix A: Management Action Plan

Matter Arising 1: Evidence of roster approval (Operation)		**Impact**
We reviewed the approval process of the rosters for the three sampled areas, we were unable to evidence the sign-off of finalised off-duty rotas for NICU. The ward currently maintains paper based rosters and whilst we were able to review these, there was no evidence of approval. We note that the move to HealthRoster will remove this issue, since approval of rosters will be date stamped within the system.		Ineffective rostering arrangements may impact high quality standards of care and exposure to greater clinical risks.
Recommendation 1		**Priority**
Prior to the transition to HealthRoster, the Neonatal Intensive Care Unit, C2, should document the approval of the off-duty rotas in advance of making them available to staff.		**Medium**
Agreed Management Action 1	**Target Date**	**Responsible Officer**
Recommendation discussed with both NICU and C2 management teams and agreement to record the approval of off-duty rotas through documentation on them prior to release to staff. This will soon be unnecessary in NICU with Acute Child Health being an early adopter site for Healthroster.	Immediate	Lead Nurses

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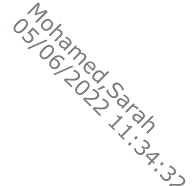
Matter Arising 2: Timeliness of Roster Dissemination (Operation)		**Impact**
We considered the arrangements in place for dissemination of the rosters, to ensure the timely receipt by staff. We identified the following: • We were unable to identify how far in advance off-duty-rotas were disseminated to NICU nursing staff, which are held in paper-based format and do not state the date of issue. • CAU/Seahorse could not evidence dissemination of their off-duty rotas for the months of September and October 2021, two of the three months sampled (See Matter Arising 3).		Late preparation and agreement of rosters may impact the work life balance of staff.
Recommendation 2		**Priority**
Prior to the transition to HealthRoster, Neonatal Intensive Care Unit, C2, should hold evidence of timely roster dissemination, by documenting the date within records held.		**Medium**
Agreed Management Action 2	**Target Date**	**Responsible Officer**
Recommendation discussed with both NICU and C2 management teams and agreement to record the approval of off-duty rotas through documentation of both approval date and dissemination date on them. This will soon be unnecessary in NICU with Acute Child Health being an early adopter site for Healthroster.	Immediate	Ward Managers



Matter Arising 3: Roster dissemination via mobile messaging (Operation)	**Impact**
We were advised by management that CAU/Seahorse and Island Ward issue their off-duty rotas through mobile messages, via WhatsApp groups. We were reliant on staff providing screen shots of their personal devices to obtain audit evidence, since no arrangements are in place to retain evidence of dissemination of rosters on Health Board systems. It was noted that the WhatsApp groups are used for professional / work related reasons beyond roster dissemination. The Health Board does not consider WhatsApp an acceptable means of communication for professional use, unless on a case-by-case basis, the clinical need out ways any associated risks. We found no parameters in place to clarify the use of WhatsApp. Within our audit sample, CAU/Seahorse could not evidence dissemination of their off-duty rotas for the months of September and October 2021, two of the three months sampled. We note the introduction of HealthRoster will enhance Health Board systems and communication methods to support the rostering process.	Late preparation and agreement of rosters may impact the work life balance of staff.
Recommendation 3	**Priority**
In line with the advice provided by the Health Board's Information Governance Manager, mobile messaging, via WhatsApp should not be used as a means of disseminating rosters. In wider instances where it is deemed on a case-by-case basis that there is a clinical need to use mobile messaging, clear parameters should be introduced.	**High**

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Agreed Management Action 3	Target Date	Responsible Officer
Recommendation discussed with both NICU and C2 management teams and agreement to cease sharing of off-duty rotas through messaging platforms. This will soon be unnecessary with introduction of Healthroster.	Immediate	Ward Managers / Lead Nurses

Matter Arising 4: Roster Management (Operation)	**Impact**
We reviewed three areas, over a three month period, August to October 2021, and selected a sample of staff. We identified some instances of non-compliance across all three areas, for example: • We were unable to verify effective and complete monitoring of make up shifts (all 3 areas); • We could not locate enhanced hours documentation to confirm approval (NICU & CAU/Seahorse); • We found an instance of overtime referred to in the Ward Sister Diary, which was not referred to in the off-duty rota (NICU); • Changes made to off-duty rotas were not supported by written authorisation (Island Ward & CAU/Seahorse); and • A change made to an off-duty rota was not supported with any narrative to show with whom the shift change was made (NICU & CAU/Seahorse).	Roster patterns to do not reflect agreed staffing establishments, resulting in increased financial cost.
Recommendation 4	**Priority**
Prior to the transition to HealthRoster, ward management must ensure that there is documentary evidence and approval of make up shifts, enhanced overtime, and all shift 'swaps'/changes.	**Medium**

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Agreed Management Action 4	**Target Date**	**Responsible Officer**
Recommendation discussed with both NICU and C2 management teams and agreement to record the approval of approval of make up shifts, enhanced overtime, and all shift 'swaps'/changes.	Immediate	Ward Managers

Matter Arising 5: Evidence of training records to support skills-mix (Operation)			**Impact**
The CAU / Seahorse does not currently hold training records to support the oversight and updating of nursing 'skills-mix'. In the absence of training records, we were unable to verify how skills-mix informs the rostering process. Within the further sampled areas, the Nurse Practice Educator was key to providing access to the training records held to substantiate skills mix. We were advised that the CAU / Seahorse does not have access to a Nurse Practice Educator.			Ineffective rostering arrangements may impact high quality standards of care and exposure to greater clinical risks.
Recommendation 5			**Priority**
The rostering process within the CAU / Seahorse should be informed by nursing skills-mix, which is underpinned by training records held that are monitored and regularly updated.			**Medium**
Agreed Management Action 5		**Target Date**	**Responsible Officer**
Ward Managers are reminded of the importance of keeping training records for staff in relation to mandatory and core clinical skills training. This should be reviewed at least annually as part of the Value Based Appraisal processes and		2022 (Complete)	Lead nurse

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every 3 years as part of revalidation. Lead & Senior Nurses will regularly monitor this activity. The Acute Child Health directorate will ensure that CAU/Seahorse are able to get education support from existing Practice educator resources within CH4W were required.		

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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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Nurse Bank (Temporary Staffing Department)

Final Internal Audit Report

April 2022

Cardiff & Vale University Health Board

NWSSP Audit and Assurance Services

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Committee:	Audit & Assurance Committee

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

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

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Executive Summary

Purpose

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the Nurse Bank.

Overview

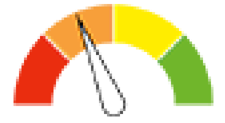
We have issued limited assurance on this area.

We have made a number of high and medium priority recommendations which require management attention that relate to the structure and operation of the Temporary Staffing Department, which holds the Nurse Bank.

There is a lack of resilience within the current structure, which is impacting the recruitment to the Nurse Bank, payment to agencies, and a general lack of engagement with service users, whether that be ward management or bank staff themselves.

Report Classification

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Policy, procedures and guidance.	Reasonable
2	Structure and operation of the Temporary Staffing Department.	Limited
3	Verification and authorisation of bank and agency shifts.	Limited
4	Accurate and timely reports on bank usage and costs.	Reasonable

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

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Lack of Temporary Staffing Guidance	1	Design	Medium
2	Inadequate structure within the Temporary Staffing Department	2	Design	High
3	Resilience of the Temporary Staffing Department	2 & 3	Operation	High
4	Roles and responsibilities for Bank recruitment	2	Operation	Medium
5	Lack of engagement with service users	2 & 4	Operation	Medium
6	Operational management of the Temporary Staffing Department	2	Operation	Medium
7	Range of agency usage	3	Operation	High
8	Ward verification of agency shifts	3	Operation	Medium

1. Introduction

1.1 The review of the Nurse Bank (Temporary Staffing Department) was completed in line with the 2021/22 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

1.2 The Health Board are reliant on the use of bank and agency staff to fill vacant shifts on hospital wards. Staff that are registered on the Bank, through the Health Board's Temporary Staffing Department can find available shifts through the Health Board's website[1], Facebook page or by telephoning the Temporary Staffing team.

1.3 The Temporary Staffing Department has experienced some organisational changes through 2021, previously within the remit of the Executive Nurse Director, Workforce Resourcing took over responsibility in September 2021, within the Executive Director of People and Culture's portfolio.

1.4 The Board Assurance Framework (BAF) refers to Workforce as a key risk, noting that across the UK and in Wales there are increasing workforce challenges for healthcare professionals. In the context of the Nurse Bank, the BAF refers to the impact of the new Nurse E-Rostering System, to be rolled out in 2022/23, with improved Bank Application (App) functionality.[2]

1.5 The Board's Strategy and Delivery sub-committee routinely receives the People Dashboard of Workforce Key Performance Indicators report, which includes the trend of 'Whole Time Equivalent Permanent, Fixed-Term and Bank Staff in post numbers'. The Dashboard presented to the sub-committee on 16 November 2021 noted, "Nurse Bank usage remains fairly static, roughly equivalent to 400 WTE per month".[3]

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

Audit Risks

1.7 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.

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[1] https://www.cardiffandvalenursebank.co.uk/en/calendar
[2] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2022-03-31-public-board-papers-v14-pdf/
[3] https://cavuhb.nhs.wales/files/board-and-committees/strategy-and-delivery-committee-2021-22/2021-11-16-audit-final-papers-v4-pdf/

Limitations to scope

1.8 At the time of audit fieldwork, given the pressures within the Health Board, our audit testing was limited to procedures, processes and documentation held by the Nurse Bank and did not extend to information held by the Clinical Boards.

2. Detailed Audit Findings

Objective 1: Health Board policy, procedures and guidance are in place to efficiently direct the use of bank and agency staff, which is appropriate and up to date.

2.1 The Health Board's Rostering Procedure for Nurses and Midwives (UHB 339 v2) highlights an objective to, *"Improve the utilisation of existing staff and reduce bank and agency spend by giving Ward Sisters/Charge Nurses/Departmental Managers, Lead/Senior Nurses and Midwives clear visibility of staff contracted hours."*[4] The procedure clarifies the circumstances where bank and temporary staffing can be utilised and the expectations placed on wards to communicate changes with the Temporary Staffing Department.

2.2 We are aware that the Health Board has commenced rolling out a new e-rostering system, HealthRoster (Allocate) to facilitate the rostering process, which will include bank and agency shifts. The revised arrangements will impact Health Board procedures and guidance in this area. Guidance to support the new system will include recording bank shift availability and self-booking of available bank shifts, which is a change in process, giving greater autonomy to bank staff.

2.3 We reviewed current procedures and guidance in place within the Nurse Bank, a Temporary Staffing Authorisation Flowchart (dated August 2018) details the process to follow for completion of rotas, which includes requesting bank or agency cover. The flowchart was sent to each Director of Nursing for the Clinical Boards for review and approval. However, whilst helpful, it was unclear from review of the document who owns and approved the flowchart. *(Matter Arising 1 – Medium Priority)*

2.4 At the time of the audit, the Nurse Bank recruitment guidance had been updated from a narrative description into a series of flowcharts, which were more succinct and easier to follow, which include:

- Temporary Staffing Students;
- Temporary Staffing Health Care Support Workers (HCSW) / Registered General Nurses / Registered Mental Health Nurse; and
- Temporary Staffing Fast Track.

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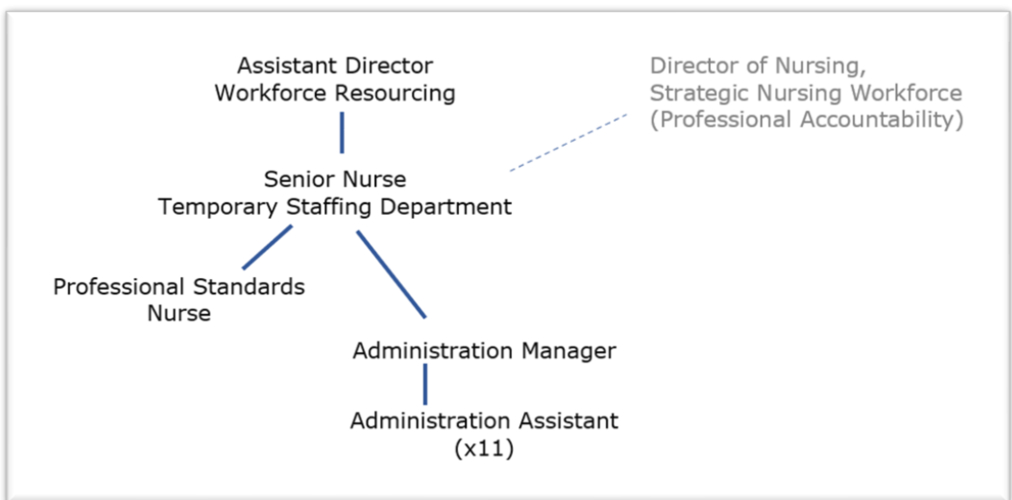
[4] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/workforce-and-od-policies/r-workforce-and-od/rostering-procdeure-for-nurses-and-mdiwves-final-v2-pdf/

2.5 We found no other process documents in place within the Temporary Staffing Department to cover areas such as, engaging with agencies or reviewing and actioning agency reports. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: Whilst we found some procedural guidance in place to support the Temporary Staffing Department, there are gaps in the available guidance. Further guidance would enhance the resilience of the team. The control of guidance could also be improved, to clarify document approval. (Reasonable Assurance)

Objective 2: The Temporary Staffing Department is adequately structured and operating effectively to enable the robust and timely recruitment of bank and agency staff.

2.6 At the time of our review, we found the structure of the Temporary Staffing Department to be as follows:



2.7 The Temporary Staffing Department's establishment holds no vacancies, however, it was evident that staff within the department are not fully proficient with the different functions and processes, for example supporting recruitment and administering agency invoices. *(Matter Arising 2 – High Priority)*

2.8 We found the current structure of the Temporary Staffing Department to be inadequate and currently presents a resilience risk, where issues have materialised through 2021/22. *(Matter Arising 3 – High Priority)*

2.9 We were advised that the recruitment of Bank staff is currently being undertaken by several areas within Workforce, therefore we were unable to verify if the Temporary Staffing Department can operate effectively, to facilitate the timely recruitment to the Nurse Bank. *(Matter Arising 4 – Medium Priority)*

2.10 We questioned the effectiveness of the Nurse Bank through the lens of service users, particularly hospital wards. However, we found no engagement activities, such as surveys to validate user experience with the Bank, or for Ward Managers

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to confirm if the Bank has been effective in obtaining adequate bank or agency staff to cover vacant shifts. *(Matter Arising 5 – Medium Priority)*

2.11 We considered the operational arrangements for managing the Temporary Staffing Department. In the first instance we reviewed the staff member's personal files, but these were found to be incomplete. We also selected a sample of sickness records from ESR to ensure that the appropriate documentation had been completed, but again found instances where these were incomplete. *(Matter Arising 6 – Medium Priority)*

Conclusion 2: The Temporary Staffing Department structure is inadequate, which impacts the operational effectiveness of the Nurse Bank. Due to current arrangements, we could not verify the ability of the Department to support the robust and timely recruitment to the Nurse Bank. There also seems to be a lack of engagement with hospital wards to obtain user feedback, although we note the COVID-19 pandemic has impacted face-to-face contact on hospital wards. (Limited Assurance)

Objective 3: All requests for bank and agency staff are supported by appropriate justification and authorisation, and all completed shifts are appropriately verified and authorised prior to payment at the correct rate.

2.12 We ascertained the process for requesting bank and agency cover. We were informed that the Ward Manager is required to record a reason for a vacant shift on Rosterpro, which confirms requirement for cover. The Temporary Staffing Department are responsible for contacting Bank workers to establish whether they can undertake a shift and they also contact the agencies to request cover.

2.13 The process will soon change as the Health Board migrates to HealthRoster and Bank staff will be able to book themselves onto a bank shift. Furthermore, the agencies will also be able to book their staff onto vacant shifts once they are released to them.

2.14 It was identified that the Health Board only utilises 36 out of an approximate 140 agencies that are on the All Wales framework to deploy agency staff. We reviewed the Bank and Agency staff report for the week commencing 27 February 2022, which noted challenging fill rates, for example 49% in the Specialist Services Clinical Board. There may be greater opportunities to deploy further agency staff, with specialist skills, when all other viable options have been exhausted to support hospital wards under pressure. *(Matter Arising 7 – High Priority)*

2.15 The Health Board implemented self-billing on 1 March 2022, which is directed by the 'Nurse Agency Self Billing - Standard Operating Procedure'. The process involves the Health Board preparing the agency's invoice and forwarding a copy to the agency with payment. As part of this process there is a reliance on ward managers to verify that agency shifts have been worked. However, it was evident during the review that the process needs to further embed amongst ward management. *(Matter Arising 8 – Medium Priority)*

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2.16 The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time reviewing and resolving issues on a weekly 'Invoices on Hold' report. The report includes invoices without a purchase order number, or instances where a shift has not been verified and requires action to enable the agencies to receive payment for the agency nurses deployed. *(Matter Arising 3 – High Priority)*

2.17 We identified that invoices are on hold for several reasons, examples include, staff on the wards failing to verify that an agency employee has worked a shift, the agency have provided an incorrect purchase order number, or the copy of a timesheet is illegible. Only two staff within the Temporary Staffing Department, aside from the Senior Nurse have been trained on the process for reviewing and actioning the 'Invoices on Hold' report, but both were absent from work at the time of the audit. *(Matter Arising 3 – High Priority)*

2.18 We requested reports on Bank usage and verification of shifts but at the close of audit fieldwork these had not been provided.

Conclusion 3: Following ward management approval, the Temporary Staffing Department is notified of unfilled shifts requiring bank and agency cover, through the RosterPro system. This process will move to HealthRoster once the roll out of the new system progresses. Our testing has identified issues with the verification of agency shifts worked, which if undertaken in a more timely manner would provide greater efficiencies to hospital wards and also the Temporary Staffing Department. Due to a lack of information provided, we were unable to evidence usage and verification of Bank staff. (Limited Assurance)

Objective 4: Accurate and timely reports on bank usage and costs are produced and distributed to appropriate staff and groups / committees within the Health Board. Reports are subject to effective scrutiny and actions are taken where required.

2.19 The Temporary Staffing Department produces a daily report showing all filled and unfilled shifts for the current day and the following day. This report is sent to all Lead and Senior Nurses within the Clinical Boards. In addition, the Temporary Staffing Administration Manager produces a report twice weekly showing the number of booked shifts and unfilled shifts for the week ahead. Once the Health Board has migrated to HealthRoster the Senior Nurses will be able to self-serve these reports.

2.20 The RosterPro Support and Training Co-ordinator produces a weekly bank and agency report which reports the weekly fill rates at different levels within the Health Board including the agency fill rate.

2.21 Although there are reports generated and circulated on nurse fill rates within the Health Board, through the lens of the Temporary Staffing Department, we were unable to evidence that these reports are scrutinised. We were also unclear what

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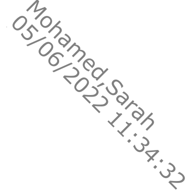
action has been taken in response to the reports. *(Matter Arising 5 – Medium Priority)*

2.22 As noted in paragraph 2.18 we requested a report on Bank usage and verification, but we did not receive this.

2.23 We reviewed the reporting arrangements into the Committee structure, and we noted that the Strategy and Delivery Committee routinely receive a Workforce Key Performance Indicators report, which incorporates a graph on the WTE Permanent, Fixed-Term and Bank Staff in Post Numbers.

Conclusion 4: There are a number of reports produced showing the filled and unfilled shifts within the Health Board, but we were unable to verify the level of engagement, scrutiny and action taken in response to the reports, given the limited feedback within the Temporary Staffing Department. We also requested reports on Bank staff and usage, but did not receive these, for example how many are employed via the Nurse Bank, and when was a shift last worked. This information was not readily available, which is fundamental management information. (Reasonable Assurance)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Appendix A: Management Action Plan

Matter Arising 1: Lack of Temporary Staffing Guidance (Design)		**Impact**
We found procedural guidance within the Nurse Bank to be lacking, for instance there is no guidance in place to support key processes, such as engaging with agencies and managing the payment of agency invoices, through the 'Invoices on Hold' report. Where guidance is in place, there was a lack of clarity of approval and ownership, such as: • Temporary Staffing Authorisation Flowchart (dated August 2018); and • The recently introduced Nurse Bank Recruitment Flowcharts. We appreciate that given the imminent roll-out of HealthRoster through 2022/23, the systems and processes in the Nurse Bank will evolve and procedures and guidance will require updating.		Potential risk of: • Procedures and guidance are not in place within the Bank to assist the Bank staff to manage the Nurse Bank adequately.
Recommendation 1		**Priority**
Management should review the Temporary Staffing Department's 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**
Agreed Management Action 1	**Target Date**	**Responsible Officer**
….	….	….

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Matter Arising 2: Inadequate structure within the Temporary Staffing Department (Design)	**Impact**
We were provided with a structure chart for the Temporary Staffing Department (see paragraph 2.6), we note the establishment, which currently holds no vacancies. Following consideration of the department's remit, we found the current structure to be lacking in terms of resilience and continuity for the following reasons: • The Senior Nurse who is responsible for managing the Nurse Bank does not have a deputy in place; • The Temporary Staffing Administration Manager is responsible for managing the administration staff within the Nurse Bank, but reports directly to the Senior Nurse, although we note the gap in pay bands. • In terms of pay bands, a further resource is placed between the two roles but does not act as a deputy or manage the Administration staff. They are responsible for professional standards and manage any complaints received about Bank and Agency staff. • Members of the team have not all been trained in the different operations within the Temporary Staffing Department. There are currently only two employees within the Department that undertake recruitment tasks for the Bank. • The Senior Nurse undertakes the review of the agency 'Invoices on Hold' report, rather than this being disseminated to the team.	Potential risk of: • Issues relating to bank and agency are not identified or addressed
Recommendation 2	**Priority**
The Assistant Director of Workforce Resourcing is to review the current structure of the Temporary Staffing Department, giving consideration to the resilience issues highlighted in this review, to ensure the Nurse Bank is operating effectively.	**High**

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Agreed Management Action 2	Target Date	Responsible Officer
….	….	….

Matter Arising 3: Resilience of the Temporary Staffing Department (Operation)	Impact
The Senior Nurse within the Temporary Staffing Department spends a considerable amount of time resolving issues with agency invoices that are listed on the 'Invoices on Hold' report, as referred to in matter arising 2. A period of absence of the Senior Nurse highlighted that this creates a lack of resilience as the report was not actioned during the period, which stopped payment. As a result, on return of the Senior Nurse the 'Invoices on Hold' report, dated 27 January 2022, reported a total invoice value of £1,280,149.06, with 2,374 line items of data. A subsequent report, dated 9 March 2022, reported a reduced value of £806,706.33, across 1,584 line items of data. We note that from 1 March 2022 the team's role in actioning the report should reduce given the introduction of agency self-billing, where greater reliance is placed on the wards to verify shifts.	Potential risk of: Issues relating to bank and agency are not identified or addressed.
Recommendation 3	**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**

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Agreed Management Action 3	Target Date	Responsible Officer
….	….	….

Matter Arising 4: Roles and responsibilities for Bank recruitment (Operation)	**Impact**
There is a lack of clarity of roles and responsibilities over the recruitment of bank staff. Recruitment is currently being undertaken by several departments, as noted below. We were therefore unable to verify if the Temporary Staffing Department can effectively operate to facilitate the timely recruitment to the Nurse Bank: • The Nursing Hub is responsible for recruiting nurses and HCSWs to the Bank; • The Workforce team is also undertaking recruitment on behalf of the Bank; and • The Temporary Staffing Department are recruiting Students. It has been proposed going forward that the recruitment of bank nurses will return to the Temporary Staffing Department. The Assistant Director of Workforce Resourcing has produced a spreadsheet to assess the effectiveness of the recruitment process, including time taken to recruit, and the numbers being recruited. If the process is undertaken in a timely manner, recruitment of bank nurses and HCSWs will return to the Temporary Staffing Department. We acknowledge the impact the COVID-19 pandemic has had on recruitment arrangements and the need to onboard greater numbers of temporary staff at speed to support mass vaccination and testing centres.	Potential risk of: • Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff

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Recommendation 4		Priority
The Health Board should draw on the experience from recruiting at pace during the COVID-19 pandemic, to reaffirm the most effective means of recruiting Bank staff, and where this is best placed.		**Medium**
Agreed Management Action 4	**Target Date**	**Responsible Officer**
….	….	….

Matter Arising 5: Lack of engagement with service users (Operation)	Impact
We found that there is currently a lack of engagement with hospital wards to ascertain if the Nurse Bank is meeting the needs of service users and therefore operating effectively. Similarly, we found that no satisfaction surveys are being undertaken with Bank staff. We note that reports are circulated by the Temporary Staffing Department on nurse fill rates, but we were unclear on the level of engagement and action following dissemination. The administrative tasks currently undertaken by the Senior Nurse hamper the available time to engage with hospital wards and key nursing contacts within the Health Board. We note that the COVID-19 pandemic has reduced face to face contact amongst staff. Although in such instances, surveys are a useful mechanism to seek feedback, but we were unable to evidence any such alternative means of ascertaining effectiveness.	Potential risk of: • Issues relating to the Nurse Bank are not identified or addressed.

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Recommendation 5		Priority
The Temporary Staffing Department's approach to engagement with service users, including ward management and bank staff requires a review, to ensure the team are continually striving to meet the needs of the Health Board, informed by service users. Engagement mechanisms used should be varied beyond face-to-face, to ensure the maximum reach.		**Medium**
Agreed Management Action 5	**Target Date**	**Responsible Officer**
….	….	….

Matter Arising 6: Operational management of the Temporary Staffing Department (Operation)	Impact
To ascertain the operational arrangements for managing the Temporary Staffing Department we requested all personal files. We selected a sample of staff who have had instances of sickness absence and we reconciled these to the relevant personal files and electronic records available, to establish if the relevant documentation had been completed correctly, in accordance with the Managing Attendance at Work Policy. We identified that: • We were unable to locate a personal file for the Professional Standards Nurse and therefore we were unable to establish if return to work interviews and forms had been completed. • For further members of the department we found two instances whereby Return to Work (RTW) forms were not completed. In addition, there was one instance of the RTW form being completed a month following the employees return to work.	Potential risk of: • Personal files are not being retained appropriately for staff. • Sickness is not being managed correctly.

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Recommendation 6	Priority
The operational management of the Temporary Staffing Department requires improvement. A personal file for all members of the team should be held by the relevant manager and updated in a timely manner, which should reconcile to electronic records.	**Medium**

Agreed Management Action 6	Target Date	Responsible Officer
….	….	….

Matter Arising 7: Range of agency usage (Operation)	Impact
We were provided with the most recent report for Bank and Agency staff fill rates and the overall fill rate for the Health Board week commencing 27 February 2022 was 66%. We reviewed the Clinical Board fill rate report, and the fill rate was 99% within CD&T whilst in Specialist Services the fill rate was 49%, with 412 requests being made and 200 shifts being filled. The low fill rate within Specialist Services is a result of the Clinical Board's requirement for specialist Nurses in Cardiac Services and Neurosciences. We were provided with the Agency 2021 Framework with all the agencies recorded, which amounted to just over 140 agencies, but currently the Temporary Staffing Department only request agency nurses from 36 agencies. More shifts could potentially be filled if the Department utilised a greater number of agencies, particularly those of a specialist nature.	Potential risk of: Wards and departments are unable to consistently operate in a safe manner due to insufficient recruitment of bank and agency staff.

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Recommendation 7		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
Agreed Management Action 7	**Target Date**	**Responsible Officer**
….	….	….

Matter Arising 8: Ward verification of agency shifts (Operation)	Impact
The Health Board implemented self-billing on 1 March 2022, which places a greater reliance on ward management to verify agency shifts worked. The 'Invoices on Hold' report dated 9 March 2022, included invoices on hold with an invoice date from 1 March 2022 onwards, which totalled £95,068.04. At the time of the audit, the Senior Nurse in the Temporary Staffing Department circulated an email to all Senior and Lead Nurses requesting them to remind Ward Managers of the need to verify the shifts for the agency to receive payment.	Potential risk of: • Agencies are not being paid in a timely manner
Recommendation 8	**Priority**
The Temporary Staffing Department are to engage with and remind ward managers of the requirement to verify agency shifts worked, until agency self-billing becomes an embedded process within the wards, to ensure timely payment.	Medium

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Agreed Management Action 8	Target Date	Responsible Officer
….	….	….

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Rating	Definition
	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*

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

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Arrangements to support the delivery of Mental Health Services

(Mental Health Clinical Board)

Final Internal Audit Report (Advisory)

April 2022

Cardiff & Vale University Health Board

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Auditors:	Geoffrey Woolley, Principal Internal Auditor Wendy Wright-Davies, Deputy Head of Internal Audit
Executive sign-off:	Caroline Bird, Interim Chief Operating Officer
Distribution:	Daniel Crossland, Director of Operations, Mental Health Clinical Board Mark Jones, Directorate Manager, Adult Mental Health Joanne Wilson, Directorate Manager, Mental Health Services for Older People (MHSOP) Martin Ford, Directorate Manager, Psychology & Psychological Therapies
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.

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Executive Summary

Purpose

The overall objective of this advisory review was to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges.

Overview

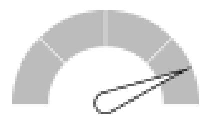
This is an advisory review to support management, rather than an assurance report, we therefore offer no assurance rating.

In contrast to internal audit recommendations, which address the design and operation of the control environment we propose opportunities that the Clinical Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will enable the Clinical Board to enhance the arrangements to support the delivery of Mental Health Services.

Management within the Clinical Board have a good understanding of the risks and challenges facing mental health services, but now need to look for solutions, at a time when there is a heightened demand on services, which is only likely to increase as the impact of COVID-19 reduces.

Report Classification

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.

Advisory Audit Objectives

Our review sought to ascertain and evaluate:

1	The services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them;
2	The means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities; and
3	The potential service delivery risks and challenges which limit the effective operation of mental health services.

	Opportunities	Audit Objective
1	Maintain a 'live' tool of documented Mental Health Services	1
2	Undertake an informed update of the Health Board's Mental Health webpages	1
3	Consider the response to issues which hamper staff efficiency and effectiveness	2
4	Undertake a review of the Clinical Board's Risk Management arrangements	3
5	Explore solutions to address the key risks and challenges identified	3

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1. Introduction and background

1.1 Our advisory review of 'Arrangements to support the delivery of Mental Health Services' was completed in line with the 2021/22 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board') and at the request of the Clinical Board.

1.2 The Mental Health Clinical Board works in collaboration with local authority colleagues, charities and third sector agencies in a variety of locations to co-create services, the majority of which are provided closer to home, supporting people within the local community.[1]

1.3 The staff and service users have a long-term vision for increasing community care and shared care models. There are community teams, primary mental health services and inpatient services, as well as managing specialist services, which includes neuropsychiatry, addictions, low secure and younger onset dementia care.[1]

1.4 The executive lead for the review is the Interim Chief Operating Officer.

Audit Risks

1.5 The potential risks considered in this review were as follows:

- Lack of public awareness of mental health services delivered by the Health Board;
- Inefficient ways of working due to not having the right people in the right place at the right time; and
- Inadequate facilities to deliver mental health services.

Advisory Audit Objectives

1.6 The overall objective of this advisory review was to evaluate and support the Clinical Board to list their services, capturing the means of delivery and any associated risks and challenges.

1.7 Our review sought to ascertain and evaluate:

- The services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them;
- The means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities; and
- The potential service delivery risks and challenges which limit the effective operation of mental health services.

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[1] https://cavuhb.nhs.wales/about-us/our-health-board-structure/mental-health-clinical-board/

2. Detailed Audit Findings

Objective 1: To ascertain and evaluate the services which fall within the Mental Health Clinical Board and the current arrangements in place for documenting them

Clinical Board Structure

2.1 The Mental Health Clinical Board operates via three directorates, each of which has a Directorate Manager who is responsible for overseeing all administrative matters:

- Adult Mental Health[2] - A range of outpatient and inpatient services including general and specialist community mental health services, addiction services, low secure and crisis and liaison services.
- Mental Health Services for Older People (MHSOP)[3] - A range of outpatient, day care and inpatient services for patients with a dementia and / or functional mental illness, including liaison teams, care home support, crisis support and support to carers. The directorate also supports the Welsh Neuropsychiatry Service, a Welsh Health Specialised Services Committee (WHSSC) funded specialist service providing neuropsychiatric rehabilitation for people with an acquired brain injury; and
- Psychology & Psychological Therapies[4] - The Psychology and Psychological Therapies Directorate provides adult counselling and psychology services throughout the Health Board, including Primary Care, which is organised into a number of specialties.

2.2 Initial audit planning with management highlighted that there is no formal documentation held by the Clinical Board to capture all services. Neither were we able to take assurance from the Health Board's Mental Health webpages, which either lack detail or require review.

2.3 Working with the Director of Operations and the Directorate Managers we developed a data collection template for completion by each Directorate Manager, which summarised the following information, for each team or service within the directorate:

- Team / Service name, description and location;
- Establishment number of staff;
- Base - Health Board facilities or Charities / Local Authority / Third sector;
- The means of delivery of the service e.g. face-to-face / virtually;

[2] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/community-mental-health-teams/adult-mental-health-specialty/
[3] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/mental-health-services-for-older-people1/
[4] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/psychology-and-psychological-therapies-directorate/

- Accessible IT infrastructure, printing and telephones; and
- Risks which limit the effective operation of Mental Health services and the challenges which exist.

2.4 Key findings identified through the data collection process are highlighted within this report. The complete data collection templates, which were populated through this review have been provided to Clinical Board management separately, and are a key output of the review.

2.5 It was evident from discussions with each of the Directorate Managers that a vast amount of information was available, in various locations and formats, which facilitated the timely completion of the data collection templates.

Opportunities for further development:

2.6 The collaborative exercise to populate the data collection template has provided the Clinical Board with a record of key information on the size and shape of the Clinical Board, which will be a useful baseline tool to inform future planning of services, whilst recovering from the pandemic. Looking ahead, the Clinical Board should attempt to hold the data collection tool as a live document, which will provide a concise and accurate overview of arrangements within the Mental Health Clinical Board. *(Opportunity 1)*

2.7 At the outset of the review, we discussed with management the public information held on the Health Board's website, regarding mental health services. It was acknowledged that work is needed to enhance the website and this exercise will assist in informing future updates of the website. *(Opportunity 2)*

Conclusion 1: Following the completion of this review, management are now enabled to collectively evaluate the services which make up the Mental Health Clinical Board, informed by the collaboratively delivered data collection tool that documents services.

Objective 2: To ascertain and evaluate the means of delivering each mental health service, for example, face-to-face or virtually, and the associated facilities.

2.8 As noted within paragraph 2.3 of this report, the data collection tool to document services incorporated the means of delivering services and the support arrangements in place. Establishment numbers populated in the template were provided by management. The below provides a summary of our findings across the three directorates, with further granular detail provided to management.

Adult Mental Health:

2.9 Adult Mental Health employs approximately 760 staff spread across multiple locations (Hafan Y Coed and Llanfair Unit at Llandough Hospital, Cardiff Royal Infirmary, and a variety of Health Centres / Clinics) with teams ranging in size according to the service. Staff are accommodated in Health Board facilities, in addition to a small number of rented facilities.

2.10 Services are mainly delivered face-to-face despite restrictions due to COVID-19.

2.11 Facilities such as telephones, IT and printing are generally available. However, intermittent IT networking issues, in addition to limited wi-fi or telephone issues were noted by some services / teams, which are expanded upon within the data collection template.

Mental Health Services for Older People (MHSOP):

2.12 MHSOP employs approximately 365 staff who are mainly based in Hafan Y Coed and the Llanfair Unit at Llandough Hospital, but other locations are also used (Park Road, Whitchurch, Monmouth House - UHW, Grand Avenue, Ely and Barry) with teams ranging in size according to the service. The locations are predominantly Health Board facilities, with the exception of Grand Avenue, Ely, which is owned by Cardiff Council.

2.13 A significant proportion of services are delivered face-to-face with a lesser amount delivered virtually.

2.14 Similar to paragraph 2.10, IT infrastructure, telephones and printing are generally available. However we noted limited access to adequate numbers of working mobile equipment (netbooks / laptops) and a need for further computers to support nursing staff within their offices.

Psychology & Psychological Therapies:

2.15 Psychology and Psychological Therapies employs approximately 110 staff who are spread across multiple locations, with a predominant presence at the Cardiff Royal Infirmary, but also Hamadryad Centre, Cardiff University's Hadyn Ellis Building and Avon House, Penarth. Prior to suspension of some services at the start of the pandemic, St David's Hospital was utilised.

2.16 Some staff have been working from home since the start of the pandemic. Services are delivered via a mixture of virtual and face to face working, with the split varying according to the service. However, rooms are also hired at church halls and other Local Authority, or third sector venues as required and, prior to the pandemic, staff were also based in GP surgeries on a peripatetic basis.

2.17 Additional laptops for home working were made available through the pandemic, in addition to mobile phones provided to some staff.

Opportunities for further development:

2.18 The data collection exercise has highlighted some localised challenges which hamper the efficiency and effectiveness of staff, which relate to intermittent IT network issues, inadequate wi-fi provision, telephone issues and an inadequate number of computers and mobile devices. This exercise has provided the means of evaluating and documenting specific issues at a granular level, by service. Management should consider the means of responding to, and addressing the issues presented within the Clinical Board. *(Opportunity 3)*

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Conclusion 2: The data collection exercise has provided a sound evidence base to evaluate the means of delivering each mental health service and has highlighted associated issues. The Clinical Board will need to reflect upon such issues and determine if they are able to resolve them, or where they might look for support.

Objective 3: To ascertain and evaluate the potential service delivery risks and challenges which limit the effective operation of mental health services

Clinical Board Risk Register

2.19 At the time of our review the Mental Health Clinical Board risk register held four risks:

- MHSOP Nursing Staff Recruitment;
- Poor Clinical Environment;
- Violence and Aggression; and
- Young Person in Adult Mental Health Placement*.

2.20 *This risk refers to a one-off incident, rather than the wider scope of how services, procedures and staff were organised.

2.21 The Clinical Board Risk Register was held in the corporate template.

Directorate Risk Registers

2.22 Each of the three directorates maintain their own risk register, which the Directorate Managers consider of value, to keep directorate risks in mind. However, despite this, the risk registers have not always been kept up to date, detailed or comprehensive. The risk management process appears to have slipped to varying degrees. We note that the directorate risk registers were held in outdated templates. There is a corporate expectation in the Health Board that all risk registers will align with the corporate template, currently being used to hold the Clinical Board risks.

2.23 The risk registers include a significant number of historic risks which have not moved on and the existing controls are rated inadequate. This is largely due to the directorate being unable to define controls to reduce the risks. This is generally because they are outside the control of the directorate and possibly the Clinical Board, for example, national risks or where significant investment is required to resolve them.

2.24 There is a need to rejuvenate discussion and communication from individual staff and teams, through directorates and on to the Clinical Board, so that all risks are adequately escalated upwards and feedback on progress, including timescales for resolution, is subsequently disseminated back to staff. We understand that greater emphasis is now being given to the risk management process, which should help identify and address the current position.

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Key mental health service risks

2.25 The most common risk identified by service teams was staffing. This relates to both the numbers of staff and their skill level, both newly qualified and experienced staff, and covers both nursing and medicine. We acknowledge that staffing is a national issue. Particular issues relate to the number of nurses per patient, leading to a nursing gap and increasing waiting lists, where Welsh Government targets are being exceeded.

2.26 The next most common risk relates to inadequate accommodation and covers both the quality and extent of premises. We were advised that the worst cases of poor quality accommodation relate to four community services bases, which are in a very poor state of repair and are deteriorating further. Management advised that this has been the case for around 10 years and despite raising outside of the Clinical Board for support, no solution has been identified. We were informed by management that any proposed improvements had been impacted by various wider proposals, which have impeded moving forward.

2.27 Space in some premises is inadequate for service needs, for example, 96 staff are currently based in one ward, there is an insufficient team base, and there is a lack of space for some group activities. This can adversely impact the quality of care provided, create inefficiencies due to travel between locations, and in some cases prevent the expansion of services to address lengthening waiting lists.

2.28 It may be possible to address these risks via Community Hubs, locality bases or use of partner organisation premises. However, care would be needed regarding information governance arrangements, for example, confidentiality of telephone calls and ensuring the sole use of NHS devices by NHS staff for data security.

2.29 In alignment with the findings under objective 2 of this report, collective risks have been identified which relate to ineffective IT systems and technology. Our discussions with Directorate Managers and a review of their risk registers has highlighted directorate specific risks, for example, three different IT systems are being used by MHSOP Community Locality Teams, which presents risks associated with accessibility and patient information gathering and sharing.

Summary of the greatest risks and challenges to the Mental Health Clinical Board:

2.30 From our discussions with the Directorate Managers and reviews of the Clinical Board Risk Register and Directorate Risk Registers, we have summarised the most reoccurring risks and challenges:

- The need to re-evaluate service delivery models. Significant changes were made at the start of the pandemic and as we move out of the pandemic, following the relaxation of COVID rules, it is unlikely that the pre-pandemic model will be re-established;
- Recruitment of sufficient and suitably skilled staff when there is limited national availability, which is not improving;

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- The wellbeing of existing staff to deliver services when demands are heightened, and the facilities or IT equipment do not facilitate efficient and effective working;
- Ensuring staff continuity of care for patients;
- Adequacy or availability of suitable accommodation for services, particularly for those who have faced long term issues;
- The ability to meet the growing demand for services;
- Resolving significant IT issues which have been identified; and
- Pressures caused by rises in Delayed Transfer of Care.

2.31 We discussed with management the extent to which the Integrated Medium Term Planning process would address the risks and challenges, which have been identified and it was concluded that the planning process would only address them to a very limited extent, rather than addressing the root-causes.

Opportunities for further development:

Risk Management processes

2.32 Further work is needed to enhance the risk management processes, to facilitate the escalation of risks from Directorate Risk Registers, through to the Clinical Board Risk Register, particularly where collective and reoccurring themes are evident across all three Directorates.

2.33 It is questionable whether the Clinical Board Risk Register is truly reflective of the current risks, given there are only four risks held on the register. The register will benefit from clarification of the risk escalation process noted in paragraph 2.32, which may see an increase in the number of risks captured on the Clinical Board Risk Register. *(Opportunity 4)*

Addressing service risks and challenges

2.34 The outcome of this review has highlighted the extent of risks and challenges facing the Clinical Board, a refresh of the risk management arrangements will prompt a review of the mitigating controls, to present a current risk position, which can be used to facilitate discussions with representatives outside of the Clinical Board for support, such as the Operations department, the Estates department, IM&T Services and Digital Health and Care Wales. *(Opportunity 5)*

Conclusion 3: This review has highlighted that there is a clear understanding of the risks and challenges facing the Clinical Board, which impact the efficient and effective operation of mental health services. However, the Clinical Board needs to undertake an exercise to document and articulate their risks through the corporate process, which facilitates the escalation and moderation of risks. The Clinical Board will also need to consider how they may look to create solutions to mitigate their risks, or where they may look inwardly within the Health Board or externally to partners for support.

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Appendix A: Opportunities for improvement

Finding 1: Maintain a 'live' tool of documented Mental Health Services	**Impact**
We collaboratively worked with management to develop a tool to enable the Clinical Board to collectively map and evaluate their services, which was absent at the commencement of the review. Whilst information was held within the directorates, in varying forms, there was no overarching position available. The data collection tool, developed through this review, now sits with management to take forward and maintain.	Inadequate collective oversight of risks and challenges facing the Clinical Board.
Opportunity 1	**Priority**
Looking ahead, the Mental Health Clinical Board should attempt to maintain the data collection tool as a 'live' document, as a means of holding a concise and accurate overview of services, which can inform future planning of services.	**N/A – Advisory Review**

Agreed Management Action	**Target Date**	**Responsible Officer**
Share the Tool with Directorate Teams and any intra-Clinical Board teams to ensure full coverage.	1 month	Director of Operations (DOO) and Directorate Managers (DMs)
Add risk rating to consolidate tool and ensure there is consistency and easy access to raise any service risks to Clinical Board level if they meet the threshold.		DOO
Yearly review and use of tool in Performance Reviews to ensure risks are being addressed.		DOO

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Ensure the templates are available on the S Drive for collation, addition and historical reference.		DOO

Finding 2: Undertake an informed update of the Health Board's Mental Health webpages		**Impact**
Whilst we noted the Health Board's Mental Health webpages, we were advised by management that they are in need of a review and update, as an example, we noted that the 'A- Z of Mental Health Services'[5] only lists four services. The data collection tool provides a means of informing an update of the Health Board's Mental Health webpages, which are a key mechanism for communicating the services offered to the public.		Lack of public awareness of mental health services delivered by the Health Board
Opportunity 2		**Priority**
Management should utilise the information collated through this review to inform an update of the Health Board's Mental Health webpages, to better inform members of the public of the services offered to support mental health.		**N/A – Advisory Review**
Agreed Management Action	**Target Date**	**Responsible Officer**
Pathway Mapping work in relation to 111 'Press 2' is currently being undertaken. This should be in concert with Comms team and the National 111 groups to ensure simple, accessible routes to urgent care are unified.	July 2022	Transformation Lead and Service Leads

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[5] https://cavuhb.nhs.wales/our-services/mental-health/a-z-of-mental-health-services/ (accessed 21/01/2022)

Finding 3: Consider the response to issues which hamper staff efficiency and effectiveness	Impact
This review has provided the means of breaking down the varying Directorates by locations, the facilities available to support staff, and any known issues. Through the data collection exercise, Directorate Managers have provided in granular detail the arrangements in place to support staff to undertake their roles, highlighting any known issues. Issues highlighted through this review include intermittent IT network access, inadequate wi-fi provision, telephone issues and an inadequate number of computers and mobile devices. As the Health Board progresses out of the pandemic, the Clinical Board will be in an opportune position to reflect on current services and the know issues currently presented, to build stronger services, which will better equip staff to respond to the demands placed upon services.	Inadequate facilities to deliver mental health services.
Opportunity 3	**Priority**
Management should consider the means of responding to, and addressing the issues highlighted through the data collection exercise. This may involve consideration of: • Quick wins which can be addressed at speed; • To seek support from the Health Board's IM&T Service and Digital Health and Care Wales; • The physical location of teams if IT issues cannot be resolved; • The impact on staff wellbeing when IT equipment is prohibiting efficient and effective working, at a time of heightened demand; • Alternative ways of working resulting from the impact of the pandemic; • The barriers prohibiting solutions and how these might be addressed; and • If the issues cannot be addressed within the Clinical Board, how these might be escalated within the Health Board.	**N/A – Advisory Review**

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Agreed Management Action	Target Date	Responsible Officer
Escalation of key priority areas to Management Executive through work with Director of Service Planning and Director of Digital Transformation	July 2022	DOO and DMs

Finding 4: Undertake a review of the Clinical Board's Risk Management arrangements	Impact
Whilst the Clinical Board has a good understanding of the risks facing mental health services, we note the following which could be improved: • The directorate risk registers require review and aligning with the corporate risk register template (currently being used to document the Clinical Board risks); • The process of escalating risks within the Clinical Board requires clarification, to better inform the Clinical Board Risk Register, particularly where risks are relevant to all three directorates, for example highlighting emerging themes; and • Following the above, the Clinical Board Risk Register would benefit from review, which may be impacted by the review of Directorate Risk Registers and associated themes.	Inadequate collective oversight of risks and challenges facing the Clinical Board.
Opportunity 4	**Priority**
The Mental Health Clinical Board would benefit from reviewing their risk management arrangements, particularly the Clinical Board and Directorate risk registers, and the mechanisms of escalation associated with the risks.	**N/A – Advisory Review**

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The Clinical Board may wish to seek support from the Risk and Regulation Team to undertake the review.		
Agreed Management Action	**Target Date**	**Responsible Officer**
Review of S Drive Risk Registers and ensuring that all Directorate Risk Registers are available for review. Any risk that cannot be adequately mitigated to be escalated to Clinical Board. Support required from Corporate Governance to rate, escalate and provide external view on mitigation.	August 2022	DOO

Finding 5: Explore solutions to address the key risks and challenges identified	**Impact**
The outcome of this review has highlighted the extent of risks and challenges facing the Clinical Board. On completion of opportunity 4, the Clinical Board will be in an informed position of having updated their risk registers. The next step would be to evaluate the risks and challenges, particularly the gaps in controls or assurances, to consider what further solutions can be sought within the Clinical Board, more widely within the Health Board, or externally through working with partners.	Potential risk of key risks and challenges not being adequately addressed.
Opportunity 5	**Priority**
The risk and challenges identified in this review should be further explored for solutions, to consider how to further address the gaps in controls or assurance and whether these may look inwardly within the Health Board or externally to partners for support.	**N/A – Advisory Review**

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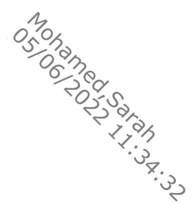
Agreed Management Action	Target Date	Responsible Officer
Internally, support from Corporate Governance will be requested. Corporate Governance Team are already providing some support around the Corporate Risk Register.	August 2022	DOO

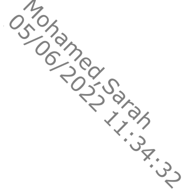


Appendix B: Assurance opinion rating

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:

Rating	Definition
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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