Public Audit Committee Meeting

Tue 07 February 2023, 09:30 - 13:00

Agenda

09:30 - 09:40
10 min

1. Welcome and Introductions

John Union

09:40 - 09:40
0 min

2. Apologies for Absence

John Union

09:40 - 09:40
0 min

3. Declarations of Interest

John Union

09:40 - 09:40
0 min

4. Minutes of the Committee meeting held on 8 November 2022

John Union

04 Draft Public Audit Minutes 8.11.22MD.NF.JU.pdf (16 pages)

09:40 - 09:40
0 min

5. Action log following meeting held on 8 November 2022

John Union

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

09:40 - 09:40
0 min

6. Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting

John Union

09:40 - 11:25
105 min

7. Items for Review and Assurance

7.1. Internal Audit Progress Report (10 mins)

Ian Virgil

7.1 Internal Audit Progress Report Cover February 23.pdf (3 pages)
7.1a Internal Audit Progress Report February 23.pdf (27 pages)

7.2. Audit Wales Update (10 mins) to include:

Wales Audit

Audit Wales Structured Assessment Report

7.2 Audit Wales Update (February 2023).pdf (12 pages)

7.2a Audit Wales Structured Assessment Report.pdf (38 pages)

7.3. Declarations of Interest, Gifts and Hospitality Report (5 mins)

James Quance

7.3 Declarations of Interest Gifts and Hospitality Tracking Report November 2022.pdf (4 pages)
7.3a Declaration of Interest Table.pdf (11 pages)

7.4. Internal Audit Tracking Report (5 mins)

James Quance

7.4 Internal Audit Tracking Report - February 2023.pdf (4 pages)
7.4(a) Appendix 1 - Internal Audit Tracker - Feb 2023.pdf (7 pages)
7.4(b) Appendix 2 - Internal Audit Summary Tables - February 2023.pdf (4 pages)

7.5. Audit Wales Tracking Report (5 mins)

James Quance

7.5 Audit Wales Tracking report covering report - Feb 2023.pdf (3 pages)
7.5(a) Audit Wales Tracker - Feb 2023.pdf (6 pages)
7.5(b) Audit Wales Tracker Summary Table - Feb 2023.pdf (1 pages)

7.6. Regulatory Compliance Tracking Report (5 mins)

James Quance

7.6 Regulatory Compliance Tracking Report February 2023.pdf (5 pages)
7.6a Regulatory Compliance Tracking Report - February 2023.pdf (3 pages)

7.7. Review Risk Management System (5 mins)

James Quance

7.7 Review of Risk Management Processes.pdf (4 pages)

7.8. BREAK – 10 MINS

7.9. Assurance Strategy and Risk Management Strategy (10 mins)

James Quance

7.9 Assurance Mapping (v2).pdf (4 pages)
7.9(a) Assurance Strategy 21-24 - Updated February 2023 (V2).pdf (20 pages)
7.9(b) Risk Management and BAF Strategy 2021 - Updated February 2023 (v2).pdf (39 pages)
7.9(c)(i) Draft Assurance Map February 2023.pdf (1 pages)
7.9(c)(ii) - Extract from Assurance Map CRR 3.pdf (1 pages)
7.9(c)(iii) - Extract from Assurance Map CRR 10.pdf (1 pages)

7.10. Scheme of Delegation and Shared Services Governance Structure (10 mins)

Catherine Phillips

7.11. Single Tender Actions (10 mins)

Catherine Phillips

7.11 Single Tender Actions.pdf (7 pages)

7.12. Procurement Compliance Report (10 mins)

Catherine Phillips Claire Salisbury

7.12 Procurement Compliance Report - Jan 2023 v1.pdf (7 pages)
7.12a Appendix 1 - Procurement Compliance Report – Chair's Action Review.pdf (3 pages)

7.13. Counter Fraud Progress Report (10 mins)

Catherine Phillips Gareth Lavington

- 7.13 Counter Fraud Progress Report Period 4 Cover Sheet.pdf (2 pages)
- 7.13a Counter Fraud Progress Report.pdf (9 pages)

11:25 - 11:55
30 min

8. Items for Approval / Ratification

8.1. Audit Wales Annual Audit Report (10 mins)

Wales Audit

- 8.1 Annual Audit Report 2022.pdf (24 pages)

8.2. Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report (10 mins)

James Quance /Catherine Phillips

- 8.2 Timetable for 2022-23 Annual Report jq.pdf (3 pages)
- 8.2a Appendix 1 Timetable for Annual Report 22-23MD jq.pdf (5 pages)

8.3. Audit Committee Annual Report 2022-23 (5 mins)

James Quance

- 8.3 Audit Committee Annual Report Cover.pdf (2 pages)
- 8.3a Draft Annual Report of Audit and Assurance Committee 2223MD.pdf (9 pages)

8.4. Audit Committee Terms of Reference and Annual Work Plan (5 mins)

James Quance

- 8.4 Cover Report ToR and Work Plan 23.24.pdf (2 pages)
- 8.4a Audit Committee TOR 2023-24.pdf (9 pages)
- 8.4b Audit Committee Work Plan 2023.24.pdf (1 pages)

11:55 - 11:55
0 min

9. Items for Information and Noting

Ian Virgil

Internal Audit Reports for information:

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

9.1. Genomics Partnership Wales – Reasonable Assurance

- 9.1a CVUHB Genomics 22-23 Final Report.pdf (36 pages)

9.2. Capital Systems Management - Reasonable Assurance

- 9.1b Capital Systems_Final Internal Audit Report.pdf (32 pages)

9.3. UHL Engineering Infrastructure - Reasonable Assurance

- 9.1c UHL Engineering Infrastructure Project Final Report.pdf (19 pages)

9.4. Core Financial Systems (Treasury Management) - Reasonable Assurance

- 9.1d Final Internal Audit Report_Core Financial Systems.pdf (15 pages)

9.5. Assurance Mapping (Advisory) – Assurance not applicable

9.1e Assurance Mapping_Final Internal Audit Report (Advisory).pdf (17 pages)

9.6. IT Service Desk System – Reasonable Assurance

9.1f New IT Service Desk System Final Internal Audit Report.pdf (15 pages)

9.7. Access to In-Hours GMS Service Standards (PCIC Clinical Board) - Reasonable Assurance

9.1g Final Internal Audit Report_GMS Access Standards_(PCIC CB).pdf (14 pages)

9.8. Endoscopy Insourcing (Medicine Clinical Board) - Reasonable Assurance

9.1h Final Internal Audit Report_Endoscopy Insourcing (Medicine CB).pdf (17 pages)

9.9. Medical Records Tracking (CD&T Clinical Board) – Limited Assurance

9.1i Final Internal Audit Report_Medical Records Tracking (CD&T CB).pdf (22 pages)

9.10. Management of Locum Junior Doctors (Children & Women's Clinical Board) - Reasonable Assurance

9.1j Final Internal Audit Report_Mgt. Locum Doctors_CW CB.pdf (17 pages)

11:55 - 11:55
0 min

10. Agenda for Private Audit and Assurance Committee

John Union

10.1. Private Audit Minutes – 8 November 2022

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

10.3. Workforce and Organisational Development Compliance Report (Confidential – this report contains sensitive information and/or (potentially) personal data)

10.4. Overpayment of Health Board Salaries (Confidential Discussion)

10.5. Learning from Cyber Attacks (Confidential Report)

10.6. Losses and Special Payments Panel Report (Confidential – sensitive information)

11:55 - 11:55
0 min

11. Any Other Business

11:55 - 12:00
5 min

12. Review and Final Closure

John Union

12.1. Items to be deferred to Board / Committee

John Union

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

Tuesday 4 April 2023 at 9:30 am via MS Teams

12:00 - 12:00
0 min

13. Declaration

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

Unconfirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 8 November 2022 at 9am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Meriel Jenney	MJ	Executive Medical Director (from 10.20 a.m.)
Ian Virgil	IV	Head of Internal Audit
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Aaron Fowler	AF	Head of Risk and Regulation
Urvisha Perez	UP	Audit Wales
Rachel Gidman	RG	Executive Director of People & Culture
Ceri Phillips	CP	UHB Vice Chair
Claire Whiles	CW	Assistant Director of OD, Wellbeing and Culture
Ed Hunt	EH	Programme Director - Redevelop
Marcia Donovan	MD	Head of Corporate Governance
Alex Scott	AS	Assistant Director of Quality Safety
Observers:		
Tim Davies	TD	Head of Corporate Business
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Wendy Wright-Davies	WW	Deputy Head of Internal Audit

Item No	Agenda Item	Action
AAC 8/11/22 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 8/11/22 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 8/11/22 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 8/11/22 004	**Minutes of the Meeting Held on 6 September 2022**	

	The Minutes were received. The Independent Member for Trade Union (IMTU) requested that "Committee Chair" be taken out of his title. **The Committee resolved that:** a) Except for the comments made above, the draft minutes of the meetings held on 6th September 2022 were a true and accurate record of the meeting.	
AAC 8/11/22 005	**Action Log – Following Meeting held on 6 September 2022** The Action Log was received. Re Action Number AAC 6/9/22 008 – the Head of Internal Audit confirmed that this report was underway and should be finalised for the next Committee meeting. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 8/11/22 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 8/11/22 007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> • 4 audits were planned for the November Committee but had not yet been completed. Table 2 gave the reasons for the delay. • There were delays in receiving information from Management to be able to complete the Administration Services in Mental Health Audit. <u>Section 3</u> • 7 reports were finalised and included within the Committee papers. • Executive summaries from the final reports were included under section 6. <u>Section 4</u>	

	• There was a total of 47 audits in the 2022/23 Internal Audit plan, of which 10 had been finalised and 1 had reached the draft report stage. • There were 10 audits that were currently “work in progress”, with a further 9 at the planning stage. <u>Section 5</u> • There were queries from the Independent Members in the previous meeting about the deliverability of the plan, given the potential pressures that may be faced by the Health Board over the Winter period. • It was proposed that the 4 identified audits which were at risk would initially be rescheduled to the end of the 22/23 plan, but with the possibility that they could be removed or deferred into 23/24 if required. • It was confirmed that the changes had been presented to the Senior Leadership Board (SLB). The Executive Director of People and Culture (EDPC) commented that Workforce was one of the biggest risks. The caveat was that the People and Culture Plan would be taken to different Committees of the Board. It could wait because there was assurance in place. <u>Section 6</u> • The Executive summaries for 7 reports had been finalised. 1. Staff Wellbeing – Culture and Values – The 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 ‘Staff Wellbeing - Culture and Values’. – Reasonable assurance was awarded. – The findings of the audit had highlighted that the Health Board had clear plans in place of how it intended to support staff wellbeing, principally driven by the People and Culture Plan 2022 – 2025. – Further recommendations around references within the Board Assurance Framework, and the need to verify source material signposted on the new SharePoint site were made. 2. Follow-up: 5 Steps to Safer Surgery – The objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed Management actions from the ‘Five Steps to Safer Surgery’ Audit (CVU-2122-16) that was undertaken as part of the 2021/22 work programme, which reported ‘Substantial’ assurance.	

	– Significant progress had been made in addressing the seven recommendations arising from the previous internal audit, completed in October 2021. 3. Implementation of National IT Systems (WNCR) – The purpose of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for the implementation and use of national IT systems. – Reasonable assurance was awarded. – The audit highlighted improved processes in collaboration. – 4 medium priority matters were highlighted. – Management had agreed actions. 4. Digital Strategy – The purpose of this audit was to ensure that the refreshed Digital Strategy met the needs of the Health Board and that there was a Roadmap for delivery. – Reasonable assurance was awarded. – The Health Board had an appropriate strategy in place which met the needs and objectives of the Health Board. The Strategy had recently been refreshed and was also supported by a Roadmap. – Whilst reasonable assurance had been provided, the audit report had provided that some priority matters should be taken forward. Those were (i) the need to provide greater detail with regard to the delivery of the Roadmap (ii) the need to clearly define the resources required to deliver the Roadmap, and (iii) a recommendation that the Health Board consider the overall funding because Internal Audit had looked at some comparable health organisation and best practice and had identified that the funding available to deliver the Health Board's Digital Strategy was potentially on the low side. It was also noted that the report had recommended that it was good practice to have Clinical Board attendance at the Digital Health Intelligence Committee meetings. – Management had agreed the report and would provide recommendations. 5. Medical and Dental Staff Bank – The overall objective of the audit was to review the effectiveness of the processes and controls operating within the Health Board's new Medical and Dental Staff Bank managed by Medacs Healthcare. – Substantial assurance was awarded. – The outcome reflected that there was a Framework in place for operating the Bank. 6. Medical Equipment & Devices	**DCG**

	– The overall objective of this audit was to review the arrangements in place for recording, monitoring and replacing medical equipment and devices. – Reasonable assurance was awarded. 7. University Hospital Llandough – Endoscopy Expansion – The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Expansion Project, and the performance, against its key delivery objectives i.e., time, cost, and quality. – Reasonable assurance was awarded. – A robust project governance structure was in place with continual liaison and effective reporting to the relevant forums. The UHB VC queried whether consideration was given to recommendations made by Health Technology Wales in terms of new equipment used to adjust the way care was undertaken. The HIA responded that it was not covered as part of the audit but they would look into this. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered. b) The proposed contingency adjustments to the 2022/23 plan and proposed amendments to timings were approved.	**HIA**
AAC 8/11/22 008	**Taking Care of the Carers Update** The Assistant Director of OD, Wellbeing and Culture (ADODWC) presented the Taking Care of the Carers Update Paper and highlighted the following: • In October 2021 Audit Wales published the report. It discussed how NHS bodies supported staff in the Pandemic. • 6 recommendations were made on how to continue to support staff wellbeing in the Pandemic. <u>Progress update on actions</u> • The Audit Wales tracker had outlined the work undertaken and any future work to be completed. • Lots of work had been undertaken since February. • Staff room refurbishments had been completed which included 26 rooms across UHL, UHW and community sites.	

	• The Health Board was part of the All Wales Staff Welfare Group. • Enhanced bespoke and targeted training was being provided. • Wellbeing retreats had started. • There was network development including the LGBT group and One Voice. • The cost of living was high on the agenda and there were lots of concerns. There have been several roadshows across sites to signpost staff. • There was a need to ensure that actions aligned with the People and Culture Plan and the Shaping our Future Wellbeing Strategy. <u>Next steps</u> • There was ongoing recruitment, retention and wellbeing to help with Winter pressures. • The People and Culture team (the Team) continued to capture and learn from the messages received from staff in order to ensure key themes and recommendations were captured. • The Team was looking at the accessibility of signposting and support. • Peer support had been introduced and embedded. • EHIA development had been improved. • Staff networks were being developed following the Wales Anti -Racist action plan. The Director of Corporate Governance (DCG) commented that the 6 recommendations from the Audit Wales report were on the Health Board Audit Wales tracker. She queried that since some of the recommendations were ongoing and could continue for long periods, could timescales be provided so that the tracker could be updated. The ADODWC would come back to the DCG. Urvisha Perez (UV) commented that it was good to see the progress that had been made against the recommendations and alignment with the Health Board strategies. The UHB VC advised that the Team could reach out to him to look at anything to do with evaluation. The EDPC responded that she would take up the UHB VC offer on evaluations to ensure that staff feel supported. **The Committee resolved that:** a) The progress update to date was noted.	**ADODWC**
AAC 8/11/22 009	**Audit Wales Update to include:**	

	UP presented the Audit Wales Update and highlighted the following: <u>Financial audit update</u> – Exhibit 1 summarised the status of current and upcoming financial audit work. – The Audit of the Health Board's 2021-22 Charitable Financial Statements would be started around late November, pending receipt of the draft Financial Statements. – The Charity Commission's deadline for the certified Financial Statements was 31 January 2023. – Audit Wales also expected to start audit planning the Audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements in January 2023. <u>Performance audit update</u> – The Review of Estates: Follow-up of Recommendations was complete. The management response was included in the paper. – Exhibit 3 showed the work currently underway. – The NHS Structured Assessment findings would be presented at the Board Development in December and the final results would be presented in February 2023. The field work was underway. – The Audit Wales team was preparing an All Wales summary report and considering preparation of a discrete Annex for each Health Board. – Exhibit 4 showed planned work that had not been started yet. – Exhibit 5 showed NHS related national reports. The Equality Impact Assessment: More than a Tick Box Exercise report had required actions from the Health Board. – That audit report had made several recommendations for Welsh Government to address and one to Public Bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the report and detailed guidance available on the Equality and Human Rights Commission and Practice Hub. **The Committee resolved that:** a) The Audit Wales Update was noted.	**AW**
AAC 8/11/22 010	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the Declarations of Interest, Gifts and Hospitality Report and highlighted the following:	

	• The Risk and Regulation Team had worked with Corporate Communications to design and implement a Communication Plan that informed staff members of the following: - The requirement now was to submit a Declaration of Interest once, but, reinforcing the requirement to update if personal circumstances changed. - That Declarations of Interest could now be made on ESR, and signposted to User and Manager guides. - The continuing need to declare Gifts, Hospitality and Sponsorship with specific emphasis being given in the Autumn (for Autumn International Rugby Tickets) and the Christmas/New Year period (for seasonal gifts). In addition to this plan the Risk and Regulation Team and the Health Board's ESR Lead had delivered a 'Declarations of Interest Power Hour' and would continue to deliver further sessions to provide guided examples of how to make use of ESR to declare interests and also to answer queries raised by those in attendance. The DCG commented that the dual process of declaring Declarations of Interest on ESR and paper needed to be stopped. Everything needed to be done on ESR and assurance taken from it. The HRR stated that regular communications would go out to encourage people to declare interests. The EDPC advised that a campaign done periodically throughout the year with Workforce would be useful. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The proposal for a complete move to ESR for the recording of Declarations of Interest, Gifts, Hospitality and Sponsorship was approved.	
AAC 8/11/22 011	**Internal Audit Tracking Report** The HRR presented the Internal Audit Tracking Report and highlighted the following: • Time was taken to refresh the view of the Tracker and focus on aged entries. • As of 25th October 2022, the Tracker recorded 104 recommendations, 17 of which were High Priority, 59 were Medium Priority, and 28 were Low Priority. • Following more direct dialogue with aged High Priority Recommendation Owners, five aged High Priority Recommendations were reported as complete. That had also prompted a review of linked aged	

	recommendations and a further 14 aged (medium and low priority) entries being recorded as complete. The IMI advised that some of the outstanding IT recommendations would take time to implement/eliminate. He added that care should be taken regarding Cyber related recommendations and should be discussed in Private forums as good practice. **The Committee resolved that:** a) The work underway and plans in place to proactively monitor aged High Priority Internal Audit Recommendations in accordance with the revised Workplan timetable for Internal Audit Recommendation Tracker Report, was noted. b) Whether a further Progress Report should be shared by the Director of Digital Health at the February 2023 Committee meeting, was considered.	
AAC 8/11/22 012	**Audit Wales Tracking Report** The HRR presented the Audit Wales Tracking Report and highlighted the following: • A meeting took place with Audit Wales to review aged recommendations on the Tracker and to make sure the Tracker was progressed. • There were 35 current entries which would increase after today. • A revised version of the Health Board's Template Assurance Map had also been prepared and shared with Internal Audit Colleagues for comment. The revised map had been designed so that it specifically mapped Assurance Levels in relation to risks that were reported within the Corporate Risk Register. • Once agreed with Internal Audit, the revised Assurance Map would be embedded within the Strategy and shared with the Audit and Assurance Committee Board for Approval. **The Committee resolved that:** a) Assurance from the ongoing work which continued in relation to the completion of Audit Wales recommendations was received and noted.	
AAC 8/11/22 013	**Assurance Mapping Phase 2** The HRR presented the Assurance Mapping Phase 2 Paper and highlighted the following: • The Assurance Strategy was approved by Board. • Due to Winter pressures and the Pandemic it had not progressed as hoped.	

	• It was a large task. • Support had been secured from Internal Audit. **The Committee resolved that:** a) The progress made against the Advisory Recommendations made by Internal Audit was noted; b) The proposed action plan detailed at point 3 above was approved; and c) It was agreed that a further Assurance Strategy update, to include an updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy for approval, be shared at the February 2023 Audit and Assurance Committee Meeting.	**DCG/HRR**
AAC 8/11/22 014	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report and highlighted the following: • 7 reports had been added to the Tracker. • The HRR met with colleagues regularly to ensure progress was being made. • A further update would be shared at the Audit meeting in February. **The Committee resolved that:** a) The updates shared and the continuing development and review of the Legislative and Regulatory Compliance Tracker were noted.	
AAC 8/11/22 015	**Procurement Compliance Report** The EDF presented the Procurement Compliance Report and highlighted the following: • Non-compliant breaches were starting to improve this year, following the work undertaken by the Head of Procurement to ensure that all procurement and non-pay went through Procurement Services. • Single tender actions were increasing and that would need to be kept under review. • A move to “whole life” procurement for securing pieces of equipment should help to reduce single tender actions. • That would take more time to complete. **The Committee resolved that:** a) The contents of the Report were noted, approved and agreed.	

AAC 8/11/22 016	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented the Counter Fraud Progress Report and highlighted the following: • Staffing was still below the desired numbers. There had been a successful recruitment campaign and interviews would be taking place this Thursday. • The annual plan was on track. • There had been few Fraud Prevention notices issued in the reporting period. • The Counter Fraud team continued to carry out awareness sessions. Three had been carried out since the last reporting period. Thought was being given to conducting lunch time sessions or pre-recorded sessions. • It was "Fraud Week" next week. The Counter Fraud team would be going out and holding pop up stores. • There was a breakdown in Appendix 1 of investigations that were currently open. • A meeting was held with the Counter Fraud compliance team in October to discuss Fraud risk management compliance. • That would be going ahead on an All Wales basis. • At the moment, they would be moving with a local Fraud register. **The Committee resolved that:** a) The content of the report was noted.	
AAC 8/11/22 017	**Net Zero Carbon Report** The Programme Director Redevelop (PDR) presented the Net Zero Carbon Report and highlighted the following: • This was created, in light of the Audit Wales report (Public Sector Readiness for Net Zero Carbon by 2030) published in January 2022. • Audit Wales have "5 calls for actions" around decarbonisation to meet the Welsh Government's (WG) ambition of a net zero Public Sector by 2030. • NHS Wales had targets – a 16% reduction by 2025 and a 24% reduction by 2030. • In 2021/22 Cardiff and Vale's emission was 202,000. • Governance structures were now in place, with the first meeting to be held this month. • There would be funding from WG to fund nurses and therapists to provide leadership on the decarbonisation agenda. • Colleagues were also working with the Medical School and embedding it into curriculum. • The diagram showed that 81% of carbon emissions came from supply chains and 18% from buildings.	

	• Currently the Health Board did not have line of sight to the 16% target by 2025. • The way supply chain data was reported was flawed. What decarbonisation meant to the Workforce needed to be defined. <u>Next actions</u> • The Shaping our Future Wellbeing Strategy refresh needed to have a strong commitment to mitigation. • Decision making across the Health Board could include carbon as a consideration. • More healthy travel initiatives should be considered. • Grant funding to address energy efficiency might be available. The EDF stated that an action plan was required. The PDR responded that the action plan should set out the Health Board's direction and where the carbon reductions could come from. The EDF responded that supply chain was a big part of the carbon reduction agenda and should be targeted to make a difference. The EMD stated that a Clinical lead had been appointed for 6 months. Clinical leadership was essential to drive the decarbonisation agenda forward. It would be good for other areas to identify their decarbonisation leads. The PDR advised that the agenda would go to the Strategy and Delivery Committee and then to Board in November. **The Committee resolved that:** a) The action CVUHB have taken regarding decarbonisation set against the calls for action so far, was noted; b) A new decarbonisation action plan was in the early stages of development which would form part of the next IMTP, was noted; and c) That there was no line of sight to the 2025 target of a 16% reduction in carbon emissions and that radical action was needed, was noted.	
AAC 8/11/22 018	**Review of Draft Charitable Funds Annual Report and Accounts** The Assistant Director of Finance (ADOF) presented the Review of Draft Charitable Funds Annual Report and Accounts and highlighted the following: • The Draft Annual Accounts were provided to the Charitable Funds and Audit and Assurance Committees for endorsement on an annual basis.	

	• The draft accounts cover the activities of the Health Charity for the period 1st April 2021 - 31st March 2022. As the Draft Annual Accounts were still being audited by Audit Wales, they were subject to change. • The Final Audited Accounts, ISA260 report and Letter of Representation would be taken to the Board of Trustee at its January 2023 meeting for formal approval. • The Audit and Assurance Committee was asked to receive and consider for endorsement the Health Charity Draft Accounts 2021/22 and the draft response provided to the audit enquiries to those charged with governance and management. • Assurance could be provided on the accuracy of the Draft Annual Accounts and associated documents by: - The response given to the audit enquiries to those charged with governance and management which had been endorsed by the Chair, Chief Executive, Chair of the Charitable Funds Committee, Chair of the Audit and Assurance Committee, Director of Corporate Governance and Director of Finance. - On completion of the audit of the Financial Statements, further assurance would be given on the annual accounts by the work that would be completed by Audit Wales in determining whether the Health Charity's Annual Report and Accounts give a true and fair view. • The Draft Annual Accounts of the Charity had been prepared in accordance with recommended practice and would be subject for external review by Audit Wales. Should any misstatements or errors be identified during the course of the audit those would be noted in the ISA 260 audit report. The key points to note were: – Donations and legacies had decreased by £0.5m in 2021/22 to £1.3m. The Health Charity had received higher donations in 2020/21 as a result of a number of generous donations during the Pandemic. – The Health Charity investments saw growth of £0.5m in 2021/22 which reflected the continuation of post Covid gains. – The value of the Health Charity had reduced slightly by £0.1m in 2021/22 to £9.0m. **The Committee resolved that:** a) The Draft Annual Accounts were reviewed. b) The reported financial performance contained within the Draft Annual Accounts was noted. c) The response of the audit enquiries to management and those charged with governance, was noted. d) Subject to any further amendments, the Draft Annual Accounts was supported and endorsed.	

AAC 8/11/22 019	**Annual Clinical Audit Plan Review** The Assistant Director of Quality Safety (ADQS) presented the Annual Clinical Audit Plan Review and highlighted the following: • In October 2021 the Health Board Clinical Audit processes were subject to an internal audit and were awarded limited assurance. • The audit had identified that: – there was adequate overall leadership of Clinical audit within the Health Board. However as a result of under resourcing of the Clinical Audit team, audit training was not being delivered to the Health Board. The Health Board was missing key documents to direct, mandate and ensure constancy of clinical audit approach. – The Clinical Audit team and the Clinical Boards were not provided with the adequate tools to effectively enable them to monitor clinical audit outcomes and the improvements taken. • Significant progress had been made. The Health Board had procured AMaT, a clinical audit quality management tool, in May 2022. That digital platform would support a systematic approach to audit proposal and approval, oversight and reporting of results and the development and monitoring of associated improvement plans. • The Clinical Audit Team was delivering AMaT training to Clinical Boards to support the use of the system. It was anticipated that all Clinical Boards would have been trained by December 2022 and would be using the system to register their local audits. • A Clinical Audit Policy and strategy had been developed to define the rationale for clinical audits and to provide a framework to support a prudent clinical audit programme designed to provide assurance to drive improvement around quality and safety priorities. **The Committee resolved that:** a) The assurance provided by the progress made against the Internal Audit recommendations, was noted.	
AAC 8/11/22 020	**UHB Policies and Procedures Review** The Head of Corporate Governance (HCB) presented the UHB Policies and Procedures Review Paper and highlighted the following:	

	• It was a large piece of work and there were several strands that were being progressed in parallel. • The plan set out a number of actions that had been completed, partially completed or needed to be commenced. • The policies on the Health Board's website and Share Point were not all accurate. • The Corporate Governance team was working with the Executive Leads to prioritise the policies that were not up to date and/or obsolete. The Committee Chair queried if this matter was listed on the Corporate Risk Register. The HCB said she would check and report back to the next Committee. **The Committee resolved that:** a) The action taken to date to address the audit recommendations as set out in this report, together with the proposed actions and timescales set out in Appendix 1 were noted.	**HRR**
	Items for Approval / Ratification	
AAC 8/11/22 019	**Internal Audit reports for information:** i. Follow-up: 5 Steps to Safer Surgery Final Report – Substantial Assurance ii. Medical & Dental Staff Bank Final Report – Substantial Assurance iii. Staff Wellbeing: Culture & Values Final Report – Reasonable Assurance iv. Implementation of National IT Systems (WNCR) Final Report - Reasonable Assurance v. Digital Strategy Final Report – Reasonable Assurance vi. Medical Equipment & Devices Final Report – Reasonable Assurance vii. UHL Endoscopy Expansion Final Report – Reasonable Assurance	
AAC 8/11/22 20	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 6 September 2022 ii. Counter Fraud Progress Update iii. Workforce and Organisational Development Compliance Report iv. Overpayment of Health Board Salaries – Verbal v. Self-assessment of Internal Audit and Audit Wales	
AAC 8/11/22 021	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
AAC 8/11/22 022	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	

	Date and time of next committee meeting Tuesday 7 February 2023 at 9am via MS Teams	

Public Action Log
Following Audit & Assurance Committee Meeting
8 November 2022
(For the Meeting 7 February 2023)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
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	8/11/2022	Complete Discussed at November meeting.
AAC 6/9/22 014	Assurance mapping phase 2	Nicola Foreman will bring this to the November meeting.	Nicola Foreman	8/11/2022	Complete Discussed at November meeting.
AAC 6/9/22 010	Field work for structured assessments	Audit Wales will bring this to the November meeting.	Audit Wales	8/11/2022	Complete Discussed at November meeting.
AAC 6/9/22 013	Audit Wales Tracking Report	An offline discussion about the new process to be held between Audit Wales, Director of Corporate Governance and Head of Risk and Regulation.	Audit Wales/Nicola Foreman and Aaron Fowler	8/11/2022	Complete Discussed at November meeting.
AAC 8/11/22 020	UHB Policies and Procedures Review present on Corporate Risk Register	To check that individual Corporate Directorates and Clinical Boards policies represented a risk which should be captured on their Risk Registers.	Aaron Fowler	November 2022	Complete The HRR confirmed that he would follow up with individual Corporate Directorates and Clinical Boards to check if the current status of their policies represented a risk which

					should be captured on their Risk Registers.
AAC 8/11/22 007	UHL – Endoscopy Audit	The Head of Internal Audit would look into the recommendations made by Health Technology Wales in terms of new equipment used to adjust the way care was undertaken.	Internal Audit	7/2/2023	Complete Health Technology Wales recommendations will be considered as part of developing future Internal Audit plans where relevant.
AAC 8/11/22 008	Taking Care of the Carers	To provide timescales for the ongoing recommendations on the Tracker	Rachel Gidman/Claire Whiles/Nicola Foreman	18/01/2023	Complete Claire Whiles has provided Nicola Foreman with an updated action plan with dates.
Actions in Progress					
AAC 8/11/22 009	Structured Assessment	The NHS Structured Assessment findings will be presented at the February 2023 committee meeting.	Audit Wales	7/2/2023	On 7 February 2023 agenda - Item 7.2
AAC 8/11/22 014	Regulatory Compliance Tracking Report	A new approach is being discussed and an update will be shared at the February 2023 committee meeting.	James Quance and Aaron Fowler	7/2/2023	On 7 February 2023 agenda - Item 7.6
AAC 8/11/22 013	Assurance Mapping Phase 2	A further Assurance Strategy update, to include an updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy for approval, be shared at the February 2023 Audit and Assurance Committee Meeting.	James Quance	7/2/2023	Update to be provided on 7 February 2023 - Item 7.8
AAC 6/9/22 008	IT Service Management Audit Report	Internal Audit will be undertaking an audit in relation to the Ivanti system.	Internal Audit	7/02/2023	On 7 February 2023 agenda - Item 9.1 vi.
Actions referred to Board / Committees					

AAC 6/9/22 014	Assurance mapping Phase 2	Phase 2 Assurance mapping to be presented to Board in November.	Nicola Foreman	24/11/2022	Completed Matter was presented to full Board at its meeting on 24 November 2022.
AAC 8/11/22 007	Digital Strategy Audit	Internal Audit re the Health Board's Digital Strategy recommended that it was good practice to have Clinical Board attendance at the DHIC Committee meetings.	James Quance	7/2/2023	Update on 7 February 2023.

Report Title:	**Internal Audit Progress Report**				Agenda Item no.	7.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	07/02/23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval	X	Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

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

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

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

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

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

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

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

The following reports from the 2022/23 plan have been finalised since the November 22 meeting:

- Development of Genomics Partnership Wales - (Reasonable Assurance)
- Capital Systems Management - (Reasonable Assurance)
- Core Financial Systems (Treasury Management) - (Reasonable Assurance)
- Management of Locum Junior Doctors (Women & Children's CB) - (Reasonable Assurance)
- UHL Engineering Infrastructure - (Reasonable Assurance)
- Endoscopy Insourcing (Medicine Clinical Board) - (Reasonable Assurance)
- Access to In-Hours GMS Service Standards (PCIC Clinical Board) - (Reasonable Assurance)
- New IT Service Desk System - (Reasonable Assurance)
- Medical Records Tracking (CD&T Clinical Board) – (Limited Assurance)
- Assurance Mapping – (Advisory)

The progress report includes details of proposed adjustments to the 2022/23 plan, due to increased pressures on the Health Board over the winter period.

Recommendation:

The Audit & Assurance Committee are requested to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed adjustments to the 2022/23 plan.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

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

Risk: Yes/~~No~~

The progress report provides the Committee with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.

Safety: Yes/~~No~~

The progress report provides an update on the delivery of the Internal Audit plan for 2022/23, which includes a number of audits will provide assurance around controls and processes relating to patient safety.

Financial: Yes/~~No~~

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

Workforce: Yes/~~No~~

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

Legal: ~~Yes~~/No

Reputational: Yes/~~No~~

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

Socio Economic: ~~Yes~~/No

Equality and Health: ~~Yes~~/No

Decarbonisation: ~~Yes~~/No

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

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee February 2023

NWSSP Audit and Assurance Services

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

Contents

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2022/23 Internal Audit plan.

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

The plan for 2022/23 was agreed by the Audit & Assurance Committee in April 2022 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

Audit	Current Position	Draft Rating	Reason
Estates Assurance – Decarbonisation	Draft	Advisory	Delay in receiving management responses
Financial Reporting and Savings Targets	Draft	Substantial	Delay in completing fieldwork and receiving management responses
Charitable Funds	Work in Progress		Delay in completing fieldwork due to availability of Internal Audit Resources
Community Patient Appliances (Specialist Services CB)	Work in Progress		Fieldwork is not yet complete.

3. Outcomes from Completed Audit Reviews

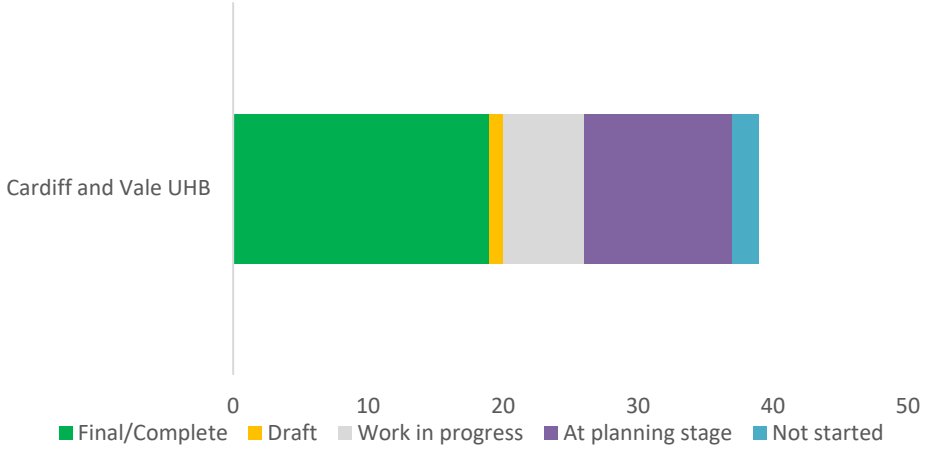
Ten assignments have been finalised since the previous meeting of the committee and are highlighted in the table below along with the allocated assurance ratings.

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

FINALISED AUDIT REPORTS	ASSURANCE RATING	
Development of Genomics Partnership Wales	Reasonable	
Capital Systems Management (From the 21/22 plan)		
Core Financial Systems (Treasury Management)		
Management of Locum Junior Doctors (Women & Children's CB)		
UHL Engineering Infrastructure		
Endoscopy Insourcing (Medicine Clinical Board)		
Access to In-Hours GMS Service Standards (PCIC Clinical Board)		
New IT Service Desk System		
Medical Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board)	Limited	
Assurance Mapping	Advisory	

4. Delivery of the 2022/23 Internal Audit Plan

There are a total of 40 reviews within the 2022/23 Internal Audit Plan (including the adjustments highlighted below), and overall progress is summarised below.



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

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

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

5. Changes to the 2022/23 Plan

At the Audit Committee meeting in September 2022, the Independent Members queried the deliverability of the Internal Audit plan given the potential pressures that may be faced by the Health Board over the winter period. It was therefore agreed that contingency arrangements would be developed to allow for reasonable adjustments to be made to the plan if and when required.

At the November 2022 meeting, the Committee then agreed an initial list of four audits to be rescheduled to the end of the 22/23 plan but with the possibility that they could be removed or deferred into 23/24 if required.

As the winter period has progressed and operational pressures have intensified, discussions with the relevant managers and Executives have highlighted that the identified audits will now need to be removed from the plan.

As part of these discussions an additional four audits have also been identified for removal from the plan. The details of all the audits are included within the following table, along with a brief explanation of the rational for removal.

Audits Identified	Lead Exec Dir	Rationale
Reporting of Covid Deaths	Nursing	The audit wouldn't be of particular value at the current time given the implementation of the Medical Examiner role and the different Covid position.
Implementation of People & Culture Plan	People & Culture	The majority of the implementation plan has already been reviewed as part of the Staff Wellbeing audit.
Application of Local Choices Framework	Chief Executive / COO	Unclear on the potential scope or benefit in current position / lack of comparability to other organisations.
Regional Planning Arrangements	Strategic Planning	Focus would be on identifying lessons to take forward into future regional planning so not a key risk area in the current year.
Strategic Programmes / Recovery & Redesign Governance Arrangements	Strategic Planning	The governance arrangements will be reviewed as part of the separate audit of Planned Care Transformation Delivery (Recovery of Services).
Administration Services (Mental Health CB)	Chief Operating Officer	Delays in receiving information to commence audit have impacted on the availability of Internal Audit resources.
Capital Systems	Finance	The 21/22 audit has only recently been finalised, so there would be little benefit in reviewing again in 22/23.
Network & Information Systems (NIS) Directive Follow-up	Digital & Health Intelligence	Follow-up of management actions to be covered as part of the Cyber Security audit.

These audits will now be considered as part of the planning discussions referenced in section 6 below, to determine if they should be included within the 2023/24 plan.

An additional audit has been added to the plan covering the UHW-Hybrid and Major Trauma Theatres, as part of the Development of Integrated Audit Plans. The Committee will receive the final report to provide assurance on the development and the outcome will feed into the Head of Internal Audit opinion for the year. However, the audit has been commissioned in accordance with the agreed Audit Plan provided within the approved Business Justification Cases for the project.

The 40 audits remaining within the 22/23 plan will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

6. Development of the 2023/24 Plan

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

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

7. Final Report Summaries

6.1 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 project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

This is the second audit of the project and considered the period from issue of the prior audit report (April to October 2022).

Overall Audit Opinion and Overview

Key matters for management attention identified during the audit included:

- The need for a lessons-learned review of the reasons for the increased project costs;
- Enhanced reporting of the residual financial risks (actioned since audit fieldwork); and
- Delayed approval of compensation events (via the Project Issues Form process).

Whilst noting the levels of assurance determined at the individual objective areas reviewed as part of the current audit, when considering the key delivery objectives of the project it was evident that with six months of the construction programme remaining, a forecast overspend of £639k (4.17%) was being reported, including the full utilisation of the £1.4m contingency budget. The increased costs have primarily been attributed to IT infrastructure delays, unforeseen works due to the existing building condition and legislative changes.

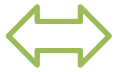
Additional funding of £239k had been approved by the Capital Management Group to partially offset this (from discretionary capital) and further funding support was being sought from Welsh Government at the time of reporting.

The full extent of the time impact of the project changes remained ongoing at the time of reporting.

Acknowledging the financial pressures at the project, an appropriate financial reporting regime was seen to be operating with all key parties made aware of the ongoing challenges. Accordingly, an overall **reasonable assurance** has been determined.

It is imperative that the project's financial outturn position is carefully managed (including change controls, risk management and Welsh Government liaison) through to completion.

Report Classification

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

Assurance summary [1]

	Assurance objectives	Assurance
1	Project Performance (time/cost/quality)	Limited
2	Validation of Management Action	Reasonable
3	Governance	Reasonable
4	Financial Assurance	Reasonable
5	Technical Assurance	Reasonable
6	Change Control	Reasonable
7	Quality Assurance	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
3.1	Insufficient clarity over the monitoring and reporting of residual financial construction risk against project funding at the time of audit fieldwork.	3	Operation	Medium
4.1	The need for a lessons-learned review of the reasons for the increased project costs.	3	Operation	Medium

6.2 Capital Systems Management

Purpose

Post reporting of potential breaches, at capital schemes, to Standing Financial Instructions and Standing Order requirements, recommendations and an action plan were agreed to be implemented to mitigate the risk of the same reoccurring. The audit was undertaken to provide assurance on the application of the plan; and to identify any enhancements to existing operational procedures / working practices.

Overall Audit Opinion and Overview

The commitment, by all parties, to address the identified actions is apparent. The action plan was endorsed by the appropriate officers and appropriate action was taken whilst recognising that some required more engagement than current workforce availability could provide.

However, whilst a process for change management was defined, this was not consistently applied across teams; and, for two changes reviewed (total circa. £120k), not in accordance with the defined delegated limits.

Monitoring and reporting arrangements also require review to ensure their consistent application across all capital schemes; notably those managed by the different teams within the Capital, Estates & Facilities department.

Key matters arising, requiring management attention include:

- Application of the change management (Project Issues Form) process at all capital schemes.
- Review of the scheme of delegation applied to capital schemes.

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	Action Plans	Reasonable
2	Capital Approvals	Substantial
3	Change Management	Limited
4	Contractual Arrangements	Reasonable
5	Delegated Limits	Reasonable
6	Monitoring and Reporting	Reasonable

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

- Review of the content, and consistency of use, of the highlight reports prepared for capital schemes; and
- Completeness of reporting to the appropriate forums.

Other recommendations, including completion of the outstanding / partial actions, are included within the detail of the report.

It is proposed that a further follow up audit will be undertaken during March/April 2023, testing further UHB projects, to ensure ongoing compliance with established procedures.

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Appropriate arrangements should be put in place to address / complete the outstanding agreed actions.	1	Operation	Medium
2.1	Irrespective of the capital project management team, the application of management processes should be consistent across the Capital, Estates & Facilities department.	3	Operation	Medium
2.2	Changes should be approved in accordance with the approved scheme of delegation.	3,5	Operation	High
2.3	Management may wish to consider the implementation of a revised scheme of delegation for capital schemes funded by Welsh Government	5	Design	Medium
4.1	Monthly highlight reporting should be applied at all major capital projects	6	Operation	Medium
4.3	Supporting procedures should be developed to ensure Lead Executives receive relevant and timely assurance to facilitate their responsibilities	6	Design	Medium

6.3 Core Financial Systems (Treasury Management)

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Core Financial Systems – Treasury Management'.

Overview

The Treasury Management function has in place adequate systems and controls for managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. Accordingly, we have concluded Reasonable assurance overall.

We have made two medium priority recommendations which are inherently linked, relating to the strengthening of the Treasury Management Financial Control Procedure, which in turn would direct operational arrangements and the controls over Bankline, the online banking system.

We have made two further low priority recommendations concerning areas for refinement and further development, full details are included within Appendix A.

Report Classification

Reasonable assurance

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	Procedural guidance	Reasonable
2	Full year cash forecast	Substantial
3	Regular updates to the cash forecast are made and reviewed	Substantial
4	Receipts, payments, and cash balances	Reasonable
5	Transfers between Accounts	Substantial
6	Bank account reconciliations	Substantial
7	Recommendations from the review of Core Financials 2021/22	Substantial

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Strengthening of the Financial Control Procedure	1	Design	Medium
2	Bankline – access and controls	4	Operation	Medium

6.4 Management of Locum Junior Doctors (Women & Children's CB)

Purpose

To review the system for agreeing and booking locum junior doctors, including appropriate use of the Envoy system before offer of increased rates and cross checking of shifts against claims.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Locum Junior Doctors were working shifts prior to approval being granted by the Directorate;
- We identified instances where Locum Junior Doctors were paid in excess of the expected rate, although we could evidence approval of the higher rate;
- Examples were identified where Locum Junior Doctors worked in excess of the shift time request, for example no rest breaks were taken; and
- There were retrospective requests for bank shifts entered onto the Envoy system.

We sampled two Directorates and found that the four matters arising raised relate to Acute Child Health, and two of the matters arising also relate to Obstetrics and Gynaecology.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

	Objectives	Assurance
1	Locum Doctors are sourced through the Bank	Substantial
2	Clinical Board approval has been granted to work in an area of interest	Reasonable
3	Requests for Locum Junior Doctors are supported by justification and authorisation	Substantial
4	Rates will be in accordance with the current rates offered	Reasonable
5	Bank shifts are verified and authorised on the Envoy system	Reasonable
6	Accurate and timely reports on bank usage and costs are produced	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Prior approval of Locum Junior Doctors – Acute Child Health	2	Operation	Medium
2	Deviations from Directorate approved rates – Acute Child Health and Obstetrics & Gynaecology	4	Operation	Medium
3	Variations in shift length – Acute Child Health	5	Operation	Medium
4	Retrospective requests for bank shifts entered on the Envoy system - Acute Child Health and Obstetrics & Gynaecology	5	Operation	Medium

6.5 UHL Engineering Infrastructure

Purpose

The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Engineering Infrastructure Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

Reasonable assurance has been determined at this stage of the project.

At the date of the audit fieldwork (September/ October 2022) the Project Manager was reporting a delay to the project's completion of approximately nine weeks. This was due to a combination of factors, including the building subcontractor being delayed starting on site and structural redesign due to the originally appointed structural designer going into administration. There is a risk that timescales could be further extended due to open Early Warning Notices (EWN) and Project Managers Instructions (PMIs) associated with the lack of engagement with the medical gas supplier

Robust cost and project management arrangements controls were in place, with continual liaison and effective reporting to the relevant forums evident.

Contractual arrangements were appropriately approved; for both the main contractor and the UHB's advisers in line with the requirements determined within the approved Business Justification Case (BJC); with no amended procurement strategy approved.

Key matters requiring management attention, include:

- The need to determine any time and cost implication surrounding the medical gas installation.
- Application of the change management (Project Issues Form) process. Note the change control mechanisms at this project had been reviewed as part of the capital systems review (published December 2022), and to avoid duplication, no recommendations have been re-raised within this report.

Other recommendations are within the detail of the report.

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	Project Performance	Reasonable
2	Financial	Substantial
3	Technical	Substantial
4	Advisers	Substantial
5	Change Control	Limited
6	Quality	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
MA5	Application of the change management (Project Issues Form) process (*refer to Capital Systems Report, December 2022 for associated recommendation*).	5	Operation	High
6.1	Resolution to the outstanding issues concerning the medical gas installation.	5	Operation	Medium

6.6 Endoscopy Insourcing (Medicine Clinical Board)

Purpose

Our audit focussed on the governance and operational arrangements in place to manage the Endoscopy Insourcing Contract.

Overview

We have issued reasonable assurance on this area.

In all but one instance we offer reasonable assurance against the audit objectives. We provide 'Limited' assurance for Objective 3 due to the lack of information made available to inform our audit testing.

In summary, the matters requiring management attention include:

- Consideration of the weekly points targets which have been fluctuating since the commencement of the new contract, including the achievability and monitoring arrangements;
- Strengthening the documentation held for key meetings, declaration of interest forms and CVs for all Remedy Healthcare Services (RHS) staff working on the contract;
- KPI's have not been developed for the contract, a requirement of the SLA; and
- The accuracy of payments made to the provider.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Declarations of Interest	Reasonable
3	Provider Staff Suitability	Limited
4	Contract Performance Monitoring	Reasonable
5	Invoices and Payments	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Weekly Points Targets	1	Operation	Medium
2	Operational effectiveness of governance groups	1	Operation	Medium
3	Declaration of Interest Forms and Working Time Regulations Opt Out Forms	2	Operation	Medium
4	Validation of RHS Staff working on the contract	3	Operation	Medium
5	Lack of Key Performance Indicators	4	Design	Medium
6	Value for money	5	Design	Medium

6.7 Access to In-Hours GMS Service Standards (PCIC Clinical Board)

Purpose

To review the processes and procedures in place for assessing GP practices achievement against the 'Access to In-Hours GMS Service Standards'

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Reporting lines from the Health Board's Access Forum do not currently reflect Welsh Government guidance, where updates are to be provided at Board level on a quarterly basis; and
- The operation of the Access Forum could be strengthened by reviewing the terms of reference, giving consideration to attendance and the required quoracy. The forum is a key mechanism of sharing best practice.

A further low priority recommendation is within the detail of the report, which is advisory in nature.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Governance and reporting structure	Reasonable
2	Engagement and support for GP practices	Reasonable
3	Monitors implementation of the Standards, with escalation of issues where necessary	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Welsh Government reporting requirements	1	Operation	Medium
2	Operation of the Access Forum	1 & 2	Operation	Medium

6.8 New IT Service Desk System

Purpose

A new IT service desk system has recently been implemented to address serious failings previously identified by both IT management and internal audit.

The purpose of the audit was to review the set-up and implementation of the new system, and to assess the extent to which the new system has been able to drive improvements.

Overview

The new Ivanti Management System has been successfully implemented, and this has addressed many of the issues previously identified. There are however some areas where further improvements are required. We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Procedural guidance needs to be developed for the monitoring and closing down of calls.
- Calls are not at present being effectively prioritised.
- System access controls need to be developed.
- Service Level Agreements and Key Performance Indicators need to be developed.

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Calls are recorded and managed	Reasonable
2	Calls are classified and prioritised	Reasonable
3	The system enables predefined calls and routing	Substantial
4	User access and privileges s controlled	Reasonable
5	Users have been trained and have access to procedures and user guides	Substantial
6	A contract for the system is in place	Substantial
7	Management information is available	Reasonable
8	The system facilitates problem & knowledge management	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Procedural guidance to be developed	1	Design	High
2	Prioritisation of calls	2	Operation	Medium
3	Control of system access and privileges	4	Operation	Medium
4	SLA's and KPI's	7	Design	Medium

6.9 Medical Records Tracking (CD&T Clinical Board)

Purpose

To review the effectiveness of the mechanisms for tracking medical records both inside and outside of the Health Records department.

Overview

The report provides limited assurance for the tracking of acute (secondary care), medical records. Four high priority and two medium priority recommendations have resulted in the overall opinion.

Matters which require management attention include the out of date Records Management Policy (UHB 142) and Procedure (UHB 326). The documents refer to governance fora no longer in operation. Currently the Health Records department have no direct link into the Executive Medical Director, the executive sponsor of the Policy and Procedure. The author of the documents also sits outside of the Health Records department.

Further high priority recommendations have been made which relate to the security and storage of acute records, and the ability to track records from the patient management system to their physical location. The majority of issues associated with the tracking of records was a result of those held in a clinical setting or outside of Health Records.

We make two further medium priority recommendations which would enhance operational effectiveness.

We also highlight within Appendix A the barriers which are currently impeding digitalisation of medical records.

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Limited
2	Governance arrangements	Reasonable
3	Operational arrangements	Limited
4	Risks and Incidents	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy and Procedure require review	1 & 3	Design	High
2	Health Records governance requires review	2	Design	High
3	Security and storage of medical records	3	Operation	High
4	Lessons learnt require formal tracking	4	Operation	Medium
5	Inaccuracies of medical records location	3	Operation	High
6	Operational effectiveness to be improved and harmonised	3 & 4	Operation	Medium

6.10 Assurance Mapping

Purpose

An advisory review to support the development of assurance mapping within the Health Board.

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 Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will enable the Health Board to fully embed the Assurance Strategy across the Health Board.

The Health Board's Assurance Strategy 2021-24 aligns to recommended best practice and the Assurance Map Template captures appropriate assurance and risk information. There is a defined governance structure underpinning the Assurance Strategy and an action plan is in place for its implementation. However, more medium-term actions are required to assist in embedding and implementing the Assurance Strategy within the Health Board

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 if:

1	The Health Board has developed a comprehensive Assurance Strategy informed by best practice, which has been approved by the Board;
2	The Assurance Strategy is supported by a robust governance structure and reporting arrangements for ensuring that the objectives are being progressed in a timely manner; and
3	The Health Board has agreed and clearly defined how it intends to apply and rollout the Assurance Strategy and develop the Assurance Map and has recognised the roles and responsibilities for implementation across the organisation.

Opportunities

		Audit Objective
1	Review and revise the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to risk, governance and assurance best practice	1
2	Review and revise the current Assurance Map template so that the layout and content takes a risk based approach, which will assist in prioritising areas to take forward	1
3	Develop a formal action plan for implementation / review of the Assurance Strategy to include actions for the medium term, to ensure the strategy becomes fully embedded across the Health Board.	3

ASSIGNMENT STATUS SCHEDULE

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

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Assurance Mapping	05	Corporate Governance	~~Q1~~	Q2	Final	Advisory	February
Management of Locum Junior Doctors (Women & Children's CB)	35	Chief Operating Officer	~~Q4~~	Q3	Final	Reasonable	February
Endoscopy Insourcing (Medicine CB)	31	Chief Operating Officer	~~Q3~~	Q2	Final	Reasonable	February
Medical Records Tracking (CD&T CB)	34	Chief Operating Officer	Q2		Final	Limited	February
Access to In-Hours GMS Service Standards (PCIC Clinical Board) (Deferred from 21/22 plan)	30	Chief Operating Officer	Q3		Final	Reasonable	February
New IT Service Desk Tool	22	Digital & Health Intelligence	Q3		Final	Reasonable	February
Financial Reporting & Savings Targets (Deferred from 21/22)	12	Finance	~~Q2~~	Q3	Draft	Substantial	February
Estates Assurance – Decarbonisation (Deferred from 21/22)	15	Finance	~~Q2~~		Draft	Advisory	March
Charitable Funds	13	Finance	~~Q3~~	Q2	Work in Progress		February
Community Patient Appliances (Specialist Services CB)	33	Chief Operating Officer	Q2		Work in Progress		February
Nurse Staffing Levels Act	10	Nursing	Q3		Work in Progress		April
Cyber Security	24	Digital & Health Intelligence	~~TBC~~	Q3	Work in Progress		April
Commissioning – IPFR Process	38	Strategic Planning	Q3		Planning – Brief agreed for February start		April

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Risk Management	01	Corporate Governance	Q4		Planning – Brief agreed for February start		April
QS&E Governance (Deferred from 21/22 plan)	03	Nursing / Medical	Q3	Q4	Planning		April
Inclusion & Equality Team	08	People & Culture	Q4		Work in Progress		April
Medical Staff Additional Sessions	16	Medical	~~Q3~~	Q4	Planning		April
Clinical Audit (Follow-up)	17	Medical Director	~~Q2~~	Q4	Planning		April
Performance Reporting	19	Digital & Health Intelligence	~~Q3~~	Q4	Planning		April
Data Warehouse	23	Digital & Health Intelligence	Q4		Planning-Draft Brief Issued		April
Consultant Job Plans (Surgery CB)	32	Chief Operating Officer	Q4		Planning		April
Management of Health Board Policies	04	Corporate governance	Q4		Planning – Brief agreed for February start		May
Planned Care Transformation Delivery (Recovery of Services)	27	Chief Operating Officer	~~Q3~~	Q4	Planning		May
ChemoCare IT System Follow-up	43	Digital & Health Intelligence	TBC				TBC
Nurse Bank (Temporary Staffing Department) Follow-up	45	People & Culture	TBC				TBC
Shaping Our Future Hospitals Programme	40	Strategic Planning	Q1-4		Planning – Brief agreed for February start		n/a

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Development of Integrated Audit Plans:	*41*	*Strategic Planning*					
• *Development of Genomics Partnership Wales*			*Q3*		*Final*	*Reasonable*	*February*
• *University Hospital Llandough – Endoscopy Expansion*			*Q2*		*Final*	*Reasonable*	*November*
• *University Hospital Llandough – Engineering Infrastructure*			*Q2*		*Final*	*Reasonable*	*February*
• *UHW-Hybrid and Major Trauma Theatres*			*Q4*		*Work in Progress*		*April*
Reviews removed from the plan							
Implementation of People & Culture Plan	*09*	*People & Culture*					
Reporting of Covid Deaths	*11*	*Nursing*					
Application of Local Choices Framework	*28*	*Chief Executive / COO*					
Administration Services (Mental Health CB)	*29*	*Chief Operating Officer*					
Regional Planning Arrangements	*39*	*Strategic Planning*					
Strategic Programmes / Recovery & Redesign Governance Arrangements	36	Strategic Planning					
Capital Systems	*14*	*Finance*					
Network & Information Systems (NIS) Directive Follow-up	44	Digital & Health Intelligence	Follow-up of management actions to be covered as part of the Cyber Security audit - To be agreed by February 23 AC				

REPORT RESPONSE TIMES

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

Endoscopy Insourcing	Reasonable	Final	21/11/22	12/12/22	18/01/23	24/01/23	R
Medical Records Tracking (CD&T CB)	Limited	Final	13/12/22	06/01/23	19/01/23	24/01/23	R
Access to In-Hours GMS Service Standards (PCIC Clinical Board)	Reasonable	Final	22/12/22	17/01/23	17/01/23	24/01/23	G
IT Service Desk System	Reasonable	Final	12/01/23	02/02/23	25/01/23	25/01/23	G

KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2022/23	A	87% 20 from 23	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	89% 17 from 19	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	A	68% 13 from 19	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 19 from 19	80%	v>20%	10%<v< 20%	v<10%

Assurance Ratings

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Archwilio Cymru
Audit Wales

Audit and Assurance Committee Update – **Cardiff & Vale University Health Board**

Date issued: February 2023

Document reference: 2875A2023

This document has been prepared for the internal use of Cardiff & Vale University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Contents

Audit and Assurance Committee Update

About this document

1 This document provides the Audit and Assurance Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Financial audit update

2 **Exhibit 1** summarises the status of our current and upcoming financial audit work.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the Health Board's 2021-22 Charitable Financial Statements	We are currently undertaking some extended audit work. We are scheduled to report to Trustee Members on 9 February and to certify the financial statements soon after that date.
Audit of the Health Board's 2022-23 Performance Report, Accountability Report and Financial Statements	We expect to start audit planning in February 2023.
Annual Audit Report	The report will be considered by the Audit and Assurance Committee on 7 February 2023.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- work completed since we last reported to the committee in September 2022 (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit and Assurance Committee
Structured Assessment 2022	This report and the Health Board's management response will be considered by the Audit and Assurance Committee on 7 February 2023.
Annual Audit Report 2022	The report will be considered by the Audit and Assurance Committee on 7 February 2023.

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
Orthopaedic Services: Follow-up Executive Lead – Chief Operating Officer	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges and consider the impact of the pandemic and orthopaedic service recovery.	Current Status: All-Wales summary report issued to Welsh Government as draft. Currently preparing a

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
	Therefore, reporting was moved to 2022.	discrete Annex for each Health Board. Planned date for consideration: TBC
Review of Unscheduled Care Executive Lead – Chief Operating Officer	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also plan to review progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs.	Current status: Fieldwork underway Planned date for consideration: TBC

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit and Assurance Committee consideration
All-Wales thematic on workforce planning arrangements	This work will examine the workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. It will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	Current Status: We issued the project brief in November. The fieldwork is planned for spring 2023. Planned date for consideration: TBC
Primary Care Services - Follow-up Review (Local Work 2022)	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made a number of recommendations to the Health Board. This work will follow-up progress against these recommendations.	Current status: Planning underway Planned date for consideration: TBC

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design, and good practice research.

5 **Exhibit 5** outlines the Good Practice Exchange (GPX) events which have been held recently. Materials are available via the link below. Details of future events are available on the GPX website.

Exhibit 5 – Recent GPX activities

Event	Details
Tackling Poverty in Wales: responding to the challenge	This shared learning event in October 2022 brought together people from across public services to share ideas, learning, and knowledge on how organisations can respond to the challenges caused by poverty.

NHS-related national studies and related products

6 The Audit and Assurance Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Administration and Public Accounts Committee to support its scrutiny of public expenditure.

7 **Exhibit 6** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 6 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
A missed opportunity – Social Enterprises	December 2022
Time for change – Poverty in Wales report and Poverty in Wales data tool	November 2022
National Fraud Initiative 2020-21 **Please see Appendix 1**	October 2022

8 The Audit and Assurance Committee might also be interested to know that we have recently published our **Fee Scheme for 2023-24**. The document is available on our website.

Appendix 1 – key messages from recent national publications

National Fraud Initiative 2020-21

9 Since we last reported on the National Fraud Initiative (NFI) in Wales in October 2020, outcomes valued at £6.5 million have been recorded. The cumulative total of outcomes from the NFI in Wales since NFI started in 1996 are now £49.4 million. Across the UK, the cumulative total of NFI outcomes is now £2.37 billion.

10 NFI outcomes in Wales decreased by £1.5 million to £6.5 million in the 2020-21 exercise. This was primarily because fewer ineligible claims for Council Tax Single Persons Discount and Housing Benefit claims were detected, reflecting the fact that some local authorities started review of NFI matches later than normal due to Covid-19 pressures.

11 Data sharing enables matches to be made between bodies and across national borders. Data submitted by Welsh bodies for the 2020-21 NFI exercise helped organisations in other parts of the UK to identify 153 cases of fraud and error with outcomes of £183,045.

12 While the majority of Welsh NFI participants display a strong commitment to counter fraud, 13 of the 22 Welsh local authorities identified 95% of the fraud and error outcomes achieved by the sector. This suggests that some local authorities have either failed to recognise the importance of the exercise or are unwilling to allocate adequate, skilled counter-fraud resources to investigate the NFI matches.

13 One Welsh local authority, Cardiff Council, agreed to participate in an exercise designed to identify fraud and error in applications for COVID-19 business support grants by verifying applicant bank details and trading status. These checks helped to identify outcomes of just under £0.6 million relating to 41 fraudulent or erroneous applications.

14 Our report made the three recommendations below, with the expectation that health bodies respond to the first two recommendations.

- All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.
- Audit committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.
- Where local auditors recommend improving the timeliness and rigour with which NFI matches are reviewed, NFI participants should take appropriate action.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2022 – Cardiff and Vale University Health Board

Audit year: 2022

Date issued: December 2022

Document reference: 3180A2022

This document has been prepared for the internal use of Cardiff and Vale University Health Board as part of work performed in accordance with statutory functions.

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2022 structured assessment work at Cardiff and Vale University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. The approach we adopted to deliver our work is detailed in summarised in **Appendix 1**.

4 We have also provided updates on progress against recommendations identified in previous structured assessment reports.

Key messages

5 Overall, we found that **generally, the Health Board's corporate arrangements support good governance and the efficient, effective, and economical use of resources in most areas. Plans to refresh the long-term strategy present opportunities to strengthen these arrangements further by ensuring key structures, processes, and resources are fully aligned to strategic objectives and risks.**

6 The Health Board has a well-established vision and long-term strategy, underpinned by a clear programme for transforming clinical services. However, it recognises they need to be refreshed to reflect current opportunities, and challenges. The Health Board's approach to planning is generally effective and inclusive, with good Board-level oversight. The Health Board has been unable to produce a financially balanced and Welsh Government approved Integrated Medium-Term Plan for 2022-25.

7 Systems of assurance continue to mature at a corporate-level, and work is underway to strengthen arrangements at an operational-level. There is scope to make greater use of the Board Assurance Framework to shape Board and committee business. There are reasonably good arrangements in place to conduct Board business effectively and transparently. There is a full Executive Team in place which appears stable following a period of operating with interim appointments. The organisational structure remains stable and appropriate; however, it will need to be kept under constant review as the Health Board refreshes its long-term strategy, and rolls-out new clinical and workforce models.

8 Whilst the Health Board achieved its financial duties for 2021-22, it is at risk of not achieving its financial duty to break-even at the end of 2022-23 given the need to manage its underlying deficit and growing cost pressures. Arrangements for financial management and controls are improving. Positive steps have been taken to enhance public transparency by ensuring detailed papers on counter fraud and procurement are discussed in public. Financial reports, which are regularly scrutinised by the Finance Committee, are clear and are open about financial challenges and risks.

9 There is good Board-level oversight of the arrangements in place to support staff well-being, but the Board should seek greater assurances that these arrangements are making a positive difference. Whilst there are good arrangements for Board-level oversight of digital matters, a lack of detailed plans, funding and staffing challenges are hampering the Health Board's pace in implementing its digital priorities. The Health Board has increased its strategic focus on the future configuration of its estate, but there is insufficient Board-level visibility of the condition of the existing estate.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response is summarised in **Appendix 2**.

Exhibit 1: 2022 recommendations

Strategic alignment of processes, structures, and resources

R1 The Health Board plans to refresh its 10-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements to ensure they are fully aligned to the organisation's refreshed strategic objectives and associated risks, with a particular focus on its:

- Board Assurance Framework;
- Performance Management Framework;

- Committee structures, terms of reference, and workplans; and
- Long-term financial plan.

Enhancing the Integrated Performance Report

R2 The Integrated Performance Report provides a good overview of the Health Board's performance. However, details of the actions being taken to sustain or improve performance that falls below target appears in some sections of the report but not others. The Health Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance.

Enhancing administrative governance arrangements further

R3 Whilst the Health Board has good arrangements in place for conducting Board and committee business effectively and transparently, opportunities exist to enhance these arrangements further. The Health Board, therefore, should:

a) Post more frequent reminders about Board and committee meetings on social media and provide links to papers;

b) Ensure the papers for all Advisory Group meetings are published on the Health Board's website in a timely manner;

c) Make abridged minutes of private Board and committee meetings available publicly as soon as possible after each meeting;

d) Ensure the dates Terms of Reference were last reviewed and approved are clearly displayed on the documents;

e) Circulate presentations in advance of meetings or, where this is not possible, make copies available to members and the public (via the website) as soon as possible afterwards; and

f) Ensure public papers include an explanation as to why some matters are being discussed in private rather than in public.

Strategic planning arrangements

11 In this section of the report, we provide our views on the Health Board's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan (IMTP);
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

12 Details of progress made on previous years recommendations relating to the Health Board's strategic planning arrangements are provided in **Exhibit 2**.

13 We found that **the Health Board's approach to planning is generally effective and inclusive, with good Board-level oversight and stakeholder involvement. Refreshing its long-term strategy and producing an approvable IMTP must remain key priorities for the Health Board.**

Vision and strategic objectives

14 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:

- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the vision and strategic objectives have been developed and adopted by the Board; and
- the long-term strategy is underpinned by an appropriate long-term clinical strategy.

15 We found that **the Health Board has a well-established vision, underpinned by a clear transforming clinical services programme. Work is underway to refresh the long-term strategy to reflect current opportunities and challenges.**

16 The Health Board's vision is clearly articulated in its 10-year strategy, Shaping Our Future Well-being (2015 – 2025). The vision is concise, future-focussed, and places a clear emphasis on improving people's health irrespective of their circumstances. It is underpinned by 10 strategic objectives that focus on population outcomes, service delivery and sustainability, and organisational culture. The strategic objectives are also the Health Board's well-being objectives.

17 The strategy, which was adopted by the Board in 2015, clearly articulates the key population health challenges at the time, as well as the relevant drivers such as key legislations and policies. The strategy was developed in collaboration with stakeholders and is accessible on the Health Board's website.

18 The Health Board plans to refresh its strategy by 2023 to reflect post-pandemic realities, opportunities, and challenges. It has put appropriate Board-level arrangements in place to oversee this work, as well as to ensure effective internal and external stakeholder engagement.

19 The Health Board's current 10-year strategy is underpinned by a clear vision for the future configuration of its healthcare services in the home, in the community, and in its hospitals. The Health Board ensured internal and external stakeholders were actively engaged in a conversation about shaping future clinical services during March and April 2021. The Health Board intends to further develop its 'Shaping Our Clinical Futures' Plan alongside the 10-year strategy refresh.

Integrated Medium Term-Plan

20 We considered the extent to which the Health Board has been able to produce an approvable Integrated Medium Term-Plan (IMTP) for 2022-2025. In examining this, we have looked at whether:

- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
- the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission; and
- the IMTP received approval from the Minister for Health and Social Services.

21 We found that **the Health Board has been unable to produce a Welsh Government approved and balanced IMTP for 2022-25.**

22 The Health Board's draft 2022-25 IMTP was agreed by the Board in March 2022 and submitted to Welsh Government within the required timeframe. However, it was not approved by Welsh Government as it was not financially balanced. Consequently, the Health Board has been escalated from routine arrangements to enhanced monitoring for planning and finance under Welsh Government's Joint Escalation and Intervention Arrangements[1]. The Health Board has since submitted an Annual Plan for 2022-23 to Welsh Government in June 2022, which sets out its broad plans for ensuring a financially sustainable position by 2024-25.

23 We found strong evidence that the Board, Finance Committee, and Strategy and Delivery Committee were given several opportunities to input, scrutinise, and challenge the IMTP prior to its submission. An Internal Audit review also found good governance arrangements in place to oversee the IMTP planning and development process, but identified opportunities to ensure lessons-learnt exercises are built into future IMTP planning timelines.

[1] Under the Joint Escalation and Intervention Arrangements, Welsh Government officials meet with Audit Wales and Healthcare Inspectorate Wales at least twice a year to discuss the performance of each health body. There are four escalation levels; routine arrangements, enhanced monitoring, targeted intervention, and special measures.

Planning arrangements

24 We considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:

- prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans;
- corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders; and
- arrangements for commissioning services are effective and efficient, and aligned to corporate strategies and plans.

25 We found that **the Health Board's approach to planning is generally effective and inclusive, with good Board-level oversight.**

26 The Health Board's approach to strategic planning is generally effective. The planning process is co-ordinated by its Strategic Planning Team, and supported by the Strategy Development and Delivery Group (SDDG), which is a senior management forum that oversees the development of corporate plans and strategies and monitors their delivery. The SDDG works closely with the Health Board's Operational Planning Group, which is chaired by the Chief Operating Officer, to ensure appropriate operational input and challenge prior to presenting key strategies and plans to Board for approval. The Health Board continues to make good use of 'Signals from Noise'[2] data to inform its planning assumptions.

27 The Board and its relevant committees maintain effective oversight of the Health Board's planning arrangements, with good reporting to the Board on the 2022-25 IMTP development process and the arrangements for refreshing the organisation's 10-year strategy.

28 It is unclear how value-based healthcare principles inform the Health Board's overall approach to planning as we found minimal references to them in corporate strategies and plans. However, we found that the Health Board has used a value-based approach to develop its programme of transformational services to address its underlying deficit, as well as to inform its commissioning intentions for 2022-23.

29 The Health Board is very effective at involving internal and external stakeholders in developing corporate strategies and plans. There is good evidence of stakeholder involvement in the process of developing the Health Board's 10-year strategy, and a detailed engagement plan is in place to ensure that stakeholders have opportunities to shape the next iteration. As stated in paragraph 19, the Health Board also engaged well with stakeholders when developing its 'Shaping Our Clinical Futures' programme.

[2] Signals From Noise is a statistically based data engine provided by a third party which supports the Health Board to uncover hidden insights from its processes and provide evidence to support decisions for change or improvement.

30 The Health Board continues to engage well with its Stakeholder Reference Group and Local Partnership Forum, with evidence of discussions on matters such as the IMTP, People and Culture Plan, and the 10-year strategy refresh taking place at these meetings. The Health Board also engages well with the Community Health Council when developing relevant corporate strategies and plans.

31 In July 2022, the Board received the Health Board's 2023-26 commissioning intentions, which support the delivery of the 10-year strategy and feed into the development of the 2023-26 IMTP. To ensure the commissioning intentions align with the Health Board's long-term ambitions, there may be some changes to them as the organisation reviews and refreshes its 10-year strategy.

Implementation and monitoring arrangements

32 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board receives regular reports on progress to deliver corporate strategies and plans.

33 We found that **positive steps have been taken to improve implementation and monitoring arrangements, which should lead to greater Board-level scrutiny and assurance.**

34 The Health Board has taken positive steps to improve its arrangements for monitoring and reporting delivery of corporate strategies and plans as recommended in last year's structured assessment (see **Exhibit 2, 2021 Recommendation 2a** and **2b**). Its Annual Plan / IMTP is clear about key deliverables, timescales, and measures to support effective monitoring and reporting, although there is some variation between different sections. The Health Board will need to ensure its refreshed 10-year strategy provides the same level of clarity. The agreed approach for reporting Annual Plan / IMTP progress to the Board, and subsequently to Welsh Government, is based on a delivery template which reports against:

- what the Health Board said it would do;
- when the Health Board said it would do it by; and
- where the Health Board actually is.

35 The Quarter 1 2022-23 progress report was presented to the Board in July 2022. It gave a good overview of Annual Plan / IMTP delivery to date, as well as an overview of progress in delivering the Health Board's strategic programmes. Further enhancements are planned, such as including Red, Amber, Green (RAG) ratings to highlight key priorities and actions, and providing greater detail on how delivery gets back on track when delays occur.

36 From Quarter 3 2022-23, the report will also be accompanied by a 'heat map' of the Health Board's outcomes framework to illustrate, at a high-level, the impact of delivery against intended outcomes. The delivery template and heatmap have been designed to be read alongside the Integrated Performance Report to give the Board a rounded view of progress.

Exhibit 2: progress made on previous-year recommendations

Recommendation	Description of progress
Recommendation 2 (2021) The Health Board's approach to planning remains robust. However, the Health Board's arrangements for monitoring and reporting on plan delivery are less robust. The Health Board, therefore, should strengthen its arrangements for monitoring and reporting on the overall delivery of its Annual Plan and future Integrated Medium Term Plans by:	
a. ensuring these plans contain clear summaries of key actions/deliverables, timescales, and measures to support effective monitoring and reporting; and	**In progress** See paragraph 34.
b. providing more information to the Board and Strategy and Delivery Committee on progress against delivery of these plans to enable full scrutiny and assurance.	**In progress** Whilst positive steps have been taken to improve monitoring and oversight arrangements, it is too early for us to comment on their effectiveness.

Governance arrangements

37 In this section of the report, we provide our views on the Health Board's governance arrangements, with a particular focus on:

- Key systems of assurance;
- Board and committee effectiveness; and
- the extent to which organisational design supports good governance.

38 Details of progress made on previous year recommendations relating to the Health Board's governance arrangements are provided in **Exhibit 3**.

39 We found that **the Health Board is generally well led and well governed. Plans to refresh governance structures and align them to revised strategic objectives provide opportunities to further enhance Board and committee effectiveness.**

Systems of assurance

40 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:

- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
- the BAF is underpinned by appropriate systems for managing risks and performance; overseeing the quality and safety of services; and handling information in a secure manner; and
- effective action is taken to address audit and review findings and recommendations.

41 We found that **systems of assurance continue to mature at a corporate-level, and work is underway to strengthen arrangements at an operational-level.**

Managing risk

42 The Health Board's strategic risks are clearly documented in its Board Assurance Framework (BAF) and there is a well-established process in place to ensure they are adequately scrutinised and reviewed. Strategic risks are clearly mapped to the Health Board's current strategic objectives. The BAF, therefore, should be reviewed and reshaped as a central part of the Health Board's 10-year strategy refresh (**Recommendation 1**).

43 The Board receives regular assurance that strategic risks are being managed appropriately. The Board receives and reviews the whole BAF at each bi-monthly public meeting, and the committees regularly scrutinise the risks assigned to them. The revised Chief Executive Report to the Board also provides a detailed overview of new risks to the Health Board's strategic position and the arrangements that have been put in place to control, mitigate, and reduce them.

44 There is also regular scrutiny of the Corporate Risk Register, which the Board receives at each bi-monthly public meeting. In November 2022, there were 24 risks on the register, 19 of which related to patient safety. The Health Board actively manages its corporate risks as illustrated in the Board cover report, which details the total number of risks, new risks, removed risks, and a comparison to the previous report to the Board.

45 In March 2021, the Health Board received a reasonable assurance Internal Audit report on its risk management process. In June 2022, a follow-up review also resulted in reasonable assurance and three additional recommendations. The new

recommendations mainly relate to clarification of roles and responsibilities and providing training to risk owners. The Health Board is hoping that the all-Wales Datix[3] digital risk management software will help to strengthen risk management processes.

Performance management

46 There are significant performance challenges across the Health Board, as with others across Wales. For unscheduled care, September 2022 saw a continued increase in emergency department attendances, with 4-hour access below target at 61.3%, and 12 hour waits remain high at 1,004 patients. The Health Board attributes the challenges to difficulties in discharging medically fit patients, and workforce issues such as nurse vacancies and high sickness rates.

47 In terms of planned care, the referral-to-treatment waiting list is significant. In September 2022, there were a total of 128,179 patients waiting, of which 7,038 had been waiting for over 104 weeks and 28,800 for 52 weeks. The waiting list for a follow-up outpatients' appointment is equally significant (183,614 patients) but 98.7% have target dates. Performance on the single cancer pathway is also a concern, with compliance at 42.8% against the 75% target in September 2022.

48 The Health Board holds monthly Executive Performance Reviews for each Clinical Board where they are held to account on their operational and financial performance. Since September 2022, all of these meetings are attended by the whole Executive Team with the aim of creating a culture of open and honest dialogue and avoiding the need for a formal internal escalation process.

49 The Board and its committees provide good oversight of the Health Board's performance. The Board routinely receives the Integrated Performance Report which provides a good overview of the Health Board's performance against key national and local quality and performance measures. The report also includes performance against the ministerial priorities. Committees provide in-depth scrutiny on measures aligned to their respective functions. However, information on the actions being taken to sustain or improve performance that falls below target features in some sections of the report, but not others. The Health Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance (**Recommendation 2**).

50 In September 2020, the Strategy and Delivery Committee approved the Health Board's Performance Management Framework. This clearly documents roles and responsibilities, performance management arrangements, and escalation processes. However, the Health Board should review this framework alongside its

[3] Datix is the software used by the Health Board for clinical and non-clinical incident reporting.

10-year strategy and committee structure refresh to ensure arrangements are current and aligned to strategic objectives and risks (**Recommendation 1**).

Quality and safety assurance

51 In June 2022, we published our review of the Health Board's quality governance arrangements. Our review found that the Health Board has an approved Quality Safety and Improvement Framework, with clearly stated quality priorities. But there is poor alignment between corporate and operational priorities.

52 Whilst there is collective responsibility and accountability for quality and safety at a corporate level, operationally we found evidence of silo working and a lack of clarity among Clinical Directors around their responsibilities for quality and safety. The Health Board reported it was addressing this through job planning.

53 The Health Board has articulated headline activities and delivery timescales to support its Quality Safety and Improvement Framework, but there was no monitoring and reporting framework in place at the time of our review. Since then, the Health Board has incorporated quality, safety, and improvement actions into its IMTP. The Board, therefore, should receive assurance on the delivery of the new framework through routine IMTP progress reports. The Health Board intends to ensure that the Quality, Safety, and Experience Committee also receives assurance on the framework's delivery.

Information governance and cyber security

54 Cyber security remains a significant risk, scoring 20 on the Corporate Risk Register. Recognising this, the Health Board is taking steps to strength arrangements in this area. In May 2022, Internal Audit completed a review of the Health Boards baseline Cyber Assessment Framework, resulting in a limited assurance rating. The review made four recommendations, which the Health Board is making reasonable progress in addressing.

55 The Digital and Health Intelligence Committee, which meets three times per year, receives an Information Governance Data and Compliance Report at each meeting. Reporting arrangements are good, with the committee receiving information and assurance on matters such as information governance staffing capacity, Data Protection Act serious incidents, progress on freedom of information request, and subject assess requests processed. The report also provides information on compliance with information governance mandatory training, which was 66% in October 2022. This is a concern, and the Senor Leadership Board is reviewing compliance with a view to prioritising mandatory training requirements across the Health Board.

Recommendations tracking

56 The Health Board continues to have good arrangements in place for tracking and implementing audit and review recommendations. Positively, the Health Board is taking steps to make its recommendations tracking arrangements more impactful and to provide greater assurance to the Audit and Assurance Committee.

57 From November 2022, the committee will consider internal and external recommendations trackers at every other meeting to allow officers more time to progress actions. In addition, high-risk or long-standing recommendation will be agreed by members to consider in-depth. The Health Board is also taking positive steps to improve its legislative and regulatory compliance tracker following a reasonable assurance report issued by Internal Audit in August 2021.

58 In November 2022, there were 35 partially complete Audit Wales recommendations. Of these, 14 recommendations were overdue. These will be scrutinised further by the Health Board ahead of the February 2023 Audit and Assurance Committee meeting.

Board and Committee effectiveness

59 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:

- the Board and its committees demonstrate appropriate levels of public transparency;
- meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
- there is an appropriate and well-functioning committee structure below the Board;
- the Board and its committees receive the right information, including views from staff and service users; and
- there is evidence of sufficient self-review by the Board and its committees.

60 We found that **there are good arrangements in place to conduct Board business effectively and transparently. However, there is scope to make greater use of the Board Assurance Framework to shape Board and committee business.**

61 The Health Board has taken several positive steps to enhance public transparency of Board business as recommended in last year's structured assessment (see **Exhibit 3, 2021 Recommendation 1a and 1b**).

62 The Health Board continues to hold committee meetings virtually, which are live streamed and recorded. Since May 2022, Board meetings have been held in-person. Whilst the Health Board planned to live stream and record all in-person Board meetings from November 2022 to maintain public transparency and

accessibility, this did not occur. The Health Board is continuing to explore how best to facilitate hybrid meetings and is hoping to have a solution by March 2023.

63 We found that upcoming Board and committee meetings are signposted on social media monthly as recommended in last year's structured assessment (see **Exhibit 3, 2021 Recommendation 1e**). However, to further enhance public awareness and engagement, the Health Board should post more frequent reminders closer to meeting dates and provide links to papers (**Recommendation 3a**).

64 The Health Board continues to publish agendas and papers for Board and committee meetings on its website in advance of meetings in line with its publishing standards. Compliance with this standard continues to be good, however we found some gaps in advisory group papers[4] (**Recommendation 3b**). Items to be discussed in private sessions are now detailed on the agendas of all committee meetings as recommended in last year's structured assessment (see **Exhibit 3, 2021 Recommendation 1d**). To further enhance the transparency of Board and committee business, the Health Board should make abridged minutes of the private sessions available publicly (**Recommendation 3c**).

65 The Health Board's arrangements support the effective conduct of Board business. Its Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions are reviewed annually. They received Board approval in April 2022 following scrutiny by the Audit and Assurance Committee in February 2022. These documents, which govern the Health Board's business, are available on its website.

66 We routinely observe declarations of interest taken at the start of Board and committee meetings as a standing item on all agendas. The Audit and Assurance Committee also receives and reviews the Registers for Gifts and Hospitality and Declarations of Interest at each meeting. The Health Board now publishes Board declarations separately to that of all staff on its website as suggested in last year's structured assessment.

67 The Health Board's committee structure remains stable and largely unchanged, except for the Shaping Our Future Hospitals Committee. This was temporarily stood-down in July 2022 pending a response from Welsh Government on the Health Board's Outline Business Case for redeveloping the University Hospital of Wales. However, the large and varied remit of the Strategy and Delivery Committee is a concern (see paragraphs 112 and 122). The Health Board intends to review its committee structure to ensure it is fit for purpose in terms of providing adequate and effective oversight and assurance across the totality of Health Board business. It is essential that the Health Board considers the committee structure alongside its 10-year strategy refresh to ensure they are appropriately aligned to

[4] Our review of the website in November 2022 found the following Advisory Group papers were unavailable: Stakeholder Reference Group held in January 2022, and Local Partnership Forum held in December 2021. No papers were available for the Health Professionals Forum.

strategic objectives and maintain oversight of the programmes of work to meet them (**Recommendation 1**).

68 The Health Board has good arrangements in place for ensuing Terms of Reference, forward workplans, and Annual Reports are annually reviewed and approved by the Board and its committees. The Corporate Governance Team ensures the latest versions of these documents are available on the website, although it would be helpful to display the date the Terms of Reference were last reviewed and approved (**Recommendation 3d**). The Health Board has also updated committee membership details on its website as recommended in last year's structured assessment (see **Exhibit 3, 2021 Recommendation 1c**). As part of refreshing its 10-year strategy, the Health Board should ensure Board and committee Terms of Reference reflect current strategic objectives and that the updated BAF is used to shape workplans (**Recommendation 1**).

69 The Board has a stable cohort of Independent Members, although the member for universities is due to stand down in December 2022. The recruitment process for his replacement is underway. The Executive Team has experienced several changes during the year. These include the appointment of a new Chief Executive, a new Executive Medical Director, a new Executive Director of Nursing, and a new Chief Operating Officer who started in February 2022, October 2021, July 2022, and August 2022 respectively. The Health Board managed these changes well by providing appropriate interim cover to maintain Board stability and continuity whilst substantive appointments were made. Board members continue to have a healthy relationship, with Independent Members offering a good balance of scrutiny, challenge, and support to Executive Members.

70 Our observations found that Board and committee meetings are generally well chaired. All members and attendees continue to observe virtual meeting etiquette, thus ensuring meetings run smoothly. Chairs are also effective in using the instructions on cover papers to guide and summarise agenda items. Meeting agendas are appropriately planned, allowing good time for discussion. Meetings are well supported by the Corporate Governance Team.

71 There is also an effective approach for referring matters to another committee or to escalate them to the Board. Highlight reports prepared by committee chairs continue to be a key source of assurance. As suggested in last year's structured assessment, these now appear further up the Board agenda and feature under the items for review and assurance, thus ensuring that key risks identified by committees are considered at the start of every Board meeting.

72 Papers for Board and committee meetings are generally well written and clear, which are supported by concise cover reports highlighting key points for members to consider. Cover reports have been strengthened further as suggested in last year's structured assessment. However, some papers continue to be lengthy, narrative based, and operationally focussed. Furthermore, we have observed instances of officers speaking to a set of presentation slides which have not been shared in advance. As a result, members have no opportunities to fully prepare for

these items beforehand. Where possible, the Health Board, should aim to circulate presentations in advance of meetings and / or make copies available to members and the public (via the website) as soon as possible afterwards (**Recommendation 3e**).

73 The Health Board continues to show good commitment to continuous improvement. In April 2022, the Board and its committees undertook annual effectiveness reviews in time to feed into its Annual Governance Statement. In May 2022, the Audit and Assurance Committee received the largely positive findings of the 2021-22 surveys and the resulting action plan. The Health Board has recognised that its method for conducting the effectiveness surveys could be more effective. As a result, the 2022-23 reviews will take the form of facilitated discussions which will provide deeper and richer feedback.

74 Board member development is well supported through the Health Board's programme of Board Development Sessions which take place every other month. Independent Members feel supported by the Chair who holds monthly meetings with members, conducts annual appraisals, and reviews members personal objectives, which they are encouraged to take ownership of. Additionally, there are opportunities for members to take part in coaching and mentoring schemes, attend training, and complete statutory and mandatory training modules.

75 The Health Board engages with staff and patients through various methods including staff surveys, monthly Board member patient safety walkarounds, its Freedom to Speak Up initiative and patient stories at Board and committee meetings. Whilst there are reasonable arrangements in place to capture patient experiences, our review of quality governance arrangements found that more work is needed to improve Board and committee oversight of patient stories.

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Recommendation 1 (2021) The Health Board has taken a number of positive steps to enhance public transparency of Board business since our 2020 structured assessment report. However, there is scope for the Health Board to strengthen public transparency further by:	
a ensuring all recordings of public Board meetings are uploaded to the Health Board's website in a timely manner after each meeting, and ensuring that links	**Complete** Board meeting recordings are up-to-date with live links. Recordings are available from July 2020 onwards.

Recommendation	Description of progress
to previous meetings remain active;	
b. making recordings of public committee meetings available on its website or publishing unconfirmed minutes of committee meetings as soon as possible afterwards;	**Complete** Committee meeting recordings are-up-to date. Recordings are available from January 2022 onwards.
c. updating the membership details of committees on the Health Board's website as soon as changes are approved;	**Complete** Committee membership details are up-to-date on the Health Board's website.
d. listing the matters to be discussed in private by committees on the agenda of their public meetings on an ongoing basis;	**Complete** Items to be discussed by committees in private are listed on the public agenda.
e. signpost the public to Board and committee papers and recordings of public Board meetings via the Health Board's social media channels on an ongoing basis; and	**In progress** Upcoming Board and committee meetings are signposted on Facebook on a monthly basis with links to the papers, but the Health Board could post more frequently and closer to meeting dates.
f. ensuring counter-fraud and procurement papers are considered by the Audit and Assurance Committee in public, with only sensitive matters reserved for private meetings.	**Complete** We have observed the Audit and Assurance Committee consider detailed counter-fraud and procurement papers in public.

Organisational design

76 We considered the extent to which the Health Board's organisational structure supports effective governance. In examining this, we have looked at whether:

- the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work;
- there is clarity on the role of the Board Secretary, and there are adequate resources in place to support the work of the Board and its committees; and
- the organisational structure supports effective governance and facilitates whole-system working.

77 We found that **whilst the organisational structure remains stable and appropriate, it will need to be kept under constant review as the Health Board refreshes its long-term strategy, and rolls-out new clinical and workforce models.**

78 The Health Board has a stable organisational structure which has remained largely unchanged since our last structured assessment. Whilst the current structure appears to be fit-for-purpose, it should be kept under review as the Health Board refreshes its 10-year strategy and rolls-out new clinical and workforce models.

79 In September 2022, the Board reviewed and approved its top-level executive structure for the first time in line with the organisation's Standing Orders. The Board also reviewed and approved the portfolios of Executive Directors, taking advantage of the opportunity to clarify roles as the new executive team settle-in. We found no concerns about the balance and equity of executive portfolios.

80 The Health Board has taken steps to strengthen its decision making structures. In September 2022, the Health Services Management Board was stood-down and replaced with a Senior Leadership Board, which met for the first time in September 2022. The Senior Leadership Board focusses on key operational and strategic risks and issues within the organisation. It comprises two groups:

- an Accountable Group, which is made up of the Executive Team and Clinical Board Directors and meets twice a month; and
- a Supporting Group, which is made up of the Accountable Group and Clinical Board Triumvirates and meets on a quarterly basis.

81 The Executive Team will continue to meet separately, but in an informal capacity. Whilst these arrangements appear positive, it is too early for us to comment on their effectiveness.

82 The Health Board has an effective, well-resourced Corporate Governance Team. Roles and remits within the team are clear and its members are proactive about improving and maturing the Health Board's governance arrangements. However, the Director of Corporate Governance / Board Secretary will be leaving the Health Board in February 2023. Interim arrangements to cover aspects of the role will be put in place whilst the Health Board seeks to appointment a replacement.

Managing financial resources

83 In this section of the report, we provide our views on the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

84 We found that **there are reasonably appropriate arrangements in place to support financial planning, management, and control. Whilst finances are well scrutinised, improving its longer-term financial position must remain a key priority.**

Financial objectives

85 We considered the extent to which the Health Board has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Health Board:

- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
- has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.

86 We found that **whilst the Health Board achieved its financial duties for 2021-22, it risks not breaking-even at the end of 2022-23 due to growing cost pressures.**

87 At the end of 2021-22, the Health Board met both its financial duty to operate within its annual revenue resource limit and within its cumulative resource limit for a three-year rolling period[5], achieving small surpluses of £232,000 and £380,000 respectively. This is the first time the Health Board has achieved these statutory duties. The Health Board also met its 2021-22 financial duty to break-even against its annual and three-year rolling capital resource limit, with surpluses of £41,000 and £234,000 respectively. However, as it failed to meet its 2021-22 savings target by £4.4 million, the Health Board started the 2022-23 financial year with a reported accumulated underlying deficit of £29.7 million.

88 At Month 7 2022-23, the Health Board reported a £15.4 million overspend against its core financial plan, £9.9 million of which was part of its agreed £17.1 million planned deficit. The remaining £5.4 million is unplanned operational overspends relating to increasing demand on services and limited resources in the social care sector to support the timely discharge of patients. These challenges, coupled with

[5] Health Boards and NHS Trusts are required to breakeven over a three-year rolling period.

other cost pressures (such as increased cost of energy, food, and medicine), is creating a difficult financial and operational environment.

89 The Health Board is working on the assumption that some exceptional costs, such as COVID-19 expenditure and inflationary increases will be funded by Welsh Government. However, given the scale of the challenges and the Month 7 financial position, there is a risk it will not meet its 2022-23 financial duties to break-even. To manage its financial challenges, the Health Board has now placed an increased focus on financial forecasts, remedial actions, and cost savings at Clinical Board Executive Performance Review meetings. Given the scale of these challenges, it is too early to judge the effectiveness and impact of these arrangements.

90 The Health Board is likely to spend within its 2022-23 capital resource limit. At Month 7, it had spent 34% of its £43.8 million capital budget, but this does not account for orders already in place which will show as spend in subsequent months.

91 The financial planning process, which is an integral part of the Health Board's IMTP planning process, considers its funding allocation, any additional funding (e.g. for COVID-19 expenditure), cost pressures, and the savings full-year effect. However, despite this, it has not been able to prepare a financially balanced plan for 2022-25, thereby failing its duty to have a balanced and approvable IMTP. The process of refreshing the Health Board's 10-year strategy presents an opportunity for long-term financial planning, which should consider its ambitions for the future (**Recommendation 1**).

92 The Health Board has taken a pragmatic approach to setting savings targets. Whilst the targets are challenging, it is aware of the need not to make them unattainable. The savings target for 2022-23 was originally the same as last year, at £16 million, broken down as £4 million non-recurrent and £12 million recurrent. However, to help it further reduce the underlying deficit, the Health Board reviewed and resubmitted its financial plan to Welsh Government in June 2022. It now includes an additional £3.7 million recurrent savings target, meaning the total savings target for 2022-23 is now £19.4 million.

93 At Month 7, the Health Board reported saving schemes totalling £17.4 million against the £19.4 million target, leaving a gap of £1.9 million to bridge in the final 5 months of the year. If it does not deliver its savings plan in full, particularly its recurrent savings, there is a risk that any undelivered recurrent savings will add to the Health Board's underlying deficit for 2023-24, and prevent it from delivering a balanced financial plan next year. As such, it is imperative that the Health Board increases its focus on delivering recurrent financial savings and addressing growing cost pressures as early in the financial year as possible.

Financial controls

94 We considered the extent to which the Health Board has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:

- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation;
- the Audit and Assurance Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- there are effective financial management arrangements in place; and
- financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.

95 We found that **the Health Board is improving its arrangements for financial management and controls.**

96 The Audit and Assurance Committee continues to receive regular assurance reports on financial controls. The Health Board has also taken positive steps to enhance public transparency of some financial controls, with the committee now considering counter fraud and procurement papers in public as recommended in last year's structured assessment (see **Exhibit 3, 2021 Recommendation 1f**).

97 The committee continues to receive the losses and special payments report every six months. However, the update is sometimes considered in public and other times in private. Whilst we accept that there might be times the report needs to be considered in the private session, public papers need to clearly explain why (**Recommendation 3f**).

98 Last year, the Health Board identified procurement breaches on some capital expenditure projects caused by poor procurement practices and weak internal controls. Since then, the Health Board has taken positive steps to review and strengthen its internal governance controls and arrangements in respect of capital schemes and expenditure by exploring the use of software to better manage sign-off processes, reviewing delegated limits, and clarifying the role of groups responsible for reviewing business cases. An Internal Audit of the Health Board's procurement process is planned.

99 In May 2022, Internal Audit completed a review of core financial systems, specifically the general ledger and accounts receivable. This received substantial assurance. Given the Health Board's previous levels of high assurance on core financial systems, Internal Audit cover individual areas on a cyclical basis.

100 The Health Board submitted its draft Financial Statements within the required timescales, which were considered by the Audit and Assurance Committee and the Board in June 2022. We issued an unqualified audit opinion on the 2021-22

Financial Statements, except for the regularity opinion, for which we issued a qualified opinion[6].

Monitoring and reporting arrangements

101 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:

- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
- Board members sufficiently challenge ongoing assessments of the financial position.

102 We found that **financial reports are clear and open about financial challenges and risks and are regularly scrutinised by the Finance Committee.**

103 The monthly Finance Committee continues to operate effectively. It is well chaired and financial reports receive robust scrutiny. The Board receives assurances through the Finance Committee chair's report and the committee's minutes.

104 Monthly finance reports are clear and provide an open and honest reflection of the Health Board's financial challenges. The reports contain a good breadth of information and are accompanied by detailed appendices should members require more information. The finance risk register is incorporated into the finance report, ensuring that risks are not considered in isolation.

105 Whilst the Finance Committee works well, there are opportunities to review its remit as part of the wider committee review to better align and integrate oversight of financial and operational performance and risks.

Managing the workforce, digital resources, the estate, and other physical assets

106 In this section of the report, we provide our high-level views on the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing (please note we will be undertaking a separate review of the organisation's workforce planning arrangements);
- arrangements for managing its digital resources; and

[6] This year, the Auditor General qualified his regularity opinion at eight of eleven NHS bodies due to the accounts including expenditure and funding in respect of clinicians' pension tax liabilities.

- arrangements for managing its estate and other physical assets.

107 We found that **whilst there is good Board-level oversight of matters relating to the workforce and digital resources, there is scope to increase the Board's focus on matters relating to the current estate and physical assets.**

Supporting staff well-being

108 We considered the extent to which the Health Board has appropriate and effective arrangements in place for supporting staff well-being. In examining this, we have looked at whether:

- mechanisms to seek staff views about their well-being needs are effective, and appropriate action is taken to respond to findings; and
- actions to support and improve staff well-being are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff wellbeing during the COVID-19 pandemic[7].

109 We found that **whilst there is good Board-level oversight of staff well-being support arrangements, the Board should seek greater assurances they are making a positive difference.**

110 The Health Board is committed to staff well-being and in January 2022, the Board approved the People and Culture Plan. Whilst an "engaged, motivated and healthy workforce" is one of the plan's seven themes, staff well-being underpins every theme. It is also in the process of developing a Well-being Strategy and Framework.

111 In November 2022, the Audit and Assurance Committee received a progress report on the Health Board's progress in addressing the recommendations of our Taking Care of the Carers? report. Whilst all six recommendations are partially complete, officers highlighted a range of positive activities designed to enhance staff well-being including:

- refurbishing over 30 staff rooms;
- delivering management and development programmes focusing on compassionate leadership; and
- well-being programmes designed for priorities areas such as emergency unit staff.

Listening to staff is also an important part of well-being and the Health Board has a range of mechanisms in place to gauge how staff are feeling, including staff surveys, staff networks, well-being conversations as part of values-based appraisal and regular 121 meetings. However, the Board receives little assurance on the impact of staff well-being initiatives. The Health Board recognises this and is in the

[7] Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

process of developing a way of effectively measuring and reporting the impact of well-being activities.

112 The Strategy and Delivery Committee routinely scrutinises workforce matters through updates on the People and Culture Plan, key workforce metrics, and scrutiny of the BAF workforce risk. The committee also receives deep-dive reports on specific topics such as values based appraisal and the staff well-being plan. However, due to the broad remit of the committee, these reports tend to be ad-hoc in nature. As a result, members have limited opportunities to maintain ongoing oversight of matters such as staff well-being which, in turn, leads to limited assurances to the Board. The review of committee structures creates the opportunity to establish a dedicated People Committee where, once approved, the Well-being Strategy and Framework can receive regular and detailed oversight.

Managing digital resources

113 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:

- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
- benefits arising from investments in digital technology are actively monitored by the Board.

114 We found that **whilst there are good arrangements for Board-level oversight of digital matters, a lack of detailed plans, funding and staffing challenges are hampering the Health Board's pace in implementing its digital priorities.**

115 The Board approved the Health Board's five-year Digital Strategy in September 2020. It sets out how digital technology will enable the transformation of clinical services to meet the ambitions described in the 10-year strategy. The Digital Strategy was recently refreshed to ensure it is still meeting the needs of the organisation.

116 In October 2022, Internal Audit issued a reasonable assurance report on the Health Board's digital strategy. It found that the strategy, which has been kept up-to-date, is appropriate and reflects the Health Board's objectives and transformation agenda. The Health Board is working to better define its Digital Road Map which currently lacks detail. The review found that digital is a key priority, but there is a funding and resource gap for delivering it. The Corporate Risk Register presented to the Digital and Health Intelligence Committee appropriately reflects this risk and details actions being taken to mitigate it. Actions include undertaking a staff gap analysis and investments bids submitted to the Business Case Assessment Group. Unfunded business cases are being reviewed and built into the Health Board's long-term financial modelling.

117 The Digital and Health Intelligence Committee is responsible for overseeing the development and delivery of the Digital Strategy. Internal Audit found that whilst oversight arrangements are clear and well established, the committee might not receive assurance on the totality of digital activities. This is because Clinical Boards have the autonomy to pursue their own digital projects, but there is little Clinical Board representation at the committee. It is also unclear whether the Clinical Boards digital projects are in line with the digital strategy.

118 Internal Audit's review also found that operational groups responsible for managing the digital programme and decision making are not meeting frequently. This again suggests that the right information might not be filtering up to the committee. Internal Audit made five medium priority recommendations.

Managing the estate and other physical assets

119 We considered the extent to which the Health Board has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

120 We found that **whilst the Health Board has increased its strategic focus on the future configuration of the estate, there is insufficient Board-level visibility of the condition of the existing estate.**

121 In August 2022, we completed a follow-up of our 2017 Review of Estates. We found that the Health Board does not have an estate strategy, but work has commenced to develop one, which will be linked to the Health Board's refreshed 10-year strategy and capital plan. Since our 2017 review, there have been structural and process changes to enable more effective estate service delivery. However, we found that local and national workforce shortages and pay differentials present significant and immediate risks to maintaining a safe and effective service. In the longer-term, this presents potential risks to the Health Board's ability to sustain its existing estate whilst it delivers its programme of replacement and redevelopment.

122 We also found that whilst the Health Board has increased its strategic focus on the future estate, there is a lack of Board-level visibility of the condition of the existing estate. The Health Board has an aging estate, which poses a potential risk to staff and patient safety if it is not adequately maintained. The Health Board's risk adjusted cost for backlog maintenance in 2021-22 was £114,835,323, of which

£75,204,780 relates to the University Hospital of Wales. Corporate risks related to capital assets are scrutinised by the Strategy and Delivery Committee, but as stated in paragraphs 67 and 112, the remit of the committee is too board to allow for regular and sustained oversight. In November 2022, of the 16 risks assigned to the committee, eight related to capital assets all with current risk scores of 20, although one of the risk scores was omitted. The current scores are the same as the initial scores which suggests the mitigating actions the Health Board is taking are not yet effective.

123 The Health Board should seek to address this through its review of committee structures, ensuring there is appropriate oversight of estate related matters such as the condition of the current estate, future developments and planning and delivery of the estate strategy (**Recommendation 1**).

Appendix 1

Audit approach

Exhibit 4: sets out the approach we adopted for delivering our structured assessment work at the Health Board.

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following Committees: • Audit and Assurance Committee; • Quality, Safety and Experience Committee; • Strategy and Delivery Committee; • Finance Committee; • Health and Safety Committee; • Mental Health Legislation and Mental Capacity Act Committee; and • Digital Health Intelligence Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes;

Element of audit approach	Description
	• Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Reports, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following: • Chair of the Board; • Chief Executive; • Executive Medical Director; • Executive Director of Finance; • Executive Director of Strategic Planning; • Interim Chief Operating Officer; • Director of Corporate Governance;

Element of audit approach	Description
	• Vice Chair of the Board; • Chair of the Audit and Assurance Committee; • Chair of the Quality Safety and Experience Committee; • Chair of the Strategy and Delivery Committee; • Chair of the Finance Committee; • Head of Corporate Governance; and • Head of Risk.

Appendix 2

Management response to audit recommendations

Exhibit 5: management response

Recommendation	Management response	Completion date	Responsible officer
Strategic alignment of processes, structures, and resources R1 The Health Board plans to refresh its 10-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements to ensure they are fully aligned to the organisation's refreshed strategic objectives and	Agree the work in relation to the **Committee Structures** is in hand and the new Committees and other changes to the Committee Structures will be established for the new financial year after approval at the Board at the end of March 2023 The **Board Assurance Framework** currently reflects the risks to the achievement of the Strategic Objectives of the organisation and once the Strategy refresh is complete the BAF will be reviewed to ensure alignment to the Strategic Objectives.	March 2023 September 2023	Director of Corporate Governance Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
associated risks, with a particular focus on its: • Board Assurance Framework; • Performance Management Framework; • Committee structures, terms of reference, and workplans; and – Long-term financial plan.	**Performance Management Framework** – This was presented to S&D Committee in 2020 and there is a need to update this document in line with the refreshed Strategy and revised Committee Structure. **Long Term Financial Plan** – The strategy refresh will be supported by the development of a long-term financial model which will build from the current resource position and show how financially the health board will deliver the strategy within its financial allocation. This will show the strategic investments and how they will be afforded over the strategic timeframe for example, public health, estates and digital strategy	September 2023 September 2023	Director of Digital Health Intelligence Executive Director of Finance
Enhancing the Integrated Performance Report R2 The Integrated Performance Report provides a good overview of the Health Board's performance. However, details of the actions being taken to sustain or improve performance that falls below target appears in some sections of the report but not others. The Health	Accepted. The Integrated Performance Report is being reviewed and will be refreshed to provide a clear overview of performance with the ability to drill down into more detail where appropriate. The format is likely to change to reflect the recommendation and to provide the Board with a more comprehensive report.	Draft to be shared by 31/03/23	Director of Digital Health Intelligence

Recommendation	Management response	Completion date	Responsible officer
Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance.			
Enhancing administrative governance arrangements further R3 Whilst the Health Board has good arrangements in place for conducting Board and committee business effectively and transparently, opportunities exist to enhance these arrangements further. The Health Board, therefore, should: a) Post more frequent reminders about Board and committee	a) We worked with our Communications department last year to issue tweets and reminders to the public via the Health Board's social media platforms. At the moment, our Communications team issues a monthly post/tweet at the beginning of the month which sets out the details of the Board and Committee meetings due to take place that month. The concern raised by our Communications team was that the public may not interact if we issue frequent posts during the month with regards to its Board/Committee meetings, and if that happens it could harm the Health Board's	End of February 2023	Director of Corporate Governance / Head of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
meetings on social media and provide links to papers; b) Ensure the papers for all Advisory Group meetings are published on the Health Board's website in a timely manner; c) Make abridged minutes of private Board and committee meetings available publicly as soon as possible after each meeting; d) Ensure the dates Terms of Reference were last reviewed and approved are clearly displayed on the documents; e) Circulate presentations in advance of meetings or, where this is not possible, make copies available to members and the public (via the website) as soon as possible afterwards; and f) Ensure public papers include an explanation as to why some	accounts/social media "overall reach". We will have a further conversation with our Communications team to see if it is feasible to issue more frequent reminders via our social media platforms. b) Noted. The Corporate Governance team will work with our colleagues to ensure that the papers for the advisory groups are published on the Health Board's website in a timely manner and to ensure that the website page is up to date with regards to the Advisory Group's meeting dates. c) Noted. We will attend to this straightway. d) Noted. We will ensure that the dates on which the Committees' Terms of Reference were reviewed and approved are clearly shown on the cover sheet of the document. e) As far as possible, we publish copies of presentations in advance of the meetings. Where the presentation slides have not been made available before the meeting, we endeavour to	End of January 2023 January 2023 March 2023 January 2023	

Recommendation	Management response	Completion date	Responsible officer
matters are being discussed in private rather than in public.	publish copies of the same as soon as possible after the meeting. We will strengthen our processes in relation to this to ensure appropriate publication of the presentations. f) Noted. Going forward, we will insert some appropriate wording in the Public agenda to explain why certain items are being referred to our Private Board/Committees.	January 2023	

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

Report Title:	Declarations of Interest, Gifts and Hospitality Tracking Report			Agenda Item no.	7.3
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	07.02.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

As required by the Audit and Assurance Committee ("the Committee") an update on Declarations of Interest, Gifts, Hospitality and Sponsorship will be provided at each Committee meeting for noting and approval of the approach taken by the Corporate Governance Directorate.

Since November 2021 the procedure for Declarations of Interest has required employees to make a single declaration of interest during their period of employment, only altering it if their circumstances change (for example undertaking secondary employment). The procedure for declarations of Gifts, Hospitality and Sponsorship has remained unaltered and staff are required to make relevant declarations on an 'as required' basis.

The Risk and Regulation Team have worked with Corporate Communications to design and implement a Communication Plan that informs staff members of the following:

- The requirement to now submit a declaration of interest once. But, reinforcing the requirement to update if personal circumstances change.
- That Declarations of Interest should now only be made on ESR, and signposting to User and Manager guides.
- The continuing need to declare Gifts, Hospitality and Sponsorship with specific emphasis being given in Autumn (for Autumn International Rugby Tickets) and Christmas/New Year (for seasonal gifts).

In addition to this plan the Risk and Regulation Team and the Health Board's ESR lead have delivered a 'Declarations of Interest Power Hour' and will continue to deliver further sessions to provide guided examples of how to make use of ESR to declare interests and also to answer queries raised by those in attendance. Similar sessions will be delivered throughout the year and in between sessions a recording of the meeting is available online for all staff.

It is hoped that the number of declarations returned will increase significantly by enhancing visibility of the process, and the ease by which declarations can be recorded via ESR.

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

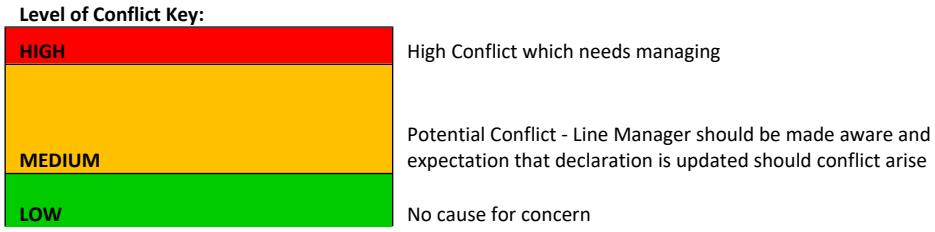
At the November 2022 Committee meeting it was agreed that the Health Board would use ESR as the sole method for the recording of Declarations of Interest, Gifts and Hospitality.

Following the November 2022 Committee additional software was procured to assist with the analysis of data held with ESR and, for the first time, an accurate Register has been able to be populated utilising the live staff information held within the ESR system.

As of the 12th January 2023 ESR holds the following records:

- 234 Declarations of Interests, Gifts, Hospitality and Sponsorship
- 619 entries recording 'No Interest' be declared.

The Declarations of Interests, Gifts, Hospitality and Sponsorship forms received are RAG rated by the Corporate Governance Officer to ensure appropriate action and monitoring. The RAG rating system is as follows:



- 97.9% of Declarations received are rated **Green** (230 Declarations).
- 1.7% of Declarations received are rated **Orange** (4 Declarations).
- 0.4% of Declarations are rated **Red** (1 Declaration)**.**

ESR currently holds 21569 live staff records which includes contracted employees, Locum and Bank Staff members.

This equates to a return rate of 4% for all staff currently recorded as operational within ESR. It is appreciated that this figure will need to improve.

The first step to improving the Health Board's return rate is for a Health Board wide email to be circulated to all live email accounts requesting that ESR submissions are submitted by all staff. This email will be circulated within the first two weeks of February 2022. Previous communications have focused on staff at Band 8A and above, which accounts for less than 10% of the Health Board workforce. It is anticipated that the vast majority of staff will have no interest to declare but we are, with the data available, unable to confirm this.

Following circulation of the aforementioned email the below additional action will be taken.

1) A daily ESR Banner update advising **ALL** staff of the requirement to declare interests via ESR. This will replace the current banner which only requests declarations from Staff Members of Band 8A and above.
2) A rolling Screen Saver to advise all staff of the requirement to declare interests via ESR.
3) Additional reminders and communications inline with the Communications Plan already established.

In the meantime a register of all interests can be found at the following link (which will need to be copied and pasted into a web browser to access): https://cavuhb.nhs.wales/about-us/governance-and-assurance/register-of-interests-gifts-and-hospitality/

Recommendation:

The Committee are requested to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour
- **NOTE** the proposals to improve Declaration of Interest reporting across the Health Board.

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x

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

Risk: Yes

There is a risk that non-declaration of an interest by staff members could result in breaches of legal and/or regulatory requirements, specifically in a procurement context. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No

N/A

Reputational: Yes

Should staff members fail to comply with the Health Board's Standards of Behaviour Policy and examples of this are made public, there is a possibility that this could have an adverse reputational impact on the Health Board and its staff body. The ongoing management and development of the Health Board's Standards of Behaviour Policy and associated procedures mitigates this risk by ensuring that staff members are aware of their obligations in this regard.

Socio Economic: Yes/No

N/A

Equality and Health: Yes/No

N/A

Decarbonisation: Yes/No
N/A

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

Level of Risk Score 1 (Low) Score 2 (Med) Score 3 (High)	Name	Job title/Role	Category of interest	Interest situation	Interest Description	Comments	From	To (Leave blank if ongoing)
1	Adams, Miss Lisa Marie	Physiotherapist	Financial interests	Clinical private practice	I work one evening a week in a private Msk physiotherapy clinic	Ongoing work	06/04/2017	08/04/2022
1	Addy, Dr Charlotte Louise	Consultant	Financial interests	Sponsored events	Support for educational lectures/activities from Gilead/Chiesi		11/03/2022	
1	Agarwala, Ms. Emma Caroline	High Intensity Therapist	Financial interests	Outside employment	I work a couple of hours per week for Canopi offering CBT to social and health service staff. I offer some private EMDR supervision to staff working in England I have previously (and may in future) work for Dr Julian offering private therapy and sub-contracted services to IAPT.		11/10/2022	10/10/2023
1	Ahuja, Mr. Sashin	Consultant	Financial interests	Sponsored events	Chaired Scientific Advisory Board Meeting for Cerapaedics Ltd	Chaired a clinical advisory group meeting for Cerapaedics Ltd on osteobiologics.	11/09/2020	11/09/2020
1	Alden, Dr Katrin	Specialty Doctor	Financial interests	Outside employment	I create an deliver training for Atrainability, a medical training company in my own time.	This was declared using the paper form at the tine I started the work and now transferred into esr.	03/08/2022	
1	Allen, Mrs. Kathryn Louise (Louise)	Pharmacist	Non-financial personal interests	Shareholdings and other ownership interests	Directorship of Davies Homes Ltd	Ongoing to date silent director of family building business no financial gain, non NHS	01/01/2010	17/11/2021
1	Allen-Ridge, Mr. Callum Charles	Senior Manager	Indirect interests	Outside employment	Bank Work for North Bristol NHS Trust	I am registered to work for North Bristol NHS Trust for both clinical bank work and also consultancy work around performance management and quality improvement.	25/06/2018	
1	Al-Rajoodi, Ms. Sheha Jameel Mohaisen	Chiropodist/Podiatrist	Non-financial professional interest	Clinical private practice	I work with Murray medical private practice. Currently still employed.		20/08/2019	14/10/2021
1	Anand, Dr Bawani	Consultant	Financial interests	Sponsored research	Astra Zeneca sponsored research in UHW . Performing tests out of hospital hours . Totally about 4-8 patients. Directorate and Consultant will receive renumeration for the study	It is a very small study .May last less than 1 year. Totally around 8 or less patients to be done 2 times 18 weeks apart	01/04/2022	31/03/2023
1	Ateleanu, Dr Bazil	Consultant	Financial interests	Clinical private practice	I have PP outside NHS in SpireHospital and Vale Clinic Cardiff and I intend to start in St. Joseph’s Hospital Newport.		06/03/2022	01/05/2027
1	Atkin, Dr Philip Alan	Consultant	Financial interests	Shareholdings and other ownership interests	I am a company director of Nuform Medical Aesthetics Ltd, a healthcare delivery company for aesthetic medicine, since Nov 2019 I am a complany director of Brynmill Ltd, a healthcare delivery complany for aesthetic medicine and orthodontic services, since March 2013		21/03/2022	21/03/2022
1	Atter, Mr. James David	Physiotherapist	Financial interests	Clinical private practice	I own my own private physiotherapy practice as a self employed practitioner. This involves running private clinics in Cyncoed Consulting Rooms and in iCare Clinics, Ely. I also under my private practice run injection clinics for GP practices. At present this is Llanishen Court Surgery and Practice of Health, Barry.		01/11/2021	
1	Attwell, Mrs. Julia Anne	Senior Manager	Financial interests	Outside employment	As a Non Executive Director with Linc Cymru Housing Association, I receive an annual payment.		01/03/2022	
1	Bailey, Mrs. Sarah Elizabeth	Dietitian Manager	Financial interests	Gifts	I wrote and article for the April 2022 edition of the Nutrition Digest magazine. £100 received for this. Money used to buy books for the dietetic department; not for personal use.		08/03/2022	08/03/2022
1	Baldwin, Mrs. Julie Ann (Ann)	Physiotherapist	Indirect interests	Clinical private practice	Husband works in private practice		01/05/2000	
1	Bales, Mr. Henry Edward Howard	Accountant	Non-financial personal interests	Outside employment	On a yearly basis I receive a contract to mark one set of examination papers for GCSE Mathematics with OCR Examination Board. The period that I have to mark these papers spans a number of weeks in the summer time (specific date varies year to year dependant on when the exam is sat) I complete this work outside of my contracted hours with the NHS (ie complete the marking in evenings and weekends).	I have informed the manager of the department and I am aware of my responsibilities.	30/05/2022	
1	Ball, Mr. Philip Edward	Staff Nurse	Financial interests	Sponsored events	I am member of Janssen sponsored All Wales Nurse Forum and this may attract a payment depending upon my contribution in the sessions		29/03/2022	
1	Banner, Mr. Timothy Elliott	Pharmacist	Non-financial personal interests	Outside employment	Wife works for Lloyds Pharmacy as Pharmacist manager in Gorseinon, Swansea.		01/08/2007	
1	Bartush, Mrs. Emma Louise	Manager	Non-financial personal interests	Hospitality	I have been Invited to West Quay Medical Practice Christmas party as this is where Iam based the cost of the party is £43.50		12/10/2022	12/10/2022
1	Beattie, Dr Robert Bryan (Bryan)	Consultant	Financial interests	Clinical private practice	Founder and Director of Innermost Secrets Limited trading as Innermost Healthcare (private clinical practice also including teaching presentation honorariums and medicolegal services). Ongoing Activity.	Items relating to Cardiff and Vale UHB to Note in 2021: - honorarium from Canon Medical (UHB supplier) for presentation at a CPD event (completed) - awarded a contract from Cardiff and Vale UHB through the formal contracting process for the provision of baby hip scanning services (yet to commence any service delivery)	01/01/2006	

1	Bennett, Mrs. Lorna Jayne	Senior Manager	Non-financial professional interest	Outside employment	I hold an honorary contract for out of hours / on-call work with Public Health		31/03/2022	
1	Beynon, Mrs. Claire	Senior Manager	Financial interests	Outside employment	I am employed on an ad hoc basis to teach for Cardiff University, Cardiff Metropolitan University, Swansea University, University of South Wales and the Faculty of Public Health. I am also an RAF reservist. I am paid for these additional duties. I hold an honorary contract with Public Health Wales to allow me to undertake on call duties. I may on occasion be paid to undertake additional shifts which are paid. I undertake roles for the Faculty of Public Health and may claim travel expenses to undertake these duties. My husband is a lecturer at Cardiff Metropolitan University.		30/12/2022	31/12/2027
1	Birdsey, Dr Nicola Emma-Louise (Nicki)	Applied Psychologist - Clinical	Financial interests	Outside employment	Occasional tutoring on a university psychology module - will be weekend or evening sessions outside of NHS working hours.		10/01/2022	
1	Bloodworth, Miss Charlotte	Specialist Nurse Practitioner	Non-financial professional interest	Sponsored events	Medical advisory group for Lymphoma Action charity		01/03/2018	
1	Bourne, Dr Michael William (Mike)	Consultant	Financial interests	Outside employment	Paid assessor for SWEDAC	No paid activity as yet undertaken.	01/01/2022	
1	Bowen, Dr Katharine Louise	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Private work for Hammet Street Consultants who offer psychological therapy to Higher Education in Wales trainees. Private work for Chris Kallis Solicitors based in Plymouth, England.		28/03/2022	
1	Boyd, Dr Jane	Applied Psychologist - Clinical	Indirect interests	Loyalty interests	Just a note re relatives/family also employed wiht C and V UHB. My son Dr Thomas Boyd now is employed by Cardiff and Vale UHB as an F1 Dr as from August 2022		14/01/2021	13/01/2022
1	Bradley, Dr Paul	Applied Psychologist - Neuropsychologist	Financial interests	Clinical private practice	I see clients for private psychotherapy.	This is ongoing. Appointments are limited and scheduled in the evenings or on weekends.	03/11/2022	
1	Brereton, Mrs. Emma Kate	Occupational Therapist	Non-financial professional interest	Clinical private practice	Employed as an Independent Occupational Therapist at Priory Mount Eveswell - Nursing home for Adults with Neurological impairment. I work one day a week in this capacity		02/03/2016	
1	Bridges, Mr. Carwyn Geraint	Physiotherapist	Indirect interests	Sponsored events	Attendance at an event where an honorarium was paid for my time. I was invited to provide an expert opinion outside of my normal clinical role. The event took place whilst I was on Anual Leave	Name Of the Company:- Insmed Ltd This was a one-off arrangement and no further work is currently planned.	04/02/2022	04/02/2022
1	Brooks, Mr. Francis Michael	Consultant	Financial interests	Clinical private practice	I wokr as a virtual specialist for Doctor Care anywhere. They are a virtual GP practice. My role is to review scans and advise what the best course of action is for that patient. I am on-call once a month for this and perform the reviews outside of NHS time. I am paid £40 per review.		01/01/2021	01/11/2023
1	Brooks, Mrs. Zoe Mary	Dietitian	Financial interests	Outside employment	Associate Tutor- Cardiff Met University- Adhoc work/zero hours contract		03/10/2022	03/10/2023
1	Broome, Miss Rachael	Senior Manager	Non-financial personal interests	Outside employment	My partner works in the Primary Care Team as a Band 6 and previously within the COVID-19 mass imms service.		03/11/2020	
1	Bruce, Mrs. Claire	Physiotherapist	Financial interests	Clinical private practice	I work for myself privately on the days I am not employed by the NHS	I completed a paper version of this declaration of interest in 2017	20/02/2017	
1	Bryant, Dr Catherine (Kate)	Consultant Healthcare Scientist;Specialist Healthcare Scientist	Financial interests	Clinical private practice	Private patient Doppler scanning at St Joseph's Hospital	still ongoing (as of 03/01/23)	14/07/2022	
1	Bulpin, Mr. Gareth Charles	Senior Manager	Non-financial professional interest	Hospitality	I have been invited to a dinner in the evening of 20th November 2022 at the St Davids Hotel Cardiff by Optometry Wales.	The invite is in recognition of the work myself and my Sharon Beatty (who has terminated her contract with the UHB) due to ill health.	20/11/2022	20/11/2022
1	Burgess, Mrs. Anna Christina	Pharmacist	Financial interests	Sponsored events	Lecture to Avon Learning Disabilities Education & Research Network	Honorarium paid for one-off lecture on excipients in antiepileptic medicines. Sponsored by Desitin Pharma.	26/05/2021	26/05/2021
1	Burnett, Ms. Judith	Staff Nurse	Indirect interests	Outside employment	I am currently on a 12 month secondment with HEIW for 30 hours per week.		04/10/2021	03/10/2022
1	Burrows, Mr. Ross Michael	Pharmacist	Non-financial professional interest	Sponsored events	Sponsored registration fees to attend European Society for Paediatric Endocrinology (ESPE) and British Society of Paediatric Endocrinology and Diabetes (BPSED) conferences. Funding was provided by Novo Nordisk. ESPE conference - 22/09/21 - 26/09/21 BSPED conference - 24/11/21 - 26/11/21 All virtual conferences - total cost of registration fees £181.40		14/03/2021	14/03/2022
1	Butterworth, Mrs. Claire	Physiotherapist	Non-financial professional interest	Clinical private practice	Outside of contracted working hours occasionally treat private patients with neurological conditions. Some of these patients may have been treated by CAVUHB or still be under there care. Patients are always directed to ACPIN private physio register to seek own choice physio and assurances are made that everyone is aware of, referred too and receiving the NHS care/rehab/ intervention that they should be if they choose. Communication with NHS providers is maintained and open and no conflict of interest is maintained.		05/04/2022	05/04/2030
1	Carr, Mr. Thomas Alexander	Occupational Therapist	Financial interests	Clinical private practice	Mindful Walks in the local community		01/01/2018	

1	Cawley, Mr. Scott	Chiropodist/Podiatrist	Financial interests	Sponsored events	attend a new virtual steering committee meeting on Podiatry-led atrial fibrillation (AF) detection among people with type 2 diabetes, which will take place on Friday 28th Jan from 2-6pm. The aim of the meeting is to develop and embed AF detection as a standard of care in the treatment and management of people with type 2 diabetes. The meeting is supported by Bristol Myers Squibb Pharmaceuticals (BMS) and will be chaired by Duncan Stang.	Contract signed from this date for meeting on the 28/01/2022, not sure of any follow up meetings at present	05/01/2021	
1	Chakraborty, Dr Arpita	Consultant	Financial interests	Clinical private practice	I undertake private assessments through Clinical Partners totally outside my working hours.		09/03/2022	09/03/2023
1	Chopra, Dr Iqroop Singh	Consultant	Financial interests	Clinical private practice	Practice both at Spire and Nuffield Vale hospitals		01/09/2008	
1	Chowdhury, Dr Mohammed Mahbub	Consultant	Financial interests	Clinical private practice	Director of private company Dr MMU Chowdhury Ltd		10/03/2022	10/03/2023
1	Christian, Dr Adam Donald	Consultant	Financial interests	Clinical private practice	I report/consult for external companies, this is generally through my own limited company, AC Pathology. This is usually reporting of backlog cases sent from NHS labs in England to a central hub for distribution. I use my NHS office and microscope for most of this work.	There is no conflict with my NHS work	01/10/2019	01/01/2024
1	Chung, Dr Yiu Fai Daniel (Daniel)	Consultant	Financial interests	Clinical private practice	I have practiced as an independent contractor at the Spire Cardiff Hospital since June 2019.	This practice is ongoing currently.	14/06/2019	
1	Clarke-Williams, Dr Jane Elizabeth	Specialty Doctor	Indirect interests	Clinical private practice	Menopause specialist working for Octavia Healthcare	Private patients for menopause advice- both over the phone and face-to-face Once or twice a month	01/07/2020	
1	Collins, Professor Peter William	Consultant	Financial interests	Outside employment	Advisory board meeting about postpartum haemorrhage with CSL Behring. Work performed during annual leave. Honorarium £1800		04/02/2021	05/02/2021
1	Connolly, Mr. Martin Peter	Specialist Nurse Practitioner	Non-financial professional interest	Loyalty interests	I am an unpaid member of the Board of Trustees of The Kent Autistic Trust who provided support to individuals on the autism spectrum in Kent.		09/10/2016	
1	Connor, Dr Philip Peter (Philip)	Consultant	Indirect interests	Sponsored events	Advisory Board for Clinigen	Annual return	23/03/2022	23/03/2022
1	Cook, Dr Sara-Catrin	Consultant	Financial interests	Outside employment	Associate Dean Simulation & Clinical Skills Health Education and Improvement Wales July 2020 to date		16/07/2020	
1	Cooke, Dr Emma Victoria	Multi Therapist Manager	Financial interests	Clinical private practice	My husband who is a physiotherapist within the service and I have a small private physio practice.		28/03/2022	31/03/2023
1	Coombs, Mr. Stephen John	Chiropodist/Podiatrist	Financial interests	Clinical private practice	private practice ongoing	ongoing private practice	01/10/2006	01/11/2022
1	Coulson, Dr James Michael	Consultant	Financial interests	Shareholdings and other ownership interests	Director and Shareholder of Medical, Scientific & Toxicology Consultancy Ltd.	I use this Limited Company for private practice, which for me is the production of medicolegal and scientific reports and other expert witness work.	01/04/2016	
1	Cousins, Dr Darren Everton	Consultant	Financial interests	Sponsored events	Sponsored registration to international Fast Track Cities 2022 conference. Free registration provided to Fast Track Cities Cardiff & Vale by conference organisers IAPAC. I am speaker at conference and so FTC C&V allow me to use their free registration in order to attend the conference and present Welsh specific findings.		11/10/2022	13/10/2022
1	Datta, Dr Dev Borunendra	Consultant	Financial interests	Clinical private practice	Clinical Private Practice via Spire Cardiff SLA with Spire Cardiff Laboratory		03/01/2011	
1	Davies, Mr. Gareth John	Specialist Healthcare Scientist	Financial interests	Shareholdings and other ownership interests	I am major shareholder and Director of a company called 'Penstone Property' which has never traded and has been dormant for > 3 years		28/11/2018	25/03/2022
1	Davies, Mr. Huw Owain Bleddyn	Consultant	Indirect interests	Clinical private practice	Private practice		31/05/2022	
1	Davies, Mr. Timothy John (Tim)	Senior Manager	Financial interests	Outside employment	Private Practice		05/09/2021	10/09/2021
1	Davies, Ms. Catherine Sarah (Catherine Washbrook)	Dietitian	Financial interests	Clinical private practice	Article written for Primary Care Diabetes Society journal/online in December 2021		23/03/2021	23/03/2022
1	Davies, Ms. Holly Adele	Applied Psychologist - Clinical	Financial interests	Clinical private practice	I undertake private practice as a Clinical Psychologist. I work as an associate practitioner through an organisation called Headwise.	Ongoing private practice	29/10/2021	
1	Davis, Dr Karl Robert	Consultant	Indirect interests;Non-financial personal interests	Loyalty interests	I am Vice Chair of Welsh BGS;I am a member of the BGS and Vice Chair of the Welsh sub-group of the BGS	I have given evidence and supported BGS submission to Welsh Govt;Ongoing role. Has included giving evidence to Welsh Government.	18/10/2022	
1	Doman, Ms. Catherine Louise (Cath Doman)	Senior Manager	Non-financial professional interest	Hospitality	Attendance at reception hosted by Q5 on 02.12.21	Attended for 45 minutes. 1 glass of wine accepted.	02/12/2021	
1	Donoghue, Miss Francine (Fran)	Technician	Financial interests	Outside employment	I work with a young adult who has Epilepsy in his own home. I work as a social care worker for a care company.	Does not interfere with my role in NHS, hours are worked outside my main occupation	08/04/2022	08/04/2022
1	Dowd, Miss Charlotte Louise	Dietitian	Financial interests	Gifts	Prize money £100 for presenting at WAGE conference 3rd place abstract (outside of working hours)		11/07/2022	11/07/2022
1	Drage, Mr. Nicholas	Consultant	Financial interests	Outside employment	Lecturing to dentists and dental care professionals on all aspects of dental radiology mainly for HEIW. Text book writing		20/09/2022	20/09/2023
1	Edwards, Dr Martin Oliver	Consultant	Financial interests	Outside employment	I work 2.5 sessions for HEIW as a deputy director for Secondary Care		01/04/2021	
1	Elliott, Dr Natalie Louise	Speech and Language Therapist Consultant	Indirect interests	Loyalty interests	Partner is an Executive at Taff Housing, Cardiff.		22/06/2021	

1	Eralil, Mr. George	Consultant	Indirect interests	Clinical private practice	Private Practice at Spire Cardiff Hospital and HMT Sancta Maria Hospital.		01/04/2022	31/03/2023
1	Evans, Dr Carol	Consultant Healthcare Scientist	Indirect interests	Sponsored research	I have applied to Abbott diagnostics for funding for a quality improvement project to distinguish between type 1 and type 2 diabetics. This is for kits to be provided for lab use. There is no personal financial gain This is with the legal team pending signature		21/04/2022	
1	Evans, Dr Caroline Rebecca	Consultant	Financial interests	Clinical private practice	~I cover 2 half days per month in Spire Hospital Cardiff Plastic surgery		11/03/2022	
1	Featherstone, Mr. Jonathan Mark (Jon)	Consultant	Financial interests	Clinical private practice	Private Practice at the Spire Hospital in Cardiff.	Ongoing	05/04/2021	
1	Fitzgerald, Dr Katherine Alexandra	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Temporary Associate Lecturing Contract - Cardiff Met University, Psychology Undergraduate Programme		29/09/2022	15/12/2022
1	Forster, Mr. Mark Campbell	Consultant	Financial interests	Clinical private practice	I run my private practice through my company Cardiff Knee Surgery Limited		07/03/2022	
1	Fowler, Mr. Aaron Martyn	Senior Manager	Indirect interests	Loyalty interests	My wife is employed by NWSSP Legal and Risk, who the Health Board contract for legal advice.		20/09/2021	19/09/2023
1	Fowler-Williamson, Mrs. Cerian Charlotte	Manager	Financial interests	Shareholdings and other ownership interests	Non executive director of a family limited company - Accelerate Freight Ltd Director of limited company - Fowler Consultancies Ltd - Public protection training, assessing and consultancy		27/05/2008	
1	Fox, Dr Joanna Catherine Oram	Consultant	Financial interests	Clinical private practice	I own my own aesthetics business, Dr Jo Aesthetics. It has no influence on my NHS work and is done in my own time. I am accredited by save face and have excellent reviews. Website www.drjoaesthetics.com		01/04/2021	01/04/2022
1	Fox, Mr. Adam Daniel	Chiropodist/Podiatrist	Financial interests	Outside employment	Clinical consultancy for Coloplast, 3 year contract and paid on a honorarium basis when requested days. These will be around 2 days a year for the 3 year period.		10/11/2021	
2	Gable, Mr. Scott	Manager	Non-financial personal interests	Shareholdings and other ownership interests	Board director LabXcell Limited		01/04/2020	
1	Gajraj, Dr Malcolm	Consultant	Indirect interests	Outside employment	HEIW role as Director of Quality Management (NHS) GMC: Enhanced Monitoring Associate (variable requirements, ad hoc payment)		10/03/2022	
1	Ganderton, Mrs. Claire	Pharmacist	Financial interests	Shareholdings and other ownership interests	I am listed as a Director in my husband's company, Llandough Medical Services Ltd.		11/09/2017	
1	Gatto, Dr Simona Renata (Simona)	Consultant	Financial interests	Outside employment	Roche Advisory Board partecipation		05/05/2021	28/05/2021
1	Gladwyn-Khan, Dr Misbah	Applied Psychologist - Clinical	Indirect interests	Clinical private practice	Private work in my free time.	No impact on NHS work and vice versa. In my free time. Declared when employment began.	05/10/2020	
1	Goldsmith, Dr Sarah Frances	Consultant	Non-financial professional interest	Sponsored research	I was the project manager for OBS Cymru, a postpartum haemorrhage QI initiative in Wales that received funding from Welsh Government, and our industry partner Werfen. This ran from 2017 to 19. I have also agreed to speak at two Werfen-sponsored meetings. At my request, all payments related to this are being transferred directly to MSF from Werfen without my involvement.		01/01/2017	04/03/2022
1	Goulding, Mrs. Vanessa Louise	Chiropodist/Podiatrist	Non-financial professional interest	Outside employment	Honorary lecturer for Cardiff University		01/01/2018	14/03/2024
1	Goyal, Dr Sumit MBE	Consultant	Financial interests	Clinical private practice	I am the director of Dr Goyal Ltd, a limited company related to my private practice	This post is current and ongoing	01/10/2014	

3	Gray, Professor Jonathon Robin	Non Executive Director	Financial interests;Indirect interests;Non-financial personal interests	Outside employment;Loyalty interests	Employed by Singapore as above - clear arrangement - I stop C&VUHB pay during 2 months. Global Healthcare advisor contracted only for work outside Wales with Q5. Unpaid leave/Annual leave taken. Billions Institute, Becton Dickinson, Strasys Ltd and CHi/Singapore;I formed a Limited Company in December 2021 called "Graymattrs", jointly with my wife Joanna Soldan. This is currently the route i am paid for for the work by Q5 - (November 2021) Becton Dickinson - (June 2021) Billions Institute - (March 2022) CHI/Singapore - January 2020) Strasys Ltd (October 2022) I anticipate using this company for any other advisory/consulting should they occur. I work up to 2 months a year in Singapore/Australia/New Zealand/U.S.A - contracted to deliver innovation work. I stop my contract with C&VUHB when I do this work I work a number of weeks - outside my NHS employment either in unpaid leave or in my own time/ holidays through my limited company Graymattrs. I have contracts with Q5 and Billions Institute (March 2022), along with occasional other work such as Becton Dickinson. I potentially could have work in Singapore in the future. I am careful to only take work with companies such as Q5, Billions Institute and Strasys Ltd that is outside Wales, to reduce any conflict of interest. I have declared such work, and I have also been transparent and discussed the approach with our Governance colleagues and with procurement. To be clear, I receive no financial benefit from contracts awarded in Wales. ;Maggies Centre and private work as mentioned above;Previous role as CEO of SWAHSN - a company limited by guarantee;Wife - as above - business;Wife owns private company delivering mindfulness/resilience training in public services.	With my wife we are joint Directors of Graymattrs Ltd. Brother-in-law is a Director of a private consultancy NK Change Ltd.;Global Ambassador for Hillary Leadership Institute (New Zealand). Health Foundation/IHI Fellow. Member Institute of Directors. Fellow of Better Value Healthcare - Led by Professor Sir Muir Gray (Not a relative) Deputy Lead - Centre For Healthcare Innovation;Note my links to Singapore and previously Life Sciences Hub. I am a 'global ambassador" for Hillary Institute - non profit leadership group in New Zealand. I am visiting Fellow Green Templeton College, Oxford.;Trustee of Fathom Trust (Feb 2020 - present), a Charitable Incorporated Organisation - bringing together comunity assests to improve wellbeing of citizens. I have no financial benefit and do the work in my personal time. Previously a member of Maggies Clinical Board. Fellow at Better Value Healthcare, Visiting Chairs - Wellington (New Zealand), Exeter, Singapore. Adjunct Professor at the Health Services Research Centre, Faculty of Health at Victoria University of Wellington. Honorary Clinical Professor, University of Exeter Medical School and Cardiff University;Wife works as Clinical Psychologist for Maggies Cancer Charity - Velindre Signed off by CEO 24.10.22	03/11/2022	
1	Green, Mrs. Hilary Margaret	Counsellor	Financial interests	Clinical private practice	Paid work with charity Cardiff Mind for providing clinical supervision sessions on a monthly basis.		09/09/2022	
1	Griffin, Dr Sian Virginia	Consultant	Indirect interests	Outside employment	Chair, Data Monitoring Committee, Emmes Corp		17/11/2021	15/03/2022
1	Groves, Dr Peter Howard	Consultant	Financial interests	Clinical private practice	As a Consultant Cardiologist, I see private patients at Spire Hospital, Cardiff. My private income resides with Groves Cardiology Services Ltd of which I am a Director but not a shareholder. My wife, Dr Helen Groves is Director and Shareholder of Groves Cardiology Services Ltd		07/03/2011	22/03/2022
1	Hale, Miss Sarah Louise	Consultant	Indirect interests	Shareholdings and other ownership interests	Member of a LLP with the ability to carry out ophthalmic work outside the NHs	health board has always been informed	04/02/2006	04/02/2023
1	Hammer, Dr Kathrin	Consultant	Financial interests	Clinical private practice	Fee for service at European scanning centre Cardiff and Spire Hospital Cardiff for radiology work in the private sector	unchanged	28/09/2020	02/09/2024
1	Haq, Mrs. Yasmeen Elmore	Pharmacist	Non-financial personal interests	Loyalty interests	Sister works for Boots corporate community pharmacy one day a week after maternity leave	if work in community pharmacy or dealings with them need to bear this in mind	28/07/2021	
1	Harrall, Miss Joanna Eleanor	Senior Manager	Financial interests	Shareholdings and other ownership interests	My partner (Benjamin Trigg) works for Cyted, a start-up company providing cyto sponges to NHS organisations across the UK. The Cytosponge is being piloted in CAVHB. Ben has shares in the company.		09/08/2022	
1	Harris, Mrs. Abigail Indiana	Board Level Director	Non-financial professional interest	Outside employment	I am a non-executive board member of Social Care Wales. The daily rate for this is paid to the Health Board and I am able to fit the commitment into my working week. My husband is a volunteer board member of Wales Council for Voluntary Action.	Ongoing The 'situation' doesn't give a category that fits this.	07/03/2022	
1	Hayes, Mr. Jamie Michael	Pharmacist	Financial interests	Outside employment	I am Director of JMH Collaborations LTD - an executive coaching and leadership consultancy that provides coaching and leadership services to organisations in the private and public sector		30/04/2021	
1	Hayhurst, Miss Caroline Susan	Consultant	Financial interests	Sponsored posts	MSc Neurosurgery program leader for University of Buckingham, on behalf of Learna Ltd (an online education company). I receive payment on an ad hoc basis from Learna Ltd for development and marking of the international MSc course.		01/09/2021	31/08/2022
1	Hewett, Dr Rhys Anthony	Consultant	Financial interests	Hospitality	A drug company paid for me to go to a conference in 2019. A drug company have paid for me to attend a one day learning event in April 2022. nil else.		31/03/2022	
1	Hingston, Mrs. Emma Jane	Consultant	Non-financial professional interest	Loyalty interests	Trustee for LATCH, Children's Cancer Charity for Wales.		29/08/2013	04/03/2022
1	Hockey, Dr Thomas Daniel	Consultant	Financial interests	Clinical private practice	do coronial post mortems and report some cases of spire, outside nhs time	wife and i co directors of mtd diagnostics ltd- nothing to do with nhs.	14/03/2022	14/03/2022
1	Holder, Dr Kerry-Ann	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Consultancy fee for CSL Behring of £150. CSL Behring. CSL Behring is a biopharmaceutical company, manufacturing plasma-derived and recombinant therapeutic products. I am often asked to participate in focus groups, or advise on resources they are developing for Children and Adults with Inherited Bleeding Disorders. This advice and consultancy is undertaken in my own time and I take Annual Leave to participate	1 hour consultation with Researchers at CSL Behring	06/06/2022	06/06/2022

1	Hopes, Miss Rebecca	Senior Manager	Non-financial personal interests	Outside employment	In the email I received, it stated that volunteering is an interest to declare. I have chosen the most applicable category (although is not reflective). I have made an application to volunteer for the Cardiff and Vale Health Board in my own time. I have made an application to renew my volunteer status with Cardiff Dogs home.		03/03/2022	
1	Howells, Dr David Mark (Dave)	Consultant	Indirect interests	Outside employment	Trustee for Charity 'RESEC', UK wide Private Practice: Mental Health Clinical Assessments and Prescriptions for Cannabis Clinic Cardiff, at Cyncoed Consulting Rooms, Cardiff (in non-contracted time) Private Practice: 4 session Mental Health Clinical Assessments for Mamedica (in non-contracted time)		21/06/2022	
1	Humphry, Dr Nia Angharad	Consultant	Financial interests	Outside employment	Cardiff University employment 0.1 WTE	Started prior to current consultant post, long-term post	04/03/2022	
1	Hunt, Dr Jeannine Anne (Jenny)	Applied Psychologist - Clinical	Non-financial personal interests	Loyalty interests	I am married to Robert Kidd, who is the professional lead in the UHB for psychology, and as I am a psychologist in the UHB there are situations which could create a conflict of interest None of the above situations apply;My partner is Rob Kidd, who is the professional lead for psychology and psychological therapies in the UHB.		10/10/2022	20/03/2023
1	Hunt, Miss Andrea Louise	Counsellor	Non-financial professional interest	Clinical private practice	I am working for the Primary Care Counselling Service part time on Mondays and Wednesdays. I now have a small private practice on non NHS days. I am declaring this and it does not conflict with my role as a Primary Care Counsellor.		01/03/2022	
1	Ingleton, Ms. Louise	Staff Nurse	Non-financial professional interest	Sponsored events	ADHD Conference attended - organised by Flynnpharma Conference dates May 4th and 15th 2022 in Berlin. Flights and hotel financed by Flynnpharma. No personal financial ganin		14/05/2022	15/05/2022
1	Ingram Holden, Mrs. Bethan Sarah	Nurse Manager	Financial interests	Sponsored posts	Awarded Florence Nightengale Foundation Scholarship to value of £9,000 from Teenage Cancer Trust. Currently undertaking scholarship (approval from Chief Nurse), to complete at end of 2022		09/03/2022	31/12/2022
1	Ingram, Dr John Robert	Consultant	Financial interests	Loyalty interests	Consultant and/or advisory board member for Novartis, UCB, ChemoCentryx, Boehringer Ingelheim, Viela Bio, Insmed, Citryll and Kymera Therapeutics in the field of hidradenitis suppurativa	Honoraria.	01/01/2019	
1	Ingram, Dr Wendy	Consultant	Financial interests	Hospitality	Takeda sponsored attendance at virtual conference - American Society Haematology Annual Conference		11/12/2022	14/12/2022
1	Jelley, Dr Benjamin James (Ben)	Consultant	Financial interests	Outside employment	I have a substantive contract with Cardiff University for 1 session per week to deliver an MSc in Clinical Geriatrics		01/01/2019	
1	Jenkins, Mrs. Colette Elizabeth	Technician	Non-financial professional interest	Sponsored events	Welsh Pharmacy Awards 2022 Ethypharm Management of substance dependency in community.		07/09/2022	07/09/2022
1	John, Mrs. Kirsty Louise	Community Nurse;Staff Nurse	Financial interests	Outside employment	I currently make occasion cakes for family and friends		04/01/2022	
1	John, Mrs. Michaela Louise	Manager	Non-financial personal interests	Outside employment	I am a trustee for a charity THE MARGARET BELL SCHOOL (charity number - 1151747)	I do not receive any financial payment for this role	22/03/2022	
1	Jones, Dr Amy	Consultant	Non-financial professional interest	Outside employment	I am on the British Geriatrics Society Cardiovascular committee - a specialist interest group within the BGS. The BGS is a charity and professional organisation, I am not paid by them for my role. For our annual conference I attend the event free of charge as a member of the organising committee. We have a hybrid meeting in London in September 2022 so I will receive one night's accommodation free of charge too. The Cardiovascular group participated in the autumn meeting held in November 2021 by organising one day of the 3 day conference. I had an organising role and moderated a session. For this I attended the virtual 3 day conference free of charge.	Ongoing role within the committee which will continue for the foreseeable future	31/03/2021	08/03/2022
1	Jones, Dr Jane Elspeth	Consultant	Indirect interests	Shareholdings and other ownership interests	I am a Company Director in Luba Care - a company providing therapeutic children's residential home placement. The company is not yet trading		26/09/2022	25/09/2023
1	Jones, Dr Nia Jasmine Russal (Nia Jones)	Chiropodist/Podiatrist	Financial interests	Clinical private practice	Receives honoraria for speaking at wound care conferences, Employed by Toetal Footcare Private Clinic.		01/12/2021	
1	Jones, Dr Sharon Mary	Consultant	Financial interests	Clinical private practice	One evening private practice clinic- 2 to 4 clinics per month at Spire Cardiff	Continuing I try to ensure it does not in any way conflict with nhs work I cancelled the clinics when too busy in nhs	10/03/2022	
1	Jones, Miss Angharad	Technician	Non-financial professional interest	Sponsored events	Welsh Pharmacy awards 2022 Management of substance dependency in the community		07/09/2022	07/09/2022
1	Jones, Mr. Stephen Austin	Consultant	Financial interests	Clinical private practice	I perform private practice at the Nuffield Cardiff & Vale Hospital My scope of practice completely mirrors my NHS practice This is performed outside of my NHS timetable/job plan	On-going	29/03/2022	
1	Jones, Mrs. Amy Clare	Dietitian	Non-financial professional interest	Sponsored events	Nutricia have sponsored me to stay in a hotel the night before their conference in London	The conference is a free event to attend. My train fare has been paid by work.	11/02/2022	11/03/2022
1	Joshi, Dr Anurag	Consultant	Financial interests	Clinical private practice	Cases referred to AWLP from Spire Hospital Cardiff- I report these when these are allocated to me.	No active coronial work No crem form duties No regular private work	02/09/2021	02/09/2022
1	Kamath, Dr Sridhar	Consultant	Financial interests	Clinical private practice	I have private practising privileges at Spire Cardiff hospital Nuffield Cardiff hospital St Josephs hospital Newport European scanning centre Cardiff		18/03/2022	

1	Kell, Dr William Jonathan (Jonathan)	Consultant	Financial interests	Outside employment	Occasional paid work as clinical expert for select pharmaceutical companies, or for NICE. Less than £5k income pa.		03/03/2022	03/03/2022
1	Kent, Mr. Russell	Senior Manager	Financial interests	Hospitality	Attended the Hewlett Packard Discover "The edge-to-cloud" Conference 7th - 8th December 2022 This invitation includes transport costs and overnight accommodation . This came from Trustco PLC in conjunction with HPE Marketing.	Registered as Hospitality, although more related to learning and technology market research.	12/07/2022	12/08/2022
1	Ketchell, Mr. Robert Ian	Consultant	Financial interests	Clinical private practice	I am the Director of Ketchell Medical Limited I use this for my private practice based at the Spire Cardiff Hospital and also any medico-legal work that I carry out.		27/09/2022	
1	Kidd, Mr. Robert Thomas	Applied Psychologist - Clinical	Non-financial personal interests	Loyalty interests	my wife is a senior consultant in the uhb		27/09/2022	27/09/2023
1	Kinnaird, Dr Timothy David	Consultant	Financial interests	Gifts	Received a watch as a gift from a patient		16/03/2022	
1	Kirwan, Mrs. Caroline Rebecca	Counsellor	Financial interests	Clinical private practice	Intermittent private genetic counselling work linking with Innermost Healthcare.	Ongoing	01/03/2021	
1	Knapper, Dr Steven	Consultant	Financial interests	Outside employment	I have participated in advisory boards with Novartis, Astellas, Servier, Pfizer. Received honoraria from Novartis, Astellas. Support for conference attendance from Servier. Research funding from Novartis.		21/12/2021	
1	Knight, Mrs. Rhian Catherine	High Intensity Therapist	Financial interests	Outside employment	I am work occasionally as a radiographer at North Bristol Trust in order to maintain my HCPC registration. I am employed as a member of the bank team with NBT Extra at North Bristol NHS Trust.		23/02/2022	
1	Lea-Davies, Miss Mari Rhiannon	Pharmacist	Financial interests	Outside employment	Facilitated a training session run by HEIW for the foundation pharmacist programme on respiratory therapeutics.	2 hour session on 4/10/21 and 2 hour session on 5/10/21. Annual leave taken, and hence the training sessions were undertaken in my own time.	04/10/2021	05/10/2021
1	Leong, Dr Fong Tat	Consultant	Financial interests	Clinical private practice	Rhythmus Cordis Ltd.	I am a company director of the above. It is solely related to my clinical private practice.	28/06/2019	01/04/2023
1	Letchford, Dr Robert Howard (Rob)	Physiotherapist Consultant	Non-financial professional interest	Clinical private practice	I and my wife are Directors of Pobren well being PLC. this is a small scale lifestyle well being company that runs yoga, meditation session and well being retreats. We use some of our professional skills in delivering this small scale venture		08/03/2022	31/03/2023
1	Lewis, Dr Aled Gethin	Consultant	Indirect interests	Shareholdings and other ownership interests	My wife is joint owner/director in private physiotherapy company specialising in exercise/rehabilitation for Parkinson's disease. I have no direct interests in this company.		23/06/2021	06/10/2022
1	Lewis, Miss Rhiain Cerys	Staff Nurse	Financial interests	Outside employment	Employed as Associate Lecturer / Practice Tutor for Open University on BSc nursing programmes.		27/01/2020	
1	Liu, Dr Andrea Cze	Consultant	Financial interests	Clinical private practice	Teleradiology		21/01/2022	
1	Lodwick, Mr. Andrew John	Applied Psychologist - Clinical	Financial interests	Clinical private practice	I work in private practice as a cognitive therapist	My practice is ongoing	01/08/2013	03/03/2022
1	Logan, Mrs. Hazel	Senior Manager	Financial interests	Hospitality	Accepted accommodation and meals for the Excellence in Healthcare Conference in Daventry on Novemeber 23/24 2022		23/11/2022	24/11/2022
1	Long, Miss Rachel Ella	Senior Manager	Indirect interests	Outside employment	Sit as Magistrate on Cardiff Bench		27/04/2017	
1	Louch, Miss Rebecca Catherine	Assistant Psychologist	Indirect interests	Gifts	Gift given from patient to myself at end of therapy - 2 small bracelets, value not exceeding £20 Given as 'thank you' for input Line manager made aware	Gift given at end of session, no further involvement with patient planned as now discharged from service.	11/11/2022	11/11/2022
1	Loyal, Dr Alice Susannah	Applied Psychologist - Clinical	Indirect interests	Outside employment	I am a company secretary for my husband who is a self employed design engineer. I sign company documentation such as minutes. I hold a 7% share in the company. This does not impact on current role for CAVUHB in any way.		10/01/2021	
1	Ludlow, Mrs. Helen	Specialist Nurse Practitioner	Financial interests	Sponsored events	Sponsored by Pharma I have undertaken 2 advisory boards and planning meetings for a leadership course I will be helping to run in March. I have also been working monthly endoscopy sessions for the Insourcing lists	I am registered as also self-employed for my outside speaking /endoscopy engagements and tax/NI has been set aside for these payments and my books are up to date and available for scrutiny if required	30/09/2020	20/02/2022
1	Maggs, Mr. Roger Gwyn	Manager	Financial interests	Shareholdings and other ownership interests	Director of a private business out side of the NHS		07/03/2022	07/03/2022
1	Mahoney-Davies, Dr Gerwyn Alyn	Applied Psychologist - Clinical	Financial interests	Clinical private practice	I run a small private practice outside of NHS service	My policy is that I will see people who are eligible for CAMHS in Cardiff, but who aren't receiving clinical care from them. For example if someone is 15, depressed and living in Cardiff I will see them. If they get referred to CAMHS I will see them whilst they are waiting, but once they have their first appointment with CAMHS and are officially under their care I will not see them any longer. This is stated in my contract of service to them.	01/04/2019	28/08/2025
1	Main, Miss Claire Asmarina	Nurse Manager	Non-financial professional interest	Outside employment	I am an executive member of Association of Nephrology Nursing UK. I receive no remuneration for this and attend educational meetings that may be sponsored by companies but will be declared separately		21/09/2022	21/09/2023
1	Marin, Dr Aleksander	Consultant	Financial interests	Clinical private practice	1. Medica Teleradiology Speciality Advisor in Thoracic Radiology 2. Spire Hospital Cardiff Reporting Radiologist		20/06/2016	

1	McCarthy, Mr. Matthew	Lawyer	Financial interests	Outside employment	Bank work for Welsh Risk Pool (part of NWSSP) as a Safety and Learning Advisor		01/05/2020	
1	McCarthy, Mr. Michael John	Consultant	Indirect interests	Outside employment	I have an ad hoc educational contract with Globus Medical. I get paid to teach on courses once to twice a year teaching other doctors. I take annual leave during this time.	At present there are no defined dates / it is indefinite	05/03/2022	31/03/2023
1	McLean, Mrs. Annette Laura	Dietitian	Financial interests	Clinical private practice	Somek: medico legal ad hoc report work. Freelandce dietetic work: Ad hoc client work and eating disorders training (Knights absorb)	I do nots ee clients from Cardiff and Vale adult services that could otherwise access NHS services.	10/01/2022	
1	Meades, Dr Peter Caleb	Counsellor	Financial interests	Clinical private practice	a have a small private psychotherapy practice seeing a few private clients in the late evenings.		28/09/2020	
1	Miles, Dr Tamsin Louise	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Limited private practice as a Clinical Psychologist (maximum 3 hours per week) for therapy and neuropsychological assessment. No clients would be eligible for support within my NHS practice and are instead referred through independent case managers.	No conflict of interest anticipated	23/02/2022	
1	Moakes, Miss Hannah Jayne	Applied Psychologist - Clinical	Non-financial professional interest	Clinical private practice	PRIVATE PRACTICE		30/07/2020	
1	Moideen, Mr. Abdul Nazeer	Consultant	Financial interests	Clinical private practice	I provide private consultations on Tuesdays and Wednesdays from 17:00 - 20:00 every week at Spire Cardiff hospital		01/03/2021	
1	Morgan, Dr Paul (Paul)	Consultant	Financial interests	Outside employment	I have taught on surgical training courses for Doctors Academy for several years now, earning modest sums of money (typically around £900 - £1000 per annum. This work takes place in my own time.	As an ad-hoc locum consultant I am continuing to work for Doctors Academy in my own time. There are no new declarations to be made	28/12/2021	28/12/2022
1	Morgan, Dr Rhiannon Meleri	Consultant	Financial interests	Clinical private practice	Coronial post mortem work	Ongoing activity. Done in NHS mortuary	04/10/2004	15/07/2021
1	Morgan, Miss Emily Frances	Specialist Healthcare Scientist	Financial interests	Clinical private practice	I provide DVT scanning for NHS patients throughout a private company (GP Care). I am bank staff with no set amount of hours per week. I provide this service in Bristol.	This is an ongoing role for now.	31/08/2022	
1	Morris, Dr Ian Paul	Consultant	Non-financial professional interest	Outside employment	2 sessions per week working as programme director for neonatal MSc with Cardiff University.		01/06/2020	
1	Morris, Mr. Daniel Simeon	Consultant	Indirect interests	Clinical private practice;Hospitality;Outside employment;Shareholdings and other ownership interests;Sponsored research	Nuffield/Spire and Ltd Company;WRU in exchange for clinical time;Member of Nuffield national advisory group with payment at an hourly rate;Spire;Horizon. Tepro study		03/01/2023	01/03/2024
1	Motley, Dr Richard John (Richard)	Consultant	Financial interests	Clinical private practice	I am self-employed in private practice		19/09/2022	
1	Murphy, Dr Rhian Eleri	Applied Psychologist - Clinical	Financial interests	Sponsored events	Presentation for Sanofi - not in work time. Payment of £448 received.	As above. Line manager aware.	04/11/2020	04/11/2020
1	Nannapaneni, Mr. Ravindra	Consultant	Financial interests	Clinical private practice	I undertake private practise at Spire Cardiff and St Joseph's Hospital, Newport		07/07/2021	
1	Oliver, Mr. George Sebastian	Physiotherapist	Indirect interests	Outside employment	I provide voluntary first aid cover for Ty Celyn U9 football team	I do not see any clear conflict here, but have applied the if in doubt declare principle	01/10/2021	31/08/2022
1	Oliver, Mr. Graham Richard	Consultant	Financial interests	Clinical private practice	Salary from clinical practice		09/10/2022	
1	O'Reilly, Mr. David John	Consultant	Financial interests	Outside employment	PP at Spire Cardiff		30/12/2022	
1	Osborne, Dr Claire Louise (Claire Willson)	Applied Psychologist - Clinical	Financial interests	Clinical private practice	I am a partner at Positive Neuro Rehab. I work as a Consultant Clinical Neuropsychologist with people who present with neurological conditions either privately or as part of a medicolegal claim.	I conduct this work outside of my NHS contracted hours. I do not take on any patients where there is a conflict of interest (e.g. on my NHS waiting list, a previous patient or someone who might be referred to me, are pursuing a claim against the UHB).	01/01/2002	
1	Parish, Dr Nicole Elizabeth	Applied Psychologist - Clinical	Financial interests	Outside employment	I deliver teaching days at Plymouth University, for which I am paid privately - usually 2 a year. I take annual leave if I am asked to do this on a day I usually work.		27/09/2021	30/09/2022
1	Patel, Mr. Chirag Kantibhai	Consultant	Financial interests	Sponsored events	Paid proctorship for teaching and training on medical courses and conferences with Boston Scientific		19/11/2020	30/11/2022
1	Peaker, Mr. James Alec	Consultant Healthcare Scientist	Indirect interests;Non-financial professional interest	Sponsored research;Donations	I was approached by a market research company on behalf of an undisclosed pharmaceutical company, to complete an anonymous question and answer interview session for 35min around my thoughts on the current and future role of biomarkers within UGI adenocarcinomas.;Involvement in a quality in pathology external assurance program reported by a donation from MSD, for the assessment of PDL1 expression in oesophagogastrectomy tumoural samples. This is a external quality assurance program run by the German company QuIP (https://www.qualityinpathology.com/en_GB/)		23/06/2022	20/07/2022
1	Phillips, Professor Ceri James	Non Executive Director	Non-financial professional interest	Loyalty interests	I am Emeritus Professor at Swansea University I am Honorary Professor at Cardiff University	There are no changes to those reported above 22/06/2022	23/09/2021	
2	Pickersgill, Dr Trevor Paul	Consultant	Financial interests	Clinical private practice	I perform Private medical Practice baed in Cardiff		02/04/2004	

1	Pink, Dr Katie Louise	Consultant	Financial interests	Sponsored events	Attendance at virtual conference (ERS) sept 2021 Honorarium for attendance and involvement in a UK (pharmaceutical sponsored) working group for severe asthma (PRECISION). Honorarium for involvement in a webinar		04/03/2022	
1	Pryce, Dr Rebekah Anne	Consultant	Indirect interests	Outside employment	clinical lead for congenital hypothyroidism paid 6 sessions / per year by public health wales -	no payment received to date	22/06/2021	
1	Pullan, Mrs. Leanne Dorice	Health Care Support Worker	Indirect interests	Clinical private practice	I will be starting direct payments for a service user who will transition from child services to adult services.	This private arrangement will not effect my job within the CCNS.	12/10/2022	
1	Quinn, Dr Clare Anne	Applied Psychologist - Clinical	Indirect interests	Clinical private practice	I undertake a limited amount of private therapy work from R&R Consulting Centres. I try to ensure as best I can that there is no conflict of interest with my NHS duties and remit		18/02/2022	25/07/2024
1	Quirke, Dr Jessica Ann	Advanced Practitioner	Financial interests	Clinical private practice	I conduct a small amount of medico-legal assessments (approximately one every 1-2 months)	I only see patients who reside outside of my NHS catchment area (CAV and CTM health boards)	01/09/2021	
1	Ramaraj, Dr Rajeswari	Consultant	Financial interests	Clinical private practice	I have registered to work for a private endoscopy company and a private virtual consulting company and provide adhoc services over the weekends and in my own personal time. I am also the director for my limited company.	My private work is only done out of hours on a weekend or in the evenings and does not impact my clinical work in the nhs	01/06/2021	01/06/2022
1	Rees, Dr Dafydd Aled (Aled)	Consultant	Financial interests	Outside employment	Advisory board and project work with Pfizer Ltd to look at outcomes of UK patients with Acromegaly using CPRD data.		01/07/2020	21/12/2020
1	Rees, Mrs. Suzanne Marie	Nurse Manager	Financial interests	Outside employment	I hold a contract with Health Inspectorate Wales for secondary employment.	I have discussed this with my line manager Sue Bailey. This is an adhoc paid additional contract with occasional work being undertaken outside of my current role several days per year as a peer reviewer undertaking HIW inspection work. I will also complete and sign an electronic secondary employment form as per CAV policy.	11/03/2022	
1	Regan, Mr. Paul Vincent	Staff Nurse	Financial interests	Outside employment	In July 2022 I registered a not for profit, social enterprise, limited by Guarentee business; ‘Stand Tall Strength and Wellbeing ltd’. We are not currently trading and have no funding other than our own personal funds. We have no current pending applications for funding. We aim to be running courses for men struggling with their mental health in Barry and wider vale. This is no association with my NHS role and potential clients to our service will self-refer and where appropriate any COI will be declared. Myself or colleagues in the Primary Mental Health Service will not signpost or direct potential clients to Stand Tall. If/when funding applications are made that with time could potentially be from NHS, COI will be declared as there could be a financial/non-financial professional interest, for example being a recipient of funds if I were to apply to NHS for funding as a director of Stand Tall Strength and Wellbeing Ltd funds. Also If I were to accessing training through my current NHS role there may be a non-financial professional interest that would also benefit my role as director of Stand Tall Strength and Wellbeing Ltd.		11/10/2022	
1	Roberts, Dr Aled Wyn	Consultant	Financial interests	Clinical private practice	Co-Director - SAGE Roberts Limited	Running a Private Medical Clinic alternate weeks at Spire Hospital Cardiff	15/03/2022	15/03/2023
1	Roberts, Dr Zoe Jane (Zoe)	Consultant	Financial interests	Outside employment	Reviewer Healthcare Inspectorate Wales Role of HIW: 'Healthcare Inspectorate Wales (HIW) regulates Independent Healthcare providers and inspects NHS Services in Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.	£250 per day, plus travel and subsistence expenses Not yet undertaken any reviews due to pandemic and limitation of reviews Will not be permitted to perform review within own health board	01/04/2021	31/03/2024
1	Roberts, Mr. Gareth Llewelyn	Consultant	Financial interests	Clinical private practice	Private orthopaedic surgeon		01/01/2019	
1	Roberts, Mrs. Debbie (Debbie)	Staff Nurse	Financial interests	Outside employment	I am employed on a sessional basis by the voluntary organisation, the Breastfeeding Network, to deliver training to volunteer peer supporters and to offer them supervision. My employer is aware of this additional employment which takes place on my days off.		10/03/2022	
1	Robertson, Dr Angus	Consultant	Financial interests	Clinical private practice	Managing Partner Cardiff Sports Orthopaedics LLP	NB : Not tendering for NHS work.	01/01/2022	01/01/2023
1	Roblin, Mr. David Graham (Graham)	Consultant	Indirect interests	Clinical private practice	Have Private practice session		04/03/2022	
1	Rodd, Mr. Matthew Jonathan	Specialist Healthcare Science Practitioner	Financial interests	Outside employment	I currently have a second employment with Assured Perfusion Medical Service. It is a service that provides Perfusion services across UK and Ireland		03/03/2022	
1	Rogers, Mrs. Sheelagh Anne	Consultant	Non-financial professional interest	Clinical private practice	Specialist Practitioner. Cathedral orthodontics; Cardiff Mostly Primary Care NHS contract. 1 day a week		01/01/2006	17/03/2022
1	Romero, Miss Patricia de la Pena	Assistant	Financial interests	Clinical private practice	Nutritional consultancy since March 2019.		13/03/2019	
1	Ruck, Miss Susan Ann	Technician	Non-financial professional interest	Sponsored events	Welsh Pharmacy Awards 2022 - Ethypharm Management of Substance Dependency in the Community		07/09/2022	07/09/2022

1	Rushforth, Miss Rachel	Health Care Support Worker	Financial interests	Outside employment	Work as a associate lecturer for the Open University. Provide 5 x online tutorials per module (in the evenings outside of working hours) and mark assignments.	Have requested no Cardiff students to be allocated to me by the Open University The Open University has lost contract in Wales for nursing students and in future. I have stepped down from role of practice tutor where I was supporting students in practice to focus on my new job.	20/01/2019	
1	Sabit, Dr Ramsey Ahmed	Consultant	Financial interests	Clinical private practice	I do a private clinic in Spire and Nuffield Cardiff Bay (alternating weeks) once per week. This has been reviewed at every job planning meeting and yearly appraisal		11/08/2015	
1	Sadiq, Mrs. Sadia	Counsellor	Financial interests	Clinical private practice	One client for TY Hafan per week.	This is to maintain my own bereavement competencies. This may end in 8 weeks or go beyond 8 weeks.	03/03/2022	
1	Scherf, Dr Caroline Franziska	Consultant	Indirect interests	Hospitality	Offered and accepted sponsorship for European Society of Contraception (ESC) meeting in Ghent, May 2022 Sponsoring organization: Gideon Richter	conference registration, accommodation, travel to Ghent included	25/05/2022	28/05/2022
1	Searle, Mr. Mathew (Mathew Price)	Senior Manager	Indirect interests	Gifts	Donation of equipment from Irwin Mitchell Solicitors - total cost for the items £4296 - equipment such as furniture, technology (TV, coffee machine etc.) and accessories such as kitchen appliances, garden games etc. Full list of donations supplied to Aaron Fowler - HEAD OF RISK AND REGULATION	Request from Aaron Fowler to log the donations of equipment for the independent living unit at UHL, Specialist Rehabilitation on ESR. paperwork Declarations Form completed by Angela Chaulk and signed by Mr Guy Blackshaw	12/02/2022	12/03/2022
1	Shah, Dr Sagar	Dental Officer	Financial interests	Outside employment	I work 1 day (7.5 hours) per week at NHS Business Services Authority, where I was previously on a secondment as a Clinical Fellow.	I am leaving NHSBSA in July 2022.	04/01/2022	01/07/2022
1	Sharp, Mrs. Jacqueline	Physiotherapist Manager	Non-financial professional interest	Clinical private practice	Husband works for private physiotherapy practice, Go Physiotherapy, in Cowbridge Health Centre		07/03/2022	06/03/2023
1	Sharp, Professor Andrew Simon Peter (Andrew)	Consultant	Financial interests	Sponsored events	Consultant/Speaker's Fees: Boston Scientific Medtronic Philips Penumbra Recor Medical	teaching/research/consultancy affiliations.	11/04/2022	11/04/2025
1	Shetty, Dr Hamsaraj Gundal	Consultant	Indirect interests	Hospitality	I have received lecture fees from Bayer PLC for delivering educational lecture s for GPs		01/03/2021	28/02/2022
1	Smit, Dr Elisa	Consultant	Non-financial professional interest	Outside employment	Senior Clinical Lecturer Cardiff University since 2015		11/01/2015	11/07/2022
1	Stephens, Mr. Michael Robert	Consultant	Non-financial professional interest	Outside employment	I am a trustee of two charities- Kidney Wales Charity and Believe Organ Donation Support.		03/03/2022	
1	Talbott, Dr Taryn Angharad	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Independent practice as a Clinical Psychologist in the Bristol area. Mainly working with adults.	This allows me to maintain my clinical skills while working in a largely non-clinical role. I work independently in a different geographical area than my NHS role.	25/06/2021	
1	Thomas, Dr Benny	Consultant	Financial interests	Clinical private practice	I hold private practice clinics at Spire Cardiff, Nuffield Cardiff and St Joseph's Hospital Newport		18/03/2022	
1	Thomas, Dr David Hywel	Consultant	Financial interests	Clinical private practice	Performing post mortems for HM Coroner.	Ongoing	23/09/2022	23/09/2023
1	Thomas, Mrs. Mary Annette (Annette)	Consultant Healthcare Scientist	Non-financial professional interest	Sponsored events	Member of International Federation of Clinical Chemistry & Laboratory Medicine Task Force on Global Quality. The TF remit is to improve the quality of laboratory diagnostics in low and middle income countries. Attended face to face meeting of TF at the IFCC Wordlab Conference in Seoul in June 2022. Flight and accommodation reimbursed by the IFCC.		03/04/2022	01/04/2023
1	Thomas, Mrs. Nerys Mai	Radiographer - Diagnostic	Non-financial professional interest	Outside employment	Public Health Wales Ultrasound Advisor. 10 sessions per annum paid to radiology department for professional services. No personal financial gain		03/03/2022	31/03/2023
1	Thomas-Turner, Mrs. Rhian	Manager	Financial interests	Outside employment	Office Holder at MHRA - Paediatric Medicines Expert Committee	Appointed as a member of the paediatric medicines expert committee. One monthly meeting outside of working hours.	11/03/2022	
1	Thompson, Professor Andrew Robert	Applied Psychologist - Clinical	Financial interests	Clinical private practice	Occassional clinical psychology private practice (registered with HMRC as a sole trader) - medico-legal reports, invited talks/workshops/teaching/external examining, very occassional psychological therapy		02/10/2020	
2	Tibbatts, Dr Clare	Consultant	Financial interests	Clinical private practice	Am registered with several locum agencies, including Remedy that currently provide weekend insourcing at UHW. I have several charitable grants from pharma to fund IBD improvement projects - Takeda, Abbvie, Johnson & Johnson.		04/03/2021	04/03/2022
2	Torkington, Mr. Jared	Consultant	Financial interests	Shareholdings and other ownership interests	Own shares in Alessi Surgical - spin out of Cardiff and Vale - make smoke management system		01/12/2010	
1	Trickett, Mr. Ryan William	Consultant	Financial interests	Clinical private practice	Vale Hand Surgery ltd		26/08/2016	
1	Twose, Mrs. Sarah Elizabeth	Physiotherapist	Financial interests	Outside employment	Presentation for kyowa kirin, paid an honourarium		23/11/2022	
1	Van-der-Voort, Dr Judith Henriette	Consultant	Financial interests	Outside employment	I provided clinical support and acted as a consultant to Chiesi, a pharmaceutical company, who is preparing a submission to the Welsh medication group for inclusion of the medication to the NHS in Wales. I was paid £720 for the time given and advice provided. I will be providing them with further input in the next months, for which I will be paid £1000.		11/03/2021	07/04/2022

1	Vaughan-Owen, Mrs. Mari	Staff Nurse	Financial interests	Outside employment	Self employed, accredited, humanist, funeral celebrant.	Employment is on an ad hoc basis.	18/05/2022	
1	Verrecchia, Ms. Jacqueline	Applied Psychologist - Clinical	Financial interests	Outside employment	As I work part time in my current role for NHS Wales, I also hold another position working privately as a sole trader for the company CF Psychology completing remote Learning Disability assessments to students.	This work is ongoing as my second from of employment.	28/04/2022	
1	Vidgen, Dr Andrew	Applied Psychologist - Clinical	Financial interests	Clinical private practice	private medico-legal work. Approximately 1.5 sessions / month outside normal working hours. Undertaken in Gwent area	Provision of supervision to health professionals outside health board 2 sessions / month.	01/03/2022	23/03/2022
1	Wardle, Dr Mark	Consultant	Financial interests	Shareholdings and other ownership interests	Director of Eldrix Ltd.		21/05/2014	
1	Watts, Mr. Jonathan Roger	Senior Manager	Indirect interests	Loyalty interests	I am a committee member of Whitchurch Hockey Club (which is part of the wider entity of Whitchurch Sports and Social Club (WSSC) WSSC have an interest in purchasing the land that CAVUHB is disposing of on the Whitchurch Hospital site		10/03/2022	
1	Wheeler, Dr Naomi Lucie	Applied Psychologist - Clinical	Non-financial professional interest	Outside employment	I hold another part time clinical position, with The Junction Cardiff, part of the charity Hope Trust Cardiff CIO. This organisation supports those who have experienced perinatal loss. Contracted 7.5 hours per week, normal working day Tuesdays.		04/10/2021	
1	White, Dr Richard Douglas	Consultant	Financial interests	Clinical private practice	Director (and spouse is director) of White Imaging Services Ltd. Paid dividends. Consultant Radiologist with 4Ways.		05/05/2022	
1	Whitehouse, Miss Kathrin Joanna (Kat)	Consultant	Financial interests	Outside employment	Neurosurgical tutor for online MSc with Learna Ltd		01/09/2021	01/09/2022
1	Whiticar, Dr Rebecca Alice	Consultant	Non-financial professional interest	Outside employment	Expert witness Emergency Medicine	Work as an independent expert witness in EM Again all my line managers aware that I do this role in my own time Conflict of interest wise I always complete a conflict check prior to being instructed in any specific EM case	17/03/2022	
1	Whittington, Dr Lauren Kate	Applied Psychologist - Clinical	Financial interests	Outside employment	I currently work half a day a week for Oxford Health NHS Foundation Trust	This is temporary and likely to end February 2021	27/11/2020	
1	Wilkey, Miss Melanie Jo	Senior Manager	Indirect interests	Outside employment	Hourly paid lecturing at University of South Wales	I am currently doing dissertation supervision in my own time. I may take on some lecturing in the coming term.	11/02/2022	
1	Williams, Dr Ian Edward	Staff Nurse	Indirect interests	Clinical private practice	I run alongside a Community Paediatrician one private clinic session per month which lasts for around 4 hours. This is in my field of practice - Paediatric neurodevelopmental disorders and in particular ADHD.		10/03/2022	31/03/2023
1	Williams, Mr. Matthew Gareth (Matt)	Nurse Manager	Financial interests	Clinical private practice	Occasional Pitch-side medical cover for Cardiff City Football Club with Lubas Medical		14/03/2021	
1	Williams, Mrs. Imogen Sofie	Physiotherapist	Financial interests	Clinical private practice	Commenced paid work in a private physiotherapy practice treating pelvic health patients via patient self-referral.		12/05/2022	
1	Winter, Mrs. Mia Krista-Maria	Applied Psychologist - Clinical	Financial interests	Clinical private practice	I am an associate with Halliday Quinn Ltd, but as yet have not undertaken any private work.		23/09/2021	
1	Witczak, Dr Justyna Karolina	Consultant	Financial interests	Sponsored events	Fee and honoraria for delivering talks and lectures for pharma companies (Astra Zeneca, Novo Nordisk, Boehringer-Ingelheim) Sponsored attendance at EASD virtual meeting in 2021	These additional paid for activities are only undertaken sporadically- 3-4/year	04/03/2022	10/05/2022
1	Wood, Dr Andrew Mayne	Consultant	Non-financial personal interests	Loyalty interests	Spouse company - EGL design	Involvement with Orchard project.	01/10/2012	
1	Wright, Mrs. Natalie Suzanne	Occupational Therapist	Financial interests	Shareholdings and other ownership interests	I have shares in my husbands business	Approx date of 23 May 2022 ongoing	23/05/2022	
1	Zaidi, Dr Syed Tatheer Abbas (Abbas)	Consultant	Financial interests	Clinical private practice	Spire Hospital Cardiff.	Private cardiology pratice. This is ongoing / indefinite time period. Hence I've entered a date in 2 years time above, becasue it seems you have to enter an 'end date'. I will update this periodically.	20/09/2022	20/09/2024

Report Title:	Internal Audit Recommendation Tracker Report				Agenda Item no.	7.4
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	07.02.2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Interim Director of Corporate Governance					
Report Author (Title):	Head of Risk and Regulation					

Main Report Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee ("the Committee") with assurance on the implementation of recommendations which have been made by Internal Audit by means of an internal audit recommendation tracking report ("the Tracker").

The Tracker was first presented to the Audit Committee in September 2019 and approved by the Committee as an appropriate way forward to track the implementation of recommendations made by internal audit.

The Tracker continues to highlight progress made against previous years recommendations albeit in a more streamlined manner. The Tracker attached to this report sets out the progress made against recommendations from 2019/20, 2020/21, 2021/22 and 2022/23.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations recorded within the Tracker has, as of 26/01/2023, since the November 2022 Committee meeting increased from 104 recorded entries to 140. This figure has increased due to the addition Internal Audit recommendations included within reports shared at the November Committee Meeting.

The audit reports added to the tracker since November 2022 are:

1) Follow Up Report - 5 Steps to Safer Surgery
2) Final Internal Audit Report - Medical and Dental Staff Bank
3) Final Internal Audit Report - Staff Wellbeing Culture and Values
4) Implementation of National IT Systems WNCR - Final Internal Audit Report
5) Digital Strategy - Final Internal Audit Report
6) Medical Equipment and Devices - Final Internal Audit Report
7) UHL Endoscopy Expansion - Final Internal Audit Report

Advisory Reports

As confirmed previously all Advisory Reports will continue to be tracked offline. At the time of writing, all tracked advisory recommendations remain live and will continue to be monitored to establish whether best practice suggestions have been implemented.

Of the 140 recommendations listed within the Tracker, 58 are recorded as completed, 54 are listed as partially complete and 28 are listed as having no action taken or reported since the last Committee meeting.

Of those actions where no action is reported, 2 are recorded as High Priority and will be flagged with relevant Executive Leads for updates prior to the November Committee Meeting.

One of these recommendations relates to the **Chemo Care IT System Audit Review** which received a Limited Assurance rating during 2021-22. 8 recommendations (1 low priority, 6 medium priority and 1 High Priority) were made within this Audit Review, all of which remain outstanding and 7 of which have exceeded their agreed implementation date. No update has been shared by Executive or Operational leads for any of the outstanding recommendations for this Audit.

It is therefore proposed that a specific update on progress made against the recommendations contained within the Chemo Care IT System Audit Review be provided by Executive and Operational Leads at a future Committee meeting.

A full review of all outstanding recommendations has been undertaken since the last meeting of the Committee where the internal audit tracker was presented (September 2022). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

There are currently 18 outstanding recommendations for 2019/20 and 2020/21, 8 of which are reported as complete. It is proposed that a review of the remaining 10 be subject to a targeted review in advance of the April Committee Meeting to ascertain whether or not the recommendations have been superseded or should be subject to a more up to date review.

It should be noted that the narrative within at Column L (Executive Update) of the attached tracker contains the updates provided for this meeting. Where no update has been shared for an individual entry this is confirmed within narrative and/or reflected in column J by an 'NA' entry.

The table below shows the number of internal audits which have been undertaken between 2019/20 and 2021/22 (to date) and their overall assurance ratings.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A - Advisory	Total
Internal Audits 2019/20	10	25	2	2	39
Internal Audits 2020/21	7	18	1	3	29
Internal Audits 2021/22	7	12	8	3	30

Attached at Appendix 2 are summary tables which provide an update on the September 2022 position as of the 26/01/2023.

ASSURANCE is provided by the fact that a tracker is in place and continues to be monitored and updated. This assurance will continue to improve over time with the implementation of regular follow ups with Executive Leads.

Recommendation:

The Committee are requested to:

(a) Note the tracking report for tracking audit recommendations made by Internal Audit.
(b) Note and be assured by the progress which has been made since the previous Audit and Assurance Committee Meeting in November 2022.
(c) Consider whether an update on progress made against the Chemo Care IT System Audit Review should be shared at a future Committee Meeting.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
By maintaining an up to date Internal Audit Recommendation Tracker the Health Board mitigates the risk that it subject to legal or regulatory penalty.
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	31.04.2020	PCIC Adults CHC Adults Follow-up	R2/3	High	**Original Recommendation:** A timescale should be set to ensure the Head of Service Agreement is agreed promptly.	The Director of Nursing has written to the leads for both local authorities to understand the timescales for the update of the Heads of Service Agreement, there has been no response. There is however a jointly commissioned working group, attended by the Health Board, which have been tasked with updating the agreement. This has a proposed finish date of April 2018, however, this date has not been formally communicated.	Chief Operating Officer	Director of Nursing PCIC	C	**Updated Management Response:** There has been significant progress with community stakeholders including Third sector providers, their legal representatives and Cardiff and Vale Local Authorities in developing an agreed contract process which will then lead to the updating of the Heads of service agreement. These discussions have been overseen by Regional Commissioning Board which has representatives from C&V UHB (PCIC and the Planning team) and both LA's. **UPDATE 12/8 • The Joint Contract was finalised and signed off in 2020** **• The new contract and service specification was fully implemented by October 2021 by both LA's albeit at slightly different times and is now fully implemented across the UHB footprint in alignment with the two LA timescales** **• The main overarching contract has been issued to all residential providers** **• There will be a review of implementation of the new contract in 2022 and the partnership team are working with the statutory partners to develop a quality outcomes based agreed joint contract monitoring process** **• Any proposed amendments to the contract are discussed and signed off by the Regional Commissioning Board of which I am a member on.**
2019-20	Nov-22	PCIC Business Continuity	R1/4	Medium	Management should ensure that all Business Units and Service Areas which require a BCP produce a formally documented one as soon as possible.	PCIC Clinical Board management are aware that all Business Units and Service Areas have been involved in the BCP process although not all have a written document completed and approved. Reviews are planned or have taken place with all Business Units and finalised documents are anticipated to be received by the Clinical Board in November and December 2019. One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units.	Director of Operations PCIC	PCIC Business Manager	C	All actions were completed in 2019 following which a rolling process was set up. Due to Covid this was delayed, however there were Covid business continuity arrangements in place which included daily and weekly operational meetings focusing on risk, prioritisation of services. For 2022 - All PCIC BUs have received updated BCP training (training delivered on 3/3/22) and after that session were asked to refressh BCP. All plans are due to go to PCIC QSE meeting for formal sign off on 8/11/22. The Implementation Date of the Rolling process was delayed due to Covid. With a return to more normal operating arrangeemetns there are now no specific challenges in completing the action. Update to PCIC Board will be on 17/11/22
2019-20	Sep-22	PCIC Business Continuity	R2/4	Medium	Management should ensure all terms of references are reviewed and updated as required.	PCIC Clinical Board Senior Management Team will ensure the terms of reference for any meetings they chair are reviewed and refreshed, and that future review dates are established. The Business Units will be advised to review the terms of reference for their established meetings and ensure they are refreshed if needed. This will also be added to the agenda for November 2019's PCIC Clinical Board Meeting, under a standing Governance update on Internal Audit.	Director of Operations PCIC	Individual members of SMT / December 2019 Business Unit Leads / December 2019 PCIC Business Manager / November 2019	C	In March 2022 a T&F group was set up in PCIC to review ToR of all meetings reporting directly to PCIC Clinical Board. This work culminated in a SMT Time Out Session held on 23/9/22 at which ToR of key business meetings were reviewed. Actiosn from the 23/9 session are now being worked through with the aim that all key meetings ToR will be refreshed by next Clincal Board meeting due 17/11/22. A follow up action after CD meeting will be ensuring ToR held for groups within BU are in line with PCIC Corporate TOR. This work was delayed due to Covid and as we return to normal operating arrangements no challenges have been encountered. Update including agenda item on Internal Audit will be shared on 17/11/22
2019-20	Mar-22	PCIC Business Continuity	R3/4	Low	Management should ensure that all members of staff are made aware of the existence of a BCP, the risk associated with possible occurrences and how to respond in such an event.	Business Unit Leads will be asked to ensure that all Service Areas make all team members aware of the existence of a BCP, where the document is located, key risks for their Service Area, and their role in the use of the document.	Director of Operations PCIC	Business Unit Leads	C	Staff are aware of BCP. Refesher training was delivered across the Clinical Board on 3/3/22. Delays in delivering refersher training due to Covid and move from normal operating arrangements. Update shared 9/6/22
2019-20	Nov-22	PCIC Business Continuity	R4/4	Low	Management will ensure that all service areas which require a BCP have their plans signed off.	One BCP (OOHs) will be submitted to PCIC QSE in November 2019 along with a briefing paper and process flowchart and the Director of Nursing will present the paper and flowchart. The other BCPs are anticipated to be submitted to PCIC QSE in January 2019 and will then enter an annual review process within their Business Units. The PCIC Business Manager maintains logs indicating the status of each BCP in the approval process and this will then form the basis of a tracker to ensure plans are reviewed on an annual basis within the Business Units.	Director of Operations PCIC	PCIC Business Manager	C	Status of all BU BCP has continued to be maintained by PCIC Business Manager. Renewed Focus on BCP has been happening over 2022. All plans for all BU will be signed off in PCIC QSE on 8/11/22 The implementation Date was delayed due to Covid but with a return to normal operating arrangements no challenges have been encountered.
2020-21	30.09.2021	UHB Core Financial Systems	R1/3	Medium	Management should ensure the FCPs are updated as soon as possible.	The FCP will be reviewed and updated. Future reviews will reflect any best practice arising from the TAG.	Director of Finance	Helen Lawrence, Head of Financial Accounts and Services – Sept 2021	C	FCPs are currently being reviewed to ensure up to date and reflective of current procedures. The position was last reported to the Audit and Assurance meeting at its November 2021 meeting. Since the last Committee meeting in July - Internal Audit has asked that this recommendation is verified before marked as complete. In response to above, the asset register was updated as per year end requirements. The 21/22 accounts have since been audited and were given an un-qualified opinion with no reference to process concerns in the matters arising section of the audit wales report.
2020-21	31.12.2021	Engagement Around Service Planning	R2/5	Medium	In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	Agreed. The importance of timely completion of a CHC Service Change Proforma for discussion with the CHC when service change proposals are being developed will be reinforced with Clinical Boards consideration given to building it into IMTP templates.	Executive Director of Planning	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle	C	Importance of timely completion of CHC Service Change Proforma for discussion with CHC when service change proposals are being developed will be reinforced with Clinical Boards; consideration given to building it into IMTP templates. Service Change Proforma has been reviewed and updated, pending discussion and agreement with the CHC. It forms a part of the Local Framework that has been reviewed as above and will be reissued to Clinical Boards once agreed between the UHB and CHC. Note decision to delay discussion with CHC pending outcome of mediation described in section 52
2020-21	31.12.2021	Engagement Around Service Planning	R5/5	Low	In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	Agreed. The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, will be reviewed and updated to include stakeholder mapping advice based on current best practice.	Executive Director of Planning	Executive Director of Strategic Planning December 2021	C	Once the actions in section 52 on Local Framework have been completed, the Practical Guide and suporting resources will be re-issued to Clinical Boards and put on the UHB intranet.
2021-22	30.09.2021	Ultrasound Governance CD&T CB	R5/5	Medium	In accordance with Sections 2 and 3 of the UHB Ultrasound Risk Management Procedure, the three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor should be formalised within the sampled audit areas.	The three key roles of Clinical Lead User, Speciality Lead User and Educational Supervisor / Training Supervisor have been formalised within Medical Physics. The O&G Directorate is setting up a quarterly formal ultrasound governance meeting, the first of which is starting in September. Within this we will be formalising roles and working through each aspect of the policy inc: roles and responsibilities and communication plan around this.	Executive Director of Therapies and Health Science	Directorate Ultrasound Governance Lead (Mark Denbow)	C	Reponses have been received from all Clinical Boards. The list of names of those in the key roles will be reviewed at the next USCGG meeting on 10th Nov 2022. The list of members of staff in the key roles will be shared on the USCGG Teams Channel.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.2022	Five Steps to Safer Surgery	R1/7	High	Mechanisms need to be established that enable the Health Board to record Step One (Briefing) and Step Five (Debriefing) of Five Steps to Safer Surgery. Whilst considering options, attention should be given to the ability to report on quantitative data from Theatreman to identify areas of concern with steps two through to four.	The Perioperative Care Directorate has worked in collaboration with Trisoft (The Manufacturer of TheatreMan, our Theatre Operating system within Cardiff & Vale UHB) to develop a mechanism for recording all 5 stages of the '5 Steps to Safer Surgery' electronically. This development will allow for quantitative data collection. All stages of the '5 Steps to Safer Surgery' will be compulsory. Prior to full implementation, the Theatre Informatics Team will need to undertake a period of testing to confirm that the correct pathways are active. The Perioperative Care Directorate will also need to ensure staff are aware of the change in process and provide any necessary training.	Executive Medical Director	IT Service Manager and Interim Lead Nurse	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update :12/1/22 Trisoft have placed the questionnaires into other test environment and are awaiting our instruction to place into live. A help guide has been written but reports have not yet been explored due to the development not being attached to the current live system.
2021-22	31.03.2022 30.11.2021 31.03.2022	Five Steps to Safer Surgery	R2/7	High	Staff should be reminded of the importance for accurately completing the safer surgery checklist and if gaps are noted, these should be escalated and resolved appropriately.	In line with Agreed Management Action 1, The Perioperative Care Directorate aim to record all 5 stages of the 5 stages of the '5 Steps to Safer Surgery' electronically. This will eliminate duplication of information and all stages of the '5 Steps to Safer Surgery' will be mandatory fields within TheatreMan. If a stage of the '5 Steps to Safer Surgery' is not completed staff will have to explain the reason why. Non-compliance reports can be generated and addressed with individuals involved. The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team and Natssips lead for the PST with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the non compliance culture associated with the '5 Steps to Safer Surgery	Executive Medical Director	IT Service Manager Interim Lead Nurse Director of Nursing & Clinical Director	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 Non compliance reports will be discussed at Theatre Manager 2:1's with the General Manager and Lead Nurse for Peri-Operative Care.A draft flow chart has been devised which shows escalation process for non-conformance. This document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification. Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting Update 12.1.22 The PST and Natssip lead are supportive of this change
2021-22	30.11.2021	Five Steps to Safer Surgery	R3/7	Medium	In conjunction with Recommendation 5, management should ensure that the processes within the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), are effectively embedded within the Health Board and fully complied with for all surgical procedures.	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting and then Surgery Clinical Board for ratification.	Executive Medical Director	Interim Lead Nurse	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 will be agreed at the next Perioperative Care Policy Meeting
2021-22	31.03.2022 31.03.2022	Five Steps to Safer Surgery	R4/7	Medium	Staff should be further educated around the value of the Five Steps to Safer Surgery and reminded of the requirement to actively engage in the process.	To improve the non-compliance culture associated with the '5 Steps to Safer Surgery' the Senior Team within Surgery Clinical Board have engaged with the Patient Safety Team with the view of securing senior support from the Executive Team within Cardiff & Vale UHB challenge the non-compliance culture associated with the '5 Steps to Safer Surgery'	Executive Medical Director	Director of Nursing and Clinical Director	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 - This has been discussed and has been supported by the Medical Director and the CD for Surgery Clinical Board The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to develop a training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. Update: the directorate have been working with the other Theatre Managers across Wales to establish whether this could be a joint project with neighbouring health boards. A working group has been set up to take this forward.
2021-22	30.11.2021	Five Steps to Safer Surgery	R5/7	Medium	As part of the scheduled review in 2021 of the 'Procedure for Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' (UHB Reference 58 v4), the following should be included: • Step Five – Debriefing, of the Five Steps to Safer Surgery; and • Clarification of the process for employees to highlight non-compliance or concerns with Five Steps to Safer Surgery.	The Perioperative Care Standard Operating Procedure (SOP) for 'Team Briefings and the application of the World Health Organisation (WHO) Surgical Safety Checklist' has been updated to provide guidance on how to escalate areas of non-compliance, this document will be agreed at the next Perioperative Care Policy Meeting.	Executive Medical Director	Interim Lead Nurse	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 will be discussed at next Perioperative Care Policy Meeting
2021-22	30.11.2021	Five Steps to Safer Surgery	R6/7	Medium	Risk surrounding Five Steps to Safer Surgery need to be incorporated within the Directorate / Clinical Boards risk management processes.	A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board.	Executive Medical Director	Interim Lead Nurse	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 The risk assessment has been updated and will be added to Surgery CB risk register.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.03.2022	Five Steps to Safer Surgery	R7/7	Low	Consideration should be given to the opportunities available to raise the profile of thematic issues of Five Steps to Safer Surgery outside of the Clinical Board, through the Health Board's revised Quality and Safety governance arrangements and to raise the profile of the work undertaken by the Peri-Operative Care Directorate to address common themes.	The Perioperative Care Directorate has undertaken a benchmarking exercise to understand how other Health Boards educate new staff and reinforce the value of the Five Steps to Safer Surgery amongst existing staff members. The Benchmarking exercise highlighted how other Health Boards have developed a training video which is shared at induction. The Perioperative Care Directorate would like to Develop a Training video to educate new and existing staff members about the application and importance of the '5 Steps to Safer Surgery'. To maximise the effectiveness of the video Senior Leaders within the UHB will be invited to participate. A risk assessment for 'Word Health Organisation (WHO) Safety checklist' has been completed (22/07/2021). This will be updated to reflect the recommendations of this Audit and will be shared with the Directorate and Surgery Clinical Board.	Executive Medical Director	Interim Lead Nurse	C	**Follow up Report issued 6 September 2022 and presented in November's meeting confirms action complete** Update 31.12.21 A letter has been drafted to share with the staff the results of this audit and the actions that will be taken.
2021-22	31.03.2022 31.03.2022	Core Financial Systems	R1/2	Low	As a point of good practice, consideration should be given to the following updates to the Financial Control Procedures: - Referencing the Health Board's Standing Financial Instructions and Standing Orders within the procedures, to demonstrate the line of sight to key Health Board documents; and - The Accounts Receivable Control Procedure should include an owner and next review date.	Agree to update and reference Health Board's Standing Financial Instructions and Standing Orders within the procedures. Accounts Receivable Control Procedure has been updated with Owner Title and next review date.	Director of Finance	Head of Financial Accounts and Services Financial Services Manager	C	Recommendation Complete
2021-22	31.03.2022	Core Financial Systems	R2/2	Low	A review of controls should be undertaken to ensure all leavers of the Health Board have their user access to the Oracle system removed in a timely manner, particularly those outside of central finance.	Agree to review controls and implement more robust process to ensure all leavers have access removed in timely manner.	Director of Finance	Director of Finance	C	Staff will be reminded of the importance of ensuring that the correct supporting documentation exists at all times.
2021-22	31.03.22	Theatre Utilisation (Surgery CB)	R1/4	High	Peri-operative Care should continue as planned to complete and seek approval of a Health Board Theatre Utilisation Procedure, in addition to a Policy. In doing so, the following should be incorporated: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; - Clarity of roles and responsibilities, including but not limited to the distinction between Peri operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). Additionally, historical information which is no longer valid should be fully removed from the Intranet to avoid confusion and incorrect action occurring.	The Peri-Operative Care Directorate will continue to write a procedure titled 'Operating Theatre Scheduling, Cancellation and Utilisation. This will be a standard operating procedure which explains the process of how theatre lists should be utilised, who should attend the scheduling and utilisation meetings and how the meetings will be run. This policy will be approved by the Peri-Operative Care directorate Governance forum and will also be sent to all stakeholders that use the Peri-Operative Care service and attend the scheduling and utilisation meetings. We have contracted with a company to support developing this policy. "Foureyes Ltd" are working with us until end of March and the focus will be on utilisation and efficiency. The Directorate will also write a Health Board policy which states the rules around the booking process of theatre lists and how performance and utilisation will be monitored and adhered to. This policy will need to be approved by the Peri Operative care Directorate and Surgery Clinical Board but will also need executive approval by the Board. These two policies will incorporate the recommendations: - The governance and assurance mechanisms to support and challenge efficient and effective theatre utilisation, which incorporates the escalation of issues for resolution; Clarity of roles and responsibilities, including but not limited to the distinction between Peri-operative Care and the Surgical Specialities; - Alignment with the Planned Care Programme of the Recovery and Redesign Portfolio (clinically led, risk-orientated and data driven); and - The actions to be taken where utilisation falls short of plans and schedules (action determined by % utilisation). These policies/procedures will be available on the Health Board's intranet pages. The Policy and procedure will be found under the policies section within the	Chief Operating Officer	General Manager Peri-operative Care	C	**Update 11/08/2022 - This has been completed**. The SCB will continue to work with "Foureyes insight Ltd" until the end of June 2022 and the main focus will be on utilisation and efficiency. **Update 11/08/2022 - This programme has ended successfully.** **Update 11/08/2022 - This has been completed.** - **Update 11/08/2022 - This has been completed**.These policies/procedures will be available on the Health Board's intranet pages. **Update 11/08/2022 this is to be actioned.** The Policy and procedure will be found under the policies section within the PeriOperative Care Directorate web site. All old policies relating to theatre scheduling, utilisation and systems and processes in relation to these will be removed from Cardiff and Vale UHB intranet pages. **Update 11/08/2022 - This is to be actioned** Update 13/10/22 - Perioperative Care are in the process of transferring and uploading all information currently displayed on the intranet pages onto the SharePoint system. This will be completed during November 2022 and a final close out date of 01/12/2022 agreed by the Perioperative Care Educational Team. All documents relating to theatre scheduling and effective utilisation will be included in this upload. **Jan 23 Update** - All Theatres related policies and information have been transferred to Sharepoint site
2021-22	28.02.2022	Welsh Language Standards	R4/6	Medium	The Equality Strategy and Welsh Language Standards Group should consider if they have appropriate capacity to provide effective oversight of the implementation of the Welsh Language Standards, and how they may wish to be further supported to ensure implementation of the Welsh Language Standards.	Feedback report, recommendations and management action plan to ESWLSG. Discuss and agree equal focus of WL and ED&I on agendas, with flexibility to reframe meeting depending on need. Ensure meeting updates include WL and ED&I from Clinical Boards and Corporate Areas.	Executive Director of People and Culture	Welsh Language Officer Equality Manager ESWSLG Chair	C	The Equality Strategy and Welsh Language Standards Group is likely to be replaced by a new group at the beginning of 2023, which will work to recieve assurances and report back from the Clinical Boards. The new group will have oversight over the Welsh Language Standards.
2021-22	28.04.2022	Welsh Language Standards	R6/6	Medium	To enhance the maturity of the risk management arrangements, the recording of the risks associated with the Welsh Language Standards should be strengthened to include risk mitigation and the nature of the risk score, to better inform the oversight and assurance forums.	Develop an enhanced dashboard to reflect recommendations. Present to ESWLSG for comment / agreement. Finalise for effective updating and reporting of risk.	Executive Director of People and Culture	Welsh Language Officer Equality Manager	C	The Welsh Language Policy has been published and Standard 79 has therefore been implemented.
2021-22	31.05.2022	Raising Staff Concerns (Whistleblowing)	R4/5	Medium	To build on existing arrangements, the following enhancements should be made to the Risk and Regulation team's Freedom to Speak Up Staff Concerns Log: • To ensure the status of Datix entries reflects the Risk and Regulation team's log; and • Greater clarity of action taken in response to a concern and the decision reached to address a concern.	Agreed – A cleanse of the Freedom to Speak up Log and Datix will be undertaken by the Head of Risk and Regulation.	Director of Corporate Governance	Head of Risk and Regulation	C	The Head of Risk and Regulation met with the Health Board's Datix lead on the 06.12.2022 to review the process for recording Freedom to Speak Up matters within the updated DATIX system. The system does not currently hold the functionality to record such entries in a confidential manner. The Head of Risk and Regulation has shared the requirements for the service and a request has been made of Civica (Datix) to provide an appropriate platform for this. It is likely that this will not be available until June 2023. It is proposed that this action is recorded as complete as the team are no longer running a Datix and Regulation team Log. There is therefore no duplication or risk of things being missed between the two systems. When the Datix system is made available it proposed that the recording of such entries moves entirely to Datix for clarity.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	30.09.2022	IT Service Management (ITIL)	R1/8	High	1.1a The re-structuring of the service desk provision should be based on the ITIL Framework. 1.1b The implementation of the new call handling system should incorporate the facility for users to raise calls via an on-line portal. 1.1c Existing and new staff should be encouraged to attain ITIL Accreditation.	1.1a In conjunction with a new ITIL compliant Service Desk software solution (Ivanti Service Manager – ISM). The current limited IT support resources will be restructured to provide a skeleton framework of an ITIL service desk structure. A business case is currently under review to increase staffing within the Service Desk, to allow for separation of key tasks and address single points of knowledge. 1.1b The new Service Desk (ISM) implementation will provide a digital front door which will include incident and problem management as well as service requests, change and asset management. There will be a User Portal on all User devices. 1.1c Staff ITIL training has already started in Jan 2022. 10x members of the IT Support/Service Desk team have successfully passed the ITIL v4 Foundation course and exam to gain their accreditation. An additional 6x team members have attended the Advanced ITIL CDS course (March 2022).	Director of Digital & Health Intelligence	Head of Digital Operations	C	1.1a/b/c Jan 2023 Update: The majority of new posts have been filled and three jobs are currently advertised within the IT support team. All staff have been on ITIL foundation courses and this is now part of the induction and staff training regime. Work continues on the development of the digital front door as this continuously being improved.
2021-22	30.09.2022	IT Service Management (ITIL)	R2/8	High	2.1a 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 these calls. 2.1b As part of these procedures a set of predefined calls should be developed for the most common / simple calls and incidents to enable these to be resolved on first contact.	2.1a CAVUHB have employed the services of a dedicated Ivanti ITSM Implementation Expert. As part of the deployment Standard Operating Procedure documents have been created. A standalone and dedicated automation server has been setup, this server will provide workflow with approval steps which will provide automation for numerous tasks including; New Starters, Leavers and Movers. Access Requests and general tasks. 2.1b The ISM implementation also contains an FAQ and Staff Help portal which will continue to be developed and expanded as part of the product use.	Director of Digital & Health Intelligence	Head of Digital Operations	C	Jan 2023 Update: This is now complete and the Service Desk have a SOP documented.
2021-22	30.09.2022	IT Service Management (ITIL)	R3/8	High	3.1a 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 are classified and prioritised correctly in accordance with the guidance. 3.1b The planned replacement for the HEAT system should not allow free text in the call category, call type and priority fields. 3.1c The call category, type and priority fields should be mandatory to complete with call handlers selecting the appropriate entry from a drop-down menu.	3.1a Automated for call category, call type and priority fields has been implemented as standard. Exceptions can be made, although require additional approval within the Service Desk management structure. 3.1b Free Text fields for call category, call type and priority fields have been removed. 3.1c Call category, call type and priority fields are all mandatory when creating incidents and service requests.	Director of Digital & Health Intelligence	Head of Digital Operations	C	3.1a/b/c Jan 2023 Update - Ivanti ITIL based service desk has now been implemented fully. There are a small number of free text fields within the system, as requested and approved.
2021-22	31.05.2022	Development of Genomics Partnership in Wales	R1/4	Low	The Project Director should provide written reports to the GPW Governance Board.	1.1 Agreed. Project monthly progress reports will be issued to GPW Governance Board as an appended paper for information.	Executive Director of Planning	Project Director	C	Happening on a regular basis
2021-22	At future Projects	Development of Genomics Partnership in Wales	R3/4	Low	3.1 Future Assurance Contracts should be in place before duties/works commence. 3.2 Future Assurance Letters of Intent do not represent good practice and should only be used in exceptional circumstances. 3.3 Future Assurance - Contracts should be dated at time of execution 3.4 Appropriate document control arrangements should be implemented for key documents such as those with contractual implications. 3.5 Management should continue to seek the early resolution of the Project Bank Account provision.	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. 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. 3.3 Agreed. Contracts to be dated at point of execution. 3.4 Agreed. Major Capital Project folder structure has been reviewed for implementation on existing and future projects. 3.5 Agreed. Risk and Assurance are currently agreeing approach to execution of PBA joining deed.	Executive Director of Planning	Project Director	C	Construction in progress
2021-22	Ongoing where appropriate	Development of Genomics Partnership in Wales	R4/4	Low	The UHB / Genomics Partnership's project risk register should be costed where appropriate.	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.	Executive Director of Planning	Project Director	C	Confirmation received that action complete.
2021-22	31.05.2022 30.06.2022	Wellbeing Hub at Maelfa - Final	R2/6	Low	The governance structure of the workstreams should be reviewed to ensure meetings are held as required and attendance of members is improved. 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).	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. Agreed. Chairs of workstreams will be asked to provide verbal reports of progress against the tasks agreed which will be SMART.	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Support Manager	C	Maelfa development completed
2021-22	30.06.2022	Wellbeing Hub at Maelfa - Final	R3/6	Medium	The risk management processes operating at workstream level require review, to ensure risks are appropriately scored, managed and escalated (where applicable).	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	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Support Manager	C	Build complete and facility open. Lessons learnt exercise being undertaken.
2021-22	April 2022 and ongoing	Wellbeing Hub at Maelfa - Final	R4/6	Low	The UHB should ensure delays in issuing Project Manager's Instructions are minimised.	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.	Executive Director of Planning	Director of Capital, Estates & Facilities; and Programme Manager	C	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.
2021-22	n/a	Wellbeing Hub at Maelfa - Final	R5/6	Low	Further explanation on changes to the cost position should be included within the Monthly Highlight Reports	Actioned since audit field work	Executive Director of Planning	Head of Capital Planning, Estates & Facilities	C	Complete
2021-22	30.06.2022	Vaccination Programme - Phase 3 Delivery	R2/2	Low	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.	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.	Executive Director of Public Health	Head of Operations Immunisations	C	A Teams channel has been established where all core documentation is collated. The Head of Ops - Immunisation is responsible for ensuring relevant documentation is saved on a regular basis so it can be accessed, as required, by the inquiry team.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	31.12.2022	Risk Management - Final	R1/3	Low	Consideration should be given to the roles and responsibilities associated with the 'check and challenge' process of proposed corporate risks, beyond the Risk and Regulation Team, and whether there would be value in holding a risk management steering group.	It is agreed that consideration will be given to this recommendation albeit the ability to achieve this recommendation will, to a large degree be dependent on the availability of risk leads to meet to discuss and review their risks at an agreeable and consistent time.	Director of Corporate Governance	Head of Risk and Regulation	C	At present there is no availability for a standalone Risk Management Steering Group. The Head of Risk and Regulation meets with Risk Leads on a bi-monthly basis to discuss risks and challenge submissions. Risk entries are also discussed and scrutinised at: 1) Directorate Q&S meetings; 2) Clinical Board Q&S Meetings; and 3) Clinical Board Performance Reviews. In addition to this Clinical Board risks are reviewed at each of their respective CB Performance Review Meetings where additional 'check and challenge' is undertaken by the Executive Team on both the risks appearing on their risks registers, the scoring of said risks and quality etc of descriptors prior to submission to the Board and various Committee of the Board. On that basis the an additional risk management steering group is not deemed necessary.
2022-23	30.09.2022	Monitoring and Reporting of Sickness Absence	R1/3	Medium	To support the Health Board's recovery from the COVID-19 pandemic, Clinical Board reporting of staff sickness absence should look beyond the high level Workforce Key Performance Indicators and provide more meaningful analysis or qualitative assessment of sickness absence.	Heads of People & Culture to provide Workforce booklet for each Clinical / Service Board to be discussed at Monthly Clinical / Service Board meetings. Representative from People Services to attend meeting as required and discuss impact of sickness absence on all KPI's and further MAAW information.	Executive Director of People and Culture	Head of People's Services	C	Booklet/report being provided by Workforce Analytics Team. Deputy Heads of People Services Attending Executive Performance Review and Clinical Board meeting to discuss data.
2022-23	30.09.2022	Monitoring and Reporting of Sickness Absence	R2/3	Medium	As a result of the changes that have taken place through the pandemic, clarification should be provided to Clinical Boards and Corporate Departments of the roles and responsibilities to manage staff sickness absence.	Communication in relation to allocation of People Services team to be cascaded and communicated to the Health Board, including Trade Unions.	Executive Director of People and Culture	Head of People Services, Executive Director of People and Culture, and People Services Team	C	People Services Team model has been communicated within the UHB. Further updates have been sent to ensure CBs up to date with any changes.
2022-23	31.08.2022	Monitoring and Reporting of Sickness Absence	R3/3	Low	Reference to the Managing Attendance at Work training on the Health Board website requires a refresh, to specifically remove dates referring to training in 2020	The Managing Attendance at Work Training to be updated on the Health Board website	Executive Director of People and Culture	People Services Manager	C	Website has been update with new dates and training dates are continually being arranged.
2022-23	30.09.2022	Integrated Medium Term Plan 2022 - 2025	R1/3	Low	Following review, the Terms of Reference for the Strategy Development and Delivery Group should be updated with the following: - The approval date; - The date of next review; and - Version number.	As is the case with all formal groups and committees it is appropriate to ensure periodic review of ToR takes place. As such at the next annual review of the group which will be during Qtr 2 22/23 we will ensure the ToR is updated (if necessary) but that regardless of any changes a subsequent approval date / next review date / version number is added.	Executive Director of Planning	Head of Strategic Planning	C	Chair of the Group is the Deputy Director of Planning and she will review the ToR regularly with the group.
2022-23	Immediately	Integrated Medium Term Plan 2022 - 2025	R2/3	Medium	To address the governance observations highlighted through our review of the IMTP development and scrutiny process, the following should be addressed: • The accessibility of the information presented to public meetings, including the Strategy and Delivery Committee and the Board; • Adherence to the 10 day advance publication of meeting papers in accordance with Standing Orders; and • The timing of meetings should be correctly stated on the Health Board's website, particularly when being live streamed.	a) Agreed. In future the Corporate Governance Team will request that documents are not embedded within covering reports and other paperwork, but are provided by the report authors as separate documents which can then be published as separate documents/appendices to the main paperwork and/or covering reports. We will update our Standard Operating Procedure (SOP) to reflect this. b) Generally the Corporate Governance Team publishes Board meeting papers at least 10 clear days before the meeting. This was not possible on this occasion due to the process to finalise the draft IMTP, which included discussions with Welsh Government before the financial elements of the draft IMTP could be agreed. The Corporate Governance Team received the IMTP papers 2 days before the Board meeting, hence the delay in publishing these papers. In future, where the Corporate Governance Team is aware that Board papers will be published late, we will publish a statement on our website to notify the Public that the paperwork will be published late. c) Noted and the Corporate Governance team will carry out a further check to ensure that the Board and Committee timings are correctly listed on the Health Board's website. This further check will be built into our SOP.	Executive Director of Planning	Head of Corporate Governance	C	These actions have been completed.
2022-23	30.09.2022	Integrated Medium Term Plan 2022 - 2025	R3/3	Low	Consideration should be given to building in a lessons learnt exercise into the planning timeline, to take forward any future learning and to build into the cyclical process.	As this audit notes The Strategy Development and Delivery Group is a key management forum for overseeing the development of the IMTP as such it is also appropriate that this group should take a leadership role in reflecting on the processes which its runs - Gathering feedback and taking learning where appropriate. A mechanism will be established within this forum to ensure there is ongoing periodic time to reflect and learn lessons regarding the IMTP process which it oversees on behalf of the UHB.	Executive Director of Planning	Head of Strategic Planning	C	Action reported as complete
2022-23	n/a	Stock Management - Neuromodulation Services (Specialist CB)	R2/5	Medium	In line with stock management best practice, stock should be stored securely at all times. The facilities available to securely store the stock should be reviewed.	In line with the above comments and lessons learnt following the review, the directorate has now ensured that all stock is appropriately counted and securely stored in two locations (main theatres or secure cabinet within secretary's office) to ensure we avoid losses and damages.	Chief Operating Officer	Neurosurgery Service Manager	C	All stock is now appropiately stored being a locked cupboard in theatres and a secured cabinet in the secretaries office for low value items. This change has been successful and has reduced the risk of stock becoming misplaced or lost. The Assistant Service Manager reviews this on a monthly basis to ensure all is in order and reports back to the Directorate Accountant and Service Manager.
2022-23	31.10.2022	Stock Management - Neuromodulation Services (Specialist CB)	R5/5	High	To address the missing stock the Directorate need to undertake the following: - Note the outcome of the July 2022 stock count; - If the variance remains, to investigate and attempt to locate the missing stock; - Depending on the outcome, implement suitable controls to ensure that this issue does not re-occur; and - Engage with central finance over the value of the missing stock. * *The implementation of the previous recommendations made within this report will strengthen the control environment.*	Following the July stock take there is still missing stock. Attempts are ongoing to find the missing stock with stores, theatres, directorate and the product supplier. The final variance with the potential missing stock will take two to three months to work through the system, due to timely receipting/delivery of products. Finance colleagues are sighted on volume of missing stock. The directorate and finance colleagues have a monthly finance meeting scheduled to review the neuromodulation stock variance in detail in order to finalise the position. The SOP sets out the processes and systems in place to track all stock from ordering to implantation/return to supplier.	Chief Operating Officer	Directorate Manager - Neurosciences	C	The concern with missing stock in the July position has been resolved using the new working practices that have been put in place since the SOP. Finance and Directorate colleagues continually review the Neuromodulation stock variance, as the process is resolving variances is due to timely receipting/delivery of products/ completed surgical cases which can be over a period of months.
2022-23	30.09.2022	Waste Management	R1/8	Medium	1.1. Waste management policies and procedures should be updated for currency / removed, in accordance with best practice guidance, and appropriately ratified. 1.2 The Environmental Management Steering Group terms of reference should be updated to appropriately reflect its waste governance responsibilities and linkage to the Health and Safety Committee.	1.1 Agreed. Update waste policy and procedures (ref MA1) to also include waste minimisation (ref MA7). Progress has been made in addressing a number of the above issues since the issue of the draft report i.e. an updated management structure, training needs and risk management processes have been drafted for inclusion within the above (ref MA1). The updated will be ratified at relevant board. 1.2 Agreed and actioned since audit fieldwork - the Environmental Management Steering Groups Terms of Reference has been updated to appropriately reflect its waste governance responsibilities and linkage to H&S Committee.	Director of Finance	Interim Head of Estates Operations	C	Action reported as complete

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2022-23	N/A	Waste Management	R3/8	Medium	The UHB should confirm appropriate risk reporting and escalation arrangements, notably to the Environmental Management Steering Group.	Agreed. Process maps required for Risk Management (ref MA3) and particularly escalation arrangements to Environmental Management SteeringGroup *Note: The "RISK MANAGEMENT PROCESS – CAPITAL ESTATES AND FACILITIES" has been defined and will be included within the updated Waste Management Policy.*	Director of Finance	Interim Head of Estaes Ooperations / Waste and Compliance Manager	C	The "RISK MANAGEMENT PROCESS – CAPITAL ESTATES AND FACILITIES" has been defined and will be included within the updated Waste Management Policy.
2022-23	N/A 30.09.2022	Waste Management	R4/8	Medium	A. The UHB should undertake training needs assessments to inform tailored training programmes encompassing all relevant UHB staff groups to determine the level and frequency of waste management training required by each staff group (which could range from general guidance on waste segregation and recycling, to technical guidance on clinical waste handling and include additional training provided due to COVID). B. Agreed, however, wider support needed from L&D to roll out across HB. Waste Manager currently sitting on a number of 'Teams' channels to deal with Waste queries as they arise.	A. Agreed, a training needs assessment matrix has been developed for all relevant Estates and Facilities staff. The matrix will be included within the updated Waste Management Policy (ref MA1). B. Agreed, however, wider support needed from L&D to roll out across HB. Waste Manager currently sitting on a number of 'Teams' channels to deal with Waste queries as they arise.	Director of Finance	Waste and Compliance Manager	C	Action reported as complete
2022-23	N/A	Waste Management	R8/8	Low	The relation between coding classifications of RIDDOR and Datix incident recording should be reviewed to ensure appropriate reporting.	Agreed, however superseded since audit fieldwork. Management advised that subsequent to the audit fieldwork, Datix has moved over to DCIQ which is powered by SharePoint and far more user friendly and coding issues should not arise.	Director of Finance	Waste and Compliance Manager	C	Refer to column G
2022-23	30.11.2022	Staff Wellbeing - Culture and Values	R8/10	Low	Efforts should be made at the next review of the Board Assurance Framework to populate the incomplete sections of the Leading Sustainable Culture Change risk, particularly the 'gaps in controls' and 'gaps in assurances' sections.	This is being addressed and will be updated by November 2022.	Executive Director of People and Culture	Assistant Director of OD, Culture and Wellbeing	C	Completed. However, review required of the Wellbeing BAF - current detail linked specificall to COVID, requires update to reflect current! situation re wellbeing, retention etc. Assistant Director of OD to speak to Governance to agree way forprward - Feb 2023.
2022-23	7.12.2022	Medical Equipment	R3/7	Low	The recommended list of medical equipment and devices held on the Clinical Engineering Services SharePoint site (formerly the intranet) should be subject to wider awareness across the Health Board.	Clinical Engineering will publicise the recommended list of medical equipment and devices via the MEG and MDSO groups.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	C	An updated version of the catalogue of recommended medical equipment has been published on the Intranet SharePoint site, and highlighted to MEG and MDSO membership.
2022-23	1.02.2023	Medical Equipment	R5/7	Medium	A periodic review of the Medusa medical equipment database should be undertaken to ascertain the status and current use of loaned medical equipment items. At the next review, the Management of Medical Equipment Procedure should be revised to provide guidance relating to the recording, oversight and active management of externally loaned medical equipment items.	The commissioning process for long term loan equipment will be changed to record information regarding the basis of the loan where available. Users will be reminded via the MEG and MDSO groups to record or share this information. The action in recommendation 4 will serve to audit old, loaned equipment.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	C	Discussed loaned equipment at December 2022 MEG, and requested that users inform CE of basis of loan agreements. Medical Equipment Procedure is currently being updated to include guidance to capure information as required in the recommendation.
2022-23	7.12.2022	Medical Equipment	R6/7	Medium	All medical equipment items that have undergone local decontamination prior to submission to the Clinical Engineering Department should be supported by a completed Contamination Status Clearance Certificate and the issuing book should be retained by the Emergency Unit. Additionally, the Management of Medical Equipment Procedure should be revised and updated to reflect the Ward/Unit based decontamination processes.	Clinical Engineering will work with the EU management to ensure decontamination certificates are available and completed. The Medical Equipment and Devices task and finish group will include the decontamination process in their revisions of the Policy and Procedure.	Executive Director of Therapies and Health Science	Head of Clinical Engineering	C	EC (aDoTH Med Equip) met with EU manager Craig Davies to disucss decontamination and cleaning equipment in the EU. There is now a HCA with responsibility for medical equipment who will assist the department in meeting this recommendation. Explicit guidance on the need for decontamination certificates will be included in the revised Med Equip Procedure.
2022-23	31.03.2023	Endoscopy Expansion	R1/9	Medium	1.1 The Project Board should confirm that the current named SRO has the necessary experience to discharge the role effectively and provide the relevant training as required. 1.2 The UHBs Capital Manual will be updated to reflect the requirements and assignment of key project roles (aligning with national guidance).	1.1 The SRO is appointed by the executive lead and they are issued with a letter of appointment which details their roles and responsibilities. In addition, all clinical board directors of Operations have been provided with Welsh Government guidance on the duties of an SRO. The UHB have been in discussion with WG to agree training for staff who are appointed as SRO. 1.2 A plan on a page has been developed with the intention to have links to relevant documentation for completion. Progress on this has been extremely slow due to lack of resource within the department. New staff will be commencing shortly and it is hoped to finalise the details to issue the updated manual.	Executive Director of Planning	Director of Capital, Estates & Facilities	C	Action reported as complete
2022-23		Endoscopy Expansion	R2/9	Low	The Project Execution Plan (PEP) should be reviewed for accuracy and updated appropriately.	Agreed. The PEP has been updated for the current juncture of the project.	Executive Director of Planning	Director of Capital, Estates & Facilities	C	Actioned since fieldwork
2022-23		Endoscopy Expansion	R4/9	Medium Low	1. Updates on the ongoing design should be incorporated into the established reporting mechanism to highlight progress and any potential issues. 2. Cost associated with changes to the project, should be reported consistently, to ensure contingency sums are accurately reported and managed.	1. Agreed. The design information is now incorporated in the highlight reports. 2. Agreed. The cost information has been updated accordingly, in the highlight reports, for consistency with the Project Manager report.	Executive Director of Planning	N/A	C	Actioned since fieldwork
2022-23	At future Projects	Endoscopy Expansion	R5/9	Medium	**Future Assurance** For future projects, in accordance with the Procedure Manual for Managing Capital Projects, a formalised design control process, including signed stage end reports, should be applied, clearly documented, and appropriately reported.	End stage reports will be implemented where appropriate, and subject to the value and complexity of the project. This will be detailed in the project execution plan going forward.	Executive Director of Planning	Director of Capital, Estates and Facilities	C	Action reported as complete

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for February 2023: Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022-23	At future Projects 31.01.2023 31.03.2023	Endoscopy Expansion	R6/9	Medium	**Future assurance** 1. For future projects, any amendments/virement from approved business cases should be documented, reported to an appropriate forum and approved (with any appropriate risks/benefits highlighted). 2. In this instance (changes in contract terms) retrospective approval should be sought through a paper, to a relevant forum, detailing the rationale, risks, benefits etc., associated with the current contractual arrangements (noting particularly in this instance reduced contractual obligations for all parties and reduced contingent liability period (see MA7)). 3. The Contract Strategy decision making process should be detailed at the Capital Manual including appropriate contract forms to be utilised and the associated advantages, disadvantages, risks, contingent liability periods etc., of the preferred approach. The same will be applied at all future projects.	Noted. The procurement strategy contained within the BJC was not updated to reflect the chosen contract. Noted. A paper will be drafted for consideration at the January 2023 UHB Board meeting. The revised capital manual will include guidance on appropriate contracts and a method of determining the strategy for each project.	Executive Director of Planning	Director of Capital, Estates and Facilities	C	Governance for buisnes case approval has been strengthened
2022-23	At future projects	Endoscopy Expansion	R7/9	Medium	Future Assurance For future projects, all contracts of a significant value/complexity should be completed as a deed i.e., affording the maximum period of contingent liability (12 years).	This action is linked to 6.3 and consideration of the type of contract if the project is of a significant value or complexity, it will be considered for formal sealing.	Executive Director of Planning	Director of Capital, Estates and Facilities	C	Action reported as complete
2022-23	30.11.2022	Endoscopy Expansion	R8/9	Low	The cashflow forecast should be incorporated within the established reporting mechanisms, so that scrutiny and challenge can occur.	The in year spend is included on the project leads report as is the spend up to the proceeding month.	Executive Director of Planning	Project Manager	C	Action reported as complete
2022-23		Endoscopy Expansion	R9/9	Low	An Early Warning Notice should be raised for the further impact on the project programme of the delay in issue of the fabrication drawing for issue.	An Early Warning Notice (EWN) should be raised where there is a perceived impact on cost or programme. In the example given, the project lead will consider the issuing of an EWN.	Executive Director of Planning	N/A	C	Actioned since fieldwork.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (February 2023 Update)

	Update September 2022				**Update September 2022**				**Update September 2022**			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months												
Overdue by over 3 months under 6 months										2		
Overdue over 6 months under 12 months												
Overdue more than 12 months		1	1			2	4					
No date set												
Total	**2**	1	1		**6**	2	4		**2**	2		

Total number of recommendations outstanding as of 26th January 2023 for financial year 2019/20 is 10 (4 of which are complete) compared to the position in September 2022 when a total of 16 outstanding recommendations were noted.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (February 2023 Update)

	Update September 2022				**Update September 2022**				**Update September 2022**			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months						2	3			1	2	
Total					**5**	2	3		**3**	1	2	

Total number of recommendations outstanding as of 26th January 2023 is 8 (3 of which are listed as complete) compared to the position in September 2022 when a total of 10 outstanding recommendations were noted.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2021/22 (February 2023 Update)

	Update September 2022				**Update September 2022**				**Update September 2022**			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached			2					4				
No date agreed				1						4		
Overdue under 3 months							1	1		1		
Overdue by over 3 months under 6 months		3		1			5				1	1
Overdue over 6 months under 12 months		3	2			5	8	7		6		2
Overdue more than 12 months			2			4					1	
Total	**14**	6	6	2	**35**	9	14	12	**16**	11	2	3

Total number of recommendations outstanding as of 26th January 2023 is 65 (26 of which are listed as complete) compared to the position in September 2022 when a total of 89 outstanding recommendations were noted.

Key: C – Complete PC – Partially Complete NA – No Action

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2022/23 (February 2023 Update)

	Update September 2022				**Update September 2022**				**Update September 2022**			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached						2	8					1
No date agreed						5				1	1	
Overdue under 3 months						3	6	3		5	1	1
Overdue by over 3 months under 6 months		1				4	5	4		3	1	2
Overdue over 6 months under 12 months												
Overdue more than 12 months												
Total	**1**	1			**40**	14	19	7	**16**	9	3	4

Total number of recommendations outstanding as of 26th January 2023 is 57 (24 of which are listed as complete).

Report Title:	Audit Wales Recommendation Tracking Report				Agenda Item no.	7.5	
Meeting:	Audit and Assurance Committee		Public	x	Meeting Date:	07.02.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Interim Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

Main Report
Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee ("the Committee) with assurance on the implementation of recommendations which have been made by Audit Wales by means of an External Audit Recommendation tracking report ("the Tracker"), a copy of which is attached as Appendix 1.

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

The tracker now includes two new reports that were presented to the September 2022 Committee. Namely, Audit of Accounts Report Addendum and the Estates Follow Up Review which records 35 external audit recommendations. Out of these, 4 are recorded as complete, 24 are partially complete and 7 indicate that no action has been taken. The status of the recommendations are as follows:

- Two recommendations have no agreed due date for implementation
- One recommendation is less than three months overdue
- Five recommendations are 1+ year's overdue
- Eight are 6+ months overdue
- Nineteen of the recommendations are yet to reach their agreed implementation dates.

A review of all outstanding recommendations has been undertaken with executive and operational leads for each recommendation since September 2022. This work will continue and be reported at each Audit and Assurance Committee to provide regular updates on the status of recommendations.

There are 6 outstanding recommendations dating back to Audit Reviews undertaken in 2019/20 and 2020/21, two of which are reported as complete. The remaining 4 recommendations will be reviewed with Audit Wales Colleagues prior to the April Committee meeting to identify opportunities for a further review in these areas or the potential for closure of the same due to recommendations being superseded.

The table at Appendix 2 shows a summary status of each of the recommendations made for external audits undertaken in 2019/20, 2020/21, 2021/22 and 2022/23 as at 25 January 2023.

Recommendation:

The Committee is requested to:

(a) Note and receive assurance from the progress which has been made in relation to the completion of Audit Wales recommendations; and
(b) Note the continuing development of the Audit Wales Recommendation Tracker.

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
By maintaining an up to date External Audit Recommendation Tracker, the Health Board mitigates the risk that it subject to legal or regulatory penalty.
Safety: Yes/No
N/A
Financial: Yes/No
N/A
Workforce: Yes/No
N/A
Legal: Yes/No
N/A
Reputational: Yes/No
N/A
Socio Economic: Yes/No
N/A
Equality and Health: Yes/No
N/A
Decarbonisation: Yes/No
N/A

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

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2019-20	No date specified	Clinical Coding Follow-up From 2014 not yet completed	R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	b) To facilitate the achievement of the Welsh Government target that 95% of coding activity should be completed within one month of the end of the hospital episode, it is important that clinical coders get timely access to the patient's medical records. From our last review we found that tracking of records was an issue. If records are not tracked effectively this means it can take longer for coders to access them. Coders are reporting that they are tracking records, however practices across the Health Board are not consistent and still cause issues.	Director of Digital and Health Intelligence	Head of Information Governance	PC	b)The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments Head of IG working with Medical Record's Directorate Manager to implement regular auditing function. **Aug '22 Update** An internal audit plan has been approved to undertake a tracking audit - * Fieldwork - September 2022 * Audit Completion - December 2022
2019-20	Mar-20	Audit of Financial Statements Report Addendum - Recommendations	R4	4: the Phase 2 and Phase 3 continuing healthcare claims require concluding The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly.	Phase 2 – all cases completed	Director of Finance	Deputy Finance Director	PC	Phase 3 – 2 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet. One case requiried a face to face meeting which had not been possible due to Covid, meeting was held at the end of May 2022 with written negotiation now in process. The other claim was awaiting correct legal authority which has now been received and claim is progressing through negotiation process.
2019-20	Dec-21	Implementing the Wellbeing of Future Generations Act	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	Programme of business cases in development with engagement on design detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) in constuction on track to be completed Dec 2021 and planning for Penarth and Ely hubs well underway. **Additional support secured in relation to planning of key future schemes which will include public and key stakeholder input. Work to be undertaken by end March 22.**	Director of Planning	Director of Operations, PCIC	C	Reporting takes place on a quarterly basis - to Committee and Board. Engagement plan developed. Resources to deliver remains a challenge.
2020-21	Mar-22	Follow-up of Operating Theatres	R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.	POAC was succesful in securing additional investment through recovery monies to increase POAC activity. Through this investment a number of additional staff have been appointed. The POAC service will move into a resdesigned facilitity to support POAC flow in June 2022. Work with external partners "Foureyes" to review the POAC service has gone well with a focus on booking, clinic flow, standardisation of clinic templates with the aim to reduce preventable cancellations. Once the services is fully embedded in the new facility there will be a focus on increasing the number of booked clinics vs walk in. We are also developing electronic POAC documentation with a view to being paperless to increase efficiency.	Chief Operating Officer	Denis Williams	C	**12/01/2023:** Now that POAC are in their new facility focus has been moved to increasing capacity of the Nurse Led clinics, reviewing the ratio of 'walk in' to booked clinics and a revised pathway for Anaesthetic Consulktant notes review. Nurses now see 7 patients per day with a 70/30 split of booked to 'walk in' clinics. Anaesthetic Consultants now have protected time each day to provide notes review and now have capacity to deal with the workload on a monthy basis. POAC is now in a state of Business As Usual
2020-21	Mar-22	Follow-up of Operating Theatres	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	The regular 2:1 Theatre Managerand Lead Nurse/General Manager meetings and the regular 2:1 Clinical Leader, Lead Nurse and General Manager meetings will continue for the forseeable future. There is also a Directorate Management meeting on a bi-weekly basis and Clinical Leaders meeting with Theatre Managers occurs on a regular basis. These meetings offer the opportunity to ensure that the Managers and Leaders within the Directorate are being supported and any issues can be discussed through a standardised agenda. Update 17/08/2022 - These meetings occur on a regular basis, are scheduled in advance either monthly or bi-monthly and are well attended. There are agendas and minutes are recordrd that are fed back during Directorate Management Team Meetings by each of the Theatre Managers. Actions are discusssed and closed when completed. THIS RESPONSE CAN BE CLOSED Workforce Manager appointment was made 20/12/2022. This role will ensure that the staff engagement work that is being carried out will continue and will drive not only workforce redesign but also the professional standards of the directorate. This project approach has been implemented and progress will be monitored. Update 17/08/2022 - The current status of main focus/priorities that are disciussed at the bi-weekly Directorate Management Meeting and 1:1 with the General Manager are 1) General establishment review, continual progress and good practice is being made that also links in with the whole workforce structure project 2) Band 7 Anaesthetic Associate role - The JD has been finalised and the role will be discussed at the All Wales Recruitment Meeting before approching the Executive Board for funding approval (awaiting update) 3) Work continues to progress well to recruit additional Anaesthetic Pactitioners 4) The Workforce Manager continues to work closely with the Cardiology and Trauma & Orthopaedic Theatre Teams to resolve ongoing cultural and stafing behaviours and this work will be completed by end of September 2022.	Chief Operating Officer	Ceri Chinn	PC	Workforce Manager appointment was made 20/12/2022. This role will ensure that the staff engagement work that is being carried out will continue and will drive not only workforce redesign but also the professional standards of the directorate. This project approach has been implemented and progress will be monitored. Update 17/08/2022 - The current status of main focus/priorities that are discussed at the bi-weekly Directorate Management Meeting and 1:1 with the General Manager are 1) General establishment review, continual progress and good practice is being made that also links in with the whole workforce structure project 2) Band 7 Anaesthetic Associate role - The JD has been finalised and the role will be discussed at the All Wales Recruitment Meeting before approaching the Executive Board for funding approval (awaiting update) 3) Work continues to progress well to recruit additional Anaesthetic Pactitioners 4) The Workforce Manager continues to work closely with the Cardiology and Trauma & Orthopaedic Theatre Teams to resolve ongoing cultural and stafing behaviours and this work will be completed by end of September 2022
2020-21	Jun-21	Assessment of Progress Against Previous ICT Recommendations	R4/5	Rollout appropriate and regular offline information governance training to employees without PC access.	An IG presentation has been produced that can be delivered by the individual service for staff who are unable to undertake online training. This has been circulated to those services with a dedicated training function.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	**June 22 Update:** a programme for digitally enabling the entire workforce is being developed, focussing initally on nursing staff, provide NADEX and email accounts to them, starting in September 2022 to support the imlpemention of the Welsh Nursing Care Record. the aim is to extend to all staff during 2022/23. **Aug '22 Update:** Roll out of additional devices to nursing staff on track to commence September 2022.

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2021-22	Windows 7 replacement - February 22 Servers - March 2023	Audit of Accounts Report Addendum - Recommendations	R2/6	The Health Board should replace its unsupported servers and devices. Where replacment is not currently feasible, the Health Board should ensure that robust mitigating arrangments are in place. Looking forward, the Health Board needs to be proactive, with better planning for its timely replacement of unsupported IT operating systems and devices.	There are ongoing programmes in place to replace or upgrade all affected devices. Jan 2022 Update: The majority of the CAVUHB workstation estate has now been upgraded with less than 8% left to complete. In Nov 2021 the server team in CAVUHB began decommissioning legacy server operating systems and upgrading where possible, this work is planned to continue throughout 2022/23. DHCW Nessus and SIEMs solutions have also been implemented in Dec 2021, along side a dedicated Ivanti patch management solution. A new Anti-Virus solution has been implemented for the CAVUHB server estate in Dec 2021.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	Aug 2022 Update - Over 75% of the existing server base has AV installed. All new servers now have McAfee AV installed by default. All compatible servers have the base AV agent on and the team is working with the clinical boards and departments to agree maintenance windows. Less than 75 Windows 7 machines remain the project is expected to completed by Sept 2022.
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R3/6	The Health Board should test its DR plan to gain assurance that IT systems can be restored if needed. The Health Board should review the DR plan regularly, and in doing so ensure that changes to the infrastructure and network are fully considered. Once updated and finalised, the Healht Board should test rhe revised DR plan to ensure that it works as intended.	The IT DR Plan is being reviewed and updated as part of a programme to refresh IT Security documentation. Jan 2022 Update: HPE StoreOnce backup and archiving solution with a capacity of 1PB has been purchased and due to be implemented in Feb 2022. This will form part of a new Backup and DR approach for CAVUHB. This will be achieved by retiring tape media and consolidated with Veeam software throughout, to be carried out during early 2022.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	Aug 2022 Update - A comprehensive review of CAV server backups has been completed. CAV are in the final stages of consolidating on a single backup vendor/product. Deployment of the new HPE storage will follow this backup work, both are expected to be completed by Dec 2022.
2021-22	Feb-22	Audit of Accounts Report Addendum - Recommendations	R4/6	The Health Board should update its IT chang control policy and procedure	The change control policy is being updated and will be implemented as part of the new Ivanti helpdesk implementation project which includes change control functionality. Jan 2022 Update: Ivanti Helpdesk and Change Management Module is scheduled to be implemented W/C 10th Jan 2022.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	Aug 2022 Update: Ivanti Change Control has been deployed in UAT and tested successful. The adoption of Digital teams using Ivanti has delayed the go live for Change Control which is now expected by Sept 2022
2021-22	Nov-22	Audit of Accounts Report Addendum - Recommendations	R5/6	The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls, or, decommissioning and replacing them with a better, fit for purpose, data centre.	Future reliance on these rooms is being reviewed and potential part decommissioning will be considered. Jan 2022 Update: Additional funding has been allocated for these improvements. Further consolidation of the two datacentres has progressed and a remote DR/Backup location in UHL has been identified. This new DR site will be developed over the next 12 months, subject to appropriate funds being available.	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	PC	Aug 2022 Update: New UPS devices for UHL, Woodland House and CRI have been procured. Cabinets have been delivered and further electrical work is required in Woodland House and UHL before DR sites can be setup. In the interim a small impementation of DR servers have been installed in Woodland House. **Electrical work expected to be completed by Sept 2022 with DR capability in WH by Oct and UHL Dec 2022.**
2021-22	Feb-25	Taking Care of the Carers	R1/6	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as eing at higher risk from COVID-19.	Cardiff and Vale University Health Board (CAV UHB) continues to maintain a strong focus on wellbeing through a variety of initiatives which include UHB-wide interventions (e.g. supporting the capacity of the Employee Wellbeing Services; wellbeing conversations promoted as part of VBAs and regular 1-2-1s; effective inductions) and targeted pieces of work (e.g. Shwartz Rounds; Med TRiM, hydration stations and staff rooms and Wellbeing Retreats). The overarching framework for this is the People and Culture plan which has been informed by colleague feedback, data and the Health Intervention Report (specifically in relation to staff wellbeing).	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	The UHB People and Culture Plan 2022-25 sets out the actions we will take over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce through the 7 themes, and monthly flash report highlight progress in each area, with regular updates to the Strategy and Delivery Committee, Local Partnership Forum; Strategic Wellbeing Group and Strategic Portfolio Steering Group. With COVID Restrictions being removed by Welsh Government, including the requirement to 'shield', the organsation has communicated guidance to staff via national guidelines which can be found at https://gov.wales/public-health-advice-employers-businesses-and-organisations-coronavirus-html . The People and Culture Team continue to porvide support and guidance to managers to manage risk in more complex situations. Work is currently under-way to further support and enhance the focus on staff wellbeing, with the development of a health and wellbeing framework. The H&WB Strategy and Framework will be discussed at Strategic Wellbeing Group Feb 23 and consultation with CBs will take place Feb/March 23 and at LPF. Final version to go initially to SLB May 23.
2021-22	Mar-25	Taking Care of the Carers	R2/6	**Considering workforce issues in recovery plans** NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.	The impact of COVID-19 on the health and care system continues to take its toll on both the delivery of services and the wellbeing of our staff. With many COVID restrictions lifted, the challenges of increasing service demand, waiting lists and financial strain continue. The People and Culture Plan sets out the themes we will focus on over the next three years, with a clear focus on improving the wellbeing, inclusion, capability and engagement of our workforce. This Plan is aligned with the Operational plan; thereby ensuring a whole-system approach. The specific developments under the People and Culture Plan are reported upon monthly and progress is documented in a flash report. Ongoing review of actions and priorities continue, informed by direction provided by WG, feedback from colleagues and workforce data. Recent engagement exercises with staff have included a Wellbeing Survey for the Medical Workforce (closed 31st July 2022), and the launch of a three month engagement platform (Winning Temp) aimed at our Nursing and Midwifery Staff and ODPs. Feedback from these exercises will inform response and priorities to ensure safe, effective and high quality healthcare.	Executive Director of People and Culture	Executive Director of People and Culture Assistant Director of Organisational Development Assistant Director of Resourcing	PC	Work continues to ensure the measures and evaluation that underpin the People and Culture Plan are established, and a review of KPIs is underway. A 12 month review of progress will identify key priorities for 23/24 to support IMTP delivery and the Strategy Refresh. Work on the Wellbeing Strategy and Framework will outline effective means of benchmarking, measureing and evaluating both services and intervention.
2021-22	Mar-22	Taking Care of the Carers	R3/6	**Evaluating the effectiveness and impact of the staff wellbeing offer** NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.	The People Health and Wellbeing Services Team, which includes Occupational Health, Employee Wellbeing Servies, Health Intervention and Physiotherapy Services, are developing effective means of measuring both delivery of services (e.g. Counselling appointments; Pre-Employment Health Checks); and impact of those services. This information is being developed to be incorporated into a quarterly report which will also feed the progress reports on the People and Culture PLan. Base-line information is collated in all areas where targeted interventions are being developed, to ensure an effective means of measuring impact and outcomes. The development of the Wellbeing Framework will also incorporate tools and templates to ensure that interventions, projects etc are effetcively measured. The People and Culture Team are working with Innovation and Improvement to shape monitoring and evaluation.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Physical environment work identified in the funding made available in 2021/22 was fully utilised. Issues remain regarding the installation of Water Fountains and the requirements and stipulations of the UHB's Water Safety Group. The UHBs is actively involved with the Welsh Government's Staff Welfare Group and the proposals are currently with the Health Minister. These include: Rest; Environment; Nutrition; Hydration; Education and Development. Evaluation of the Wellbeing Retreats to be undertaken Feb 23.

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2021-22	Nov-23	Taking Care of the Carers	R4/6	**Enhancing collaborative approaches to supporting staff wellbeing** NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.	Recent developments in this area include Cardiff and Vale's participation and involvement in the All Wales Staff Welfare Group, looking at ways to support and improve the wellbeing of NHS colleagues across Wales. Part of this involvement is the sharing of the work CAV are doing around Wellbeing Retreats; hydration and physical environment work. Work continues to progress, and the UHB now has representation on the working groups that have stemmed from the over-arching steering group.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Dashboards to highlight the themes of the engagement and wellbeing platforms and surveys to be presented to CBs Feb/March 2023. This will inform the focus of targeted intervention which may include: retention; wellbeing; eduaction and development. Review of People and Culture Plan priorities and KPIs to support main effort in the first oinstance, but to incorporate lessons learned 2022/23. Employee Wellbeing Service and Occupational Health Team have developed a dashboard of delivery which is reviewed monthly. Further work on EWS dashboard to identify themes etc to inform work on retention; wellbeing. EHIA recently completed to support Strategy Refresh Work, and review of Shaping Our... EHIAs to be undertaken to ensure relevant. Anti-Racist Action Plan draft has been designed through co-design, and will be discussed as part of Board Development, Feb 2023 and presented to Strategy and Delivery Committee, and Board in March 2023.
2021-22	Feb-25	Taking Care of the Carers	R5/6	**Providing continued assurance to boards and committees** NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.	Quarterly updates to the Board / more regular reports for management executive team meetings Updates and discussions at Local Partnership Forums and LNCs. Update, discussion and feedback at Clinical Boards Bi-monthly Wellbeing Strategy Group meetings - latest update 03/08/2022 Ongoing evaluation of staff wellbeing offer, including access, impact and value awaiting OH Services evaluation. Feedback and discussion at staff networks to inform priorities / direction of travel Attendance of AD of OD at key strategy meetings / COVID recovery meetings to ensure staff wellbeing at forefront of decisions ; EHIA completion to support policy / process and decision making - EHIA Process currently being reviewed in partnership with Innovation and Improvement Team to embed in organisational programmes of work. Staff feedback regarding wellbeing also obtained via NHS Wales Staff Survey, MES, localised surveys and trial of engagement tool with nursing staff (March-May 2022). MES Workshops took place in March and April 2022, follow up focus groups scheduled for June and July 2022 led by the Medical Director and AD of Organisational Development. Wellbeing Survey for Medical Workforce going live in June 2022. Winning Temp engagement platform being trialled with all Nursing and Midwifery staff opened w/c18th July 2022, open until mid October 2022, enabling weekly 'check ins' and temperature checks. Communication plan in development to be shared with staff to manage expectations and provide regular updates. Wellbeing retreats have started, two held to date - informal feedback very positive with further engagement to obtain more meaningful feedback scheduled for September 2022 working with The Fathom Trust. Analysis of the Medical Workforce Wellbeing Survey to be carried out in August 2022. This information to be triangulated with other engagement outputs (MES; other surveys) to inform wellbeing priorities via the Executive Medical Director. Work also commencing on Anti-Racist Wales Action Plan.	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	Dashboards to highlight the themes of the engagement and wellbeing platforms and surveys to be presented to CBs Feb/March 2023. This will inform the focus of targeted intervention which may include: retention; wellbeing; eduaction and development. Review of People and Culture Plan priorities and KPIs to support main effort in the first oinstance, but to incorporate lessons learned 2022/23. Employee Wellbeing Service and Occupational Health Team have developed a dashboard of delivery which is reviewed monthly. Further work on EWS dashboard to identify themes etc to inform work on retention; wellbeing. EHIA recently completed to support Strategy Refresh Work, and review of Shaping Our... EHIAs to be undertaken to ensure relevant. Anti-Racist Action Plan draft has been designed through co-design, and will be discussed as part of Board Development, Feb 2023 and presented to Strategy and Delivery Committee, and Board in March 2023.
2021-22	Mar-23	Taking Care of the Carers	R6/6	**Building on local and national staff engagement arrangements** NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.	xisting staff engagement mechanisms include: •NHS Wales Staff Survey - planned for October 2022 (as per information from HEIW) •Medical Engagement Scale - follow up online engagement sessions in March/April 2022; focus groups and visits to targeted areas planned in June/July 2022 and a follow-up wellbeing survey to all Medical Workforce June-August 2022 •Freedom to Speak Up - CAV part of all Wales working group •HR Processes and Procedures •Respect and Resolution Policies and Procedures •Trade Union Representatives •Existing Staff Networks – LGBTQ+; One Voice (Black, Asian, Minority Ethnic); Long Covid; Access Ability Network launched April 2022 •14,000 voices campaign (on-site visits / staff groups / teams etc) •Live, online 'Ask the CEO / Exec etc' sessions held bi-monthly •Localised engagement aligned to specific strategic projects, e.g. Shaping our future clinical services	Executive Director of People and Culture	Assistant Director of Organisational Development	PC	All Wales NHS Staff Survey unlikely to take place until at least Summer 2023 (update from HEIW Jan 2023); UHB involvement in Freedom to Speak Up All-Wales work continues and toolkit and information likely to be rolled out Q1 2023/24. Diverse Cymru have been procured to review All Wales NHS Policies and Guidelines with an 'anti-racist' lens. Work to commence Feb 2023. Strategy Refresh work commenced and engagement plan has been agreed, led by Deputy Director of Planning and Strategy. Anti-Racist Action Plan work re Board Development to continue Feb 2023, was delayed from Dec 22 due to industrial action. Staff Networks to be discussed as part of Board Development. Executive Director of P&C, Deputy Director of P&C and assistant Director of OD, Wellbeing and Culture to meet with Strategy and Planning in Feb 2023 to discuss OD requirement for Shaping our.... Challenges will be around lack of OD capacity.
2021-2022	Apr-22	Structured Assessment 2021 (Phase 2)	R2/2	The Health Board's approach to planning remains robust. However, the Health Board's arrangements for monitoring and reporting on plan delivery are less robust. The Health Board, therefore, should strengthen its arrangements for monitoring and reporting on the overall delivery of its Annual Plan and future Integrated Medium Term Plans by: a. ensuring these plans contain clear summaries of key actions / deliverables, timescales, and measures to support effective monitoring and reporting; and b. providing more information to the Board and Strategy and Delivery Committee on progress against delivery of these plans to enable full scrutiny and assurance .	a. It is intended that the IMTP for 22/23 will have clear actions, timescales and deliverables which can be tracked. This is already well established for the Recovery Programme and the Strategic Programmes so we will ensure it covers the other areas included within the IMTP. b. We will look at how best to report on the key deliverables set out in the Annual Plan/IMTP to ensure the Board is able to scrutinise and seek assurance. We will do this in a way that aims to minimise duplication with the Performance Report that is provided to the Board regularly.	Director of Corporate Governance	Executive Director of Strategic Planning	PC	No update received for February 2023 meeting
2022/23	Sep-22	Review of Quality Governance Arrangements	R1/7	The Surgery Clinical Board and Surgical Services Directorate revised their quality priorities in response to the COVID-19 pandemic. However, there appears to be poor alignment between these operational priorities and the Health Board's key delivery actions for quality and safety as outlined in its Annual Plan for 2021-22. The Health Board, therefore, should ensure there is better alignment between operational and strategic quality and safety priorities as articulated in the Health Board's 10-year strategy and new Quality, Safety, and Patient Experience Framework.	To work with all Clinical Boards to agree the QSE priorities aligning to the framework and Annual Plan and to the IMTP. Develop generic and specific Quality indicators aligned to the QSE Priorities in the QSE framework for Clinical Boards which are reported through QSE structure. and QSE Committee. These will be reported by exception as required and in totality at their scheduled presentation to the Committee.	Executive Nurse Director	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality	NA	No update received for February 2023 meeting

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2022/23	Oct-22	Review of Quality Governance Arrangements	R2/7	Risk Management There is scope to ensure the corporate Quality, Safety and Experience Committee maintains greater oversight of risks scrutinised by other committees where there is a clear quality and safety impact. There is scope to improve the quality of risk information recorded on operational risks registers and the escalation and de escalation of risk to / from the Corporate Risk Register. The Health Board, therefore, should ensure: a) the corporate Quality, Safety and Experience Committee seeks assurance from other Health Board committees where their risks potentially impact on quality and safety; and b) review and improve the quality of risk information recorded on operational risks registers and introduce an appropriate process for the escalation and de-escalation of risk to / from the Corporate Risk Register.	a) All risks detailed within the Corporate Risk Register that might impact on quality and safety will continue to be shared at the Quality, Safety, and Experience Committee. In addition, risks detailed within the Board Assurance Framework that are shared at other committees, such as Work Force, which is discussed at the Strategy and Delivery Committee will, where the risk may have Quality and Safety implications, also be shared with the Quality Safety and Experience Committee. b) The Health Board's Risk and Regulation Team operate a check and challenge system to manage the escalation and de-escalation of risks from the Corporate Risk Register. Training is also provided to risk leads to improve the detail recorded within risk registers. Both areas remain a work in progress and will continue to be implemented and improved.	Director of Corporate Governance	Head of Risk and Regulation	C	All Patient Safety risks as they are recorded will be referred to relevant Committees for review.
2022/23	Oct-22	Review of Quality Governance Arrangements	R3/7	Clinical Audit The Health Board is developing a Clinical Audit Strategy and Policy, but there has been a delay in progress due to capacity and IT system challenges within the Clinical Audit Team. Internal Audit completed a review of the Health Board's clinical audit arrangements during 2021 and gave a limited assurance rating, identifying several key matters that need to be addressed. Whilst the Health Board is making some progress in this area, it should: a) complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide, and local audits informed by areas of risk. This plan should be approved by the corporate Quality, Safety and Experience Committee and progress of its delivery monitored routinely; and b) ensure that recommendations arising from the Internal Audit review of clinical audit are implemented as a priority.	The Clinical Audit Plan is to be shared at the Audit and Assurance Committee and discussed at the October QSE Committee meeting. The plan will reference all of the actions from this report. Compliance with internal audit findings will continue to be monitored via the Audit and Assurance Committee. Some investment has been provided to Clinical Audit from in year one form the internal Business case (monies to be provided over a 3 year period). Posts are being recruited into - investment was provided for a Clinical Effectiveness lead Band 8a and an Audit co-ordinator band 5. Additional resource was provided for a band 5 post to support the AMAT programme. AMAT - Audit management and tracking system has been purchased and is being rolled out through a phased implementation	Executive Nurse Director	Head of Quality Assurance & Clinical Effectiveness	NA	No update received for February 2023 meeting
2022/23	QSE Framework to 2026 May 2023 Project plan completion October 2022	Review of Quality Governance Arrangements	R4/7	Values and Behaviours The Health Board's Values and Behaviours Framework sets out its vision for a quality and patient-safety-focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses, incidents, and raising and listening to staff concerns. The Health Board, therefore, should undertake work to understand why some staff feel: a) that their mistakes are held against them or kept in their personal file; b) that the Health Board does not provide feedback about changes put into place following incident reports or inform staff about errors that happen in their team or department; and c) they don't feel free to question the decision or actions of those with more authority and are afraid to ask questions when something does not seem right .	A safety culture with a focus upon psychological safety is an enabler of the QSE Framework. Members of the team are undertaking an IHI (Institute for Healthcare Improvement) Leadership course, and their focussed piece of work will address these issues. A project plan is being developed and will be part of the QSE implementation of the framework Culture surveys and feedback will be part of the evaluation with our quality metrics and will be undertaken annually in quarter 4 to assess whether values and behaviours have improved. Work will be aligned with organisational development colleagues supported through the people and culture plan.	Executive Nurse Director	Head of Patient Safety and Quality reporting to Executive Nurse Director as Executive sponsor for the programme	NA	No update received for February 2023 meeting
2022/23	Mar-24	Review of Quality Governance Arrangements	R5/7	**Personal Appraisal Development Reviews (PADRs)** The Health Board compliance rate for appraisals is consistently below the national target of 85%. The Health Board reports that operational pressures are adversely affecting compliance and enabling work has not delivered the level of improvement anticipated over the COVID-19 pandemic period. The Health Board, therefore, should take appropriate action to improve performance in relation to PADRs at both corporate and operational levels.	The UHB has recognised the issue regarding VBA compliance and an improvement plan has been put in place focusing on communication and engagement, training and support and the impact on staff wellbeing and performance outcomes. This improvement plan has been developed with Trade Union Partners and will be delivered in collaboration with TU Partners. Recognising ongoing service pressures across the UHB as we manage the pandemic recovery phase and ever increasing service demands, the UHB target is to increase compliance to 50% in 2022/23, followed by a target of 85% in 2023/24. These KPIs are reflected in the People and Culture Plan and are reviewed monthly. A focus on promotion and engagement of the new VBA approach (launched in 2019), will develop manager capability and team buy-in through effective and accessible training and development, engagement and support, including development in delivering an effective VBA, the importance of VBAs on staff wellbeing, performance, motivation and quality.	Executive Director of People and Culture	Assistant Director of OD, Wellbeing and Culture	PC	VBA complaince was a focus of Executive Performance Reviews in November 2022 with a Deep Dive Paper presented to Strategy and Delivery Committee 15th Dec which included current status and trajectory plans (as agreed in Exec Performance Review). The current targets are 65% by the end of March 2023, and 85% end of Quarter 1, 2023/24.
2022/23	Aug-22	Review of Quality Governance Arrangements	R7/7	**Monitoring and Reporting** There is no evidence to indicate that the four harms associated with COVID-19 have routinely been reported to the Board either through the integrated performance report or systems resilience update. Furthermore, there was limited evidence that Clinical Boards consider the four harms associated with COVID-19 as part of the reporting to the corporate Quality, Safety, and Experience Committee. The Health Board, therefore, should ensure that the four harms associated with COVID-19 are routinely considered by Clinical Boards and reported to the corporate Quality, Safety, and Experience Committee and Board	The revised template for the Clinical Boards QSE meetings will incorporate the 4 harms associated with COVID-19 reporting The notes and action logs of the clinical Boards will be shared at the QSE Committee meetings.	Director of Corporate Governance	Assistant Director of Patient Experience and Assistant Director of Patient Safety and Quality	NA	No update received for February 2023 meeting

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2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R1/9	**Weaknesses in the stocking taking arrangements:** The Health Board should strengthen its stocktaking procedures. In doing so the Health Board should introduce a corporate set of stocktaking procedures for all its stock sites. As part of the process the Health Board should use sequentially numbered stock-count sheets.	Whilst the Health Board has robust stock procedures documented, it is accepted that these need to be reinforced and recommunicated to the relevant stock take teams and accountants. Training sessions will be held to ensure guidance is followed and understood. If any additional steps are required due to specialised stock being held (i.e. ALAS) additional specific guidance will be issued.	Executive Director of Therapies and Health Sciences	Executive Director of Therapies and Health Sciences	PC	Governance: -We will adhere to the Corporate stock take guidance issued by Financial Accounts (including the use of sequential numbered stock-count sheets). -Multiple members of the finance team will be onsite during the 22/23 audit to aid compliance with directions. Team structure: -Stock team lead formally appointed. -Joint finance/operational manger appointed to improve understanding of systems/impact upon stock holdings. Education and Training: -Enhanced training/education for all stock team members.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R2/9	**Weaknesses in the processing of a retire and return application and an underpayment to an employee:** The Health Board should ensure that line managers always evidence their approval, and that such approval is verified by another officer before an application is processed. Also, the Health Board should review its procedures for the payment of untaken leave, to establish how the underpayment had first occurred, and, how it had not been picked up as an error. The Health Board should then strengthen its controls where necessary.	Procedures are being reviewed and any identified additional controls will be implemented in 2022/23.	Executive Director of People and Culture	Executive Director of People and Culture	C	If any Executive Directors apply to retire and return, the People Assurance and Experience Team will double check that the appropriate application form has been completed and been approved. The 2021/22 All Wales Annual Leave Selling Scheme was a one-off scheme so the issue will not be repeated
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R3/9	**Delays in receiving working papers and supporting evidence:** For 2022-23 the Health Board should provide us with all the relevant records, per the agreed Audit Deliverables document in place for that year. Also, the Health Board should ensure that all supporting records are provided in a timely manner, particularly during the first couple of weeks of the 2022-23 audit.	The main working papers were delivered as per the deliverables document however some additional supporting papers were provided in week 2 (following the additional WG reporting deadlines which fall in week 1 of the annual audit). A review of all working papers and deliverable dates will be carried out to help ensure audit have all the information they require in the first week of audit to prevent delays going forwards. A review of working paper formats for debtors and creditors will also be carried out to identify improvements to minimise the need for multiple files/supporting papers.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review prcess has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R4/9	**Lack of detailed instructions to the valuers:** Prior to a valuation being undertaken, the Health Board should issue and agree a formal instruction to its valuers.	A full specification has been issues in relation to the quinquennial view by Welsh Government. In relation to our ad hoc valuations throughout the year, we will agree formal instructions to the District Valuer by valuation type going forward.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review prcess has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R5/9	**Assets not being depreciated when brought into use:** The Health Board should accurately apply its accounting policy and depreciate all assets when they are brought into use.	Additional controls have been added to the year-end procedures to ensure assets are depreciated correctly.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review prcess has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R6/9	**Some working papers were not referenced to the agreed Audit Deliverables Document:** For 2022-23 the Health Board should reference all its information to the agreed Audit Deliverables Document.	To ensure satisfactory naming and sharing of documents in 22/23 a premeeting would be advisable to get agreement on titles and distribution list. Working paper titles where amended in 21/22 to aid understanding of contents but this was based on accounts notes not deliverables – will update further in 22/23 based on Audit Wales guidance.	Director of Finance	Director of Finance	PC	Part of 2022-23 Annual Accounts Processes. A Review prcess has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines.
2022/23	Year end 2022/2023	Audit of Accounts Report Addendum	R7/9	**Weaknesses in network security vulnerability assessments:** The Health Board should strengthen its assessment of network security vulnerability by: • completing regular external penetration testing on the network perimeter, including at least annually by an accredited third party; and • actively monitoring the internal network penetration testing to promptly identify and address any weakness.	The UHB is currently in the process of appointing a dedicated cyber team. Two positions have been filled and we are recruiting a further two posts. An externally performed penetration test is being scheduled for Q4 of 2022/23. Once the cyber posts are in place, we will be in a position to proactively use a number of cyber tools at our disposal. This includes: SIEM, which is currently operational and staff are in the process of being trained. Defender for Endpoint, currently in the process of being onboarded and,Nessus, operated by the server team but will be supported by the cyber department. We anticipate that all roles will be appointed to by Q3 of 2022/23	Director of Digital and Health Intelligence	Director of Digital and Health Intelligence	NA	No update received for February 2023 meeting
2022/23	31-Mar-23	Audit of Accounts Report Addendum	R8/9	**Monitoring and review of user access to the WellSky Hospital Pharmacy system can be strengthened:** The Health Board should strengthen its formal monitoring of user access rights to the WellSkysystem. Also, the Health Board should ensure that its monitoring is based on regular reviews, and a clear and up-to-date record (retaining historic details) of all users, and confirmation that each user's access is appropriate.	The WellSky system management team will review user access profiles by the end of March 2023, this will also include putting in place a regular annual review process.	Clinical Director Pharmacy and Medicines Management	Clinical Director Pharmacy and Medicines Management	PC	Working with DHCW to review list of staff with access to WellSky. Process for removing/ammending staff access level when the leave/change roles is being developed. Report to identify who has access to which features is not available - DHCW resolving this with WellSky so only who has access to the system can be reviewed not what level they can access.
2022/23	31/03/2023	Audit of Accounts Report Addendum	R9/9	**Progress against previous years' recommendations:** The quality of some of the Health Board's underlying working papers requires further improvement **1. 2019-20:** The Health Board should review and simplify its supporting records for certain areas of its annual financial statements, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand how some of the documentation affects our audit. **2. 2020-21:** The Health Board should replace its unsupported Windows 2008 servers and W7 devices. **3. 2020-21:** The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed. **4. 2020-21:** The Health Board should update its IT change-control policy and procedure. **5. 2020-21:** The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls	1. The Health Board improved some of its processes and records for 2021-22 and we understand that it plans more improvements for 2022-23. We will continue to liaise with the finance team on the improvements. 2. The Health Board has an ongoing programme in place to replace or upgrade all affected devices. 3. The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation. 4. The Health Board is updating its change control policy as part of its new helpdesk system. 5. The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them	Director of Finance	Director of Finance	PC	1. Ref : Financial Accounts Issues :-Part of 2022-23 Annual Accounts Processes. A Review prcess has been undertaken to improve 2022-23 Accounts functionality and improve input to WAO during the Audit period. Work is ongoing in line with Accounts preparation and submission deadlines. 2. Work to replace Win7 devices is complete. work to replace 2008 server estate is on-going due to clinical service dependencies (additional controls have been put in place in the interim, pending migration and replacement). 3. The DR plan has been updated and is scheduled to be tested (Qtr4 22/23) 4. IT change control policy and procedure has been produced in draft, which will be published by end Qtr4 22/23). 5. The IT1 DC is being consolidated into IT2 with a second site identified and being set up as additional resillience (in by Qtr4 22/23 and fully operational by Q1 23/24).

Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Recommendation	Management Response	Executive Lead for Report	Operational Lead for Recommendation	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update Please provide the following information for each recommendation: 1. A general update; 2. Has there been a change to the Implementation date, if so why? 3. Any specific challenges that you are encountering or have encountered; 4. The last date the recommendation was shared at its assurance committee.
2022/23	31/03/2023	Estates Follow Up Review	R1/3	**Develop a fully-costed Estates Management Strategy:** The Health Board could not provide a copy of its estate management strategy, which it reported was agreed in 2017. However, the Health Board is currently in the early stages of developing a new estates strategy. The new strategy should clearly set out: - a baseline assessment of the condition of the current estate and the total resources (including workforce) needed to maintain it against available resources; - how the estate will be maintained and resourced to the required standard in the short- and medium term; and - plans for maintaining and investing in the current estate whilst implementing its estates investment programme.	A copy of the estate's strategy based on the operational team requirements was provided, but this strategy dealt with service delivery and did not review, in depth, the outlined areas contained within this audit recommendation. The Estates Strategy going forward will provide the following as outlined within the recommendation. In the interim and immediate; it will state how the estate will be maintained, based on current workforce and funding, until the baseline assessment has been completed. The strategy will outline, where necessary, the prioritisation of work in relation to patient safety, health and safety, structural integrity and statutory compliance against the backdrop of available budgets and workforce. It will indicate that a baseline assessment will be completed and programme of completion provided. The baseline assessment will include a condition survey review in accordance with Estatecode, six facet survey or similar. This survey information will then be used to assess, prioritise and re-align the workforce, required to maintain the site, dependent on the highlighted risks within the survey, and the available budget within the Health Board, in the short- and medium-term. It is anticipated that the survey information will take approximately 18 months to procure and complete. A further period of implementation will be essential if workforce changes are required as a result of the outcome. This detail will be provided within the Estate Strategy.	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	NA	No update received for February 2023 meeting
2022/23	28/02/2023	Estates Follow Up Review	R2/3	**Introduce a system to inspect a percentage of repairs each month:** We found that the Health Board is yet to develop a system to inspect a percentage of repairs each month. This is an essential element for any estate maintenance service, providing vital assurance that work is being carried out in compliance with the relevant safety and quality standards. The Health Board should introduce a monthly inspection regime by March 2023.	Agreed MiCAD interrogation and monthly reports set up (Complete) Initial agreement of content of inspections and form they will take (October 2022) Initial KPI's developed and monitoring commencement (November 2022). Review of forms and KPI's (February 2023).	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	PC	Work remains ongoing. A further update will be shared at the April Committee meeting.
2022/23	31/01/2023	Estates Follow Up Review	R3/3	**Strengthen performance management:** We found that the Health Board is continuing to develop KPIs for its estates and facilities services but is yet to establish a suitable format to report the information internally and up to the Board for assurance. By March 2023, the Health Board should ensure that: - relevant estates and facilities KPIs are included in the integrated performance report which is received by the Board; and - the KPIs are linked to the new estates strategy.	Agreed. Current KPI formats are being assessed along with content (December 2023). Once KPI content is agreed and data capture refined, information will be presented to the Board with bi-monthly performance feedback at the Service Board meetings (January 2023). The KPI's will help inform and be linked into the Estates Strategy when completed.	Director of Capital Estates and Facilities	Director of Capital Estates and Facilities	PC	Work remains ongoing. A further update will be shared at the April Committee meeting.

Audit Wales Recommendations 2019/20 – 2022/23 (February 2023)

External Audit	Complete	No action	Partially complete	No Date Specified	0 mths	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Assessment of Progress Against Previous ICT Recommendations			1						1	1
Audit of Accounts Report Addendum – Recommendations 2022-23	1	1	7		9					9
Audit of Accounts Report Addendum – Recommendations 2021-22			4		1			1	2	4
Audit of Financial Statement – Report Addendum - Recommendations			1						1	1
Clinical Coding Follow-up from 2014			1	1						1
Estates Follow-up Review		1	2		**2**	**1**				3
Follow-up of Operating Theatres	1		1					2		2
Implementing the Wellbeing of Future Generations Act	**1**								1	1
Review of Quality Governance Arrangements	**1**	**4**	1	1	1			4		6
Structured Assessment 2021 (Phase 2)			1					1		1
Taking Care of Carers			6		6					6
Total	**4**	**6**	**25**	**2**	**19**	**1**		**8**	**5**	**35**

From the above table it can be seen that 12 recommendations have been added to the tracking report since the last report to Committee in September 2022. The total number of recommendations is currently 35, with 4 completed. 25 actions are partially completed, with 5 outstanding actions that are more than a year behind schedule. 8 are more than six months overdue, with another 2 indicating no date specified. 19 actions have not exceeded their agreed-upon deadlines.

Report Title:	Regulatory Compliance Tracking Report			Agenda Item no.	7.6
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	07.02.2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

The purpose of this report is to provide Members of the Audit and Assurance Committee ('the Committee') with assurance on the implementation of recommendations which have been made by external regulatory and legislative bodies, of which the Health Board is obliged to comply with. Assurance in this regard if provided by means of a Legislative and Regulatory Compliance Tracking report.

This report also continues to include commentary on the Health Boards management of Welsh Health Circulars and Patient Safety Solutions: Alerts and Notices which will continue to be reported as a matter of course.

At the September Committee Meeting it was agreed that the procedure for Internal and External Tracking Report updates would be varied (See minute: AAC 5/7/22 018) so that the Tracker is now reported at alternating Committee meetings, as opposed to every meeting.

The rationale for this change was to provide those with responsibility for actioning audit recommendations with additional time to implement required changes, inform updates and close out recommendations. The additional time between meetings will also provide the Risk and Regulation team with the ability to meet with colleagues, internally and externally to provide support and guidance to ensure that recommendations are proactively managed. This support will enable the identification of superseded entries (as a result of subsequent Follow Up and/or external reviews) and the identification of other aged recommendations that can legitimately be regarded as complete.

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

The tracker provides the following details:

- All Regulatory Bodies that have active recommendations with the Health Board. Also contained within the tracker are the details of Regulatory Bodies that have previously inspected the Health Board despite there being no live recommendations. This is to ensure that the tracker remains a comprehensive list of all potential regulatory bodies.
- The Regulatory Standard which is being inspected is listed where this information is available.
- The Lead Executive in each case is detailed as is the accountable operational lead so that it is clear who is responsible for completion of the recommendation at an executive and operational level.
- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection. This column, coupled with the comments section, provides assurance to the Committee that progress against and compliance with recommendations is being routinely monitored and scrutinised.

- A Red, Amber, Green (RAG) rating that highlights where the recommendation sits against the agreed implementation date. Entries are rag rates as follows:

  Green – Over 1 month until due date for implementation of recommendation
  Amber – Due date for implementation of recommendation within 1 month; and
  Red – Due date for implementation of recommendation met or exceeded.

In addition to the above the below updates are also shared in relation to the Health Board's Management of Welsh Health Circulars (WHCs) and Patient Safety Solutions: Alerts and Notices (PSN's). Separate Tracker documents are held for the monitoring of WHC's and PSN'S and are managed by the Risk and Regulation and Patient Safety teams respectively.

An extract from the WHC tracker is copied below as an example of the information recorded:

Welsh Health Circular (WHC) No	Name of WHC	Date Issued	Status	Action Needed By	Category	Overarching Actions Required	Lead Executive	Work in Progress	Work Completed	Status RAG Rated: Blue Complete; Green On track to Meet deadline; Red	Comments
2021/006	Elections to Senedd Cymru May 2021 Guidance for NHS Wales	11.03.21	Action	24.03.21	Governance	The principles set out in the guidance apply to the NHS at all times, but particular note should be taken in the period between the start of the formal campaign on 25 March and up to and including polling day 6 May.Chief Executives of NHS organisations should ensure that the principles in this guidance are followed.	CEO		Yes		Guidance shared with CEO and Chair and Board Secretary and referred to in various meetings where discussions or decisions could be election relevant.

Since the November 2022 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- WHC/2022/026 – More than Just Words - Welsh Language Awareness Course
- WHC/2022/029 - Urgent polio catch-up programme for children under 5 – Follow up from WHC/2022/027
- WHC/2022/031 - Reimbursable Vaccines and Eligible Cohorts for HTE 2023-24 season flu vaccine programme
- WHC/2022/035 Influenza Vaccination programme deployment 'mop up' 2022-2023
- WHC/2022/036 - Eliminating hepatitis (B and C) as a public health threat in Wales – Actions for 2022-23 and 2023-24

As of the 26.01.2023 the Health Board's WHC tracker was fully up to date and each WHC detailed on the Welsh Government website had been allocated to an Executive Lead to monitor and action.

Patient Safety Solutions: Alerts and Notices

PSN's are monitored and managed by the Patient Safety and Organisational Learning Manager ("PSOLM") who maintains a tracker of all PSN's that are received and ensures that each PSN is shared with relevant clinical and corporate directorates for action. The PSOLM also regularly chases colleagues to ensure that actions are undertaken and reported through the use of compliance forms which record completion of required actions. Once a PSN is recorded as complete the PSOLM notifies the relevant Welsh Government delivery Unit and copies of all such notifications and completed compliance forms are logged by the PSOLM and the Risk and Regulation Team.

Compliance with Patient Safety Solutions: Alerts and Notices can also be tracked at the following NHS Wales Delivery Unit website: https://du.nhs.wales/patient-safety-wales/patient-safety-solutions-compliance/ (this link will need to be copied and pasted into your internet browser for access).

As of the 26.01.2023 the Health Board is reported to be compliant with all 63 Patient Safety Notices which date back to the 31.07.2014.

The Health Board is currently Non-Compliant with the following two Patient Safety Alerts:

PSA Number:	Title of Safety Solution:	Compliance Date:	PSQ Team update:
PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm	30.11.2017	An All Wales Training Solution is awaited to enable compliance with this alert across Wales.
PSA012	Deterioration due to rapid offload of pleural effusion fluid from chest drains	01.07.2021	A Pleural Effusion pathway has been developed and approved by the Medicine Clinical Board Quality and Safety Group. This will be adopted more widely across the Health Board in the coming months to demonstrate compliance with this Alert.

Regulatory Tracker

The Regulatory Tracker attached to this report is up to date as of the 26th January 2023 and will continue to be updated throughout the organisation and reported to the Committee on a bi-meeting basis.

Following November's Committee Meeting a total of 2 completed entries were removed from the register. A further entry has been reported as complete since the November Committee Meeting with the remaining entries reported as partially complete on the attached Tracker.

Following November's Committee Meeting the following additional entries have been added to the Tracker:

External Regulator	Report Area	Number of Recommendations	Responsible Executive Officer
Health Inspectorate Wales	CD&T – Diagnostic Imaging Department	9	Executive Director of Therapies and Health Science
Health Inspectorate Wales	Diagnostic Imaging at University Hospital of Wales – Improvement plan update	9	Executive Director of Therapies and Health Science
Health and Safety Executive	CEF- Led by Health and Safety	Investigations remain ongoing in relation to extract ventilation systems.	Head of Health & Safety
Health and Safety Executive	UHW Surgery - Theatres	Investigations remain ongoing in relation to manual handling practices.	Head of Health & Safety

It should be noted that further inspections by the Health and Safety Executive were undertaken on the 01.02.2023. The outputs of those investigations will be shared once communicated to the Health Board.

The ongoing review of progress against regulatory body inspections and recommendations should reduce the risk that key regulatory requirements are missed and the procedure for tracking such progress will also enable the Committee and Board to have oversight of the Health Board's compliance with regulatory requirements so that appropriate action can be taken to address emerging trends.

Assurance can be taken from the ongoing monitoring and management of External Regulatory Reports and Recommendations.

Recommendation:

The Committee is requested to:

(a) note the updates shared and the continuing development and review of the Legislative and Regulatory Compliance Tracker.

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	
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		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	x	Collaboration	x	Involvement	

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: Yes

Whilst no specific Legal Impact assessment has been undertaken the monitoring and tracking of compliance with regulatory recommendations contribute to the Health Board's compliance with its legal requirements.

Reputational: No

Socio Economic: No

Equality and Health: No
Decarbonisation: No

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

Clinical Board	Directorate	Regulatory body/inspector	Service area	Initial - Inspection Date:	Title of Inspection/Regulation/Standards	Lead Executive	Assurance Committee or Group	Accountable individual	Next Inspection Date	Recommendation Narrative / Inspection outcome	Date for Implementation of recommendations:	Management Response / Update	RAG Rating	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES THERAPEUTICS AND TOXICOLOGY CENTRE														
AUTHORISING ENGINEER - NWSSP														
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Ventilation AE	May-22	Authorising Engineer (Ventilation) Annual Report - Ventilation AE	Executive Director of Finance	Strategy and Delivery Committee/Ventilation Safety Group	Director of Capital Estates and Facilities	May-23	4 recommendations	May-23	A review of recommendations made has been undertaken. 1 of the 4 Recommendations has complete - 3 remain Partially Complete		PC
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	Low Voltage Systems	Feb-22	Authorising Engineer (Low Voltage) Annual Report	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	Feb-23	9 recommendations	Feb-23	A review of recommendations made has been undertaken. 2 of the 9 Recommendations have been completed - 7 remain Partially Complete		**PC**
Capital Estates and Facilities	**Capital Estates and Facilities**	NWSSP	(Medical Gas Pipe Line Systems	May-22	Authorising Engineer (Medical Gas Pipe Line Systems) Annual Report	Executive Director of Finance	Strategy and Delivery Committee	Director of Capital Estates and Facilities	May-23	13 recommendations	May-23	A review of recommendations made has been undertaken. 3 of the 13 Recommendations have been completed - 10 remain Partially Complete		**PC**
ALL WALES QUALITY ASSURANCE PHARMACY														
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	27.01.2020 - Re - Inspected 04.05.2022	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	05.05.2023	105 Actions Highlighted	05.05.2023	Currently reviewing actions for action plan submission. **No update since July 2022 meeting.**		**pc**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	06.08.2020 - Re Inspected - 22.11.21	Quality Assurance of Aseptic Preparation Services	Executive Medical Director	QSE Committee/ Management of medicines group	Clinical Director of Pharmacy and Medicines Management	01.11.2023	50 deficiencies highlighted	01.11.2023	Deficiencies addressed and completed. Decision as to the funding for the 4 glove isolator and the required works on the facilities required to progress several of the deficiencies. **No update since July 2022 meeting.**		**pc**
BRITISH STANDARDS INSTITUTE														
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS														
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygeine Ratings	Central Production UHW	12.05.2022	Unnanounced inspection	Executive Director of Finance	Health and Safety Committee	**Head of Catering Services**	N/A	A Food Hygiene rating of 2 was received which, in the main, was due to kitchen drains leaking into a non food store room located below the production kitchen	23.06.2022	No EHO Inspections since tracker last updated to update the position.		**PC**
CAPITAL EXPENDITURE INTERNAL REVIEW														
Clinical Coding														
Digital Health	Clinical Coding	DHCW	Clinical Coding	24.06.2022	Clinical Coding Audit	Director of Digital Health Intelligence	Digital Heath Intelligence Committee	**Director of Digital Health Intelligence**	N/A	A total of 5 recommendations were made regarding clinical coding practice within the Health Board.	N/A	Of the 5 recommendations, 4 are recorded as complete. Work remains ongoing within endoscopy to compete/close out the final recommendation.		**PC**
COMMUNITY HEALTH COUNCIL														
Specialist Services - Ward B1	Ward B1	CHC	Ward B1	TBC	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Specialist Services CB Director of Nursing	N/A	A total of 7 recommendations were made regarding ward B1's facilities.	ASAP	3 of the 7 Recommendations are reported as complete. The remaining recommendations remain in progress.		**pc**
Medicine	Stroke Rehab Ward	CHC	Medicine CB - Stroke Rehab Ward	31.08.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Medicine CB Director of Nursing	31.08.2022	A total of 4 recommendations were made regarding the Stroke Rehab Ward's facilities.	ASAP	All 4 recommendations require estates input. An estates survey was request on 08.08.2022		**pc**
Children and Women	Childrens Hospital for Wales	CHC	Island Ward	08.08.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Children and Women CB Director of Nursing	N/A	A total of 4 recommendations were made regarding the Patient and Parent Experience and facilities within Island Ward	ASAP	1 of the 4 recommendations is reported as complete.		**PC**
Medicine	Medicine	CHC	Ward East 4	06.07.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Medicine CB Director of Nursing	N/A	A total of 7 recommendations were made regarding ward East 4's facilities.	ASAP	4 of 7 Recommendations are reported as complete. The remaining recommendations remain in progress and require estates input and purchase of equipment.		**PC**
Children and Women	Maternity Led Unit	CHC	Maternity Led Unit	18.07.2022	CHC Recommendations	Executive Director of Strategic Planning	QSE Committee	Children and Women CB Director of Nursing	N/A	A total of 4 recommendations were made regarding Patient and Staff experience, Staffing Levels and Estates infrastructure, most notably lift services.	ASAP	All 4 recommendations require are partially complete but rely on wider UHB support to finalise.		**PC**
FIRE AND RESCUE SERVICES														

Mental Health	Capital and Asset Management	Fire and Rescue Services	Mental Health HYC	14.04.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	N/A	Duty of Works: EN01 - (EN3/21) Article 8 - Duty to take general fire precaution's is not being complied with EN3/21 Schedule states: "During the inspection carried out on 14th April 2021 there was evidence of illicit smoking found throughout the premises. These matters have previously been raised by this Authority and also within previous FRA's carried out by the UHB fire safety advisor. This is unacceptable. The UBN's smoking policy should be appropriately managed to ensure that smoking and ignition sources are controlled and monitored to reduce the potential for accidental and deliberate fire setting."	Ongoing	Robust control measures have been agreed and implemented between the Director of CEF and senior premises managers. This has been communicated to the enforcing authority. A further inspection was carried out on 20th May by the enforcing authority and due to a number of non compliances found at that time an EN 03 was served i.e. ' Enforcement Notice not complied with'. This matter still rests with the Fire Authority's Compliance team for deliberation as to whether they might proceed with prosecution. N.B. An Article 27 letter dated 15th September 2021 was served on the CEO requiring pertinent information to be forwarded to the Fire Authority within 14 days of the date of the letter. This information was duly forwarded to the Fire Authority. A letter under caution was issued against the executive director for public health on 01/12/2021. This has been responded to and a subsequent meeting held with the chief fire officer for SWFRS, the UHB CEO, new responsible exec for fire and new fire safety manager. The notice remains open but close collaboration exists between the two parties. On 1st November 2021 significant organisational changes were made resulting in the fire team moving to sit under H&S. 11/01/2023: SWFRS have taken the decision to prosecute the UHB for alleged contraventions. A plea hearing was conducted by Cardiff magistrate court where the UHB entered 'No plea'. Hearing was held at Cardiff Crown court on 13th January 2023 where the UHB entered 'Not guilty' pleas to all 4 offences.		**PC**
Medicine	Capital and Asset Management /UHW - Ward A4	Fire and Rescue Services	UHW Ward A4	29.09.2021	Regluatory Reform (Fire Safety) Order 2005	Executive Director of People and Culture	Health and Safety	**Head of Health and Safety**	31.03.2023	Duty of Works: EN59/21 - Article 8: Duty to take general fire precautions Article 13: Fire fighting and fire detection Article 15: Procedures for Serious and Imminent Danger and for Danger Areas Arcile 21: Training	31.03.2023	Measures have been agreed with and implemented by senior managers of the UHB's Estates Service Board. Consequenlty the enforcing authority inspector has agreed to extend the date of this notice for 12 months to enable all works to be completed. The reasonably practicable work has been completed within the timesacale, work is currently being undertaken to complete the outstanding scope of work. Compliance date is 31/03/2023. The work has now been completed by the CEF team with the exception of a fire door set which has yet to be delivered. The head of health and safety is to obtain assurance that all aspects of the enforcement notice have been satisfied before inviting SWFRS back for a reinspection. This is likey to take place in early February.		**PC**

HEALTH EDUCATION AND IMPROVEMENT WALES

HEALTH INSPECTORATE WALES

Children & Women	Maternity	HIW	Maternity Services	TBC	HIW	Executive Nurse Director	QSE Committee	Head of Midwifery	**TBC - Matter on Hold**	HIW are undertaking a national review of maternity services across Wales (Phase 2). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.	On hold. An update on all HIW inspections are shared at each Quality, Safety and Experience Committee. Updates were last shared at the June QSE Committee. No update since November's meeting.		**N/A**
Mental Health	Community Mental health	HIW	Community Mental Health	TBC	HIW	Executive Nurse Director	QSE Committee	Director of Nursing for Mental health Services	**TBC**	National Review of Mental Health Crisis prevetnion in the Community	**N/A**	The terms of reference have been published by HIW and the final report was due to be published in December 2021 and is awaited.		**PC**
PCIC	HMP Cardiff	HIW	HMP Cardiff	N/A - Desktop review	HIW	Executive Nurse Director	QSE Committee	Executive Director of Nursing - Head of HMP Cardiff Healthcare	**N/A**	A total of 11 recommendations made.	**Various**	2 of the 11 recommendations have completed with a number of the remaining entries recroded as partially complete.		**PC**
Medicine	Welsh Ambulance Services NHS Trust	HIW	A&E	Oct-21	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director/Chief Operating Officer	**N/A**	A total of 13 recommendations were made.	**N/A**	10 of the 13 recommendations have completed. The remaining 3 recommendations are parially complete.		**PC**
Medicine	Emergency / Assessment Units	HIW	A&E	20.06.2022	HIW	Executive Nurse Director	QSE Committee	Executive Nurse Director	**TBC**	A total of 16 recommendatons were made	**N/A**	5 of the 16 recommendations are reported as complete completed. The remaining 11 recommendations have not been progressed with additional detail required to update HIW.		**PC**
Specialist Services	Cardiothoracic Services	HIW	Surgery Ward 6	Mar-22	HIW	Executive Nurse Director	QSE Committee	Specialist Services Clinical Board Triumvirate	**TBC**	A total of 21 recommendations were made in relation to a number of issues, including Patient Safety, Patient Experience, Quality and Estates.	**N/A**	All recommendations are reported as partially complete with progress being made against sub-recommendations.		**PC**
CD&T	Diagnostic Imaging Department	HIW	Diagnostic Imaging Department	Aug-22	HIW	Executive Director of Therapies and Health Science	QSE Committee	CD&T Clinical Board Triumvirate	**TBC**	A total of 9 recommendationswere made relating to improvement of Staffing and operational procedures and guidelines.	**N/A**	All 9 recommendations are reported as Partially Complete with detailed progress updates provided		**PC**
CD&T	Nuclear Medicine Department	HIW	Nuclear Medicine Department	Oct-22	HIW	Executive Director of Therapies and Health Science	QSE Committee	CD&T Clinical Board Triumvirate	**TBC**	A total of 7 recommendationswere made relating to improvement of Staffing and operational procedures and guidelines, including Welsh Language Standards.	**N/A**	Updates are awaiting in relation to all 7 recommendations.		**NA**

HEALTH AND SAFETY EXECUTIVE

Capital Estates	CEF- Led by Health and Safety	HSE	Laboratory Testing Services - UHW	27/01/2022	HSE Statutory Inspection	Executive Director of People and Culture	Health and Safety Committee	Head of Health & Safety	01.02.2023	Request for information in relation to local exhaust an extract ventilation systems. Details of maintenance and agreements in place between UHB and Cardiff University forwarded to HSE.	Ongoing	Information provided to HSE. 05/01/2023 - Meeting held at the request of HSE with the intention of taking a voluntary statement from the Head of Estates and Facilities. Agreement on the day that CAVUHB would formally provide answers to HSE questions by the end of January 2023 and the Head of Estates and Facilities would then sign a voluntary statement to this. The Head of H&S signed a voluntary statemtent during the meeting in relation to information previously sent to them in February 2022.		**PC**
Surgery	Surgery - Led by Health and Safety	HSE	UHW Theatres	27/01/2022	HSE Statutory Inspection	Executive Director of People and Culture	Health and Safety Committee	Head of Health & Safety	01.02.2023	25/01/2022. Request to review Theatres manual handling systems in relation to the pushing and pulling of theatre trolleys.	Ongoing	Information provided to HSE. No feedback from HSE, the Head of Health and Safety requested an update during a meeting in relation to T2 animal house and the issue was verbally closed out. Requested this be put into writing. Not received at time of writing 16/01/2023		**PC**

HUMAN TISSUE AUTHORITY														
INFORMATION COMMISSIONERS OFFICE														
Digital Health Intelligence	IM&T and Information Governance	ICO	Digital Health	13.03.2020	ICO Data Protection Audit	Director of Digital Health	Digital and Health Intelligence Committee	Head of Information Governance	TBC	25 recommendations were made in relation to Governance and Acocuntability. 1 of these recommendations required urgent action, 14 were rated high, 7 medium and 3 low. 20 recommendations were made in relation to Cyber Security. 1 of these recommendations required urgent action, 9 were rated high, 9 medium and 1 low. An overall assurance rating of reasonable was achieved in both areas.	25.10.2021	9 of the 25 recommendations made by the ICO remain outstanding. The ICO undertook a follow up investigation in November 2021 and concluded that there was still a risk of non-compliance with data protection legislation and recommended urgent action tto complete outstanding recommendations. An update was shared at the Digital Health and Information Committee in June 2022.		**PC**
JOINT EDUCATION ACCREDIATION COMMITTEE														
Specialist Services	Haematology	JACIE	South Wales BMT Programme	TBC	6th edition of JACIE standards	Executive Director of Medicine	QSE Committee	Executive Director of Medicine	01.09.2024	Minor deficiencies noted	01.09.2024	Programme received formal re-accrediation notice - There are ongong discussions with the executive board regarding a new facility for BMT / Haematology as the service will not achieve re-accreditation post he next inspection cycle. A capital planning project team has been established to develop the business case to support the development of a refurbhsied facility for the service. No further update provided since Sepetember Committee Meeting.		**PC**
MEDICAL GENETICS														
MHRA														
CD&T	Pharmacy	MHRA	Pharmacy UHL	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	3 majors 2 others	31.03.2020	Descalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator		**PC**
CD&T	Pharmacy	MHRA	Pharmacy SMPU	TBC	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	8 Recommendations	16/12/2021	Following inspection and KPI improvement, restrictions to licence removed and no longer subject to IAG but de-escalation to compliance management team with quarterly KPI data submission for the next 9 months		**PC**
NATURAL RESOURCES WALES														
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
WELSH WATER														
Capital Estates and Facilities	UHW	Welsh Water	UHW	13.05.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee	Director of Capital Estates and Facilities	tbc	Contraventions of sections 73-75 Water Industry Act 1991 and Water Supply (water fittings) Regulations 1999 (The Regulations) relating to contamination, waste, misuse, erroneous meassurement and undue consumption of water at the premises.112	20.06.2022	Action plan developed and working through actions before Revisit.		PC
Capital Estates and Facilities	St Davids	Welsh Water	St Davids Hospital	24.06.2022	Site Inspection	Executive Director of Finance	Health and Safety Committee	Director of Capital Estates and Facilities	n/a	Remedial works recommended pursuant to the Water Supply (Water Fittings) Regulations 1999 (The Regulations).	TBC	Re-Inspection awaited.		PC
WSAC														
Surgery	Audiology	WSAC	Newborn hearing screeing wales	04.11.2021	Audiology / Newborn Hearing Screening QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.2024	Results awaited.	01.01.2022	All recommendations are complete		**C**
Surgery	Audiology	WSAC	Audiology - paediatrics	04.11.2021	Audiology / Paediatric QS	Executive Director of Therapies and Health Science	QSE Committee	Paediatric Cochlear Implant Lead - Razun Miah/Rhian Hughes/Ellen Thomas	01.11.20224	85% target met in individual standards and 90% overall target met - 95.22% overall compliance score achieved	01.01.2022	5 recommendations made relating to Standards, 1a.3, 2a.8, 3a.5 &3a.6, 6a.1 and 7b.1. 3 of the 5 recommendations are reported as complete, Two recommendations remain partially complete with action plans in place.		**PC**
WEST MIDLANDS QRS														

Report Title:	Review of Risk Management Systems			Agenda Item no.	7.7
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	07.02.2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

Internal Audit undertook an Audit of the Health Board's Risk Management procedures in June 2022 which received an overall Reasonable Assurance rating.

A copy of the Audit Report was shared at the July 2022 Audit and Assurance Committee ("the Committee") meeting and contained the following recommendations:

1) Consideration should be given to the roles and responsibilities associated with the 'check and challenge' process of proposed corporate risks, beyond the Risk and Regulation Team, and whether there would be value in holding a risk management steering group.

2) Risk owners should be reminded of their roles and responsibilities to ensure that the risk management information held within the risk registers is complete and regularly reviewed and updated.

3) Continued efforts should be made to provide risk management training to risk owners, to maintain momentum of risk management maturity within the Health Board.

As of February 2023, all 3 recommendations were reported as complete with appropriate actions being embedded into Risk Management practice.

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

The Risk Management Process involves the systematic application of policies, procedures and practices to the activities of communicating and consulting, establishing the context and assessing, treating, monitoring, reviewing, recording and reporting risk in strategic and operational settings.

The Board Assurance Framework ("BAF") provides the Board with information on the key Strategic Risks that could impact upon the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. It provides information on the controls and assurances in place to manage and/mitigate the risks identified and any further actions which are required. As of January 2023, the following areas were identified as posing the greatest risk to the Delivery of the Health Board's Strategic objectives:

1. Workforce
2. Patient Safety
3. Sustainable Culture Change
4. Capital Assets
5. Delivery of 22/23 commitments within the IMTP
6. Staff Wellbeing
7. Exacerbation of Health Inequalities
8. Financial sustainability
9. Urgent and Emergency Care

10. Maternity
11. Critical Care
12. Cancer
13. Stroke
14. Planned Care
15. Digital Strategy and Road Map

Committees of the Board routinely review their risks on the BAF to provide further check, challenge and assurance to the Board when the BAF is presented in full. The Director of Corporate Governance also meets with executive colleagues and strategic leads to discuss and review the above risks to ensure that they are dynamically and proactively managed.

The Strategic Objectives are mapped to the risks on the BAF so there is clarity which risks impact on the objectives.

The 'lines of defence' have been added to the assurances on the controls provided for each risk. The 'lines of defence' define whether the assurance is: Level 1 – Operational management, Level 2 – Oversight and Scrutiny Functions or Level 3 Independent Assurance. The purpose of this is to aid the Board to understand the overall levels of assurance on the controls in place to manage each risk.

The BAF identifies from the Corporate Risk Register ("CRR") the highest risks faced by the Health Board in achieving its strategic objectives, and the gaps in assurances on which the Board relies.

The Corporate Risk Register maps extreme level risks (specifically those scoring 20/25 or above), as well as risks that, whilst having a relatively low current risk rating, are sufficiently complex or wide in their potential impact, to require Executive Level/Board scrutiny.

Candidate risks for the CRR are shared with the Risk and Regulation Team by Clinical Boards and Corporate Directorates on a bi-monthly basis for consideration and review. All risks received are reviewed and measured against the Health Board's Risk Scoring Matrix. Whilst the vast majority of risks are included within the CRR, a number are not and feedback is provided to risk owners with appropriate rationale.

This process of 'Check and Challenge' is undertaken by the Risk and Regulation team as a whole and, where appropriate, escalated to the Director of Corporate Governance. Following review, a feedback form is completed and shared with Risk Owners to detail recommendations and the detail of any changes made or proposed to the submitted risks.

To supplement this process Extreme Risks are also shared and scrutinised at Bi-Monthly Clinical Board Review meetings which are attended by Executive and Operational Leads.

The Health Board's Risk Appetite is firmly embedded within the Health Board's Risk Management and Board Assurance Framework Strategy and is incorporated into all training sessions delivered by the Risk and Regulation Team. There is however still plenty of work to be done to ensure that Risk Appetite is incorporated into all risk-based decisions.

Assurance Strategy

Internal Audit Colleagues have undertaken an advisory review of the Health Board's Assurance Strategy, a copy of which will be shared at the February 2023 Audit and Assurance Committee ("the Committee") Meeting.

That advisory Audit made a number of recommendations that have resulted in the realignment of the strategy and the following changes being implemented:

1) A revised Three Lines of Defence Model has been included within the Health Board's Risk Management Policies and Procedures and the Assurance Strategy. That model incorporates elements of best practice highlighted within the Advisory Review so that it aligns with examples of external risk, governance and assurance models. Specifically, the updated model re-aligns functions within the Lines of Defence to ensure that the more accurately reflect recognised best practice.

2) A revised version of the Health Board's Template Assurance Map has also been prepared which is designed to specifically maps Assurance Levels in relation to risks that are reported within the Corporate Risk Register.

   It is hoped that monitoring the level of Assurance that can be provided against those risks held within the Corporate Risk Register will enable more targeted action to be taken to proactively manage these risks and identify opportunities to control the same.

   Once this approach is fully embedded it is proposed that supplemental Assurance Maps will be populated and reviewed within specific corporate and clinical areas. These maps will identify what levels of assurance can be provided to the Board in areas where high scoring risks are frequently held for prolonged periods of time and will enable more targeted reviews and support to be undertaken/provided by Internal Audit and other colleagues.

A copy of the updated Risk Management Policies and Procedures and Assurance Strategy, which incorporate Internal Audit advisory recommendations will be shared with the Board at it's March Meeting for approval.

Recommendation:

The Committee is requested to:

a) **NOTE** the update on the Review of the Health Board's Risk Management Systems and ongoing developments in this area.

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	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	x

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

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

This review contributes to the Health Board's Risk Management processed and procedures.
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:

Report Title:	Assurance Strategy Update			Agenda Item no.	7.8
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	07.02.2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval		Information x
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report
Background and current situation:

At the November 2022 meeting of the Audit and Assurance Committee ('the Committee') it was agreed that a further Assurance Strategy update would be shared following the implementation of advisory recommendations made by Internal Audit.

The advisory recommendations/opportunities identified by Internal Audit are:

1) Consideration should be given to reviewing and revising the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to risk, governance and assurance best practice.

2) The Health Board should consider reviewing and revising the current Assurance Map template, appended to the Assurance Strategy, so that the layout and content takes a risk based approach, which will assist in prioritising areas to take forward.

3) The Assurance Strategy Action Plan should be further developed to include actions for the medium term, to ensure the strategy becomes fully embedded across the Health Board.

The Assurance Strategy Advisory Audit, which is shared at this Committee Meeting as agenda item 9.1(e) reports that recommendations/opportunities 1 and 2 have been completed.

The output of completion of these advisory opportunities are included within the following updated documents which are shared with the Committee for approval and referral to Board for ratification:

1) Updated Assurance Strategy (with Tracked Changes) (Opportunity 1). Also included within this document is the updated Assurance Map (Opportunity 2) which can be found at Appendix 6 of the document;
2) Updated Risk Management and Board Assurance Framework Strategy with tracked changes to identify changes made.

An updated Action Plan, as recommended within Opportunity 3 of the Advisory Audit is detailed below.

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

Alongside amendments made to the Assurance Strategy, work has been undertaken to embed the delivery of the Strategy across the Health Board, starting with the population of an Assurance Map that is aligned to the Corporate Risk Register.

Attached as Appendix 3(a) to (c) is a copy of the Assurance Map that continues to be populated following preparation of the Corporate Risk Register for the January 2023 Board meeting. This document is attached for reference purposes at this stage, a full, working version of the Assurance Map will be shared at the March 2023 Board meeting.

- Appendix 3(a) is a copy of the updated Assurance Map;
- Appendices 3(b) and (c) are evidence of the detailed feedback and assurance that is held in relation to specific risks, in this instance, risks CRR3 and CRR10.

The following action plan has been prepared and agreed internally to ensure that the Assurance Strategy is embedded across the Health Board.

Action:	To be actioned by:	Completion Date:
Updated Assurance Strategy and Risk Management and Board Assurance Framework Strategy shared with the Board for approval.	Interim Director of Corporate Governance/ Head of Risk and Regulation	March 2023
Working Assurance Map shared with Board alongside Corporate Risk Register.	Interim Director of Corporate Governance	March 2023
Bi Monthly Meetings with Clinical Board Triumvirates and Corporate Directorates to encourage and support the use and implementation of the Assurance Strategy and Assurance Mapping alongside the Corporate Risk Register following which this will become part of existing pre Board Corporate Risk Register reviews	Head of Risk and Regulation	March - September 2023
Progress Review and consideration of the expansion of the strategy to wider areas.	Director of Corporate Governance/Head of Risk and Regulation	October 2023
Update and revised proposals shared with the Audit and Assurance Committee	Director of Corporate Governance/Head of Risk and Regulation	November 2023
Update and revised proposals shared with the Audit and Assurance Committee	Director of Corporate Governance/Head of Risk and Regulation	January 2024
Lifecycle review and Refresh of Assurance Strategy	Head of Risk and Regulation	June 2024

Recommendation:

The Committee is requested to:

- **NOTE** the progress made against the Advisory Recommendations made by Internal Audit;
- **APPROVE** the updated Assurance Strategy 21-24 and Risk Management and Board Assurance Framework Strategy and **RECOMMEND** referral to Board for ratification.

- **NOTE** the updated draft Assurance Map that will be formalised and shared with Board in March 2023.
- **NOTE** the updated Action Plan prepared to ensure that the Assurance Strategy is embedded across the Health Board.

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	
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	
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	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The Health Board's Assurance Strategy forms part of a suite of documents that support the Health Board's Risk Management and Assurance processes. No specific Impact assessment has been undertaken, however by its very nature, the development of the Assurance Strategy will consider risk and the areas detailed below.
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:

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

Cardiff and Vale University Health Board Assurance Strategy					
Document Reference No:	C&V UHB TBC	**Version No:**	1	**Previous C&V UHB Ref No:**	N/A
Document Type:	Corporate Strategy			Non-Clinical	
Issue Date:	Xxxx 2021				
Implementation Date:	Xxxx 2021				
Review Date:	Xxxx 2022 (1 year post issue date).				
Documents to be read alongside this policy:	• Standing Orders • Scheme of Reservation and Delegation • Standing Financial Instructions • UHB 024 - Risk Management Procedure • UHB 435 - SOP Managing Concerns • UHB 043 – Raising Concerns (Whistleblowing Policy) • UHB470 – Risk Management and Board Assurance Framework Strategy				
Executive Summary:	This strategy sets out the UHB's approach to the Assurance Strategy. For more information on the Assurance Strategy please contact the Director of Corporate Governance~~: Nicola.Foreman@Wales.nhs.uk~~				

Disclaimer

The latest version of this document is located on the UHB's intranet. Please check the review date and if there are any doubts contact the author.

Proprietary Information

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Author/Reviewer:	Director of Corporate Governance
Document Owner:	Director of Corporate Governance
Accountable Executive:	Director of Corporate Governance
Consultation method/time period:	
Consultees:	
Approved by:	
Date approved:	
Scope:	UHB Wide

Engagement has taken place with:

Name	Title	Date Consulted

Version Control Table

Version	Issue Date	Summary of Amendment
1	25.11.2021	New Strategy to be approved by the Board in

		November 2021

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as 'uncontrolled' and, as such, may not necessarily contain the latest updates and amendments.

Contents

Introduction

1. Assurance is term that is often used although not always fully defined. Within the NHS it has become an ever increasingly important concept. The introduction over a decade ago of the requirement for the Chief Executive, on behalf of the Board, to write and publish an Annual Governance Statement, made sure public sector organisations were able to demonstrate that they are properly informed about the totality of their risks. Put simply they needed to have confidence in their governance framework.

2. Over a number of years organisational failures, within both the public and private sector have been attributed to poor governance or failings in risk management. The response to this has been heightened control in these areas via legislation and publications of governance codes. Yet the failures continue to happen and therefore concentration has shifted to assurance and how Boards of Directors know what is being undertaken in their name.

3. The Health Board understands the challenges that large and complex organisations face when developing robust governance, risk management and assurance systems that are both proportionate and fit for purpose.

Aim

4. The aim of this strategy is to ensure that there is a common understanding throughout the Health Board of what is meant by assurance and its importance in a well- functioning organisation.

5. Assurance is underpinned by a number of elements: a robust governance framework with clearly defined and understood strategic objectives, a developed maturity in relation to risk management and effective internal controls. Assurance is about getting the right balance of strategy, risk and control. It is acknowledged that it is never possible to provide complete and absolute assurance and as such the concept of reasonable assurance is adopted.

Our Assurance Vision

6. Our vision is to ensure an assurance system exists that adds value to the Health Board by eliminating duplication of effort and resources, reducing the burden of bureaucracy and providing a central point of expertise in relation to governance, risk management and assurance.

7. We aspire to provide guidance on how to assess the value of assurance more widely across the Health Board. The promotion of a better understanding of assurance should lead to improved knowledge of the systems and processes in place. This should in turn lead to an improvement in the assurance tools used in the Health Board and the ability the Health Board has to address identified gaps.

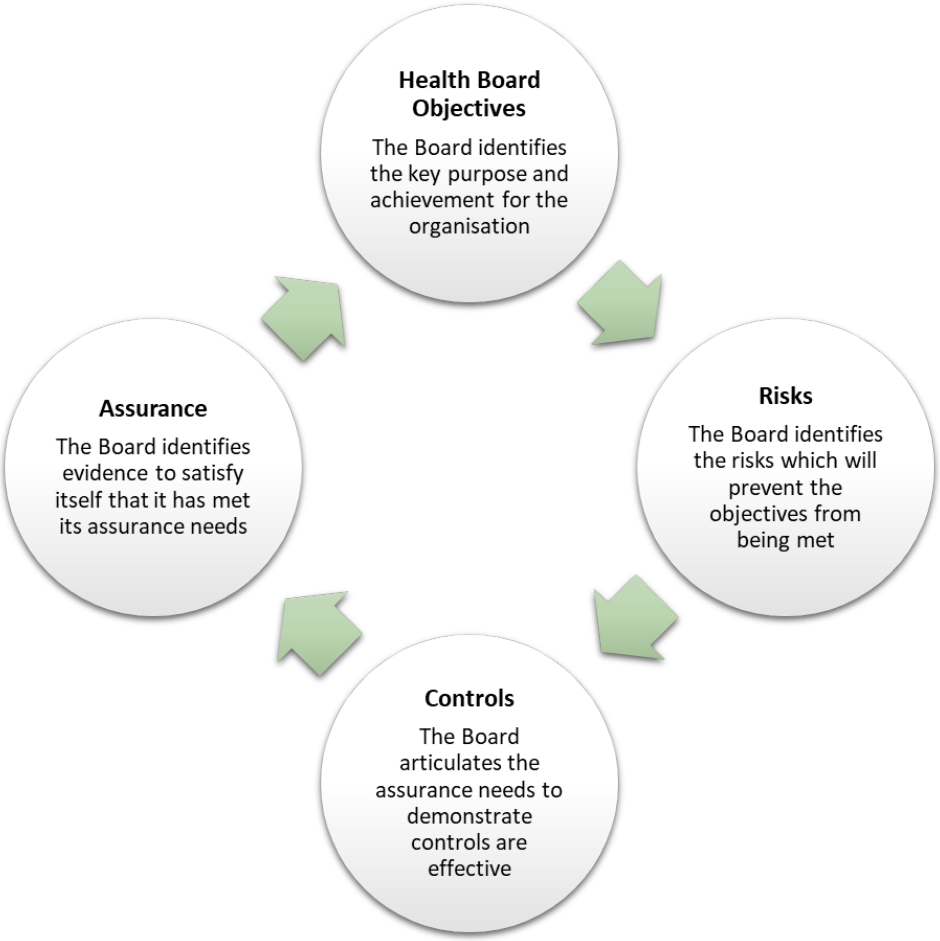
The Assurance System

8. The assurance system will enable the Board and senior management to review the corporate governance, risk management and internal control framework and address any weaknesses identified.

9. It is the policy of the Health Board to ensure that there is a robust methodology for enabling evidence based assurance to be provided to the Health Board on the key risks and the key controls within the organisation as well as stakeholders as required and at the appropriate levels.

10. The methodology is based on the principles of assurance in relation to risk management as defined by the HM Treasury Orange Book, Management of Risk – Principles and Concepts. These principles, which have been expanded to cover all areas of governance, and the method of application within Cardiff and Vale University Health Board, can be found at Appendix 1.

11. The following diagram summarises a model of assurance within the NHS, considered applicable for the Health Board



Benefits of an Assurance System

12. An assurance system achieves a number of benefits:

- Provides confidence in the operational working of the Health Board.
- Maximises the use of resources available in terms of audit planning, avoiding duplication of effort.
- Ensures assurances are appropriately gathered, reported and that the governance structure is working as intended
- Identifies any potential gaps in assurances relating to key risks and key controls, and that these are understood and accepted or addressed as necessary
- Supports the preparation of the Annual Governance Statement within the Annual Report and regular assurance reports to the Audit and Assurance Committee.

Implementation of the Assurance Strategy

13. The implementation of this strategy will be achieved through clear leadership, effective delivery and defined roles and responsibilities. Roles and responsibilities in relation to assurance within the Health Board can be found in Appendix 3. This document applies to all areas of activity within the Health Board. All employees of the Health Board, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff are required to comply with any requirements in relation to assurance noted within this Strategy.

14. The Director of Corporate Governance acts as a champion for this area, providing support across the Health Board.

15. All members of the Health Board will be involved in the evaluation of assurance, except where delegated to Committees of the Board.

16. The Health Board will ensure that the appropriate infrastructure in terms of Committee and individual responsibilities is in place to facilitate the embedding of the Assurance Strategy. The Corporate Governance Directorate will deliver education and training across the organisation on an on-going basis, ensuring that guidance follows best practice.

Types, Sources and Levels of Assurance

17. There are three types of assurance that can be sought: verbal, written and empirical. All can be of use depending on the circumstances. Each will be valued differently depending on other factors. There are many sources of assurance, examples of which can be found in Appendix 2.

18. The Health Board has defined the overarching Lines of Defence (levels of assurance) within its Risk Management and Board Assurance Framework Strategy as noted below:

Level 1 – Operational (Management)
Level 2 – Oversight functions (~~Board or Committees~~Compliance/Risk Management/Quality and Assurance/Health and Safety)
Level 3 – Independent (Audits / Reviews / Inspections etc.)

19. Supplementary assurance processes developed within the Health Board will have their levels of assurance cross matched using the overarching levels set out above.

20. Management has the primary responsibility for providing assurance on the adequacy of risk management and internal control, which is often subject to challenge from the oversight functions for example the Audit and Assurance Committee. It is however essential that there are robust frameworks in place to support the managerial assertions about the adequacy and effectiveness of internal control.

21. Independent assurance is used to confirm management assertions and is often seen as of highest value. This is however dependent on many other factors as noted below.

Assurance Values

22. Regardless of the type, source and level of assurance there are a number of issues that impact on its value, all of which need to be considered:

Age – the time elapsed since assurance was obtained, this may erode the value of assurance.

Durability – whether it endures as a permanent assurance on an historical matter e.g. Auditors Report on Financial Statements, or loses relevance over passage of time e.g. clinical audit.

Relevance – the degree to which assurances aligns to specific area or objective over which it is required.

Reliability – trustworthiness of the source of assurance.

Independence – the degree of separation between the function over which assurance is sought and the provider of assurance.

23. The value of assurances used for the Board will be assessed by the Corporate governance Directorate.

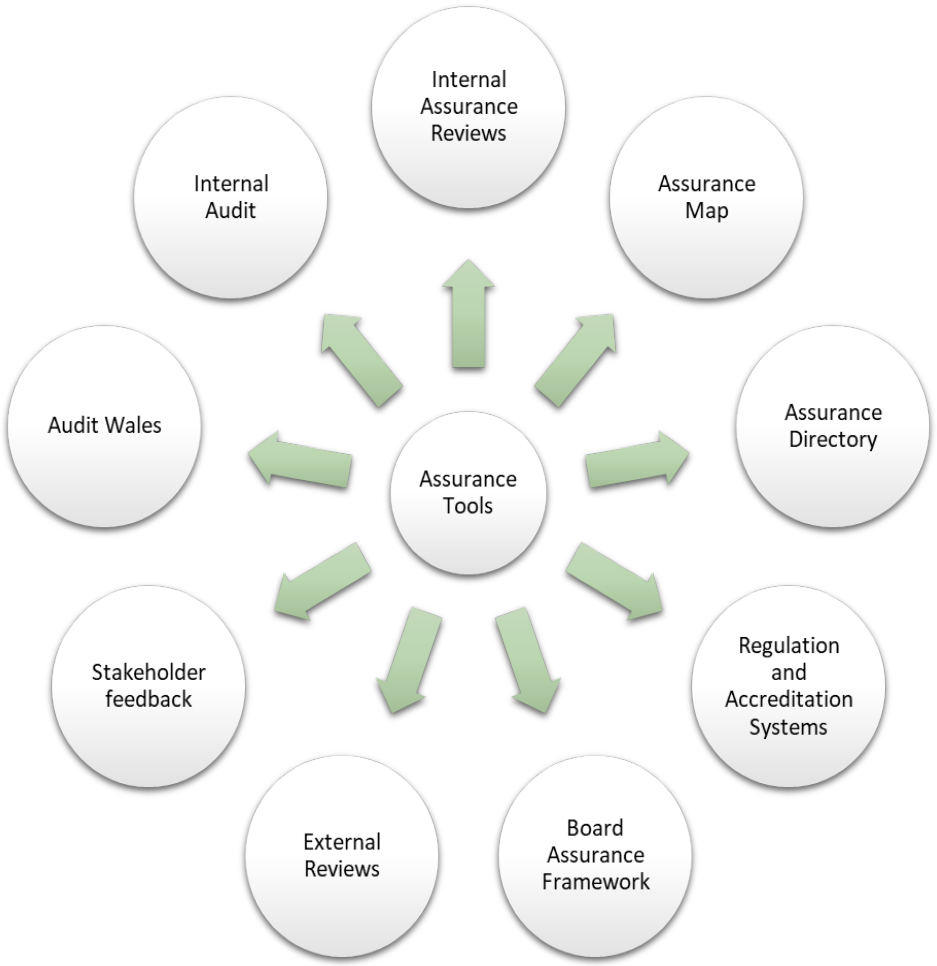
Assurance Reporting / Use of the Assurance Information

24. The various mechanisms and tools described in the strategy will enable the assurance process and the assurance information that is produced as a result to be assessed in terms of value and enable any gaps in assurance identified to be reported, at an appropriate level, and addressed, where considered necessary.

Assurance Tools

25. A number of mechanisms, known as Assurance Tools, will be used as part of the methodology for providing evidence based assurance.

26. There are various assurance tools which feed into the overall system of assurance. Through the mapping of sources of assurance, issues can be identified relating to gaps in control or gaps in assurance, and duplication of effort. Where the need for additional control measures or assurances are recognised, these will be reported through an appropriate mechanism, e.g. addition to risk register, performance reporting, or the Board Assurance Framework.



Assurance Directory

27. An Assurance Directory is a central register of assurances, detailing the types and value

of assurance. This will maintained by the Corporate Governance Directorate. The information held within the Directory is used to create a map of assurances.

Assurance Map

28. An Assurance Map is created in order to obtain clarification in relation to assurance currently provided. There is more than one purpose for such a map and this will depend on who wants the map and why. One map should not be everything to everyone and therefore a number of different maps at various levels can be produced. Assurance Maps can be used at different levels and for different reasons as determined by need. The starting point can also vary depending on purpose. Initially the Corporate Governance Directorate will develop and maintain an Assurance Map that aims to provide assurance to the Board that those risks reported within the Corporate Risk Register, from time to time, are being appropriately treated, mitigated and/or controlled.

29. Gaps, including where assurance has been provided but is deemed to be insufficient and duplications of assurance can be identified and addressed thereby consolidating assurance and reducing the amount of irrelevant information provided. Assurance maps will be created and maintained by the Corporate Governance Directorate.

Internal Assurance Reviews

30. Internal assurance reviews may be undertaken in any area of the Health Board and are one of the ways the Health Board assures itself that relevant standards, regulation and other requirements including best practice are being met. Whenever internal assurance reviews are undertaken, terms of reference are prepared and agreed by all parties. The Corporate Governance Directorate provides support for such reviews. E.g. Health and Safety Review.

Internal Regulation and Accreditation Systems

31. Internal regulation and accreditation systems ensure that suitable evidence exists to support adherence with regulation and accreditation standards. The Risk and Regulation Team track Legislative, Regulatory and Alerts compliance which is then reported to the Audit and Assurance Committee.

Board Assurance Framework

32. The Board Assurance Framework, ~~an NHS requirement,~~ sets out the strategic objectives, identifies risks in relation to each strategic objective and the controls to mitigate these risks. The details of the assurances on the effectiveness of these controls are also included. As such gaps in controls and assurances can be identified and acted upon. This forms an integral part of the risk management reporting system. This document is then used as a tool for further discussion in relation to the levels of assurance received and required at Board and Board Committee level as set out in the Risk Management and Board Assurance Framework Strategy. The Board Assurance Framework also provides the starting point for the Health Board to record the risks in relation to the strategic objectives that then link and are cross referenced to the Corporate Risk Register.

Internal Audit

33. Internal Audit is an independent objective function which can help the Health Board accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control, and governance processes. The scope of reviews are agreed in advance with relevant Executive Directors and Management Executive, and the annual Internal Audit plan agreed by the Audit and Assurance Committee. Contingency days may be built into the Internal Audit plan to allow for any issues identified where review or further assurance may be required.

Clinical Audit

34. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of

change. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery and improve the overall quality of services.

Audit Wales

35. The Auditor General is the statutory external auditor of most of the Welsh public sector. This means that he audits the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies.

The Auditor General's role includes examining how public bodies manage and spend public money, including how they achieve value in the delivery of public services. The Auditor General publishes reports on that work, some of which are considered by the Welsh Parliament's Public Accounts Committee

Stakeholder Feedback

36. Valuable assurance is provided to the organisation through feedback from stakeholders, including patients, visitors, our staff, and partner organisations. The views of our patients are captured through various including patient safety visits. Additionally, internal feedback processes provide additional sources of assurance, including:

- Surveys carried out with patients and staff
- Reactive risk processes, such as complaints, claims, inquests or incidents
- Monitoring and compliance information received from other organisations such as the Community Health Council (CHC) an Independent watchdog and Healthcare Inspectorate Wales (HIW) an independent inspectorate and regulatory of healthcare in Wales.

External Reviews

37. The Corporate Governance Directorate administer the coordination and evaluation of recommendations arising from external agency visits, inspections and accreditations and the process for disseminating and performance managing the implementation of actions arising from the recommendations and providing assurance against them.

Training

38. There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan. The Risk and Regulation Team will also provide targeted training to Executive Colleagues, Risk Management, Clinical and Corporate Leads.

Monitoring Compliance

39. Compliance with the document will be monitored in line with the key principles and applications as set out in Appendix 1 as summarised below.

Aspect of compliance or effectiveness being monitored	Monitoring method	Responsibility for monitoring (job title)	Frequency of monitoring	Group or Committee that will review the findings and

System of internal control/effectiveness of assurance strategy	Internal audit of Board Assurance Framework	Head of Risk and Regulation	Annual	Audit Committee

Review

40. This policy will be reviewed in 3 years, unless best practice dictates the need for an earlier review.

References

41. The Assurance Strategy forms a key component of the wider Health Board governance framework and links closely to the Risk Management and Board Assurance Strategy.

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42. Equality Impact Assessment

C&V UHB aims to design and implement services and policies that are fair and equitable. As part of its development, this Strategy and its impact on staff, patients and the public have been reviewed in line with the Cardiff and Vale's Equality Impact Assessment. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as "no impact".

Appendix 1: Assurance Principles and Application

Assurance Principle	Application within the Health Board
1. Planning to gain assurance Overall assurance will only be gained if there is a strategy for obtaining it. The Assurance Strategy should be approved by the Board and the Audit and Assurance Committee. Supporting processes for obtaining assurance should be embedded into existing processes.	An Assurance Strategy, which reflects the assurance system in operation within the Health Board and therefore the supporting processes, has been approved at Board Level after consultation with the Audit Committee. The Assurance Strategy has been prepared to align with the other key strategies such as the Risk Management and Board Assurance Framework Strategy.
2. Making explicit the scope of the assurance boundaries To form an overall opinion the scope of the processes need to include the whole of the organisation's governance, risk and performance management lifecycle. Whilst this does not reflect the need to review every risk and internal control it should cover: Assurance on the Risk Management Strategies and how these work in practice (the extent to which line managers review the risks and controls within their responsibility and maintain dynamic risk and performance management arrangements) Assurance on management of risks and controls themselves. Assurance on the adequacy of the assurance processes.	The Corporate Governance Directorate will be responsible for ensuring that there is adequate assurance on the risk management system and the risks / controls themselves. The overall Assurance and Risk Management system is subject to Annual Audit.
3. Evidence The evidence supporting assurance should be sufficient in scope and weight to support the conclusion and be: - Relevant - Reliable - Understandable - Free from material misstatement - Neutral / free from bias - Such that another person would reasonably come to the same conclusion All evidence does not carry the same weight and should be weighted in accordance to independence and relevance. Evidence may be flawed in terms of both quality and quantity, leading to limitations in the assurance that can be provided.	The Corporate Governance Directorate will define 'what good evidence looks like', ensuring that the details within this principle are adhered to.

Appendix 1: Assurance Principles and Application

(continued)

Assurance Principle	Application within the Health Board
4. Evaluation The objective is to evaluate the adequacy of: - the governance and risk policies and strategies to achieve their objectives; - the risk management processes designed to constrain residual risk to the risk appetite; - Identify limitations in the evidence provided or in the depth or scope of the reviews undertaken - Identify gaps in control and / or over control and provide the opportunity for continuous improvement - Support the preparation of the Annual Governance Statement as part of the Annual Report.	The independent review of all key areas will be co-ordinated by the Corporate Governance Directorate. The Audit and Assurance Committee will approve the internal and external audit plans. Gaps and duplications in assurance will be identified by the development of an assurance map, the responsibility for which falls within the remit of the Corporate Governance Directorate. A directory of sources of external assurances will be maintained. This will populate, in part, the assurance directory, which will also contain internal sources of assurance. Central reviews of evidence held will be undertaken by the Corporate Governance Directorate. Training and guidance will be provided across the Health Board to enable Clinical Boards and Corporate Directorates to be the first line of evidence assessment.
5. Reviewing and Reporting Assurances are reported from many different sources within an organisation and therefore the Assurance Strategy needs to define stages where assurances will be evaluated and opinions reported through the various layers of management to the Health Board. Assurance opinions need to be reported clearly and worded so as to clearly communicate the scope and criteria used in arriving at those conclusions.	The Assurance Strategy makes it clear that assurances for the Health Board will be assessed in terms of value by the Corporate Governance Directorate. Training and education will be undertaken across the Health Board in relation to reporting of assurances.

Source: *The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)*

Appendix 2: Sources of Assurance (examples only)

Source	Assurance Scope	Assurance Process	Type	Level
Audit Wales	Financial accounts and Governance Arrangements reviews as determined	Financial audit and review reports	Written	3 - Independent Assurance
Internal Audit	All areas related to corporate governance, risk management and internal control. Will be limited by number of days in audit plan and expertise of staff	Head of Internal Audit Opinion and individual review reports. Scope of reviews agreed in advance with relevant Executive Directors. Internal Audit Plan agreed with Audit and Assurance Committee	Written	3 - Independent Assurance
Clinical Audit	Area under review, defined by the Clinical Audit Plan	Report to Quality, Safety and Effectiveness Committee with oversight through Audit and Assurance Committee	Written	1 - Operational Assurance / 3 - Independent Assurance
Audit Committee	All areas related to corporate governance, risk management and internal control, as determined by Terms of Reference	Report to Health Board annually through Annual Report to the Board and update to Health Board via issue of minutes after each meeting and Chairs report to the Board	Written and Verbal	2 - Oversight function
Management Executive	All areas related to corporate governance, risk management and internal control	Report relevant areas to Health Board	Written or Verbal	21 - ~~Operational Assurance~~Oversight Function
Other Accreditation Systems	Restricted to area of accreditation	Report to relevant Committee and regulatory compliance tracked through Audit and Assurance Committee	Written	3 - Independent Assurance

Integrated Performance report	Specific to identified targets, internal and external, for finance, performance, quality and workforce	Reports to relevant Committees of the Board culminating in integrated report to Board	Written	1 – Operational Assurance 2 – Oversight function
Walkabouts	Specific to area of visit	Reports to Patient Safety and Experience Team	Empirical	1 - Operational Assurance
Information Governance Toolkit	Specific to area of responsibility	Reports to Management Executive and, DHI Committee etc.	Written	1 - Operational Assurance, 2 – Oversight function
Patient Feedback	Specific where internally driven	Reports Quality, Safety and Experience Committee	Written	3 - Independent Assurance

Appendix 3: Responsibilities

The **Chief Executive Officer** has overall responsibility for the system of internal control within the Health Board and for preparing an Annual Governance Statement within the Annual Report.

The **Director of Corporate Governance** has delegated authority for the assurance system that underpins the Annual Governance Statement.

The **Head of Risk and Regulation** is accountable to the Director of Corporate Governance for the overall delivery of the Health Board's Assurance strategy and the Risk Management and Board Assurance Framework Strategy and is responsible for overseeing the systems for assuring compliance with regulatory standards.

The **Head of Corporate Governance** is accountable to the Director of Corporate Governance for the overall performance of corporate governance functions including the system of internal control.

The **Corporate Governance Directorate** is responsible for the:

- maintenance of key assurance tools
- education and training programme in relation to assurance processes, accreditation, assessment and supporting evidence
- assessment of assurance and evidence in relation to compliance with regulations
- provision of consultancy and advice in relation to assurance, accreditation, assessment and supporting good evidence processes.

All Executive Directors are responsible for the related management assurances in relation to those strategic objectives delegated to them by the Chief Executive.

All Clinical Board Directors are responsible for the management of risks and internal controls and assurance within their Clinical Boards

All Managers are responsible for the management of risks and internal controls within their area.

All members of staff are responsible for adhering to internal controls in the undertaking of their work.

The Health Board is responsible for clarifying expectations around the scope and depth of Board assurance requirements.

The **Audit and Assurance Committee** supports the Board by critically reviewing the governance, risk and assurance processes on which the Board places reliance. At the corporate level these include systems of internal control, including the risk management system and the Board Assurance Framework.

Appendix 4: Glossary and definitions of terms used

The terms in use in this document are defined as follows:

Assurance – 'confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved' (*Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health)*

Reassurance – the process of telling others that risks are controlled without providing reliable evidence in support of this assertion

Risk – the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events

Risk Management – the system for identifying, assessing and responding to risks

Corporate Governance – the 'system by which organisations are directed and controlled in order to achieve their objectives and meet the necessary standards of accountability and probity' (*Department of Health)*. Governance refers to many areas including clinical, information, human resources; all of which fall under the remit of the phrase 'corporate governance' in relation to this document

Internal Control – a method of restraint or check used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation; the result of robust planning and good direction by management

Key Risk / Key Control – risk to the achievement of a strategic objective / control to mitigate key risks

Evidence – information that allows a conclusion to be reached

Sufficient – in relation to the definition of assurance given above sufficient is defined as whatever is adequate to provide the level of confidence required for the Health Board

Reasonable – based on sound judgement

Empirical based on observation or experience

Accreditation – to be awarded official recognition

Assessment – a review of evidence in order to form an opinion; this can be undertaken either internally in the form of a self-assessment or by a third party

Compliance – to act in accordance with requirements

Stewardship – entrusted with the responsibility for and on-going management of a particular area

Stakeholders – person or persons with an interest in the Health Board

Management assertions – a statement made, whether verbal or written

Appendix 5: Using Assurance Sources in Practice

Assurance maps can be created in a variety of different ways, depending on the required purpose. Maps may be used to show:

- Sources of assurance for a given area, topic or target
- Sources of assurance on identified risks e.g. against specific targets or across different areas of business
- Sources of assurance on the effectiveness of control measures
- How the assurances are reported and at what level of the organisation
- Areas where further assurance may be required, or areas of duplication

The examples below demonstrate different functions of an assurance map, and how these can be used by different audiences.

Example 1: Identified Sources of Assurance for a Integrated Performance Report target e.g. RTT waiting time over 36 weeks

Source	Assurance Scope	Assurance Process	Type	Level
Integrated Performance report	Specific monitoring of performance against the target and assessment of data quality	Reports to Strategy and Delivery Committee and The Health Board	Written	1 – Operational Assurance
Audit Wales	Review of data quality for all NHS Delivery Framework targets	Data quality audit and review reports. Scope of review agreed nationally.	Written	3 - Independent Assurance
Internal Audit	Testing of process for recording clock stops and breaches along the pathway by random sample basis. Scope of reviews agreed in advance with relevant directors.	Report to Audit Committee	Written	3 - Independent Assurance
Adult Inpatient Survey	Sample interview survey conducted on a quarterly basis.	Report to Quality, Safety and Experience Committee and Health Board	Written	3 - Independent Assurance
Clinical Audit	Review of adherence to admission criteria in theatres. Scope agreed as part of local clinical audit plan	Report to Quality Safety and Experience Committee	Written	1 - Operational Assurance / Independent Assurance

Example 2: Identified Sources of Assurance for Information Governance

Source	Assurance Scope	Assurance Process	Type	Level
Integrated Performance report	Specific monitoring of performance against the target and assessment of data quality	Reports to Digital Health Intelligence Committee and Health Board	Written	1 – Operational Assurance
External Audit	Review of data quality for all NHS Delivery Framework targets	Data quality audit and review reports. Scope of review agreed nationally.	Written	3 - Independent Assurance
Internal Audit	Independent review of Information Governance as required bythe Information Commissioner. Scope of reviews agreed in advance with relevant directors. Internal Audit Plan agreed with Audit and Assurance Committee	Report to Audit Committee	Written	3 - Independent Assurance
Clinical Audit	Review of adherence to Health Records Policy Scope agreed as part of local clinical audit plan	Report to Quality, Safety and Effectiveness Committee.	Written	1 - Operational Assurance / Independent Assurance

Appendix 6 – Example Assurance Map

CRR Reference as at [*DATE*]	Corporate Risks as at [*Date*]	Current Risk Score as of [*Date*]:	First Line of Defence Management Controls: Operational Processes and Management	First Line of Defence: Management information and data.	First Line of Defence: Other - Self assessment	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and: Compliance / Quality	Second Line of Defence: Health and Safety / Estates	Second Line of Defence: Risk Management	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers.: Regulatory Body	Third Line of Defence: Internal Audit	Third Line of Defence: External Audit	Reviewed Assurance Level
CRR1	Risk of patient harm due to obsolete Oxygen and Nitrous Oxude medical gas Plant and Equipment at various UHB sites	5x4=20	x				x	x				
CRR2	Risk of patient harm due to interruption of oxygen supply to the whole of UHW resulting from a corroded oxygen pipeline.	5x4=20	x				x	x				
CRR3	due to serious corrosion of Main Boiler F&E Tanks	5x4=20	x				x	x				
CRR4	compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	5x4=20	x				x	x				
CRR5	Risk to estimated expenditure in financial plans due to significant increases in energy tarrifs	4x5=20	x				x	x				
CRR6	Risk of staff and patient harm due to difficulties recruiting sufficient numbers of nursing staff.	5x5=25	x			x		x	x	x		
CRR7	Risk of patient harm due to patients being added to Routine waiting lists secondary to increased Referal to Treatment times.	5x4=20	x			x		x				
CRR8	Risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit	5x4=20	x			x		x				

No Evidence	Not evidenced on Risk Register/ Not Applicable
Assurance on one line of defence, limited or no third line of defence, assurance over 3 years old.	Low
Assurance across two lines of defence, poitive assurance on third line of defence, assurance within last three years.	Medium
Assurance across all three lines of defence, positive assurance on the third line of defence, assurance within last three years.	High

No Evidence	Not evidenced on Risk Register/ Not Applicable
Limited	
Reasonable	
Substantial	

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

Cardiff and Vale University Health Board Risk Management and Board Assurance Framework Strategy					
Document Reference No:	C&V UHB 470	**Version No:**	2	**Previous C&V UHB Ref No:**	N/A
Document Type:	Corporate Strategy			Non-Clinical	
Issue Date:	30 July 2021				
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Review Date:	30 July 2022 (1 year post issue date).				
Documents to be read alongside this policy:	• Standing Orders • Scheme of Reservation and Delegation • Standing Financial Instructions • UHB 024 - Risk Management Procedure • UHB 435 - SOP Managing Concerns • UHB 043 – Raising Concerns (Whistleblowing Policy)				
Executive Summary:	This strategy sets out the UHB's approach to the Board Assurance Framework and Risk Management. For more information on the Board Assurance Framework or Risk Management please contact the Head of Risk and Regulation email: aaron.fowler@wales.nhs.uk.				

Disclaimer

The latest version of this document is located on the UHB's intranet. Please check the review date and if there are any doubts contact the author.

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Scope:	UHB Wide

Version	Issue Date	Summary of Amendment
1	27/09/2019	New Strategy approved by the Board in July 2019
2	30/07/2021	1. References added. 2. 3 Lines of Defence

		added. 3. Revised risk scoring matrix. 4. Revised risk appetite.

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as ‘uncontrolled’ and, as such, may not necessarily contain the latest updates and amendments.

Risk Management and Board Assurance Framework Strategy

TABLE OF CONTENTS

1. Introduction and Aims

Risk is inherent in everything we do to deliver high-quality services. Effective and meaningful risk management… remains as important as ever in taking a balanced view to managing opportunity and risk (HM Government, Orange Book, 2020).

The purpose of risk management is the creation and protection of value. It improves performance, encourages innovation, and supports the achievement of objectives (ISO 31000, 2018). Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice. Risk needs to be continuously managed in a systematic and consistent manner in all areas; patient, staff, health and safety, environmental, organisational, financial and commercial (NHS Wales Governance e-Manual, 2013)

Cardiff and Vale University Health Board (C&V UHB) is committed to developing and implementing a Risk Management and Board Assurance Framework Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives. The Board Assurance Framework (BAF) is the key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control (GGI, 2018). Therefore, the BAF will be used by the Board to identify, monitor and evaluate risks which impact upon Strategic Objectives. It will be considered alongside other key management tools, such as performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

Based on results, audit evidence and a wider understanding of the context, decisions will be made on how to improve the risk management policy, framework, processes and tools. These decisions will be aimed at improving the management of risk and risk culture throughout the organisation. The Risk Management Strategy will be reviewed annually.

The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the BAF within the organisation.

It aims to:

- Set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation.
- Describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives.

The objectives of C&V UHB's Risk Management and BAF strategy is to:

- Minimise the impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management.

- Maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively.
- Maintain a cohesive approach to corporate governance and effectively manage risk management resources.
- Ensure that risk management is an integral part of C&V UHB's culture.
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy.
- Ensure that C&V UHB meets its obligations in respect of Health and Safety.
- Describe the resources available for risk management in the organisation.

2. Scope

The Risk Management and BAF Strategy covers the management of strategic and operational risks and the process for the escalation of risks for inclusion on the BAF.

This Strategy applies to those members of staff that are directly employed by C&V UHB and for whom C&V UHB has legal responsibility.

The Risk Management and BAF Strategy is intended to cover all the potential risks that the organisation could be exposed to. A Risk Management Procedure (UHB 024) has been produced as a subordinate adjunct to this strategy.

3. Definitions

A full list of required definitions is provided in UHB 024 Risk Management Procedure but the following list of terms is provided to ensure understanding of this strategy:

- **Board Assurance Framework (BAF).** The key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control (Good Governance Institute, 2018).

- **Corporate Risk Register.** Clinical Boards/Corporate Directorates submit their candidate risks to the Risk and Regulation team. Candidate risks comprise of all risks with a current risk rating of 20 or above, or those risks with a lower score which in the opinion of the risk owner can no longer be managed at the local level due to a lack of authority/resource, or their complexity or the potential for a health board wide impact. Following review and, if required further consultation or clarification, these risks will then be placed onto the Corporate Risk Register to ensure the notification and the engagement of Executives, Committees or the Board.

- **Controls**. Any process, policy, device, practice or other conditions/actions which modify risk (ISO 31000, 2018). A risk treatment becomes a control once the effectiveness of the treatment has been confirmed through assurance processes.

- **Consequence.** The outcome of an event that has affected objectives. Can be certain or uncertain and can have positive, negative, direct or indirect effects on objectives. Can be expressed qualitatively or quantitatively (ISO 31000, 2018).

- **Current Risk Rating.** The risk score (consequence x likelihood) assessed at a specific period of time. The current risk rating will usually be lower than the initial rating but higher than the target risk rating.

- **Escalation** The act of advancing a risk to a higher management level for resolution, action or attention.

- **Event.** The occurrence or change of a particular set of circumstances. An event can have one or more occurrences and can have several causes and several consequences (ISO 31000, 2018).

- **Initial Risk Rating**. The risk score (consequence x likelihood) assessed before the application of risk treatments/controls.

- **Likelihood.** The chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively, or quantitatively, and described using general terms or mathematically (ISO 31000, 2018).

- **Operational risks**. These are key risks that affect individual Clinical Boards and Corporate Directorates. They are managed within the Clinical Boards and Corporate Directorates and if necessary, escalated through the risk reporting structure to the Corporate Risk Register and potentially the BAF.

- **Risk.** The effect of uncertainty on objectives. An effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities or threats. Risk is usually expressed in terms of risk sources, potential events, their consequences, and their likelihood (ISO 31000, 2018).

- **Risk Assessment.** The overall process of risk identification, risk analysis and risk evaluation. It should be conducted systematically, iteratively and collaboratively, drawing on the knowledge and views of stakeholders. It should use the best available information, supplemented by further enquiry as necessary (ISO 31000, 2018).

- **Risk Appetite** The amount and type of risk that the Trust Board is willing to take in order to meet its strategic objectives. (IRM, 2021). This reflects the Trust values, policies and objectives.

- **Risk Domains**. Risk domains help classify risks based on potential consequences for example risks impacting on safety or reputation.

- **Risk Management.** The systematic method of identifying, analysing, managing, monitoring and reviewing of risks (ISO 31000, 2018).

- **Risk Register.** A register of all identified risks within a team, department, speciality, board/directorate or the UHB as a whole.

- **Risk Treatment**. Any process, policy, device, practice or other conditions/actions with the potential to modify risk in a desired manner. Risk treatments become controls once their effectiveness in modifying the risk is assured.

- **Strategic risks**. These are significant risks that have the potential to impact upon the delivery of Strategic Objectives and therefore need to be raised and monitored by the Executive Team and the Board**.**

- **Target Risk Score** The estimated achievable risk score when all risk treatments and mitigations are in place and operating at maximum effectiveness.

4. Risk Management Organisational Structure

C&V UHB's risk management and reporting structure is attached at Appendix 1.

4.1 The Lines of Defence in Effective Risk Management and Control

This strategy describes risk and control functions across C&V UHB. The identification, management, coordination and assurance of risk in a broad and complex organisation such as ours involves an association of individuals and teams from diverse professional backgrounds such as internal auditors, risk specialists, compliance officers, health and safety and clinicians etc. Because these advising and controlling functions are increasingly split across multiple areas, the optimum coordination and control needed for effective risk management can become compromised and result in gaps in control or unnecessary duplication of coverage.

The Three Lines of Defence Model (see figure 1) has been designed to outline in principle the risk management roles, responsibilities and accountabilities to enhance communication and coordination of risk management and control across the organisation (The Institute of Internal Auditors, 2013).

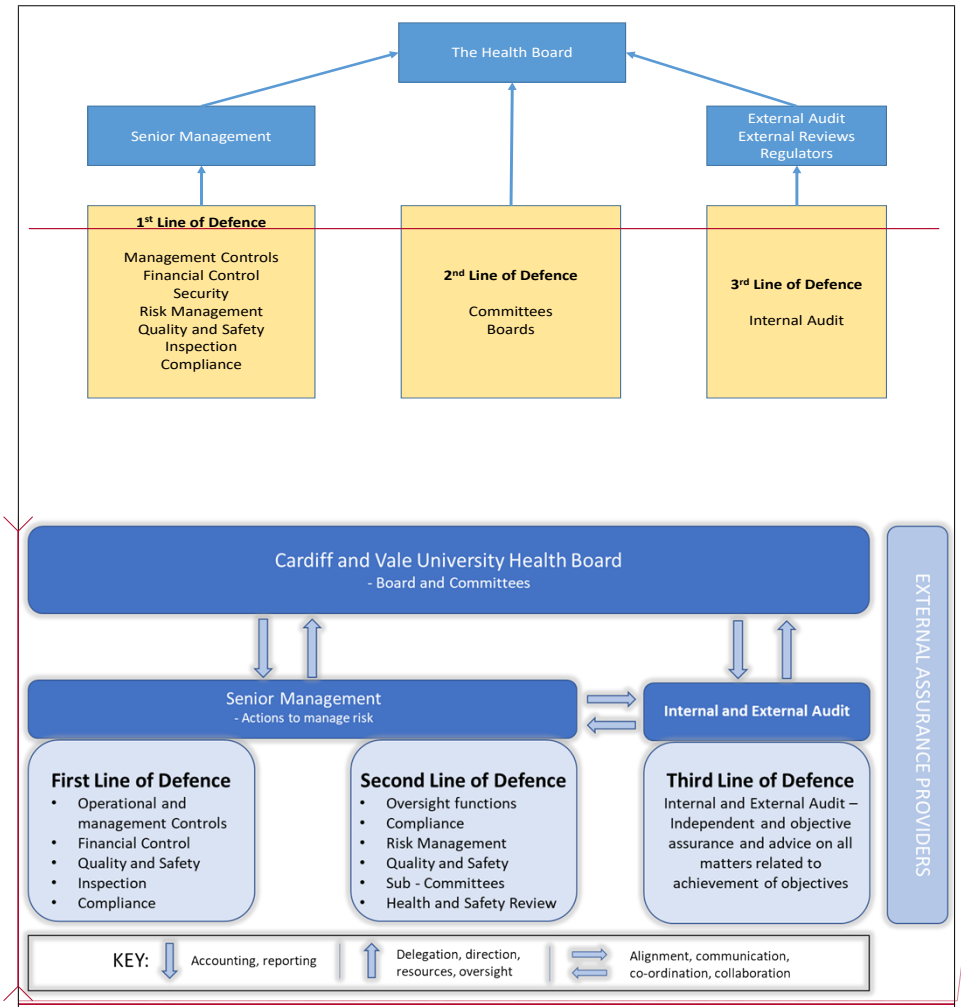

Figure 1: The Three Lines of Defence Model

Executives and the Board collectively have responsibility and accountability for identifying and attaining the organisation's objectives. Risk management is an essential part of governance and leadership and fundamental to how organisations are directed, managed and controlled at all levels (HM Government, The Orange Book, 2020). Therefore, Executives and Boards establish risk management structures and processes, including the lines of defence, to optimise their risk management framework to realise their strategic objectives.

The 1st Line of Defence is the level of operational management where managers own and manage risks. Operational management have responsibility for day to day risk management: identifying, assessing, recording, controlling and (where necessary)

Commented [AF(aVU-H1]: Updated Lines of Defence Model Added

reporting risks to senior management. Operational management control of risk is ostensibly through the design, implementation and assurance of controls. This also involves the implementation of Financial, Governance and Compliance controls alongside local inspections and reviews.

The Second Line of Defence ~~Also operating within the 1st Line of Defence~~ are those risk management and compliance functions that have the specific authority, specialist tools, systems and advice to support those who own and manage risk. They work with risk owners and managers to ensure that the 1st Line of Defence is properly designed, and functioning as designed. Examples of these functions include Health and Safety, Risk and Regulation Teams, Patient Safety, Financial Control, and Corporate Governance. These functions have been established to ensure that the 1st line of defence is properly designed and functioning as designed.

The ~~2nd~~ 3rd Line of Defence are ~~the UHBs committees and management boards. These are ostensibly assurance functions independent of the first line of defence. The Institute of Internal Auditors (2013) identifies the responsibilities of the 2nd Line of Defence functions as follows:~~

~~• Supporting management policies, defining role and responsibilities, and setting goals for implementation.~~
~~• Providing risk management frameworks.~~
~~• Identifying known and emerging issues.~~
~~• Identifying shifts in the organisations implicit risk appetite.~~
~~• Assisting management in developing processes and controls to manage risks and issues.~~
~~• Providing guidance and training on risk management processes.~~
~~• Facilitating and monitoring implementation of effective risk management practices by operational management.~~
~~• Alerting operational management to emerging issues and changing regulatory and risk scenarios.~~
~~• Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of reporting, compliance with laws and regulations, and timely remediation of deficiencies.~~

~~The 3rd Line of Defence are~~ those functions providing independent internal assurance that the 1st and 2nd lines of defence are operating in a manner which ensures the overall effectiveness of the risk management framework, reporting the results of their assessment to Senior Management and the Board.

Each of the 3 Lines of Defence have responsibility for employing the Risk Management and BAF Strategy and accounting and reporting to the UHB Board and Committees.

4.2 The Board and Committees

Executive Directors and Independent Members share responsibility for the success of C&V UHB, including the effective management of risk, and compliance with relevant legislation. In relation to risk management, the Board and Committees are ~~is~~ responsible for:

- Articulating the Strategic Objectives for the organisation.
- Protecting the reputation of the organisation.
- Providing leadership on the management of risk.
- Approving the risk appetite for the organisation.
- Ensuring the approach to risk management is consistently applied.
- Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately.
- Reviewing the BAF (strategic risks) and the Corporate Risk Register (operational risks 20 and above) at each meeting.
- Endorsing risk related disclosure documents.
- Approving the Risk Management and BAF Strategy on at least an annual basis**.**

4.3 Audit and Assurance Committee

The Audit and Assurance Committee operates in the 2nd Line of Defence. It has a specific role to assess the effectiveness of the Risk Management and BAF strategy by reviewing the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of strategic objectives, the effectiveness of the systems and processes for the management of risks, the BAF and the appropriateness of disclosure documents.

4.4 Other Committees of the Board

The Committees of the Board all have a role to play in ensuring effective risk management. In particular they will, through the scrutiny inherent in their committee activity, provide onwards assurance to the Board in relation to their elements of the BAF.

4.5 Management Executive and Health Systems Management Board

A critical component of the 2nd Line of Defence, the Management Executive and Health Systems Management Board (HSMB) undertake the following duties:

- Promote a culture within the Health Board which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board.
- Ensure appropriate actions are applied to both clinical and non-clinical risks Health Board wide.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure Clinical Board and Corporate Directorate Risk Registers are appropriately rated and agreeing action plans to control them.
- Review the risks on the Corporate Risk Register to determine whether any of them will impact on the Health Boards Strategic Objectives, and if so, adding the risk to the BAF.
- Review the BAF before presenting it to the Board.
- Advise the Board of exceptional risks to the Trust and any financial implications of these risks.
- Review and monitor the implementation of the Risk Management and BAF Strategy.

- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Annual Governance Statement.
- Approve documentation relevant to the implementation of the Risk Management and BAF Strategy.

These duties have the ultimate aim of providing assurance to the Board that there is an effective system of risk management across the organisation.

4.6 Clinical Boards and Corporate Directorates

The Clinical Boards and Corporate Directorates operate within the First Line of Defence. They are responsible for risks within their areas of operation and providing assurance to the Management Executive and HSMB on the operational management and any support required in relation to the management of risk.

The Clinical Boards and Corporate Directorates will review and update existing risks, consider new risks for inclusion and escalate any extreme risks, utilising, where required, specialist input from individuals/teams within the 1st Line of Defence. These are presented to the HSMB by the Clinical Boards or Corporate Directorates.

5. Duties

The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

5.1 All staff

All members of staff are accountable for maintaining risk awareness, identifying and reporting risks as appropriate to their line manager. More specifically they will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the health board's business.
- Report all incidents/accidents and near misses and comply with the health board's incident and near miss reporting procedures;
- Be responsible for attending mandatory and relevant education and training events.
- Participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed.
- Be aware of and comply with the health board's Risk Management and BAF strategy, processes, and associated procedures.

5.2 Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels. This First Line of Defence recognises that staff are best placed to understand the risks relevant to their areas of responsibility and that the identification and management of risk requires the active engagement and involvement of operational teams.

Therefore, staff must be supported and enabled to manage these risks, within a structured risk management framework, and Managers are expected to take an active lead to ensure that risk management is embedded into the way their service/team /ward operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the UHB's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

5.3 Clinical Board Directors

Clinical Board Directors are responsible for implementation of the Risk Management and BAF Strategy and any other policies which support the health board's risk management approach.

Specifically, they will:

- Ensure a forum for discussing risk and its management is maintained within their Clinical Board to encourage integration of risk management and the creation of a positive risk management culture.
- Co-ordinate the risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure that there is a system for monitoring the application of risk management within their area, and that risks are treated in accordance with the risk grading guidance contained in this document.
- Provide reports to the appropriate committees of the Board that will contribute to the UHB-wide monitoring and auditing of risk.
- Assess and communicate the risk management related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.

5.4 The Director of Corporate Governance

The Director of Corporate Governance will:

- Work closely with the Chair, Chief Executive, Chair of the Audit and Assurance Committee and Executive Directors to implement and maintain the Risk Management and Board Assurance Strategy and related processes, ensuring that effective governance systems are in place.
- Work with the Board to develop a shared understanding of the risks to the UHB's strategic objectives.
- Develop and communicate the Board's risk awareness, appetite and tolerance.
- Lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a UHB basis.
- Work closely with the Chief Executive and Directors to support the development and maintenance of Corporate and Directorate level risk registers.
- Develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein.
- Monitor the action plans and the processes for risk reporting to the Board and relevant Committees.
- Develop and implement the Health Board's Risk Management and Board Assurance Framework Strategy.

5.5 Executive Directors

Executive Directors are accountable and responsible for ensuring that their directorates are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives.

Specifically they will:

- Communicate to their directorate the Board's strategic objectives and ensure that directorate, service and individual objectives and risk reporting are aligned to these.
- Ensure that a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management.

- Co-ordinate risk management processes to encompass risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register.
- Ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading guidance contained in this document.
- Provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk.
- Assess and communicate the risk related training needs of their staff and ensure staff attend relevant mandatory and local training programmes.
- Ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting.
- Ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

Executive Directors are also responsible for ensuring that the BAF and the risk management reporting timetable are delivered to the Board**.**

5.6 Chief Executive

The Chief Executive is the Accountable Officer of the UHB and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls and governance.

The Chief Executive has overall accountability and responsibility for ensuring that the health board maintains an up to date Risk Management and Board Assurance Framework that is endorsed by the Board. In addition, the Chief Executive will:

- Ensure that there is a framework in place which provides assurance to the Board in relation to the management of risk and internal control.
- Ensure that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives.
- Have in place an effective system of risk management and internal control.
- Set out the C&V UHBs commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

5.7 Internal Auditors

Operating as the 3rd Line of Defence Internal Audit Services, provided by NHS Wales Shared Services Partnership, through a risk-based programme of work, will provide the health board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Assurance Committee as appropriate.

5.8 Central Corporate Functions

Central Corporate Functions such as Corporate Governance, Patient Safety and Learning, Health and Safety Advisers, Capital Estates and Facilities, Finance Directorate, Workforce and Organisational Development Directorate, Occupational Health etc operate in the 1st Line of Defence. They will assist clinicians and managers by providing risk related advice and support specific to their area of responsibility.

5.8.1 Local Counter Fraud Services. The UHB's Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The UHB's Annual Counter Fraud Work Plan, as agreed by the Audit and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit and Assurance Committee as appropriate. The LCFS works with the Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned and are then escalated through the UHB's escalation process**.**

5.8.2 Health and Safety Team. The Health and Safety Department will be responsible for providing advice where a risk is related to Health and Safety (H&S). H&S issues are closely linked with risk management and specialist H&S advisers can assist with the conduct of specific and/or specialist assessments.

5.8.3 Risk and Regulation Team. The Risk and Regulation are responsible for co-ordinating the Health Board's operational and strategic risks, including the Corporate Risk register and the BAF. The team has a remit to work with Executives and Managers to co-ordinate, integrate, oversee and support the risk management agenda, ensuring that risk management principles are embedded across the Health

Board. The team will also coordinate the Risk Management Internal Audit process. On a quarterly basis they will receive from Clinical Boards and Corporate Directorates candidate risks for potential inclusion on the Corporate Risk Register, as well as updates on those risks already being managed on the Corporate Risk Register. The team also provides training and support for C&V UHB individuals and teams engaged in Risk Management.

6. Risk Management Process

The Risk Management Process involves the systematic application of policies, procedures and practices to the activities of communicating and consulting, establishing the context and assessing, treating, monitoring, reviewing, recording and reporting risk.

The risk management process can be applied at strategic and operational level, for risks of all types, and it may be customised to achieve objectives within specific external or internal contexts (ISO 31000, 2018). Risk management must be collaborative and informed by the best available information and expertise (HM Government, The Orange Book, 2020).

6.1 Communication and Consultation

The purpose of communication and consultation is to assist relevant stakeholders in understanding risk, the basis on which decisions are made and the reasons why particular actions are required (ISO 31000, 2018). Communication and consultation aims to bring together expertise for each step of the risk management process, ensure that different views are considered when defining and evaluating risk, provide information to enable oversight of risk and to build or maintain a sense of risk ownership within the team.

This strategy recognises that communication and consultation is primarily the business of those individuals/teams operating in the 1st Line of Defence and therefore it does not prescribe specific mechanisms for risk communication and consultation. However, the specialist functions operating in the 2nd Line of Defence may be consulted as required.

6.2 Types of Risk

There are two categories of risk, **strategic** and **operational**. These include risks from all domains i.e. safety, financial, regulatory, clinical and non-clinical etc.

Strategic risks are risks that could significantly interfere with the Health Board achieving its strategic objectives as outlined in its IMTP. Operational risks are risks that, if they occur, will affect the quality, safety or delivery of services or continuity of

business. They are not mutually exclusive and a risk may escalate from an operational risk to a strategic risk or be both.

6.3 Risk Appetite

Organisations should specify the amount and type of risk that it may, or may not take, relative to objectives. They should define the amount of risk they are willing to take in pursuit of value, or that it is prepared to accept in the pursuit of its strategic objectives (ISO 31000, 2018). This is achieved through the publication of a risk appetite matrix that describes the organisation's willingness or tendency to take risk in specific circumstances, with the purpose of providing managers and stakeholders with guidance that enables a consistent approach to risk-based decision making at all levels of the organisation.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant and/or the risk has a very low possibility of occurring.
- A higher risk consequence is outweighed by the chance of a much larger benefit if the risk is appropriately managed.
- The potential financial costs of minimising the risk outweigh the costs that would arise if the risk event occurred.
- Treating the risk may lead to further unacceptable risks in other ways.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risks or all other alternatives, including nothing, is even greater (NPSA, 2004).

The Board's assessment of Risk Appetite is based on the Good Governance Institute Matrix for NHS Organisations (GGI, 2019) and is published at Appendix 2. The Board will review its risk appetite on an annual basis.

The C&V UHB risk appetite matrix recognises the key elements described in the GGI matrix (financial, compliance, innovation/quality/outcomes and reputation) but it adds sub-elements to improve the precision of application to UHB activities and consequently greater risk sensitivity in decision making.

The C&V UHB risk appetite matrix retains the 5 risk levels described in the CGI Risk Appetite Maturity Matrix:

Avoid	Avoidance of risk and uncertainty is a Key Organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
Figure 2: CGI Risk Appetite Levels	

6.4 Risk Assessment

Risk assessment is a collective term for an overall process of risk identification, risk analysis and risk evaluation that is conducted systematically, iteratively and collaboratively across stakeholders (ISO 31000, 2018).

Each Clinical Board or Corporate Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.

Detailed guidance on Risk Assessment is provided in UHB 024 Risk Management Procedure.

6.4.1 Risk Identification. Risk identification is the finding, recognition and description of risks that have the potential to assist or prevent an organisation from achieving it's objectives, or which might cause harm or loss. A range of techniques can be used to identify risk and this might include specific techniques advised or delivered by the risk management and compliance functions operating in the second line of defence. A variety of factors may be considered when identifying risk, either individually or in a co-relationship:

- Risk causes and risk events.
- Threats and opportunities.
- Vulnerabilities and capabilities.
- Changes to the internal or external context.
- The nature and value of assets and resources.
- Limitations of knowledge and the reliability of information.
- Time related factors
- The biases, assumptions and beliefs of those involved in decision making.

6.4.2 Risk Analysis. The purpose of risk analysis is to understand the nature of the risk including the level of risk it might present to the organisation. Risk analysis is an essential prelude to risk evaluation, where decisions are made on whether risks need to be treated, and if they are to be treated then how they are to be treated. Risk analysis requires a detailed consideration of context (including objectives),

uncertainties, risk sources, consequences, likelihood, events, scenarios and the effectiveness of any existing controls.

Risk analysis can involve varying degrees of detail and complexity according to the potential extent of the threat, the available decision-making time and the available resources. It should consider factors such as:

- The likelihood of a risk event and the consequences (impact) on objectives, or the harm/loss, if a risk event occurs.
- The complexity of a risk event and any connectivity with other risks.
- Time related factors (where feasible).
- The effectiveness of existing controls.
- The general level of confidence in the reliability of information and decision making related to the risk.

The approach to quantifying risk is described in Appendix 3. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target (after completion of actions) circumstances.

The score of a particular current risk rating will determine at what level decisions on acceptability of the risk should be made and where it should be reported to. The Board defines as “Extreme” any risk that has the potential to damage the organisation’s objectives. General guidelines are in Figure 3:

Risk Level	Risk Score	Action
Extreme Risk	15 -25	Immediately report the risk to the relevant Executive Director who will inform the Chief Executive. In the event that this might cause delay, the Clinical Board Director should report directly to the Chief Executive.
High Risk	8-12	Report to Clinical Board (or for Corporate Directorates to the Executive Director).
Moderate Risk	4-6	Report to Heads of Service with proposed treatment/action plans, for particular monitoring.
Low Risk	1-3	Report to local manager for local action to reduce risk
Figure 3: Risk Levels		

6.4.3 Risk Evaluation. Risk evaluation supports decisions. The evaluation takes account of the wider context and is a comparison of the results of the risk analysis

with the established risk criteria and risk appetite to determine what subsequent action is required. Potential decisions could be to:

- Do nothing further because the risk likelihood/impact, complexity or connectivity are within established risk criteria and the risk can therefore be tolerated. No active management of the risk is required.
- Decide that existing controls for this risk are effective. Therefore, no new risk treatment is required but the risk will require continued active management.
- Decide that the risk is at an intolerable level and it therefore requires treatment and continued active management.
- Reconsider objectives if the threat from the risk, even after treatment, remains significant.
- Undertake further analysis to better understand the risk.

6.5 Risk Treatment

Risk treatment is an iterative process in which options for the reduction of risks are identified, selected, implemented and monitored.

Identifying and selecting the most appropriate risk treatment option(s) requires the balancing of cost, effort or disadvantages inherent in their implementation, against the benefits to be derived in the achievement of objectives or minimisation of losses/harms.

ISO 31000 (2018) identifies that options for treating risk may involve one or more of the following:

- Remove the source of the risk i.e. eliminate the hazard(s) that create the risk potential.
- Avoid the risk by deciding not to undertake the activity that provokes the risk i.e. avoid exposure to the hazard(s).
- Accept the risk because it is unavoidable or because it might create opportunity.
- Reduce the likelihood.
- Reduce the impact (consequence).
- Share the risk (for example through contracts or insurance).

Risk treatments may not produce the desired outcomes, may produce unintended consequences, may not take effect within the desired timeframe or may even introduce new risks. Therefore, if there are no treatment options available or if they do not modify the risk in the required timeframe and/or to an acceptable level, then the risk should be recorded on a risk register and be regularly monitored and reviewed.

6.6 Monitoring and Review

Risk management should be continually improved through learning and experience (HM Government, The Orange Book, 2020). The purpose of monitoring and review is to assure and improve the quality and effectiveness of the (risk) process design, implementation and outcomes (ISO 31000, 2018).

Once a risk has been identified, analysed and evaluated a Risk Owner should be appointed. Risk owners should be the individuals best placed through their authority and influence to take responsibility for mitigation of the risk. The identified risk owner is responsible for:

- Ensuring that the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures.
- Reviewing the risk register at appropriate intervals to ensure the descriptor, controls and risk score accurately reflect the level of risk and that progress is being made at sufficient pace to reduce the risk score to the target risk level.
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions.
- Reporting on the overall status of the risk, escalating where appropriate in line with local risk procedure and the risk escalation process detailed in this policy.

Action owners have responsibility for the activities needed to address gaps in control measures and the assurance of the effectiveness of existing controls. Action owners are required to report progress to Risk Owners in a timeframe and manner identified by the Risk Owner. Action owners will normally be identified from within the same Clinical Board or Corporate Directorate as the Risk Owner but specialists from other areas of the organisation, such as HR or H&S may also be required to perform as specialist action owners.

Ongoing and continuous monitoring supports risk owners and the organisation in understanding if and how risks may be changing, and the extent to which risk treatments are operating as intended. The results of monitoring and review provide assurance that risks are managed to a level that is unlikely to threaten the attainment of objectives or create significant loss or harm. Risk owners are responsible for monitoring and reviewing their own elements of the risk management process; this will generally occur through the recording of assurance on risk registers but may also occur through the delivery of assurance reports to committees and boards. Functions within the second line of defence have specific responsibilities for the monitoring of the overall risk process through ongoing, regular, periodic and ad-hoc monitoring and review.

All C&V UHB risk management policies will be reviewed on an annual basis and as and when required in accordance with the following:

- Legislative changes.
- Good practice guidance including 1st and 2nd line audit.
- Case law.
- Significant incidents.

- New vulnerabilities.
- Changes to organisational structures.

Overall accountability for procedural documents across the Health Board lies with the Chief Executive who has overall responsibility for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

Overall responsibility for the Risk Management and Board Assurance Framework Strategy lies with the Director of Corporate Governance who has delegated responsibility for managing the development and implementation of the strategy to the Head of Risk and Regulation.

6.7 Recording and Reporting

The purpose of risk recording and reporting is to communicate risk management activities and outcomes across the organisation, provide information for decision making, meet governance requirements and support the Board and oversight bodies in meeting their responsibilities.

6.7.1 Risk Registers. Risk registers will cover all risk types to create central references that informs the decision making of managers, executives, risk committees and the Board. Four levels of risk register will be maintained as follows:

- Ward/Department/Team Risk Register.
- Directorate Risk Register.
- Clinical Board/Corporate Directorate.
- Corporate Risk Register.

Risks registers will record the Initial Risk Rating, Current Risk Rating, and Target Risk rating. Current controls (and the assurance of their effectiveness) will be listed along with outstanding actions needed to create the control necessary to reach the target risk rating.

6.7.2 The Escalation of Risks. Action should be taken at each level of the organisation to lessen or remove the risk. As may be seen in Figure 4, risks will predominantly be escalated according to the current risk rating score. However, if the appointed Risk Owner feels that the risk can no longer be managed locally and requires more senior input and support, or that the risk event may impact across the wider UHB enterprise, then irrespective of its risk score it may be escalated, if necessary up to the Board. This should not be seen as failure but instead as prudent risk management that seeks to ensure an appropriate response at the most appropriate level within the organisation. The Risk and Regulation team are available for further advice on risks of this type.

Any risks identified and evaluated as having a low/moderate current risk rating (1-6) can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded in the local risk register within each ward / department; the Clinical Board/Corporate Directorate to which the ward/department belongs are responsible for the oversight and governance of these risk registers.

Risks identified and evaluated as having a high rating current risk rating (8-12) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead who will place the risk onto the Clinical Board/Corporate Directorate risk register and monitor/report the progress of the risk thereafter.

Risks identified and evaluated as having an extreme current risk rating (15-25) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead. The Risk Lead will immediately report risk greater than 20 to the relevant Executive Director who will inform the Chief Executive. In the event that this will cause delay the Clinical Board Director can report directly to the Chief Executive. Following this urgent notification process, risks greater than 20 should be notified to the Risk and Regulation Team for placement onto the Corporate Risk Register, using the proforma at Appendix 4.

The Corporate Risk Register will map extreme level risks, as well as risks that, whilst having a relatively low current risk rating, are sufficiently complex or wide in their potential impact, to require Executive Level/Board scrutiny. Risks appearing on this register have potential to impact on the achievement of strategic objectives. This information will be used by the Risk and Regulation Team to shape the agenda for Board and Committee meetings and the BAF, to ensure that the Health Board is actively responding to and considering its key risks.

6.7.3 Review of Risks. Risk Owners should consider the frequency with which they want to review risks, and this decision will usually be influenced by the type of risk, or the strength of current controls. The decision may also be influenced by specific requirements imposed by statute or by regulators/auditors/inspectors. However, as a minimum standard low risk (1-3) should be reviewed and updated at least biannually, moderate risks (4-6) should be reviewed and updated at least quarterly, and high (8-12) and extreme (15-25) risks should be reviewed and updated monthly.

Assurance	Current Risk Rating	Level	Actions
Board Bi-Monthly HMSB Quarterly	20-25	Board Assurance Framework (BAF)	Strategic Risks identified by Committees, Clinical Boards or Corporate Directorates.
		Corporate Risk Register	Extreme Operational Risks or Risks to Strategic Objectives

Board Bi-Monthly			
Clinical Board/QSE Quarterly	15-25	Clinical Board/Corporate Directorate	Risks scoring 20 or > require immediate escalation to Risk and Regulation team who will pass to appropriate Executive and/or committee and consider for placement on the Corporate Risk Register and, if strategic objectives are threatened, for ultimate placement on the BAF. Risks scoring less than 20 should be retained and managed at Clinical Board/Corporate Directorate level unless they require escalation to their complexity or cross health board impact.
Directorate Meeting Monthly	8-12	Directorate	Risk added to Directorate Risk Register. Risks to be reviewed monthly.
Ward Department Risk Review meetings – at least quarterly.	4-6	Ward/Department/Team	Inform Line Manager and risk may be added to the Risk Register. These risks will be managed by the Line Manager/Department Manager. These risks will form part of the departmental risk register that will be reviewed by the department at least every 6 months.
Risk Review meetings – at least 6 monthly	1-3	Ward/Department/Team	If unable to immediately mitigate the risk, add to local risk register. This risk should be managed locally with all staff having authority to manage the risk. These risks form part of the departmental risk register.
Figure 4: Risk Escalation Guide			

6.7.3 Board Assurance Framework (BAF)

The BAF identifies from the Corporate Risk Register the highest risks faced by the Health Board in achieving its strategic objectives, and the gaps in assurances on which the Board relies.

The BAF is developed through the following key steps:

a. The Board annually agree the Strategic objectives as part of the business planning cycle.

b. The Management Executive, with the support of the Director of Corporate Governance, will draft the principle risks that may threaten the achievement of the strategic objectives; these risks will then be discussed and approved by the Board of Directors.

c. For each principle risk the Executive Lead will:

(1) Give an initial (inherent) risk score, by determining the consequence and likelihood of the risk being realised.

(2) Link the risk to the strategic objectives.

d. Risks from the previous year's BAF will be reviewed and a decision made whether to:

(1) Transfer the risk on to the BAF for the current year.

(2) Move the risk to the Corporate Risk Register and nominate a Risk Owner or Management Group.

(3) Accept or Close the risk.

e. The Executive Lead will then:

(1) Identify the key controls in place to manage the risks and achieve delivery of the strategic objective(s).

(2) Identify the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk.

(3) Evaluating the assurance across all areas of principal risk i.e. identifying sources of assurance the Health Board is managing the risks to an acceptable level of tolerance.

(4) Identify how / where / when those assurances will be reported.

(5) Identify areas where there are gaps in controls (where the Health Board is failing to implement controls or failing to make them effective).

(6) Identify areas where there are gaps in assurances (where the Health Board does not have the evidence to assure that the controls are effective).

(7) Develop an action plan to mitigate the risk.

(8) Agree a current (residual) risk rating for the first quarter of the financial year which is determined by the consequence and likelihood of the risks.

f. The BAF will be presented to the first HSMB meeting of the new financial year. It will moderate the risk scores and ensure there are appropriate controls and assurances. Where gaps in control and assurances exist, they will ensure that associated action plans are in place for each risk thus affected.

g. Bi-monthly the Executive lead, supported by the Director for Corporate Governance, will review and monitor the controls and reported assurances and update the risk score and action plans for each of the risks for which they are responsible.

h. The Executive will review and monitor all of the risks on the BAF each month prior to presentation to the Board. In particular the Management Executive will ensure that progress is being made to reduce or eliminate the impact of the risk.

i. Once agreed by Management Executive the completed BAF will be presented to the Board for scrutiny and approval on a monthly basis. At the first meeting of the financial year it will be reviewed in its entirety.

The Audit and Assurance Committee, as a sub-committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

The BAF is an integral part of the system of internal control and defines those extreme risks with potential to impact upon the delivery of Strategic Objectives. It also summarises the controls and assurances that are in place, or the plans to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks, the implementation and progress against the action plan is then monitored by the Board for implementation.

Levels of assurance are applied to each of the controls as follows:

(1) Management Reviewed Assurance.

(2) Board or Committee Reviewed Assurance.

(3) External Reviewed Assurance.

This provides an overall assurance level on each of the strategic risks.

7. Risk Management Training

The following training is designed to complement the risk related elements of the Core Mandatory Training identified in C&V UHB Mandatory/Statutory Training Procedure (UHB 080). The aim of the tiered Risk Management training is to enable UHB personnel to meet their Risk Management responsibilities outlined in this strategy:

Level One – Risk Management Awareness. This will be provided to all staff on induction, as part of Core Mandatory Training, and will be repeated on ESR every 2 years. The intended learning outcomes are to understand what risk is, what risk management is, how a risk is reported and how the organisation's risk appetite and culture operates.

Level Two – Practical Risk Management. This level of training is targeted for any employee undertaking risk management as part of their primary or secondary roles, and for Team Leaders/Managers/Departmental Heads. Line Managers, Clinical Board Directors and Executive Directors have a specific role to play in identifying candidates for this training, ideally in prelude to assuming a risk facing role, but if not then as soon as practicable after assumption of role. Level Two training does not require repetition, though this does not mean that additional risk related training and education should not be identified through PDR. This training will be in two parts:

- **Part 1**. To understand the risk management framework including the risk management strategy, the BAF, the corporate risk register, risk appetite, risk culture, and roles and responsibilities.
- **Part 2**. To understand the risk management process including context, risk versus issue and incidents. Risk assessment, risk tolerance, risk scoring, risk treatments, escalation, communication, monitoring and review.

Level Three – Board Level Risk Management Awareness. This level of training is designed for Board Members and Board Directors. It will be provided on induction and to meet governance requirements it must be repeated every two years thereafter. Level Three training will be facilitated by the Director of Corporate Governance and scheduled within the rhythm of board meetings. The training aim is to provide the audience with an understanding of: the risk management framework, with specific emphasis on the operational risk management approach; the risk management strategy;

'setting the tone' and risk culture; risk appetite; the corporate risk register and the Board Assurance Framework.

Non-Specific Training and Support. It is recognised that, in addition to these three levels of specified training, there may emerge a need for non-specific risk management training and support. Where this is applicable the Risk and Regulation team can discuss the apparent training need and either signpost to external sources of training/education or provide a bespoke training event for individuals or small groups.

8. References

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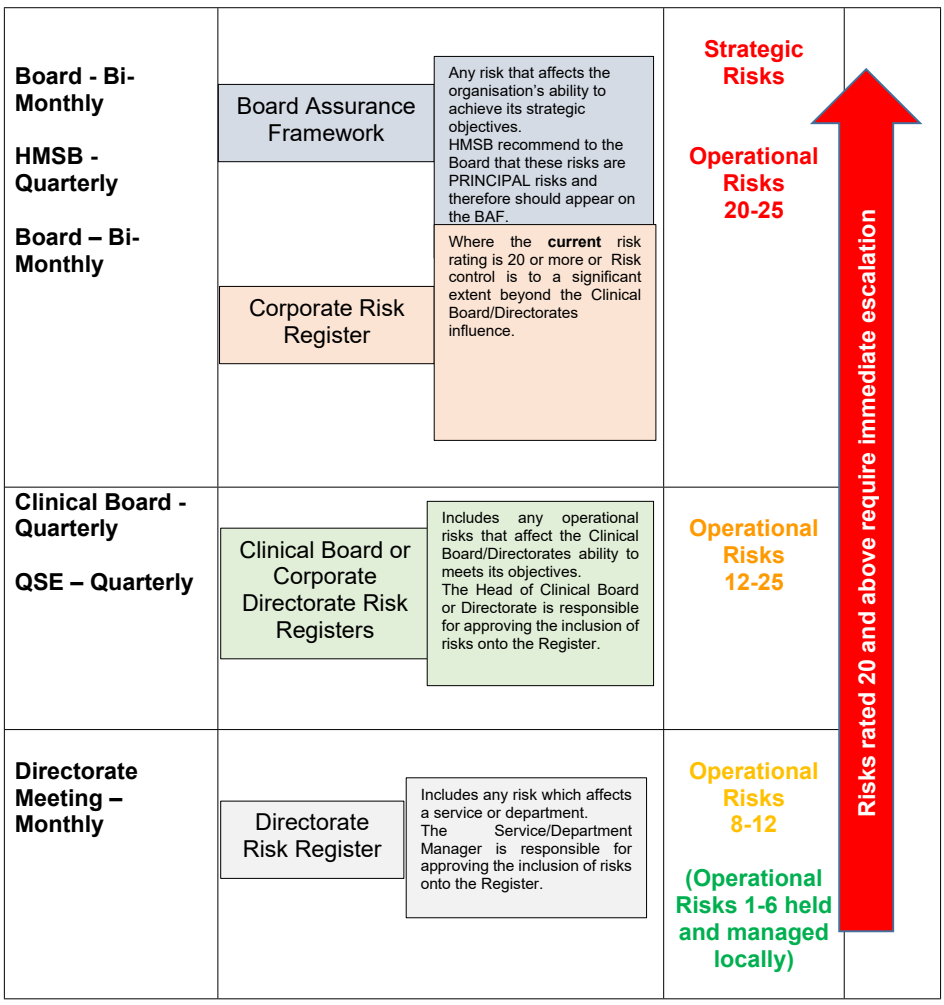
9. Equality impact assessment

C&V UHB aims to design and implement services and policies that are fair and equitable. As part of its development, this Strategy and its impact on staff, patients and the public have been reviewed in line with the Cardiff and Vale's Equality Impact Assessment. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as "no impact".

Appendix 1

Risk Registers and Risk Reporting Hierarchy



Appendix 2

Cardiff and Vale UHB – Summary Risk Appetite Matrix

GGI Key Element/Lead	Sub Element	Current Risk Appetite	Target Risk Appetite
1. Financial/Value for Money (VfM) Executive Director of Finance	1a. The availability of Financial Resources and the value derived from their application.	**Cautious:** VfM remains our primary concern but we are prepared to accept limited financial loss or higher cost options where improvements to service delivery standards are possible.	Seek: We invest for the best possible return. We have controls in place but we still accept the possibility of financial loss.
2. Compliance and Regulatory Director of Corporate Governance	2a. The Regulation & Governance of our activity to ensure legal compliance and recognised best practice.	**Cautious**: Challenge of our decisions/actions/omissions *will* occur and we want to be reasonably sure that such challenge is defensible.	Open: Challenge will occur and *could* be problematic. However, the gain will outweigh the adverse impact
3. Quality and Outcomes Executive Nurse Director & Executive Medical Director	3a.The Safety, Quality and Accessibility of Care.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We often challenge current clinical practices and often pursue innovative treatment and care solutions. Confident in our risk control we allow non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We routinely challenge current clinical practices and routinely pursue innovative treatment and care solutions.
	3b. The Accessibility, Quality and Security of Information.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current information management practices and pursue innovative technological solutions. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We *routinely* challenge current information management practices and pursue innovative technological solutions.
	3c. An effective, valued and well developed Workforce.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current recruitment, retention, training and regulation practices and/or procedures. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we recognise potential for long term gain. We *routinely* challenge current recruitment, retention, training and regulation practices and/or procedures.
	3d. The availability of the Materiel, Infrastructure and Sustainability required to meet our objectives, business needs or statutory obligations.	**Open**: There are short term inherent risks to the availability or sustainability of materiel/infrastructure. However, we are willing to manage these risks to a tolerable level because we recognise potential for long term gain.	Seek: Allocation and investment decisions related to sustainability, materiel and infrastructure will seek the best possible return. With rigid controls in place there is an acceptance of the possibility for financial loss, loss of resource availability or failure to meet statutory obligations.
4. Innovation Director of Transformation	4a.The application of Foresight & Innovation to our current and future activities	**Cautious**: Innovations in practice and/or risks arising from technological developments will only be considered if they have a strong potential to improve service quality, financial position or statutory compliance.	Seek: We consider the risks associated with innovation, creativity and research to be an essential component part of C&V UHB activity. We have devolved the authority for risk decisions to an operational level.
5. Reputation Chief Executive	5a.The positive Reputation of C&V UHB and the wider Wales NHS	**Open**: We are willing to take decisions that have potential to expose the organisation to additional scrutiny or interest. The means to manage the organisation's reputation are in place.	Seek: We recognise that the organisation will be subject to additional scrutiny/interest but we feel that the potential benefits outweigh the risks. New ideas are seen as potentially enhancing the reputation of the organisation.

Appendix 3

Approach to assessing Risk

Consequence scores
Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work Physical injury to self/others that requires no treatment (including first aid) Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation – requiring no intervention.	Minor injury or illness, requiring minor intervention. Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation managed by local level intervention.	Moderate injury requiring professional intervention. Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Physical injury to self or others requiring medical treatment Psychological distress requiring formal intervention by mental health professionals. Vulnerability to abuse or exploitation requiring increased intervention	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Significant physical harm to self or others Significant psychological distress requiring specialist mental health intervention. Vulnerability to abuse or exploitation requiring significant levels of intervention	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence × likelihood (C × L)

	Likelihood

Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated. Where a risk has multiple impacts score the impact with the highest consequence.

Determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score).

Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 4

Corporate Risk on a page Report as at Click or tap to enter a date.

<table>
<tr><td colspan="2">Update: ☐</td><td colspan="4">New Risk for Corporate Risk Register: ☐</td></tr>
<tr><td rowspan="4">Risk Reference: Click or tap here to enter text.</td><td colspan="2">Director Lead:</td><td colspan="3">Date of identification: Click or tap to enter a date.</td></tr>
<tr><td colspan="2">Assuring Committee Click or tap here to enter text.:</td><td colspan="3">Date Last Reviewed: Click or tap to enter a date.</td></tr>
<tr><td colspan="2">Risk: Click or tap here to enter text.</td><td colspan="3">Frequency of Review: Click or tap here to enter text.</td></tr>
<tr><td colspan="5">Impact: Click or tap here to enter text.</td></tr>
<tr><td colspan="6">Links to Strategic Objectives: Click or tap here to enter text.</td></tr>
<tr><td colspan="2">Movement Since Last Update:</td><td></td><td>Consequence</td><td>Likelihood</td><td>Score (CxL)</td></tr>
<tr><td>↑</td><td>☐</td><td>Initial Risk Rating</td><td>Choose an item.</td><td>Choose an item.</td><td>Choose an item.</td></tr>
<tr><td>↓</td><td>☐</td><td>Current Risk Rating</td><td>Choose an item.</td><td>Choose an item.</td><td>Choose an item.</td></tr>
<tr><td>↔</td><td>☐</td><td>Target Risk Rating</td><td>Choose an item.</td><td>Choose an item.</td><td>Choose an item.</td></tr>
<tr><td colspan="3">Controls</td><td colspan="3">Assurances of Control Effectiveness</td></tr>
<tr><td colspan="3">Click or tap here to enter text.</td><td colspan="3">Click or tap here to enter text.</td></tr>
<tr><td colspan="3"></td><td colspan="3">Additional Risk Treatments Required</td></tr>
<tr><td colspan="3"></td><td colspan="3">Click or tap here to enter text.</td></tr>
</table>

Key :
- CRR - Corporate Risk Register

CRR Reference as at [*DATE*]	Corporate Risks as at [*Date*]	Current Risk Score as of [*Date*]:	**First Line of Defence** Management Controls			**Second Line of Defence** Oversight functions, e.g. Compliance and quality sub-groups and risk management			**Third Line of Defence** Internal Audit, External Audit and other regulators and independent assurance providers.			**Reviewed Assurance Level**
			Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit/NWSSP Estates	External Audit	
CRR1	Risk of patient harm due to obsolete Oxygen and Nitrous Oxude medical gas Plant and Equipment at various UHB sites	5x4=20	x	x	x	x	x	x		x		
CRR2	Risk of patient harm due to interruption of oxygen supply to the whole of UHW resulting from a corroded oxygen pipeline.	5x4=20	x	x	x	x	x	x		x		
CRR3	Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	5x4=20	x	x		x	x	x		x		
CRR4	Risk to staff safety and regulatory compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	5x4=20	x	x	x	x	x	x		x		
CRR5	Risk to estimated expenditure in financial plans due to significant increases in energy tarrifs	4x5=20	x	x		x	x	x		x		
CRR6	Risk of staff and patient harm due to difficulties recruiting sufficient numbers of nursing staff.	5x5=25	x	x	x	x		x	x	x		
CRR7	Risk of patient harm due to patients being added to Routine waiting lists secondary to increased Referal to Treatment times.	5x4=20	x	x	x	x		x				
CRR8	Risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit	5x4=20	x	x	x	x		x				
CRR9	Risk of patient harm due to delayed cancer diagnosis secondary to accumulation of therapeutic and surveillance case numbers.	4x5=20	x	x	x	x		x				
CRR10	Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	5x4=20	x	x	x	x		x	x			
CRR11	Risk of delay in the assessment of patients leading to clinical risk and poor patient experience due to an inability to provide medical cover across the Medicine Clinical Board.	5x4=20	x	x		x		x				
CRR12	Risk of overcrowding in the Emergency and Acute Medicine footprint resulting in an ability to meet key quality standards impacting on patient experience, quality of care and discharge.	5x4=20	x	x	x	x	x	x	x			
CRR13	Risk of harm to compromised fetuses and reduced options for termination of pregnancy due to capacity shortfalls witin Fetal Medicine	5x4=20	x	x	x	x		x	x			
CRR14	Risk of patient harm and poor patient experience due to staffing difficulties and shortages within maternity services.	5x4=20	x	x	x	x		x	x			
CRR15	There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the Clinical Board	5x4=20	x	x	x	x		x				
CRR16	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce	5x4=20	x	x		x		x				
CRR17	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	5x4=20	x	x		x		x				
CRR18	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	5x4=20	x	x		x		x				
CRR19	Risks to harm to haematology patientx (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	4x5=20	x	x		x		x				
CRR20	Risk failure to achieve revenue statutory duty breakeven duty and achieve an approved three year IMTP	5x4=20	x	x	x	x		x			x	
CRR21	Risk of failure to achieve an approved Three Year IMTP due to a planned defecit of £17.1 million	5x4=20	x	x	x	x		x			x	
CRR22	Risk of service interruption and potential patient harm due to cyber security threats	5x4=20	x	x		x		x	x	x		

Assurance Level Key:	
No Evidence	Not evidenced on Risk Register/ Not Applicable
Assurance on one line of defence, limited or no third line of defence, assurance over 3 years old.	Low
Assurance across two lines of defence, poitive assurance on third line of defence, assurance within last three years.	Medium
Assurance across all three lines of defence, positive assurance on the third line of defence, assurance within last three years.	High

Third Line of Defence Assurance Level Key:	
No Evidence	Not evidenced on Risk Register/ Not Applicable
Limited	
Reasonable	
Substantial	

	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit/NWSSP Estates	External Audit
Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Weekly visual monitoring of the tank is carried out.	Continually monitored through maintenance reports	Review of euqipment in line with replacement schemes for 2023/2024.	Assurance & compliance meetings are held monthly at which escalated risks can be discussed. Six monthly reviews of risk assessments carried out by Assurance & Compliance team.	Continually monitored through maintenance reports	Last risk register workshop for CEF was held on 5th October 2022. Risk reviewed by Risk and Regulation team in January 2023	None as system still meeting requirements.	Replacement of the F&E Tanks has been included in the EFAB replacement schemes for 2023/2024. This has been endorsed by NWSSP and we await final approval from WG for replacement of F&E Tanks.	

	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	*Triage of all patients held on an ambulance and clear escalation process in place for a deteriorating patient. Protection of resus buffer wherever possible. Standard Operational Policy in place to support Immediate Release requests. Joint partnership with OPAT and the use of FCP and onboarding when ambulances are held for 3 hours. Transformational work undertaken and the implementation of initiatives to support flow eg, RATZ, Virtual Ward, and Speciality Hub. 2 hourly safety huddles.*	*BIS used to provide data on waiting times. Use of WAST Launchpad in the Emergency Unit and OPAT to monitor performance. E Datix submitted for long waits and acuity of patients in the department*	*Performance is tracked, and discussed at Directorate Performance Reviews monthly. Joint meetings with the Clinical Board and WAST colleagues to monitor performance.*	*. Directorate Performance Reviews and Quality and Safety meetings. Discussed at Clinical Board Quality and Safety Meetings bi monthly.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk. (Unlikely for this risk)*	*Reviewed by Risk and Regulation team in January 2023 and within bi-monthly Clinical Board Reviews.*	*HIW WAST Local Review 2021 and updated October 2022*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

Report Title:	Single Tender Actions				Agenda Item no.	7.11	
Meeting:	Audit Committee		Public	X	Meeting Date:	7th February 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that the purchase of all goods and services be subject to competition in accordance with good procurement practice, making reference to minimum thresholds for quotes and competitive tendering arrangements.

There are some situations where this is not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) are made in accordance with the Procedure for the Approval of Single Tender Action. There are sound reasons why STA/SQA's are permitted within the Health Board, these are as follows but not limited to:-

- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

To support the management of STA/SQA requests, an online quotation system was implemented in April 2019, to test the market and promote competition, this should reduce the number of STA/SQA's.

There are also some situations where contracts are extended outside of the original contract scope to ensure patient safety and operational delivery of the Health Board's core services.

Unfortunately, there are times where individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (17)

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Staffing Invoices for Vanguard Ophthalmology Nurses	£106,003.00	N/A	6 months	Surgery	No Procurement involvement in engagement of services	Complete – Compliance put in place
Provision of Ophthalmology Services	£20,200.00	N/A	2 months	Surgery	No Procurement involvement in engagement of services	Ongoing – Compliance being put in place via STA
Subscription to BEAM clinics	£5,600.00	N/A	12 months	Medicine	No Procurement involvement in engagement of services	Complete – Advised of SFI's and included in workplan
Trident award	£5,852.64	N/A	4 months	Specialist	No Procurement involvement in engagement of services	Complete – no further action
UC3	£25,000.00	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
HBS Insourcing Pre-Assessment	£16,014.00	N/A	1 month	Surgery	Outside scope of current insourcing contract.	Ongoing – Advised of scope of contract, awaiting information on whether this is a recurring requirement
Research Grant Claim	£11,521.66	N/A	3 months	Specialist	No Procurement involvement in engagement of services	Complete – no further action
Hanover Jackson	£14,034.80	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
MHRA Payment	£7,965.00	N/A	One off payment	C,D&T	No Procurement involvement in engagement of services	Complete – one off, no further action
Palliative Care Admin Support	£6,635.50	N/A	12 months	Children and Women	No Procurement involvement in engagement of services	Ongoing – Scoping potential future activity
Sexual Assault Resource Centre Artwork	£8,154.16	N/A	One off purchase	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action

Taff Wellbeing Space	£5,322.05	N/A	One off purchase	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
Loan Hire	£7,808.00	N/A	One off payment	Surgery	No Procurement involvement in engagement of services	Complete – one off, no further action
Vertebra Models and Patient Bone Models Loan Charge	£6.840.00	N/A	One off payment	Surgery	No Procurement involvement in engagement of services	Complete – one off, no further action
Care and consumables for end of life patient	£11,634.02	N/A	3 months	Surgery	No Procurement involvement in engagement of services	Ongoing – compliance contract being put in place
RDS Farm MFA Enablement	£11,794.00	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
Synovis Group LLP	£49,928.06	N/A	12 months	AWMGS	No Procurement involvement in engagement of services	Ongoing – Scoping potential future activity

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (Nil Return)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status

Other Non-Compliant Activity (3 Return)

This section details activities which were out of the Department/Health Board's control as a result of any of the following;

- Emergency activity
- Unforeseen/Unplanned circumstances
- Exemptions

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Emergency hire of air conditioning units	£10,711.20	N/A	One off period	Capital Planning, Estates and Facilities	Emergency	Complete – emergency situation
Provision of Conference Stand	£7,420.80	N/A	One off period	Medicine	Conference engaged at last minute and could not complete internal paperwork in time for payment to attend	Complete – one off urgent turnaround
Barrister Fees	£10,044.30	N/A	One off period	Executives – L&R	NWSSP L&R select barristers, no involve in appointment	Complete – no further action

Contracts engaged at risk as a result of Covid-19 requirements (Nil Return)

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status

Report of Single Tender/Quotations Actions

Retrospective – (3)

The report outlines all SQA/STA (3) requests during the period the 1st October 2022 to 31st December 2022.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
Women and Children	Robert Haf	Provision of Agency Staff	£16,869.00	Urgent Operational Requirement
C,D&T	DQD Engineering	Maintenance of water generation system	£69,668.38	Sole Supplier of Goods or Services
Executives - RPB	Cardiff People First	Provision of learning disability support service	£17,493.60	Urgent Operational Requirement

Should Retrospective STA/SQA's occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

Prospective (within the permitted guidelines)

The report outlines all SQA/STA () requests during the period the 1st October 2022 to 31st December 2022.The volume processed was higher than normal activity, as a consequence of the following:-

1. Bevan Exemplar initiatives – WG approved
2. Year-end Monies/ Capital
3. National Programmes
4. Trials, Testing and Education Programmes
5. Bespoke software support and/or licences
6. Specialist Maintenance and Repairs
7. Partnership Arrangements
8. Compliance / Regulatory Requirements
9. Charitable Funds
10. Standardisation of goods or services
11. Covid-19/ Unforeseen circumstances/Emergencies
12. Exemptions

Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
CD&T	Horizon Strategic Partners	MicroGuide App Support Service	£12,000.00	Sole Supplier of Goods or Services
Specialist	PASS Software	PASS Software Service	€75,825.00	Sole Supplier of Goods or Services
Mental Health	4 Mental Health	Specialist Mental Health Training	£15,800.00	Urgent Operational Requirement

Mental Health	Open Dialogue UK	Delivery of Open Dialogue training to Staff in Mental Health Services for Older People within the Mental Health Clinical Board.	£95,000.00	Capability with existing equipment or service
PCIC	Reveal Services Ltd	Provision of Security Staff to the Alternative Treatment Service providing General Medical Services to High Risk Patients	£22,464.00	Urgent Operational Requirement
PCIC	Time for Teeth	Urgent Dental Service in HMP Cardiff	£34,342.50	Urgent Operational Requirement
Medicine	Mediteam	Locum for Gastroenterology	£148,800.00	Urgent Operational Requirement
Capital Planning, Estates and Facilities	ORBIS PROTECT LTD	Emergency Works	£5,656.71	Urgent Operational Requirement
CD&T	The Gambica Association Ltd	Weqas Medlab Exhibition	£7,884.00	Sole Supplier of Goods or Services
Executives	Christine Bell	Independent Investigator	£24,000.00	Urgent Operational Requirement
Specialist	Quantum	Patient Specific Wheelchair	£6,999.60	Sole Supplier of Goods or Services
CD&T	Agena Bioscience	Custom Pharmacogenomics Panel	£23,801.00	Sole Supplier of Goods or Services
Specialist	Queen Mary University of London	Tuition fees	£6,800.00	Sole Supplier of Goods or Services
Executives	Sleign	Training, Events and Consultancy	£20,700.00	Sole Supplier of Goods or Services
Specialist	Queen Mary University of London	Tuition Fees	£6,800.00	Sole Supplier of Goods or Services
CD&T	Cardiff University	Tuition Fees	£20,400.00	Sole Supplier of Goods or Services
CD&T	Genial	Maintenance of IMS Software	£74,304.00	Sole Supplier of Goods or Services
Specialist	RD Biomed	Cardiff Pneumonia Endotracheal Tube Study 8290 VAP-X	£10,500.00	Sole Supplier of Goods or Services
CD&T	University of South Wales	Tuition Fees - Daniel Thompson	£28,916.25	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	BSI Assurance UK Ltd	ISO 45001 Health and Safety Management Standard	£32,288.00	Sole Supplier of Goods or Services
PCIC	Marie Curie	Speciality Doctor Cover	£10,000.00	Urgent Operational Requirement
PCIC	City Hospice	Speciality Doctor Cover	£12,000.00	Urgent Operational Requirement
CD&T	Rees Scientific UK	Annual revalidation of Rees temperature monitoring system	£59,300.70	Sole Supplier of Goods or Services
CD&T	Baxter Medical Limited	Maintenance of E2400 Compounders	£46,802.60	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	2021/22			2022/23		
Clinical Board	**Non-Compliant Breaches**	**Exemption**	**Covid-19**	**Non-Compliant Breaches**	**Exemption**	**Covid-19**
AWMGS	1	0	0	0	0	0

Children and Women	2	1	0	1	0	0
Capital Planning, Estates and Facilities	7	8	1	2	1	1
Clinical, Diagnostics and Therapies	6	0	1	1	0	0
Executives	14	8	3	1	4	0
Medicine	3	0	0	1	0	0
Mental Health	0	0	0	2	0	0
PCIC	1	0	0	0	0	0
Specialist	6	0	0	0	1	0
Surgery and Dental	4	0	1	2	1	0
TOTALS	**44**	**17**	**6**	**10**	**7**	**1**

Please note that in February 2021, the reporting of non-compliant activity was spilt into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

	2020/21		2021/22		2022/23 (Year To Date)	
Clinical Board	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**
AWMGS	N/A – Previously recorded as part of CD&T		4	3	3	3
Children and Women	3	0	2	0	2	0
Capital Planning, Estates and Facilities	3	1	2	0	7	0
Clinical, Diagnostics and Therapies	28	4	14	1	9	2
Executives	20	4	9	3	13	0
Medicine	6	3	6	1	3	0
Mental Health	3	0	1	0	0	0
PCIC	8	2	2	0	5	2
Public Health Commissioning Team	0	0	1	0	1	0
Specialist Services	7	1	6	2	7	1
Surgery Services and Dental	9	3	5	1	5	0
Grand Total	**87**	**18**	**52**	**11**	**55**	**8**

Recommendation:

The Committee is requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Report Title:	Procurement Compliance Report				Agenda Item no.	7.12	
Meeting:	Audit Committee		Public	X	Meeting Date:	7th February 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that the purchase of all goods and services be subject to competition in accordance with good procurement practice, making reference to minimum thresholds for quotes and competitive tendering arrangements.

There are some situations where this is not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) are made in accordance with the Procedure for the Approval of Single Tender Action. There are sound reasons why STA/SQA's are permitted within the Health Board, these are as follows but not limited to:-

- Sole Supplier of Goods or Services
- Proprietary items, i.e. Trademarked, patented
- Capability with existing equipment or service
- Regulatory, i.e. Human Tissue Act (HTA)
- Urgent Operational Requirement
- Covid-19
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

To support the management of STA/SQA requests, an online quotation system was implemented in April 2019, to test the market and promote competition, this should reduce the number of STA/SQA's.

There are also some situations where contracts are extended outside of the original contract scope to ensure patient safety and operational delivery of the Health Board's core services.

Unfortunately, there are times where individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

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

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (17)

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Staffing Invoices for Vanguard Ophthalmology Nurses	£106,003.00	N/A	6 months	Surgery	No Procurement involvement in engagement of services	Complete – Compliance put in place
Provision of Ophthalmology Services	£20,200.00	N/A	2 months	Surgery	No Procurement involvement in engagement of services	Ongoing – Compliance being put in place via STA
Subscription to BEAM clinics	£5,600.00	N/A	12 months	Medicine	No Procurement involvement in engagement of services	Complete – Advised of SFI's and included in workplan
Trident award	£5,852.64	N/A	4 months	Specialist	No Procurement involvement in engagement of services	Complete – no further action
UC3	£25,000.00	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
HBS Insourcing Pre-Assessment	£16,014.00	N/A	1 month	Surgery	Outside scope of current insourcing contract.	Ongoing – Advised of scope of contract, awaiting information on whether this is a recurring requirement
Research Grant Claim	£11,521.66	N/A	3 months	Specialist	No Procurement involvement in engagement of services	Complete – no further action
Hanover Jackson	£14,034.80	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
MHRA Payment	£7,965.00	N/A	One off payment	C,D&T	No Procurement involvement in engagement of services	Complete – one off, no further action
Palliative Care Admin Support	£6,635.50	N/A	12 months	Children and Women	No Procurement involvement in engagement of services	Ongoing – Scoping potential future activity
Sexual Assault Resource Centre Artwork	£8,154.16	N/A	One off purchase	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action

Taff Wellbeing Space	£5,322.05	N/A	One off purchase	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
Loan Hire	£7,808.00	N/A	One off payment	Surgery	No Procurement involvement in engagement of services	Complete – one off, no further action
Vertebra Models and Patient Bone Models Loan Charge	£6.840.00	N/A	One off payment	Surgery	No Procurement involvement in engagement of services	Complete – one off, no further action
Care and consumables for end of life patient	£11,634.02	N/A	3 months	Surgery	No Procurement involvement in engagement of services	Ongoing – compliance contract being put in place
RDS Farm MFA Enablement	£11,794.00	N/A	One off payment	Executives	No Procurement involvement in engagement of services	Complete – one off, no further action
Synovis Group LLP	£49,928.06	N/A	12 months	AWMGS	No Procurement involvement in engagement of services	Ongoing – Scoping potential future activity

Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (Nil Return)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status

Other Non-Compliant Activity (3 Return)

This section details activities which were out of the Department/Health Board's control as a result of any of the following;

- Emergency activity
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Barrister Fees	£10,044.30	N/A	One off period	Executives – L&R	NWSSP L&R select barristers, no involve in appointment	Complete – no further action

Contracts engaged at risk as a result of Covid-19 requirements (Nil Return)

Contract Title	Value at Risk	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action/Status

Report of Single Tender/Quotations Actions

Retrospective – (3)

The report outlines all SQA/STA (3) requests during the period the 1st October 2022 to 31st December 2022.

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Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Type
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Mental Health	Open Dialogue UK	Delivery of Open Dialogue training to Staff in Mental Health Services for Older People within the Mental Health Clinical Board.	£95,000.00	Capability with existing equipment or service
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Medicine	Mediteam	Locum for Gastroenterology	£148,800.00	Urgent Operational Requirement
Capital Planning, Estates and Facilities	ORBIS PROTECT LTD	Emergency Works	£5,656.71	Urgent Operational Requirement
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CD&T	Baxter Medical Limited	Maintenance of E2400 Compounders	£46,802.60	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	2021/22			2022/23		
Clinical Board	**Non-Compliant Breaches**	**Exemption**	**Covid-19**	**Non-Compliant Breaches**	**Exemption**	**Covid-19**
AWMGS	1	0	0	0	0	0

Children and Women	2	1	0	1	0	0
Capital Planning, Estates and Facilities	7	8	1	2	1	1
Clinical, Diagnostics and Therapies	6	0	1	1	0	0
Executives	14	8	3	1	4	0
Medicine	3	0	0	1	0	0
Mental Health	0	0	0	2	0	0
PCIC	1	0	0	0	0	0
Specialist	6	0	0	0	1	0
Surgery and Dental	4	0	1	2	1	0
TOTALS	**44**	**17**	**6**	**10**	**7**	**1**

Please note that in February 2021, the reporting of non-compliant activity was spilt into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

	2020/21		2021/22		2022/23 (Year To Date)	
Clinical Board	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**	**No. of SQA's/STA's**	**SQA/STA's Breached**
AWMGS	N/A – Previously recorded as part of CD&T		4	3	3	3
Children and Women	3	0	2	0	2	0
Capital Planning, Estates and Facilities	3	1	2	0	7	0
Clinical, Diagnostics and Therapies	28	4	14	1	9	2
Executives	20	4	9	3	13	0
Medicine	6	3	6	1	3	0
Mental Health	3	0	1	0	0	0
PCIC	8	2	2	0	5	2
Public Health Commissioning Team	0	0	1	0	1	0
Specialist Services	7	1	6	2	7	1
Surgery Services and Dental	9	3	5	1	5	0
Grand Total	**87**	**18**	**52**	**11**	**55**	**8**

Recommendation:

The Committee is requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	

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

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Report Title:	Procurement Compliance Report – Chair's Action Review				Agenda Item no.	7.12	
Meeting:	Audit Committee		Public	X	Meeting Date:	7th February 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Finance						
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead – C&V						

Main Report
Background and current situation:

The UHB's Standing Orders & Standing Financial Instructions require that Board approval is obtained for the purchase of all goods and services for contracts over the value of £500k.

There are some situations where approval must be sought outside Board approval and therefore, a Chair's Action request is submitted. The reasons can be as follows;-

- Urgent Operational Requirement
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

A review of the number of Board and Chair's Actions reports was requested by the Director of Finance.

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

A review of Board approvals was undertaken for financial year 2021/22 and up to December 2022 for this financial year.

In 2021/22 the majority of approvals (72) were issued via the Chair's Action route with 2 through the formal Board meeting. This was highlighted to Procurement Services and therefore, planning for approval was advised to be in line with Board meeting dates.

During the financial year 2022/23, Procurement Services have issued 36 requests to date. In order to confirm the number of genuine Chair's Action requests, Procurement commenced tracking these requests from September 2022 with the following categories;

1. Board Agenda does not have capacity for request
2. Emergency/Unforeseen circumstances
3. Exemption - contract value above estimated contract value
4. Procurement have not provided sufficient time within Board dates for approval
5. Urgent Operational Requirement

Unfortunately, a number of these requests were issued via Chair's Action for the reasons outlined in the table below.

2022/23 (YTD)	Total Number	Category of Request				
		1	2	3	4	5
Chair's Action	2	7	2	0	0	24
Board Meeting Approval	34					

It should be noted that the majority of urgent operational requirements were a result of CEF unplanned additional works.

Procurement will continue to work with the Clinical Boards to channel all over £500k requests via the appropriate formal Board approval process.

Recommendation:

The Committee is requested to:

- **NOTE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		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		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk:
As outlined in the above section
Safety:
As outlined in the above section
Financial:
As outlined in the above section
Workforce:
As outlined in the above section
Legal:
As outlined in the above section
Reputational:
As outlined in the above section
Socio Economic: No

Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Counter Fraud Progress Report				Agenda Item no.	7.13	
Meeting:	Audit and Assurance Committee		Public	X	Meeting Date:	07/02/2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Catherine Phillips - Executive Director of Finance						
Report Author (Title):	Gareth Lavington – Head of Counter Fraud						

Main Report
Background and current situation:

This report builds on the previous Counter Fraud progress reports verbally presented at Audit Committee. This report provides an update of all the work undertaken by the CF team at CAVUHB on behalf of CAVUHB for this reporting period.

The reports seek to provide assurance that the planned activity in the Annual Plan is being carried out and that the CF fraud provision for CAVUHB is robust and fit for purpose.

It is asked that the committee note the content of the report.

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

Progress made against the Annual Counter Fraud Plan.
Current Investigations.
Other activity

Recommendation:

The Committee is requested to:

Note the content of the report.

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

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
Financial loss impacting upon patient care. Risk of reputational impact as a secondary result.
Safety: No
Financial: Yes
Possible financial loss as a result of fraud which will lead to impact upon patient care
Workforce: Yes
Reduction of available staff during investigations and sanctions; demotivation
Legal: Yes
Use Statutory legislation to conduct investigations
Reputational: Yes
Negative publicity resulting in negative publicity that undermines public confidence
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

Mohamed,Sarah
03/02/2023 11:53:14

NHS WALES
Cardiff and Vale University Health Board

Counter Fraud Progress Report
20/10/2022-31/12/2022

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of Cardiff and Vale Health Board from the 20th October 2022 to 31st December 2022.

The report's format has been adopted in order to update the Audit and Assurance Committee about counter fraud referrals, investigations, activity and operational issues.

At 31st December 2022, 276 days of Counter Fraud work have been completed against the agreed 500 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness, investigating referrals in relation to fraud and financial crime, and the recruitment of a new team member.

This report builds upon previous progress reports delivered to Audit Committee during the financial year 2022-2023.

The breakdown of these days is as follows: (P=Period)

TYPE	Days P1	Days P2	Days P3	Days P4	Days P5	Days P6
Proactive	15	14	35	37		
Reactive	70	42	25	38		
TOTAL	85	56	60	75		

2. Progress

Staffing

For the duration of this reporting period the team has been understaffed by 25%. The recruitment campaign that was carried out has seen a conditional offer made to the successful candidate. This person will commence in their new role in the team on 3rd January 2023. The successful applicant will be joining from their current role at the counter fraud service wales and will bring with them a wealth of experience of the NHS and Counter Fraud. They are an existing accredited Counter Fraud Specialist (ACFS).

Activity

Infrastructure/Annual Plan

During this reporting period, work has continued in developing the infrastructure that will allow successful compliance with the Counter Fraud Plan for 2022-2023. In this period the below activity has taken place in relation to this area of work -

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – the CAVUHB Counter Fraud Bribery and Corruption Policy review has been delayed. It is anticipated that this will take place during the course of Quarter 4.
c. Maintenance of Counter Fraud digital presence – Fully functional, modern, Counter Fraud Intranet site continues to be developed and improved (Link to the site for reference : Counter Fraud - Home (sharepoint.com))
d. Counter Fraud e-Learning arrangements – the situation with regard to this remains the same as previously reported. Development of Counter Fraud education page on the All Wales 'Learning @ Wales Platform' is now complete. This awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. When complete this

will be available to all Cardiff and Vale University Health Board staff as a, Counter Fraud, education, learning and awareness tool. It will be signposted internally within the organisation and will be available to all staff.

Fraud Prevention Notices and IBURN notices

(These notices are issued nationally by the NHS Counter Fraud Authority and require action by Local Counter Fraud Teams)

During this reporting period two fraud prevention notices issued by the NHS Counter Fraud Authority.

(1) This FPN was issued in relation to Mandate fraud and foreign payments following a successful fraud being perpetrated in NHS England. The methodology involved the impersonation of the Chief Finance Officer via email requesting staff to make a payment to a foreign supplier. There have been no issues internally and the organisation's financial staffing cohort alerted to the MO being used to ensure vigilance. FPN inclusive of advice and mitigating actions issued to relevant staffing cohorts within the distribution list.

(2) This FPN was issued to raise awareness as to the possible fraud risks in relation to fraudulent attempts for payment of office supplies/consumables concentrating mainly on printer toners and printer drums. This type of fraud appears to be prevalent in the primary care domain i.e. GP practices. Information passed to Primary Care team in order for cascading to GP practices. Liaison made with NHSWSSP accounts payable team and supplier maintenance team and assurance provided that the risk to the organisation is extremely low. Investigation with DHCW Cyber Security team provides assurance that no NHS Wales organisations have been targeted using the rogue supplier details and prevention activity taken in relation to blocking of rogue IP addresses. FPN, along with advice and mitigating actions forwarded to the relevant staffing cohorts in line with the distribution list restrictions.

Local Alerts/Bulletins

During this reporting period there has been no requirement to issue any local alerts or bulletins.

Awareness Sessions

During this reporting period six (6) awareness sessions have been delivered in person to different staffing groups.

Referrals/Enquiries

During this reporting period the Counter Fraud team have received ten (10) referrals via the online reporting tool. Two of these have been promoted to formal investigation and reported on the CLUE database. They can be seen at **Appendix 1** highlighted in red.

The other eight referrals have been informally resolved or are ongoing as below without the need for formal investigation.

1. False reporting of sickness – no proof of such following initial assessment. **Resolved.**
2. Theft of wooden pallets – no criminal issues. Advice issued re processes. **Resolved.**
3. Working elsewhere whilst sick – no evidence of such. Resolved.
4. Patient email scam – initial enquiries proved a legitimate email. **Resolved.**
5. Pension contribution anomalies – no evidence of fraud. Information passed to Audit Wales. **Resolved.**
6. Working elsewhere whilst sick – work related stress, already carrying on a business prior to sickness. No fraud issues, advice given – managerial concern only. **Resolved.**
7. Allegation of false reporting of sickness – no evidence to support the allegation. **Resolved**.
8. Fraudulent claim for compensation by staff member – ongoing.

Investigations

A summary of investigations carried out by the team since the beginning of this financial year is provided at **Appendix 1**. The cases highlighted in red relate to the two new investigations commenced within this reporting period.

As can be seen from the table during this reporting period:

Two (2) new investigations have been started; and five (5) have been closed.

There are therefore, four (4) investigations open at the time of reporting.

Other

Fraud Awareness Week

International fraud awareness week took place between 14th November and 18th November. A number of digital support materials were issued and made available to all staff within the organisation via emails shots, notices and via the intranet site. This included a new SWAY newsletter which can be found at this link Sway (office.com)

'Pop up' stalls were arranged to be held at UHW at Y Gegin Restaurant and The Childrens' Hospital of Wales Foyer. A further stall was held at UHL. The purpose of the stalls was to raise awareness of the Counter Fraud Team among staff and the public and to foster engagement with these groups.

Fraud Risk Profile

A fraud risk profile has now been developed for the organisation. This profile aims to assist in achieving compliance with the Government Functional Standard GovS 013: Counter Fraud NHS requirement 3 – Risk Assessment. This profile is included at **Appendix 2.** The profile lists the inherent risks to NHS organisations provided by the NHS Counter Fraud Authority that are relevant to CAVUHB. These areas will now be subject to fraud risk assessment work by the counter fraud team. This profile will be added to as necessary when further risks are identified as a result of investigation or information received from other sources. The first risk assessment into staff expenses fraud has been completed and forwarded to the organisation for review and inclusion on the local risk register in order to comply with the CAVUHB Risk Management Policy. This assessment is included at **Appendix 3.** A second risk assessment has been carried out into staff claiming of overtime following an investigation by the Counter Fraud team into allegations of dishonest claiming within the organisation. This can be found at **APPENDIX 4.**

Counter Fraud Arrangements NHS Wales

A report has been produced in relation to the current and future NHS Wales Counter Fraud provision. This report has been shared among Directors of Finance and at the All Wales Counter Fraud Steering Group at their most recent meetings. Local Counter Fraud Managers and teams have not been involved in this consultation. The report has been commissioned by NHS Wales Shared Services Partnership and has been produced by the Head of the Counter Fraud Service Wales. The report aims to report on the current situation and presents different options for the future of the provision. The options for the future of the service have been described as follows:

Option 1

No change – continue with the current three tier service provided via CFS Wales, LCFS and NHSCFA.

Option 2

Hybrid system – all health bodies have the option to opt into a NWSSP led service. LCFS services provided by NWSSP would retain a local presence at the health bodies they represent, maintaining a strong operational relationship with the relevant Finance Directors. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

Option 3

Centralised Model – CFS Wales and all LCFSs move across to an NHS Wales Shared Service Model which retains a strong local presence at the relevant health bodies, similar to the current NWSSP procurement provision. LCFS would report directly to the Finance Director of each Health Body, but staff would be part of a Counter Fraud Division within the NWSSP Finance Directorate and led by the Head of Counter Fraud Wales.

It is understood that these options will now be further explored within a working group.

Archwilio Cymru
Audit Wales

Annual Audit Report 2022 – Cardiff and Vale University Health Board

Audit year: 2021-22

Date issued: January 2023

Document reference: 3286A2022

This document has been prepared for the internal use of Cardiff and Vale University Health Board as part of work performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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

Contents

Summary report

About this report

1 This report summarises the findings from my 2022 audit work at Cardiff and Vale University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.

4 I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Health Board's officers.

6 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit and Assurance Committee on 7 February 2023. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Health Board's 2021-22 accounts[1] were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

13 However, I qualified my regularity opinion because the accounts include an accounting provision (and corresponding expenditure) of £2.193 million, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.

14 I found no other regularity matters of a material adverse nature. In terms of financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022, against both its revenue and capital resource limits.

15 I reported eight audit issues, together with my audit recommendations, to officers and the Health Board's Audit and Assurance Committee. Officers formally accepted all the recommendations and agreed management actions and dates of

[1] I audit and certify the Health Board's Performance Report, Accountability Report and Financial Statements. 'Accounts' is a generic term.

implementation. I will review the Health Board's progress with the actions as part of my 2022-23 audit.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- Despite the additional investment in waiting list recovery, the significant growth in the numbers of people waiting is likely to mean that waiting lists will not return to pre-pandemic levels for many years.
- The Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement. Further investment is required to enable the Health Board to fully roll out and embed planned quality and safety improvements.
- The Health Board has increased its strategic focus on the future configuration of its estate, but there is insufficient Board-level visibility of the condition of the existing estate.
- Generally, the Health Board's corporate arrangements support good governance and the efficient, effective, and economical use of resources in most areas. Plans to refresh the Health Board's long-term strategy present opportunities to strengthen these arrangements further by ensuring key structures, processes, and resources are fully aligned to strategic objectives and risks.

17 These findings are considered further in the following sections.

Detailed report

Audit of accounts

18 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

19 My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

20 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

21 I concluded that the Health Board's accounts were properly prepared and materially accurate (true and fair) and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).

22 I reported eight audit issues, together with my audit recommendations, to the officers and the Health Board's Audit and Assurance Committee. Officers formally accepted all the recommendations and agreed management actions and dates of implementation.

23 I must report issues arising from my work to those charged with governance (the Members of Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues to the Board on 14 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Board

Issue	Auditors' comments
Uncorrected misstatements	There is one area of uncorrected misstatements. It relates to the value of the Health Board's buildings, with their disclosed value as at 31 March 2022 being understated by £10.280 million. Three associated disclosures were also misstated, by amounts of £8.184 million, £2.096 million, and £331,000. I judge the four misstatements not to be material to my audit opinions on the 2021-22 accounts.

Issue	Auditors' comments
Corrected misstatements	I reported a number of important corrected misstatements, which mainly relate to accounting classifications and disclosures.
Other significant issues	I reported eight recommendations for improvement, with management's formal responses. The Health Board's Audit and Assurance Committee considered them on 6 September 2022.

24 I also undertook a review of the Health Board's Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position at 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.

25 My separate audit of the charitable funds' financial statements is currently ongoing. I am due to report my findings to the Health Board's Charitable Funds Committee on 9 February 2023.

Regularity of financial transactions

26 I qualified my regularity opinion because the 2021-22 accounts include an accounting provision (and corresponding expenditure) of £2.193 million, which I deem to be irregular. The amount relates to the Health Board's estimated liability arising from a Ministerial Direction in 2019 to the Permanent Secretary of the Welsh Government. This matter also affected other Welsh health boards.

27 The Ministerial Direction covered the need for interim remedial action to address the impact of HM Treasury's changes to the tax arrangements on senior clinicians' pension contributions. I placed an explanatory narrative report alongside my audit report on the accounts.

28 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

29 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. **Exhibits 2 and 3** show that the Health Board met both its revenue and capital resource allocations.

30 Except for the £2.193 million, I found no material financial transactions that were not in accordance with authorities nor used for the purposes intended. In terms of

financial performance, the Health Board achieved financial balance for the three-year period ending 31 March 2022. Since the introduction of the National Health Services Finance (Wales) Act 2014, this outcome is the first time that the Health Board achieved a three-year financial balance, across both revenue and capital resource limits.

Exhibit 2: financial performance against the revenue resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Operating expenses	1,025,612	1,205,955	1,213,676	3,445,243
Revenue resource allocation	1,025,670	1,206,045	1,213,908	3,445,623
Under (over) spend against allocation	58	90	232	380

Exhibit 3: financial performance against the capital resource allocation

	2019-20 £'000	2020-21 £'000	2021-22 £'000	Total £'000
Capital charges	58,070	95,343	70,948	224,361
Capital resource allocation	58,159	95,447	70,989	224,595
Under (over) spend against allocation	89	104	41	234

Source: audited 2021-22 accounts

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

31 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- undertaking a high level review of how NHS Wales is tackling the planned care backlog;

- reviewing the effectiveness of the Health Board's quality governance arrangements;
- undertaking a follow-up review of the recommendations made in my 2017 review of the Health Board's arrangements for managing its estates; and
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

32 My conclusions based on this work are set out below.

Tackling the planned care backlog in Wales

33 In May 2022, I published a report that set out the extent of the planned care backlog in NHS Wales, and the key actions the system needs to take to start to tackle the backlog. My report highlighted the continued growth of the overall waiting list numbers month on month, whilst noting the rate of growth was slowing. It also noted that the inevitable drop in referrals seen during the pandemic would likely result in this latent demand eventually coming back into the system. Taking these and other factors into account my work estimated that it could as much as seven years before overall waiting list numbers in Wales returned to pre-pandemic levels.

34 The Welsh Government has produced a national recovery plan for planned care with key milestones for health boards to achieve, including an initial focus on those patients facing very long waits. However, those milestones are already proving difficult to achieve.

35 In line with the key actions I set out in my report, the Health Board, along with others in Wales, will need to both build and protect capacity for planned care, and continue to maintain a focus on efficiency and productivity.

36 The Health Board will also need to ensure that it actively manages the clinical risks to patients that are facing long waits for treatment, and enhance its systems for communicating with patients to help them manage their condition whilst they are waiting and inform them of what to do if their condition deteriorates.

Quality governance arrangements

37 My review examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. The review focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

38 My work found **that the Health Board has agreed quality and safety priorities at all levels of the organisation. Corporate and operational structures for quality governance are reasonably effective. However, there are opportunities to strengthen aspects of culture and quality improvement, and**

further investment is required to enable the Health Board to fully roll out and embed its planned quality and safety improvements. Arrangements for clinical audit need significant improvement and there is scope to enhance the effectiveness of the Quality, Safety and Experience Committee by ensuing it provides greater oversight of risks related to quality and safety.

39 Although the Health Board has agreed quality and safety priorities at all levels of the organisation, we found they were not sufficiently aligned with each other. We also found that the Health Board's arrangements for monitoring and reporting on their delivery needs to be strengthened. There is effective collective responsibility for quality and safety amongst Executive Leadership, and corporate and operational structures and processes for quality and safety are improving.

40 There are reasonable corporate and operational arrangements in place for monitoring and managing risk. However, there is scope to ensure the corporate Quality, Safety, and Experience Committee maintains greater oversight of risks overseen by other committees where there is a clear quality and safety impact. Agendas for corporate and operational quality and safety meetings provide a wide coverage of quality and safety issues for discussion. However, the agenda of corporate Quality, Safety, and Experience Committee meetings could be more dynamic to reflect new and emerging quality risks and issues.

41 The Health Board produces sufficient information to support scrutiny and assurance at both corporate and clinical board levels. The Health Board's use of quality data is maturing, and its arrangements for monitoring mortality and morbidity are developing. The Health Board has effective arrangements to monitor and track progress with complaints, where it consistently achieves performance targets. Its arrangements for capturing patient experience are reasonably effective. However, arrangements for clinical audit require significant improvement.

42 The Health Board has a well-established values and behaviour framework, which is embedded in workforce processes. However, it needs to ensure that staff feel able to raise concerns.

Estates Follow-up Review

43 My work considered the Health Board's progress in implementing the recommendations arising from my 2017 review of the Health Board's arrangements for managing its estates. I found **that the Health Board has made reasonable progress against the recommendations made in my 2017 report. The Health Board has increased its strategic focus on the future estate but there is insufficient Board-level visibility of the condition of the existing estate**.

44 In 2017, we made seven recommendations. My follow-up review found that the Health Board had implemented two recommendations, two had been superseded, and one was ongoing. No progress had been made against two recommendations. My follow-up review made three recommendations, designed to enable the Health Board to address outstanding issues.

45 Specifically, I found the Health Board has commenced work to develop a new estate strategy, which will be linked to the Health Board's refreshed ten-year strategy and capital plan. However, there is little Board level oversight and scrutiny of issues related to the condition of the existing estate.

46 The Health Board has implemented structural and process changes to enable more effective estate service delivery, but local and national workforce shortages and pay differentials present significant and immediate risks to maintaining a safe and effective service. In the longer-term, this presents potential risks to the Health Board's ability to sustain its existing estate while it delivers on its programme of replacement and redevelopment.

Structured assessment

47 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19 but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.

48 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

Strategic planning arrangements

49 My work considered the Health Board's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

50 My work found **that the Health Board's approach to planning is generally effective and inclusive, with good Board-level oversight and stakeholder involvement. Refreshing its long-term strategy and producing an approvable IMTP must remain key priorities for the Health Board**.

51 The Health Board has a well-established vision and long-term strategy, underpinned by a clear programme for transforming clinical services. However, it recognises the vision and strategy need to be refreshed to reflect current opportunities, and challenges. The Health Board planning arrangements are generally effective, with good evidence of stakeholder involvement and engagement in the development of corporate plans and strategies. There is also

evidence of good Board-level oversight of the Health Board's planning arrangements. However, the Health Board has been unable to produce a financially balanced and Welsh Government approved Integrated Medium-Term Plan (IMTP) for 2022-25. The Health Board has taken positive steps to improve its arrangements for implementing corporate plans and strategies and monitoring their delivery. This should provide the needed assurances at Board-level.

Governance arrangements

52 My work considered the Health Board's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design support supports good governance; and
- key systems of assurance.

53 My work found **that the Health Board is generally well led and well governed with maturing systems of assurance, an appropriate organisational structure, and a stable executive team. Plans to refresh governance structures and align them to revised strategic objectives provide opportunities to further enhance Board and committee effectiveness and systems of assurance**.

54 The Health Board's systems of assurance continue to mature at a corporate-level, and work is underway to strengthen arrangements at an operational-level. However, there is scope to make greater use of the Board Assurance Framework to shape Board and committee business. Whilst the Board and its committees provide good oversight of the Health Board's performance, reports do not always provide sufficient assurances that appropriate action is being taken to sustain or improve performance.

55 The Health Board has good arrangements in place to conduct Board business effectively and transparently. There is a full Executive Team in place which now appears stable following a period of operating with interim appointments. The organisational structure remains stable and appropriate; however, it will need to be kept under constant review as the Health Board refreshes its long-term strategy, and rolls-out new clinical and workforce models.

Managing financial resources

56 My work considered the Health Board's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

57 My work found **that there are adequate arrangements in place to support financial planning, management, and control. Whilst finances are well**

scrutinised, improving its longer-term financial position must remain a key priority.

58 The Health Board achieved its financial duties for 2021-22. However, it failed to produce a financially balanced IMTP for 2022-25. It also risks not achieving its financial duty to break-even at the end of 2022-23 due to the need to manage its underlying deficit and address growing cost pressures.

59 The Health Board's arrangements for financial management and control are adequate. It has taken positive steps to enhance public transparency by ensuring detailed papers on counter fraud and procurement are discussed in public, rather than in private Audit and Assurance Committee meetings, where this is appropriate.

60 Financial reports are regularly scrutinised by the Finance Committee, and provide a clear and open overview of the Health Board's financial performance, challenges, and risks.

Managing the workforce, digital resources, the estate, and other physical assets

61 My work considered the Health Board's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing;
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

62 My work found **that whilst there is good Board-level oversight of matters relating to the workforce and digital resources, there is scope to increase the Board's focus on matters relating to the current estate and physical assets**.

63 There is good Board-level oversight of the arrangements in place to support staff well-being. However, the Board receives little assurance on the impact of the Health Board's staff well-being initiatives. The Health Board recognises this and is in the process of developing a way of effectively measuring and reporting the impact of well-being activities.

64 The Health Board has a clear Digital Strategy which is aligned to its current long-term strategy. There are good arrangements in place for ensuring Board-level oversight of digital matters. However, a lack of detailed delivery plans, limited funding, and staffing challenges are hampering the Health Board's pace in implementing its digital priorities.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2022
Opinion on the Financial Statements	June 2022
Audit of Financial Statements Report Addendum	August 2022
Charitable Funds (2020-21 Accounts)	January 2022
Performance audit reports	
Tackling the Planned Care Backlog in Wales	May 2022
Review of Quality Governance Arrangements	June 2022
Estates Follow-up Review	November 2022
Structured Assessment 2022	December 2022
Other	

Report	Date
2022 Audit Plan	March 2022

My wider programme of national value for money studies in 2022 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Orthopaedics	February 2023
Unscheduled care – patient flow out of hospital	March 2023
Primary Care Services - Follow-up Review	June 2023
Review of workforce planning arrangements	June 2023
Unscheduled care – access to unscheduled care services	September 2023

Appendix 2

Audit fee

My 2022 Audit Plan set out my fee estimate of £394,965 (excluding VAT, which is not chargeable). I will write to the Director of Finance soon to confirm the actual chargeable fee relating to the above fee estimate; and for the separate fee estimate and actual fee for my audit of the Health Board's 2021-22 charitable account (the audit is due to conclude in February 2023).

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Health Board's 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed a number of the accounting estimates and a sample of transactions that included journal entries. My audit findings were materially satisfactory.
Under the NHS Finance (Wales) Act 2014, health boards ceased to have annual resource limits with effect from 1 April 2014. They instead moved to a rolling three-year resource limit, with a limit for	I will continue to monitor the Health Board's financial position for 2021-22 and the cumulative three-year position to 31 March 2022, for the both revenue and capital-resource limits.	As set out in this report, my audit confirmed that the Health Board met its three-year resource allocations for both revenue and capital.

Audit risk	Proposed audit response	Work done and outcome
revenue and another limit for capital. The first three-year period ran to 31 March 2017. The Health Board has exceeded its rolling three-year revenue limit in the past five years, and I have therefore qualified my regularity opinion on the financial statements for those years. For 2021-22 and the three years to 31 March 2022, Health Board forecasts[2] 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. If the Health Board receives the anticipated funding, and maintains its forecast position, it would support an unqualified regularity opinion. Your current financial pressures do however increase the risk that management's judgements and estimates could be biased in an effort to	This review will also consider the impact of any relevant uncorrected misstatements over the three years. If the Health Board fails to meet the three-year resource limits for revenue and/or capital, I would expect to qualify my regularity opinion on the 2021-22 financial statements. I may also place a substantive report on the financial statements to explain the basis of the qualification and the circumstances under which it had arisen. I will focus some of my testing on areas of the financial statements which could contain reporting bias.	

[2] Based on the Month 11 year-end forecast, which the Health Board has reported to the Welsh Government.

Audit risk	Proposed audit response	Work done and outcome
achieve the financial duty.		
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an 'emphasis of matter' paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, I would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money.	I will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	As set out in this report, for 2021-22 the Health Board provided for an estimated liability and costs of £2.193 million and, as advised in the 2022 Audit Plan, I qualified my regularity opinion accordingly.
While COVID-19 restrictions are due to be removed in Wales on 28 March 2022, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of the financial statements. There is a risk that the quality of the accounts and supporting working	I continue to discuss your closedown process and quality monitoring arrangements with the relevant officers.	I continued my discussions with officers and monitored the arrangements in place and I am pleased to report that no significant problems arose.

Audit risk	Proposed audit response	Work done and outcome
papers may be compromised, leading to an increased incidence of errors.		
There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. They could have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include: fraud, error and regularity risks of additional spend; valuation (including obsolescence) of year-end inventory, including PPE; and the estimation of year-end annual leave balances.	I will identify the key issues and associated risks and plan my work to obtain the assurance needed for my audit.	I reviewed transactions and balances relating to COVID-19, and tested them where appropriate. My audit findings were satisfactory.
I audit some of the disclosures in the remuneration report to a far lower level of materiality, such as the remuneration of senior officers and independent members. The disclosures are therefore inherently more prone to material misstatement. In past audits I have identified material misstatements in the draft	I will examine all entries in the remuneration report to verify that it is materially accurate.	I examined all entries and misstatements were corrected where necessary.

Audit risk	Proposed audit response	Work done and outcome
remuneration report submitted for my audit, which the Health Board had to correct. I therefore judge the 2021-2022 disclosures to be at risk of misstatement.		
I also audit the disclosure of related party transactions and balances to a far lower level of materiality. Last year I identified a number of material disclosures that had been omitted and had to be added.	I will verify that all the necessary signed declarations have been received, evaluated, and disclosed appropriately and accurately. My examinations also include other means of testing, such as my review of Companies House records using data analytics.	I reviewed all the disclosures and undertook my intended tests for completeness. I found some anomalies that were corrected, and my overall testing was therefore satisfactory.

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

Report Title:	Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report			Agenda Item no.	8.2
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	7 February 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Interim Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

The purpose of this report is to provide Members of the Audit and Assurance Committee with the opportunity to discuss and comment upon the draft timetable for the production of the 2022-2023 Annual Report (see Appendix 1), prior to submission to the Board for formal approval.

The Welsh Government has issued, as in previous years, guidance for the preparation of annual reports and accounts. This guidance is based upon HM Treasury's Government Financial Reporting Manual (FReM)1 and is intended to simplify and streamline the presentation of the annual reports and accounts.

The Committee is asked to note that at the time of writing this covering report, the reporting timescales set out in the 2022/23 Manual for Accounts have not yet been confirmed and may be subject to change.

NHS Bodies are required to publish, as a single document, a three part Annual Report and Accounts document, which must include:

Part 1 The Performance Report, which must include:

- An overview
- Performance analysis

Part 2 The Accountability Report - this is to demonstrate how the Health Board has met key accountability requirements to the Welsh Government and must include: -

- A Corporate Governance Report - this explains the composition and organisation of the Health Board's governance structures and how they support the achievement of the Health Board's objectives.

- A Remuneration and Staff Report - this contains information about the remuneration of senior management, fair pay ratios, sickness absence rates etc.

- A Parliamentary Accountability and Audit Report - this contains a range of disclosures relating to the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long term expenditure trends and the audit certificate and report.

Part 3 The Financial Statements – this includes: -

- The Audited Annual Accounts 2022-23

For 2022-23: -

- There will be no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report. Information on dealing with concerns should be contained in the Performance Report, unless a separate report has already been developed.

- The Sustainability Report should be included in the Annual Report if available by the Accounts final submission date of 14 June 2023. If the data is not available at this date, the Health Board should make a statement in its Annual Report indicating where and when the metrics will be available, and when available, these should be published on the Health Board's website.

Based upon the current draft Manual for Accounts guidance, the Final Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by 14 June 2023.

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

Similar to other large corporate bodies, the Health Board is required to publish an annual report each year by the end of July. These are presented formally at the annual public meeting, which is held in July each year. The content is prescribed by regulation but, in essence, the Annual Report is an important public facing document which provides an oversight of what has been happening during the year within the Health Board, how the Health Board has performed and how it has spent its money.

A detailed draft timetable for the production of the 2022-23 Annual Report is provided at Appendix 1.

At the time of writing this report, the proposed timetable is due to be reviewed by the Executive Directors and Clinical Directors at the Senior Leadership Board on 2 February 2023.

Recommendation:

The Committee is requested to:

a) **Ratify** the proposed timetable and approach, as set out in this report, for the Annual report 2022-22 prior to the same being presented to full Board in March for formal approval.

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	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: Yes/No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Senior Leadership Board	2 February 2023

Mohamed,Sarah
03/02/2023 11:53:14

Appendix 1: DRAFT GOVERNANCE TIMETABLE FOR THE ANNUAL REPORT 2022-23 (*Please note – the reporting timescales set out in the 2022/23 Manual for Accounts have not yet been confirmed and may be subject to change*)

Main Tasks	Lead Exec	Jan	Feb	Mar	Apr	May	Jun	Annual General Meeting (AGM
Annual Report Part 1 Performance Report (including Performance Overview, Performance Analysis, Well-being Statement and Sustainability Report)	Paul Bostock Chief Operating Officer	Review content requirements and frame the scope of the report	Draft report, circulated for comment	Coordination and review of comments, updating of draft report. Draft report / update to be considered by Management Executive on 27 March 2023	Finalise Draft Internal Audit to receive draft report by 7 April 2023 to comment in respect of Sustainability elements Internal Audit to return comments April 2023 (date TBC)	Audit Committee Workshop on 11 May 2023 to - Review draft Letter of Representation, Draft Annual Accounts and draft Accountability, and support and endorse Sign off by Board Submission of draft Performance Report Overview, Accountability Report (including the Governance Statement) and the draft Remuneration Report to Welsh Government and WAO by 5 May 2023	Comments back from WG to be incorporated into final draft Annual Report and Accounts. **Special Audit Committee** on 13 June 2023 to review (i) the ISA 260 Report, Head of Internal Audit Annual Report, Letter of Representation, the response to the audit enquiries to those charged with governance and management, and (ii) the final draft Annual Report and Accounts, and recommend the same to Board for approval. **Special Board meeting** to (i) agree and endorse the Audit Wales ISA 260 Report, the Head of Internal Audit Opinion and Annual Report, the response to the audit enquiries to whose charged with governance and management, and (ii) approve the final draft Annual Report (including the Performance Report, the Accountability Report and Financial Statements (Accounts) on 13 June 2023 The Annual Report including the Performance Report and the Financial Statements (Accounts) should be completed and submitted to Welsh Government by the **14 June 2023**	The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on 18 July 2023
Annual Report Part 2a Accountability Report Governance Statement	James Quance Interim Director of Corporate Governance	Review content requirements and frame the scope	Draft report, circulated for comment.	Draft Accountability report submitted to Internal Audit & Wales Audit Office by 31 March 2023	Reviewed at Management Executive Meeting 24 April 2023. Internal Audit Sign off Draft Report in	Audit Committee Workshop on 11 May 2023 - - Review draft Letter of Representation, Draft Annual Accounts and draft Accountability, and support and	Comments back from WG to be incorporated into final draft Annual Report and Accounts. **Special Audit Committee** on 13 June 2023 to review (i) the ISA 260 Report, Head of Internal Audit Annual Report, Letter of Representation, the response to the audit enquiries to those charged with governance and management, and (ii) the final draft Annual Report and	

					readiness for submission to Audit Committee April 2023 (TBC)	endorse Sign off of the same by Board Submission of draft Performance Report Overview, Accountability Report (including the Governance Statement) and the draft Remuneration Report to Welsh Government and WAO by 5 May 2023	Accounts, and recommend the same to Board for approval. **Special Board meeting** to (i) agree and endorse the Audit Wales ISA 260 Report, the Head of Internal Audit Opinion and Annual Report, the response to the audit enquiries to whose charged with governance and management, and (ii) approve the final draft Annual Report (including the Performance Report, the Accountability Report and Financial Statements (Accounts) on 13 June 2023 The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the **14 June 2023**	
Annual Report Part 2b Accountability Report, Remuneration and Staff Report Mohamed-Sarah 03/02/2023 11:53:14	Rachel Gidman Executive Director of People and Culture Catherine Phillips, Executive Director of Finance	Review Content requirements and frame scope		Draft submitted to Internal Audit & Wales Audit Office by the 31 March 2023	Reviewed by Management Executive on 24 April 2023 Internal Audit Sign off Draft Report to Audit Committee April 2023 (TBC) Board on 27 April 2023 - Approve draft Accounts for submission to WG & WAO	Audit Committee Workshop on 11 May 2023- - Review draft Letter of Representation, Draft Annual Accounts and draft Accountability, and support and endorse Sign off of the same by Board Submission of draft Performance Report Overview, Accountability Report (including the Governance Statement) and draft Remuneration report to Welsh Government and WAO by 5 May 2023	Comments back from WG to be incorporated into final draft Annual Report and Accounts. **Special Audit Committee** on 13 June 2023 to review (i) the ISA 260 Report, Head of Internal Audit Annual Report, Letter of Representation, the response to the audit enquiries to those charged with governance and management, and (ii) the final draft Annual Report and Accounts, and recommend the same to Board for approval. **Special Board meeting** to (i) agree and endorse the Audit Wales ISA 260 Report, the Head of Internal Audit Opinion and Annual Report, the response to the audit enquiries to whose charged with governance and management, and (ii) approve the final draft Annual Report (including the Performance Report, the Accountability Report and Financial Statements (Accounts) on 13 June 2023 The Accountability Report, Remuneration and Staff Report should be completed and	

							submitted to Welsh Government by the **14 June 2023**	
Main Tasks	**Lead Exec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Annual General Meeting (AGM**
Annual Report Part 3 Audited Financial Statements (Annual Accounts)	Catherine Phillips, Executive Director of Finance	Review Content requirements and frame scope of report.			Board on 27 April 2022 - Approve Accounts for submission to WG & WAO Draft Submission of Unaudited Accounts to Welsh Government by NOON on 27 April 2023	Audit Committee Workshop on 11 May 2023- Review draft Letter of Representation, Draft Annual Accounts and draft Accountability, and support and endorse Sign off of the same by Board	Comments back from WG to be incorporated into final draft Annual Report and Accounts. **Special Audit Committee** on 13 June 2023 to review (i) the ISA 260 Report, Head of Internal Audit Annual Report, Letter of Representation, the response to the audit enquiries to those charged with governance and management, and (ii) the final draft Annual Report and Accounts, and recommend the same to Board for approval. **Special Board meeting** to (i) agree and endorse the Audit Wales ISA 260 Report, the Head of Internal Audit Opinion and Annual Report, the response to the audit enquiries to whose charged with governance and management, and (ii) approve the final draft Annual Report (including the Performance Report, the Accountability Report and Financial Statements (Accounts) on 13 June 2023 Audited Financial Statements (Accounts) should be completed and submitted to Welsh Government by the **14 June 2023** WG to issue Debtor & creditor Matrix Income and expenditure matrix	The Annual Report and Audit Accounts will be presented at a Public Meeting (AGM) on 18 July 2023

							by 19 June 2023	
Annual Report – Executive Summary	James Quance Interim Director of Governance	Review Content requirements and frame the scope	Draft the Executive Summary	Issue draft for comment	Finalise Summary	Audit Committee Workshop on 11 May 2023- Review draft Letter of Representation, Draft Annual Accounts and draft Accountability, and support and endorse Sign off of the same by Board Draft document to Medical Illustration Team for graphic design work Equality Impact Assessment	Comments back from WG to be incorporated into final draft Annual Report and Accounts. **Special Audit Committee** on 13 June 2023 to review (i) the ISA 260 Report, Head of Internal Audit Annual Report, Letter of Representation, the response to the audit enquiries to those charged with governance and management, and (ii) the final draft Annual Report and Accounts, and recommend the same to Board for approval. **Special Board meeting** to (i) agree and endorse the Audit Wales ISA 260 Report, the Head of Internal Audit Opinion and Annual Report, the response to the audit enquiries to whose charged with governance and management, and (ii) approve the final draft Annual Report (including the Performance Report, the Accountability Report and Financial Statements (Accounts) on 13 June 2023 The Annual Report including the Performance Report, Accountability Report and Financial Statements (Accounts) should be completed and submitted to Welsh Government by the **14 June 2023.** Welsh Translation Welsh version to Medical Illustration Team to design Welsh version	

Report Title:	Draft Audit Committee Annual Report 2022/23			Agenda Item no.	8.3
Meeting:	Audit Committee	Public	X	Meeting Date:	07.02.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Corporate Governance Officer				

Main Report
Background and current situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

The purpose of the Annual Report is to provide Members of the Audit Committee with the opportunity to discuss the attached draft annual report before being submitted to the Board for approval by the end of March 2023.

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

At the time of writing this covering report, the Committee has achieved an overall attendance rate of 87.5% from the period 1 April 2022 to date and has met on six occasions (not including this meeting) during the year. Subject to the Committee approving the recommendations set out below, the Annual Report will be updated to reflect the business discussed at the meeting today together with the attendance rate and forwarded to the Committee Chair for approval.

The attached Annual Report 2022/23 of the Audit Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference.

Recommendation:

The Committee is requested to:

a) **REVIEW** the draft Annual Report 2022/23 of the Audit Committee; and

b) **RECOMMEND** the Annual Report to the Board for approval.

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

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

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

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

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:

Mohamed,Sarah
03/02/2023 11:53:14

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

Annual Report of Audit and Assurance Committee 2022/2023

1.0 INTRODUCTION

In accordance with best practice and good governance, the Audit Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of three Independent Members, one of whom must have financial experience and one of whom must be a member of the Quality, Safety and Experience Committee. During the financial year 2022/23 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Director of Finance (Lead Executive), Director of Corporate Governance, Head of Internal Audit, Local Counter Fraud Specialist and a Representative of External Auditor (Audit Wales). Other Executive Directors attend as required by the Committee Chair. The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

3.0 MEETINGS AND ATTENDANCE

The Committee met seven times during the period 1 April 2022 to 31 March 2023. This is in line with its Terms of Reference.

At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

The Audit Committee achieved an attendance rate of 87.5% during the period 1st April 2022 to 31st March 2023 as set out below:

Commented [SM(aVU-CG1]: To be finalised after February's meeting

	05.04.22	12.05.22	14.06.22	05.07.22	06.09.22	08.11.22	07.02.23	Attendan
John Union (CC)	✓	✓	✓	✓	×	✓		
David Edwards (VC)	×	✓	✓	✓	✓	✓		
Mike Jones	✓	✓	✓	✓	✓	✓		
Ceri Phillips	✓	✓	✓	✓	×	✓		
Total	**75%**	**100%**	**100%**	**100%**	**50%**	**100%**		

Commented [SM(aVU-CG2]: To be completed after February's committee meeting

4.0 TERMS OF REFERENCE AND WORKPLAN

The Terms of Reference and work plan were reviewed and recommended for Board approval by the Committee on 7 February 2023. The Terms of Reference are due to be considered by the Board for approval on 30 March 2023.

Commented [SM(aVU-CG3]: To confirm following February's committee meeting

5.0 WORK UNDERTAKEN

As set out in the Terms of Reference, the purpose of the Audit and Assurance Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's assurance framework – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Board's objectives, in accordance with the standards of good governance determined for the NHS in Wales. In particular, the Committee's role includes (but is not limited to) commenting upon: -

- Compliance with relevant regulatory requirements, standards and other directions/requirements set by Welsh Government and others;

- The efficiency, effectiveness and economic use of resources;

- Adequacy of arrangements for (i) declaring, registering and handling interests, and (ii) dealing with offers of gifts or hospitality;

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Health Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist; and

- The adequacy of executive and management response to issues identified by audit, inspection and other assurance activity.

During the financial year 2022/23 the Audit and Assurance Committee reviewed the following key items at its meetings:

PRIVATE AUDIT AND ASSURANCE COMMITTEE

APRIL, MAY, JUNE, JULY, SEPTEMBER, NOVEMBER 2022 & FEBRUARY 2023

Papers presented to the private session of the Audit and Assurance Committee were as follows:

- Counter fraud Progress Report
- Procurement Compliance Report
- Workforce and Organisational Development Compliance Report
- Procurement Influenceable Spend Report and Improvements
- Overpayment of Health Board Salaries
- Learning from Cyber attacks
- Losses and Special Payments Panel.

PUBLIC AUDIT AND ASSURANCE COMMITTEE

The work undertaken and considered by the Committee during the financial year 2022 to 2023 included the following: -

- **Internal Audit Progress and Tracking Report & Internal Audit Plan 2022/23**

Internal Audit Reports were submitted to each of the Audit and Assurance Committee meetings (apart from the special meeting in June 2022). The reports provided details on outcomes, key findings and conclusions from the finalised Internal Audit assignments and specific detail relating to progress against the Audit Plan and any updates that occurred within the Plan.

April 2022

In April 2022, the IT Service Management Final Report was presented to the Committee. Internal Audit were only able to provide 'limited' assurance. Four high priority recommendations were made, which the Digital Team agreed with.

The Committee also received the following final reports: -

(i) Verification of Dialysis Sessions. The outcome was Substantial Assurance.
(ii) Raising Staff Concerns. The outcome was Reasonable Assurance.
(iii) Arrangements to Support the Delivery of Mental Health Services. This was an Advisory Review Report which highlighted opportunities and contained no recommendations

Internal Audit also advised the Committee that seven audits were delayed and not finalised in time for this meeting. Those would be brought to the next Committee meeting.

May 2022

In May 2022, the Committee received a number of completed Internal Audit reports which included: -

(i) COVID-19 Vaccination Programme - Phase 3 delivery Final Report - Substantial Assurance.
(ii) Health & Safety Final Report - Substantial Assurance.
(iii) Wellbeing Hub at Maelfa Final Report - Reasonable Assurance.
(iv) Development of Genomics Partnership Wales Final Report - Reasonable Assurance.
(v) Network and Information Systems (NIS) Directive Final Report - Limited Assurance. The Committee was advised that the Health Board's Management team had immediately dealt with the high priority recommendation.
(vi) Welsh Risk Pool Claims - Substantial Assurance.
(vii) Nurse Rostering: Children's Hospital for Wales, Children and Women's Clinical Board - Reasonable Assurance.
(viii) Nurse Bank Final Report - Limited Assurance.
(ix) Delivery of Mental Health Services. This was an advisory report.

Management agreed with the findings of the two Limited Assurance reports and would implement the changes.

July 2022

In July 2022 the Committee received a number of completed Internal Audit reports which included: -

(i) Recovery of services and Delivery of the Annual Plan 2021 – 2022 Final Report - Substantial Assurance.
(ii) Risk Management Final Internal Audit Report - Reasonable Assurance.
(iii) Performance Reporting (Data Quality) Final Report - Reasonable Assurance.
(iv) ChemoCare IT System Final Report - Limited Assurance.

It was noted that against the 41 reviews were scheduled for 2022/23. Four audits were a work in progress and six were in the planning stage.

September 2022

At the September meeting, the Committee received five Internal Audit reports which related to:

(i) Monitoring and Reporting of Staff Sickness Absence – Reasonable Assurance
(ii) Ultrasound Governance Follow-up (CD&T CB) – Reasonable Assurance
(iii) Integrated Medium Term Plan 2022 – 2025: Development Process – Substantial Assurance
(iv) Stock Management – Neuromodulation Service (Specialist Services CB) – Reasonable Assurance
(v) Waste Management – Reasonable Assurance

The Committee also received an update on the Limited Assurance Internal Audit Reports relating to the IT Service Management. The Director of Digital and Health Intelligence advised the Committee of the actions which had been taken to address the Audit recommendations. One of those actions was the implementation of the Ivanti system. Internal Audit confirmed that they would carry out a Follow Up Audit and that they also planned to undertake a separate audit with regards to the Ivanti system.

The Director of Digital and Health Intelligence informed the Committee that there had been a delay in implementing some of the required actions in relation to the ChemoCare IT System report. That delay was mainly due to the DHCW building interfaces and having that signed off. There had also been a delay in implementing Version 6. The Committee was advised that all of the changes were scheduled to take place at the end of October. Furthermore, that the delay should not give rise to any real risks.

November 2022

At the November meeting, the Committee received seven finalised reports:

(i) Staff Wellbeing: Culture & Values – Reasonable Assurance
(ii) Follow-up: 5 Steps to Safer Surgery – Substantial Assurance
(iii) Implementation of National IT Systems (WNCR) – Reasonable Assurance
(iv) Digital Strategy – Reasonable Assurance
(v) Medical & Dental Staff Bank - Substantial Assurance
(vi) Medical Equipment & Devices – Reasonable Assurance
(vii) UHL Endoscopy Expansion - Reasonable Assurance

Annual Clinical Audit Plan Review – the Committee received an update on the progress that had been made since the Internal Audit's Limited Assurance report in October 2021. Members were advised that significant progress had been made which included (i) a clinical audit quality tool (ie AMaT) had been procured and implemented, and it was anticipated that all of the Clinical Boards would be trained with this new technology by December 2022, and (ii) a Clinical Audit Policy and Strategy had been developed to provide an appropriate framework to support a prudent audit programme which was designed to provide assurance and to drive improvement in quality and safety priorities.

February 2023

To be added following the February meeting.

- **Internal Audit Tracking Report**

The Internal Audit Tracking Report is presented at each Committee meeting in order to provide Members with assurance on the implementation of recommendations made by Internal Audit.

November 2022

The Committee was advised that there was a strong focus on the "aged" entries on the Tracker. It was also noted that care should be taken regarding Cyber related recommendations, in particular that the same should be considered in a Private forum as a matter of good practice.

February 2023

To be added following the February meeting.

- **Audit Wales Update**

At each Committee meeting, Committee Members received and considered an update from Audit Wales in relation to the current and planned Audit Wales work. Accounts and performance audit work were considered, and information was also provided on the Auditor General's wider programme of national value-for-money examinations.

April 2022

The Committee was informed that the scope of the 2021 Local Work had now been agreed. That would include a review of the Estates which followed the recommendations made in 2017.

June 2022

At the Special meeting held in June, and as part of the standard "end of year" arrangements, the Committee considered and ratified the Health Board's audited accounts, Performance Report and Accountability Report alongside the audit report, with a recommendation to full Board to approve the Annual Report and Annual Accounts 2021/22 in readiness for the documents being submitted to Welsh Government by the June 2022 deadline.

July 2022

The Committee received a report which related to the Health Board's Quality Governance Arrangements. Whilst Audit Wales had found that the Health Board's corporate and operational structures for quality governance were reasonably effective, it had commented that there are opportunities to strengthen aspects of culture and quality improvement. Seven recommendations were made and the Committee was advised that the Health Board's Management team was addressing those recommendations.

September 2022

At the meeting in September the Committee received the Audit of Accounts Addendum Report. The report set out eight recommendations arising from the annual audit of the Health Board's 2021-22 accounts, together with the management responses.

The Committee also received the Estates Follow Up Review Report. The overall conclusion was that the Health Board had increased its strategic focus on the future estate but there

was insufficient Board-level visibility of the condition of the existing estate. Work had commenced to develop a new estate strategy, which would be linked to the Health Board's ten-year strategy and capital plan.

Audit Wales also confirmed that they were continuing with their field work in relation to the Annual Structured Assessment and were due to present this Report to the next Audit Committee in November.

November 2022

The Committee received an update from the Director of People and Culture which set out the detailed work which the Health Board had been undertaking in relation to the recommendations made by Audit Wales in their report "Taking Care of the Carers - How NHS Bodies supported staff wellbeing during the COVID-19 pandemic."

The Committee was advised that the Recommendations in relation to the Estates follow-up review management response had been completed.

The Committee also received the "Equality Impact Assessments: More than a tick box exercise" report. It made several recommendations for Welsh Government to address and one to Public Bodies requiring them to review their approach to Equality Impact Assessments considering the findings within the Report and the detailed guidance available on the Equality and Human Rights Commission and Practice Hub.

Audit Wales published a report ("Public Sector Readiness for Net Zero Carbon by 2030") which set out five calls for action to be taken by Public Bodies in order to tackle climate change. At its meeting in November, the Committee received a paper, by way of assurance, to confirm the actions being taken by the Health Board in response to that report.

February 2023

To be completed after February 2023 meeting.

- **Audit Wales Tracking Report**

The Committee received an Audit Wales Tracking report at each meeting in order to provide Members of the Committee with assurance on the implementation of recommendations which had been made by Audit Wales. The team would focus on older entries and continue developing the tracker.

February 2023

To be completed after February 2023 meeting.

- **Declarations of Interest, Gifts, Hospitality & Sponsorship**

The Committee routinely received an update with regards to the Health Board's Declaration of Interest, Gifts, Hospitality and Sponsorship register.

The Committee had noted that there had been a significant increase in the amount of declarations made on ESR, which suggested reasonable success from the advertising campaign.

February 2023

To be completed after February 2023 meeting.

- **Regulatory Compliance Tracking Report**

The Regulatory Compliance Tracking Report is presented to the Committee at each meeting. Amongst other matters, the report provided details with regards to regulatory standards the Health Board is required to meet and regulatory inspections that have been carried out and/or are due to be carried out.

The Committee noted that there were growing recommendations from legislative bodies and Welsh Government Welsh Health Circular (WHC) updates were regularly provided at Management Executive meetings.

February 2023

To be completed after February 2023 meeting.

- **Review of Risk Management and Assurance Mapping**

The Committee received several reports during the year which related to the work being undertaken to improve the Health Board's Risk Management systems. This included working with colleagues from Internal Audit to further develop assurance mapping to specifically map Assurance Levels in relation to risks that are reported within the Corporate Risk Register and to enable more targeted action to be taken to proactively manage these risks and identify opportunities to control the same.

- **Standing Orders, Standing Financial Instructions, Reservation and Delegation of Powers**

The Committee reviewed the Health Board's Standing Financial Instructions and accounting policies at its meeting in April.

Update after February 2023 meeting.

- **Review of Draft Charitable Funds Annual Report and Accounts**

At the November meeting the Committee received and discussed the draft accounts which related to the activities of the Health Board's Charity during the period 1 April 2021 to 31 March 2022.

- **Procurement Compliance Report**

The Committee was presented with the Procurement Compliance Report at each of its meetings.

In the November meeting, the Committee was informed that the number of single tender actions was increasing and that this was being kept under review

- **Counter Fraud**

The Committee noted that a lot of time had been spent on developing the infrastructure of the Counter Fraud Team and that Team had developed Fraud awareness tools in order to raise awareness of Counter Fraud throughout the organisation. At it's May meeting, the Committee received and approved (i) the Counter Fraud Annual Plan which set out the Counter Fraud Team's proposed work for 2022/23, and (ii) the Counter Fraud Annual Report 2021/22 which set out an assessment of the work undertaken by the Counter Fraud Team during the previous year.

- **Management of Policies, Procedures and Other Written Control Documents Policy**

In July the Committee reviewed and ratified (i) the Management of Policies, Procedure and other Written Control Documents Policy (UHB 001) and (ii) Written Control Documents – Development and Approval Procedure (UHB 242).

At the November meeting, the Committee was informed of the action plan that was in place in order to put the Health Board's Corporate Policies management system on a much better footing.

- **Board and Committee Effectiveness Survey 2021 – 22**

As part of the Health Board's assurance arrangements, in May the Committee was presented with (i) the findings of the Annual Board Effectiveness Survey 2021-22, and (ii) an update on the action plan following the survey undertaken in in 2021-22.

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Audit and Assurance Committee meeting by presenting a summary report of the key discussion items at the Audit Committee. As per the Committee's Terms of Reference, the report is presented by the Committee Chair in which he must:

1) Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of Committee minutes and written reports throughout the year;
2) Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
3) Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.0 OPINION

The Committee is of the opinion that the draft Audit and Assurance Committee Report 2022/23 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

John Union

Committee Chair

Report Title:	**Audit and Assurance Committee – Terms of Reference and Work Plan 23/24**			Agenda Item no.	8.4
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	7th February 2023
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	
Lead Executive:	**Interim Director of Corporate Governance**				
Report Author (Title):	**Director of Corporate Governance**				

Main Report
Background and current situation:

In line with the UHB's Standing Orders, Terms of Reference and Work Plans for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Audit and Assurance Committee with the opportunity to review the Terms of Reference and Work Plan 2023/24 prior to submission to the Board for approval.

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

The Terms of Reference for the Audit and Assurance Committee were last reviewed in February 2022 and approved by the Board in March 2022. Although there are no significant changes to highlight the Terms of Reference and Work Plan has been reviewed by the Director of Corporate Governance.

The work plan for the Audit and Assurance Committee has been developed based upon the requirements set out in its Terms of Reference. It ensures that the Committee will advise and assure the Board and the Accountable Officer on whether effective governance and assurance arrangements are in place. The Terms of Reference are also in line with standards of Good Governance determined by the NHS Wales.

Recommendation:

The Committee are requested to:

(a) Review the Terms of Reference and Work Plan 2023/24 for the Audit and Assurance Committee;
(b) Ratify the Terms of Reference and Work Plan for the Audit and Assurance Committee 2023/24 and
(c) Recommend the changes to the Board for approval on 30th March 2023.

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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	x	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
Financial: ~~Yes~~/No
Workforce: ~~Yes~~/No
Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: ~~Yes~~/No

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

Mohamed,Sarah
03/02/2023 11:53:14

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

Audit and Assurance Committee

Terms of Reference

Reviewed by Audit and Assurance Committee: 7th February 2023
Approved by the Board:

Mohamed.Sarah 03/02/2023 11:53:14

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Audit and Assurance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the UHB's assurance framework - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- the adequacy of the UHB strategic governance and assurance framework and processes for risk management and internal control designed to support the Accountable Officer's statement on internal control, providing reasonable assurance on:

  - the organisations ability to achieve its objectives;

- compliance with relevant regulatory requirements, standards and other directions and requirements set by the Welsh Government and others;

- the reliability, integrity, safety and security of the information collected and used by the organisation;

- the efficiency, effectiveness and economic use of resources; and

- the extent to which the organisation safeguards and protects all its assets, including its people

- the adequacy of the arrangements for declaring, registering and handling interests at least annually

- the adequacy of the arrangements for dealing with offers of gifts or hospitality

to ensure the provision of high quality, safe healthcare for its citizens;

- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- the Schedule of Losses and Compensation;

- the planned activity and results of internal audit, external audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- the adequacy of Executive and Managements response to issues identified by Audit, Inspection and other assurance activity;

- anti-fraud policies, whistle-blowing processes and arrangements for special investigations; and

- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by:

- reviewing the ***comprehensiveness*** of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the UHB's activities, both clinical and non-clinical;

- reviewing the ***reliability and integrity*** of these assurances; and

- considering and approving policies as determined by the Board.

3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- there is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- there is an effective Counter Fraud Service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Quality, Safety and Experience Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees

- the work carried out by key sources of external assurance, in particular, but not limited to the UHB External Auditors (Audit Wales), is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- the results of audit and assurance work specific to the UHB, and the implications of the findings of wider audit and assurance activity relevant to the UHB's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.6 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit (Audit Wales) shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.7 The Committee will meet with Internal and External Auditors (Audit Wales) and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.8 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.9 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board
Vice Chair	Chosen from amongst the Independent members on the Committee
Members	At least one other independent members of the Board *[one of which should be the member of the Quality and Safety Committee (or equivalent)]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance

Chief Executive
Director of Finance (Lead Executive)
Director of Corporate Governance
Head of Internal Audit
Local Counter Fraud Specialist
Representative of External Auditor (Audit Wales)
Other Executive Directors will attend as required by the Committee Chair

4.3 By invitation — The Committee Chair may invite:

- any other UHB officials; and/or
- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 Secretary
- As determined by the Director of Corporate Governance

Member Appointments

4.5 The Membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Committee Members' Terms and Conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair.

Support to Committee Members

4.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than quarterly, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint (sub) Committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

6.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or

Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

7.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.4 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Audit and Assurance Committee Work Plan 2023 - 24								
App. -Approval Ass.- Assurance Inf. - Information	**Exec Lead**	**04-Apr**	**11-May**	**13-Jun**	**04-Jul**	**05-Sep**	**07-Nov**	**06-Feb**
Agenda Item								
Governance								
Review the system of assurance	JQ	Ass.					Ass.	
Review the risk management system	JQ							Ass.
Note the business of other Committees and review inter-relationships	JQ							Ass.
Review Draft Quality Statement (not required for 22.23)	RW	Ass.	Ass.	App.				
Review the UHB Draft Annual Report and Accounts	JQ	Ass.	Ass.	App.				
Review of Standing Orders	JQ							Ass.
Report on Declarations of Interest and Gifts and Hospitality	JQ	Ass.			Ass.	Ass.	Ass.	Ass.
Receive relevant reports from Regulatory Bodies	JQ	Ass.			Ass.	Ass.	Ass.	Ass.
Receive tracking report from Regulatory Bodies	JQ	Ass.			Ass.		Ass.	
Receive tracking report from internal audit recommendations	JQ	Ass.			Ass.		Ass.	
Receive tracking report from Audit Wales recommendations	JQ	Ass.			Ass.		Ass.	
Financial Focus								
Agree final accounts timetable and plans	CP							App.
Review of audited annual accounts and financial statements	CP		Ass.	App.				
Review changes to SFIs and changes to accounting policies	CP/JQ	Ass.						
Review losses and special payments	CP	Ass.	Ass.	App.			App.	
Single Tender Actions	CP	Ass.			Ass.	Ass.	Ass.	Ass.
Review of Draft Charitable Funds Annual Report and Accounts	CP						Ass.	
Internal Audit								
Review and approve annual internal audit plan	IA	App.						
Review the effectiveness of internal audit	IA						Ass.	
Review of internal audit progress reports	IA	Ass.			Ass.	Ass.	Ass.	Ass.
Receive internal audit reports undertaken during the period	IA	Ass.			Ass.	Ass.	Ass.	Ass.
Receive annual internal audit report and associated opinions (HoIA)	IA		Ass.	App.				
Audit Wales								
Agree Auditor General's Audit Plan	AW							App.
Review the effectiveness of external audit	AW						Ass.	
Review External Audit Progress Reports	AW	Ass.			Ass.	Ass.	Ass.	Ass.
Receive the Auditors report to those charged with governance	AW		Ass.	App.				
Receive the Auditors Annual Audit Report	AW							App.
Receive Annual Structured Assessment Report	AW						Ass.	
Clinical Audit								
Review annual Clinical Audit Plan	JR/MJ						Ass.	
Counter Fraud								
Review and approve annual counter fraud plan	CF	App.						
Review counter fraud progress reports	CF	Ass.			Ass.	Ass.	Ass.	Ass.
Review the effectiveness of Counter Fraud Specialist	CF						Ass.	
Receive counter fraud annual report	CF	Ass.		App.				
Audit Committee								
Annual Work Plan	JQ							App.
Self assessment of effectiveness	JQ	Ass.						
Induction Support for Committee Members	JQ	Ass.						
Review Terms of Reference	JQ							App.
Produce Audit Committee Annual Report	JQ							App.
Minutes of Audit Committee Meeting	JQ	App.	App.	App.	App.	App.	App.	App.
Action log of Audit Committee Meeting	JQ	Ass.	Ass.	Ass.	Ass.	Ass.	Ass.	Ass.

Report Title:	**Internal Audit Reports for Information**				Agenda Item no.	9.1	
Meeting:	Audit & Assurance Committee		Public	X	Meeting Date:	07/02/23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		X
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Internal Audit						

Main Report
Background and current situation:

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

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

The 2022/23 plan was formally approved by the Audit Committee at its April 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:

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

- Eight Reasonable Assurance
- One Limited Assurance
- One Advisory

Recommendation:

The Audit & Assurance Committee are requested to:

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

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

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

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

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

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

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Development of Genomics Partnership Wales

Final Internal Audit Report

December 2022

Cardiff & Vale University Health Board

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

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

Contents

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Committee:	Audit Committee

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

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

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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 project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

This is the second audit of the project and considered the period from issue of the prior audit report (April to October 2022).

Overall Audit Opinion and Overview

Key matters for management attention identified during the audit included:

- The need for a lessons-learned review of the reasons for the increased project costs;
- Enhanced reporting of the residual financial risks (actioned since audit fieldwork); and
- Delayed approval of compensation events (via the Project Issues Form process).

Whilst noting the levels of assurance determined at the individual objective areas reviewed as part of the current audit, when considering the key delivery objectives of the project it was evident that with six months of the construction programme remaining, a forecast overspend of £639k (4.17%) was being reported, including the full utilisation of the £1.4m contingency budget. The increased costs have primarily been attributed to IT infrastructure delays, unforeseen works due to the existing building condition and legislative changes.

Additional funding of £239k had been approved by the Capital Management Group to partially offset this (from discretionary capital) and further funding support was being sought from Welsh Government at the time of reporting.

The full extent of the time impact of the project changes remained ongoing at the time of reporting.

Acknowledging the financial pressures at the project, an appropriate financial reporting regime was seen to be operating with all key parties made aware of the ongoing challenges. Accordingly, an overall **reasonable assurance** has been determined.

It is imperative that the project's financial outturn position is carefully managed (including change controls, risk management and Welsh Government liaison) through to completion.

Report Classification

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

Assurance summary [1]

	Assurance objectives	Assurance
1	Project Performance (time/cost/quality)	Limited
2	Validation of Management Action	Reasonable
3	Governance	Reasonable
4	Financial Assurance	Reasonable
5	Technical Assurance	Reasonable
6	Change Control	Reasonable
7	Quality Assurance	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
3.1	Insufficient clarity over the monitoring and reporting of residual financial construction risk against project funding at the time of audit fieldwork.	3	Operation	Medium
4.1	The need for a lessons-learned review of the reasons for the increased project costs.	3	Operation	Medium

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 Construction commenced in January 2022 and, at the time of review, was forecast for completion in April 2023, one week ahead of the current (extended) contractual completion date.

1.4 This was the second audit of the project and considered the progression of the construction works in the period since the 2021/22 audit (April – October 2022).

1.5 The cost position of the project, as reported in October 2022, was:

	Forecast costs £	WG approvals £	Variance £
SCP pre-construction	720,303	719,688	615
Target cost	9,643,589	9,233,607	409,982
Accepted and forecast compensation events	1,285,282	-	1,285,282
UHB Fees	466,385	453,414	12,971
Non-works costs (inc. IT)	1,393,244	1,234,843	158,401
Equipment	182,000	182,000	0
Contingency	0	1,401,238	(1,401,238)
SCP NEDO	150,000	-	150,000
Landlord contributions	(296,000)		(296,000)
VAT (net of recovery)	2,120,243	2,073,152	47,090
Totals	**15,515,045**	**15,297,943**	**217,102**

1.6 Following publication of the October 2022 cost report, management undertook a cost and risk review, which updated the forecast outturn to a £639k overspend. This was reported to Welsh Government in the October Project Progress Report.

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

- Potential failure to achieve key project objectives (e.g., delivery to time, cost, and quality).
- Inadequate governance and approval arrangements in place to provide the required scrutiny and project control.
- Poor performance may not be identified and addressed.
- Insufficient readiness for handover.

2. Detailed Audit Findings

Project Performance: Consideration of performance against project objectives (e.g., time, cost, quality, benefit, critical success factors etc.)

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

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

Time

2.3 In the latest progress report, planned completion was reported as 6 April 2023 with contract completion 12 April 2023 (extended via a compensation event by 10 days from the original date, primarily due to changes in the drainage design).

2.4 The risk of further delays has been reported (both to the construction programme and the wider "moving in" timeline), arising as a result of:

- Delayed ordering of the fibre cabling.
- The requirement for additional funding to enable the ordering of the digital infrastructure equipment; and
- The requirement for additional funding to enable the instruction of other compensation events (such as the landlord works).

2.5 The full extent of the time impact of the above remained ongoing at the time of reporting.

2.6 Whilst noting the potential for delays to the handover and moving in dates, management confirmed that mitigating arrangements were already in place

regarding the condition of the current GPW accommodation, which has been deemed not fit for purpose for a number of years. These will continue as required until the new premises are ready.

Cost

2.7 The latest progress report presented a forecast project overspend of £217k i.e., 1.4%, with all contingency (£1.4m) expended, and six months of the construction programme remaining (see *para. 1.5*).

2.8 Following publication of the progress report, a cost and risk review updated this forecast to a £639k (4.17%) overspend (incorporating £364k of costed risk, not yet materialised). This updated position has been reported to WG.

2.9 This is attributable to the following key cost increases (including those forecast but not yet agreed):

Description	Key individual elements	Totals
Increase to target cost		£409,982
Non-works costs (inc. IT)		£158,401
End-user changes:		
Works to hub room including cooling and future proofing	*£200,000*	
Other end user changes (11no.)	*£75,028*	
Sub Total:		£275,028
Other changes (building condition, programme etc.):		
Drainage redesign (programme delay)	*£73,788*	
Landlord works	*£86,665*	
Removal of additional redundant services	*£61,560*	
Generator base	*£49,104*	
Other construction items individually under £49k (22no.)	*£320,557*	
Sub Total:		£591,674
Legislative changes[1]:		
Inflation	*£110,000*	
Red diesel ban	*£86,244*	
Sub Total:		£196,244
Total cost increases		**£1,631,329**

[1] *Potential for recovery from Welsh Government.*

2.10 The Capital Management Group has approved an additional £239k support from the UHB's discretionary capital budget, to support the forecast overspend. Whilst

recognising this has been funded from available discretionary funds, this will adversely impact on the UHB's discretionary programme objectives / allocations in the current financial year.

2.11 The Project Director has also been liaising with Welsh Government with regards potential support for other costs, however no further support had been confirmed at the time of reporting.

2.12 Whilst a forecast overspend position has been appropriately determined, full funding has not yet been secured.

Quality

2.13 The UHB has robust quality assurance mechanisms in place, with routine site inspections and monthly reporting by the Supervisor. No significant quality issues have been identified in the period reviewed.

2.14 Recognition the above and the current financial pressures, **limited assurance** has been determined in respect of project performance at the current time.

Validation of Management Action: Assurance that previously agreed actions have been appropriately actioned by management.

2.15 The status of recommendations arising from the previous review, for action at the Genomics project (report issued April 2022: *Reasonable Assurance*), was as follows:

	High	Medium	Low	Total
Closed	-	-	2	**2**
Outstanding	-	-	2	**2**
Total	**0**	**-**	**4**	**4**

2.16 A further five actions were included in the prior report, for future assurance (i.e., they could not be actioned at this project). Of these, two have been closed following audit work undertaken on another capital project at the UHB. The remaining three will continue to be considered at future project audits.

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

2.18 It is noted that of the four recommendations within the UHB's control to action at this project, two remain outstanding. However, recognising the nature of the outstanding actions, **reasonable assurance** has been determined in respect of this follow up.

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

2.19 Governance arrangements have continued to function as previously reported, with key roles and forums operating effectively, including:

- The Project Team (chaired by the Project Director).
- GPW Governance Board (acting as Project Board) and GPW Programme Board (with the GPW Boards both chaired by the UHB Chief Executive); and
- The UHB's Capital Management Group continues to provide scrutiny over project performance, as a part of the UHB's capital programme management.

2.20 The budget pressures facing the project have been reported to the GPW Governance Board and Capital Management Group in a timely manner. However, concerns have been noted over the accuracy of reporting to these forums in relation to the potential forecast overspend (see ***Financial Assurance***).

2.21 The supporting GPW governance structure, including specialist workstreams, had been updated following the FBC stage, to deliver the work required in readiness for the relocation of the three GPW partner organisations to the new facility. The structure incorporated:

- Senior Estates Team;
- Subject Matter Management Group; and
- Supporting workstreams (Digital; Exit Strategy; and Facilities Management).

2.22 Whilst the roles and responsibilities of each forum had been clearly identified within the terms of reference, workstream arrangements were still being finalised at the time of review (**MA1**).

2.23 An appropriate range of project reports were received by Capital, Estates and Facilities from external advisers. Whilst the reports reviewed were comprehensive, two errors were identified, whereby information presented at the external Project Manager's progress report and the Welsh Government Project Progress Report didn't reconcile with the Cost Adviser's reports (**MA2**).

2.24 Key information from the external reports was summarised within the internal Capital Highlight Reports. Whilst previously only shared with the Project Team, as previously recommended to enhance the level of information shared, these were now included within GPW Governance Board papers.

2.25 Recognising the recommended improvements to current reporting arrangements (both in this section and at ***Financial Assurance***), **reasonable assurance** has

been determined in respect of governance arrangements being applied at the project.

Financial Assurance: Assurance that adequate cost control and reporting systems are operated, both internally and by the External Cost Adviser. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.

2.26 Noting financial pressures experienced at the project, a full review of project costs was undertaken by the Cost Adviser in July 2022 (in conjunction with the Project Manager and UHB), with the aim of improving clarity over remaining funds across all budget areas.

2.27 At the time of fieldwork, an overspend of £217k was forecast (see *para.1.5*), with no contingency remaining (and a further 6 months remaining until contract completion). This was subsequently revised to a £639k overspend following a further cost review exercise in October 2022.

2.28 The Capital Management Group had recently approved funding of £239k to support this position. It was also recognised that discussions were ongoing with Welsh Government regarding potential support for the increased costs, however a decision had not been communicated at the time of reporting.

2.29 At the time of the current review, the construction risk register presented a total of £363k remaining costed risks. The project reports reviewed during fieldwork, however, did not provided commentary on the total residual risk and how this may impact the forecast overspend. Management confirmed that the £363k risks had not been incorporated into the £217k forecast previously reported. Costed risks should inform internal reporting and decision-making, and communications with Welsh Government (**MA3**). It is recognised that during audit fieldwork, discussions were ongoing with the cost adviser to clarify the figures, and at the date of reporting, the forecast outturn had been updated (to the above mentioned £639k) to incorporate costed risks. The same had also been reported to WG in the October project return. This issue has therefore now been addressed.

2.30 Recognising the increased costs in a number of areas across the project, a lessons learned exercise has been recommended, to review the decisions made and project management practices which may have contributed to the current budget pressures (**MA4**)**.**

2.31 Noting the above, **reasonable assurance** has been determined in this area recognising the actions taken since audit fieldwork.

Technical Assurance: Assurance that adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract.

2.32 The August 2022 valuation was selected for detailed review. The in-month valuation was £576,429, from a cumulative total of £5,253,100.

2.33 A review of a sample of costs (see table below) confirmed they were adequately supported.

Elements sampled	Cumulative Valuation	Audit Sample	
People	£848,824	£311,461	37%
Equipment (accrual)	£87,184	£37,314	43%
Materials (accrual)	£0	-	
Charges	£58,503	-	
Insurance	£8,512	-	
Subcontractors	£4,035,922	£3,270,058	81%[1]
Fee	£214,155		
Total	**£5,253,100**	**£3,618,833**	**69%**

[1] *the largest sub-contractor account totalled £2,697,584 and therefore represented a significant proportion of the overall valuation. For this account, only the in-month valuation for August was reviewed in detail. All other accounts were reviewed against the cumulative total.*

2.34 A sample of four payments to the Supply Chain Partner (SCP) were assessed for timeliness, with two having been paid outside the stipulated contractual timeframes. It is recognised that the UHB has not incurred any interest charges as a result of the late payments to date, and the anticipated implementation of the Project Bank Account should improve payment timeframes (**MA5**).

2.35 Whilst noting the above **reasonable assurance** has been determined.

Change Control: Assurance that appropriate internal and contractual change control mechanisms were applied at the project.

2.36 Six instructed Compensation Events were reviewed, totalling £304,386 (representing 72% of total agreed changes as recorded at the Change Control Tracker). All changes were appropriately substantiated, had been subject to scrutiny and adjustment (where required) by the Cost Adviser and Project Manager, and had been authorised by the UHB in accordance with defined delegated limits.

2.37 However, delays were noted in both the receipt of Project Issues Forms (PIFs) within Capital, Estates & Facilities from the Project Manager, and in their subsequent authorisation. This risks non-compliance with stipulated contractual

timeframes, and ultimately the potential for quotations to become accepted by default, if a formal response is not provided by the PM within the required contractual period (**MA6**).

2.38 Noting the above**, reasonable assurance** has been determined in this area.

Quality Assurance: Assurance that appropriate project management controls have been applied, including in the management of contractor and adviser performance; and adequate arrangements are in place for commissioning and handover.

2.39 Key Performance Indicators had been appropriately completed for the period. Whilst some lower-than-average scoring was noted, management confirmed that performance continued to be monitored and no adverse issues had arisen which required further management action to be taken.

2.40 Monthly reports have been received from the Supervisor, with no significant quality issues identified in the work undertaken by the SCP or sub-contractors for the period reviewed. No health and safety issues have been reported, with the site noted to be well maintained.

2.41 Technical commissioning activities were incorporated into the main programme, and included witness testing, Specialist Estates Services compliance testing, and client training, and were due to commence mid-December 2022. The SCP has been asked to commence preparation of the testing and commissioning strategy in readiness.

2.42 As per *para. 2.22*, GPW workstream arrangements to support the operational commissioning process were being finalised at the date of fieldwork. Roles and responsibilities had been clearly assigned and recorded within the respective terms of reference. However key deliverables and associated timelines had not been confirmed, and monitoring and reporting arrangements were not operational at two of the three workstreams (Exit Strategy and Facilities Management) (see **MA1**).

2.43 Noting no significant quality issues have been identified, and with commissioning arrangements appropriate to the current stage of the project, **substantial assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Governance – GPW Workstreams (design)	Impact
A detailed Genomics Partnership Wales (GPW) governance structure has been implemented to manage the move to the new facility (see *para. 2.22*). The Digital workstream was fully operational, with highlight reporting in place to provide assurance to the Project Team and GPW Governance Board. The Exit Strategy and Facilities Management arrangements were still being finalised at the date of fieldwork. Whilst appropriate terms of reference were in place for each workstream, programmes and critical milestones were still being confirmed, and reporting processes were not yet operating. Management advised that, within the coming weeks, all activities and outcomes would be finalised, and timelines developed, to highlight critical paths and dependences. Highlight reporting arrangements will be required to be embedded into the process, to ensure the senior team receives clear assurance as to progress / slippage across the complex workstreams. These then can be communicated to the Project Team and GPW Governance Board, where appropriate, if there is a risk to the wider programme.	Potential risks of: • Failure to identify and report slippage in workstream activity which may impact the wider programme.

Recommendations		Priority
1.1	As the GPW workstream arrangements are finalised and become operational, it should be ensured that for each workstream: • Key deliverables are clearly identified, including target dates for achievement. • The GPW senior teams receive routine highlight reports presenting progress against these milestones/dates; and	**Low**

	• Any risks to the achievement of the same, which may impact the wider programme, should be reported to the Project Team and GPW Governance Board through the existing GPW reporting process.	

Agreed Management Action		Target Date	Responsible Officer

1.1	Agreed.
	• Workstreams established under the Subject Matter Management (SMM) Group jurisdiction, each led by a Project Manager who reports progress to the SMM Group Chair.
	• Each Project Manager maintains the following (minimum) for each workstream:
	  ○ Terms of Reference
	  ○ Project Plan, identifying objectives and deliverables
	• SMM Group Chair (or deputy) compiles SMM Group Report which is shared with and reported to GPW Estates Senior Team (fortnightly)
	• Report identifies:
	  ○ Overall progress report and RAG status
	  ○ New risks and issues identified at a work stream, or overall level Workstream progress and planned work for next period, as well as any items for escalation to the GPW Estates Senior Team (e.g. for review, approvals, assurance, etc.)
		April 2023	GPW Programme Manager

	• SMM Group maintains a central Risk / Issues / Actions / Decisions log, contributed to by all workstream leads with operational output from workstream activities • All risks to be identified at the SMM Group level, escalated to the GPW Estates Senior Team and risk assessed as appropriate • GPW Estates Senior Team will then capture risks on meeting Risk Log as appropriate, for escalation to Project Team and/or GPW Governance Board through the risk registers as appropriate.		

Matter Arising 2: Governance – Reporting (operation)	Impact
Two points of inaccuracy were identified when reviewing the suite of project reports, as follows: • The external Project Manager's report (2 September 2022) incorrectly stated that the forecast overspend position (£217k) would be improved following receipt of the landlord's contributions for the main entrance and generator works. It was confirmed that these contributions had already been factored into the Cost Adviser's reporting of the forecast £217k overspend; and • The Welsh Government Project Progress Report (July 2022), at section 5, presented cash flow information showing all project funding to be expended by the end of 2022/23 – whereas the Cost Adviser has presented a cash flow profile into 2023/24. Whilst noting these errors, the supporting reports appended to the above clearly showed the correct position. It is also recognised that, in presenting the financial position upwards to the Project Team and GPW Governance Board through the Capital Highlight Report, the correct information had been incorporated.	Potential risk of: • Confusion as to the correct financial position. A false sense of security in terms of project budget. Potentially misleading information presented to WG.

Recommendations		Priority
2.1	Key project reports should accurately reflect the supporting detailed financial reporting.	**Low**

Agreed Management Action		Target Date	Responsible Officer
2.1	Agreed. The October 2022 Project Manager's report, and the October 2022 Welsh Government PPR, had both been updated as recommended above.	Actioned since fieldwork	N/A

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Matter Arising 3: Financial Assurance – Risk & Contingency Management (operation)	Impact
The Cost Adviser confirmed the risk register had been updated in July 2022, in conjunction with a full review of the project budget - with the aim of identifying a clear overall position in terms of contingency and overspend. The construction risk register appended to the latest external Project Manager's Progress Report (October 2022) was dated April 2022. The risk register recorded total costed risks of £662k. Management have subsequently advised that, following further review, this has now been reduced to £363k. Project reports (including those to Capital Management Group) have not, to date, provided commentary on the total residual risk as per the risk register, and how this impacts the forecast overspend currently being reported. Management have confirmed that the costed risks had not, at the time of audit fieldwork, been incorporated into the forecast overspend. The project therefore faced additional cost pressures to those reported, if these risks materialised. This information should inform Capital Management Group decision making and communications with Welsh Government, in terms of whether the budget position is expected to worsen, or whether it is considered deliverable within the revised funding envelope. At the time of reporting, management confirmed that a further cost review exercise had incorporated the costed risks into the forecast outturn, revising the forecast overspend to £639k. This has been reported to WG to seek additional funding support. Project reports should always be clear as to whether additional risks may impact (within a potential range of values), any reported forecast outturn.	Potential risk of: • The UHB is unaware of potential future impacts to the project budget, from risks not yet materialised. • Decision making is not fully informed.

Recommendations		Priority
3.1	The impact of the construction risks should be fully recognised at cost reports (and reported outturn position), highlighting any variances between remaining contingency funds and the residual value of costed risks.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed. A cost review exercise undertaken on 13 October 2022 reviewed the cost forecast and incorporated costed risks into the outturn figure. This resulted in a revised forecast overspend of £639k. This has been reported to Welsh Government, and additional funding support is being sought. Prior to this date, the costs involved were still being confirmed, and it would not have been possible to provide an accurate figure for inclusion in project reports until this time.	Actioned since fieldwork	N/A

Matter Arising 4: Change Management –Lessons Learned (operation)	Impact
The reported forecast overspend of £217k at the time of fieldwork (including full utilisation of the £1.4m contingency), is attributable to cost increases in a range of areas, with the associated costs summarised in the table included at para. 2.8. These cost increases include: • An increased target cost of £410k, noting the Full Business Case was submitted to Welsh Government at risk, ahead of finalised design development (as previously discussed in the 2021/22 audit report); • Significant Digital Infrastructure changes of £158k, with further changes to the hub room (including cooling and futureproofing) of £200k – a total 29.8% increase from the FBC cost allowance of £1.2m; • Further end-user changes of £75k; and • Changes to the construction contract in relation to building condition, and associated programme implications, totalling £592k. Potential further costs of £363k have been included at the risk register, primarily in relation to: • Programme prolongation as a result of delayed decision making and instruction of key outstanding elements of work; and • The unsuitability for use of existing infrastructure and services. A lessons learned review should be undertaken to consider these and any other relevant factors contributing to the current budget pressures, to aid improved decision-making and project management practices at future projects, where applicable.	Potential risk of: • Lessons may not be learned from issues encountered at this project and may be experienced at future projects.

Recommendations		Priority
4.1a	A lessons learned review should be undertaken by Capital, Estates & Facilities, to ensure full understanding of the factors leading to the budget overspend in respect of management of the construction contract.	**Medium**
4.1b	A lessons learned review should be undertaken by Digital to ensure full understanding of the factors leading to the budget overspend; and to ensure improved processes can be applied at future projects in respect of the determination of the IT budget requirements at the business case stage.	
4.1c	A report should be presented to an appropriate forum (e.g., Capital Management Group) setting out the findings of the above exercises.	

Agreed Management Action		Target Date	Responsible Officer
4.1a	Agreed.	On project completion (or sooner if resources permit)	Project Director
4.1b	Agreed.		Director of Digital & Health Intelligence
4.1c	Agreed.		Project Director

Matter Arising 5: Technical Assurance – Timeliness of payments (operation)	Impact
The NEC contract 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 the last four payments made to the Supply Chain Partner were reviewed for timeliness, totalling £1,516,484.25. Two of the four payments were made outside the contractual timeframe, as follows:	Potential risk of: • Breach of contractual payment terms. • Potential interest charged.

Certificate no.	Value	Date of Cost Adviser's assessment	Contractual due date	Oracle Payment date	No. days late
20	£507,168.24	19/05/2022	09/06/2022	22/06/2022	13
21	£283,636.10	16/06/2022	07/07/2022	13/07/2022	6
22	£432,887.39	14/07/2022	04/08/2022	27/07/2022	-8
23	£576,428.62	15/08/2022	05/09/2022	22/08/2022	-14

It is recognised that timeliness improved for the latter payments, and further that delays may sit outside Capital Estates & Facilities, once the payment has been approved for processing.

Recommendations	Priority
5.1 Payments should be made in accordance with contractual and/or legislative requirements.	**Low**

Agreed Management Action		Target Date	Responsible Officer
5.1	Agreed. The DocuSign system has recently been implemented, which will expediate the process of payment approvals going forward.	November 2022 and ongoing	Project Director

Matter Arising 6: Change Management – Timeliness of approvals (operation)	Impact
A total of £424,275 Compensation Events (CEs) were recorded on the Change Control Tracker as instructed at the time of review. A sample of six CEs, totalling £304,386 (72%) were selected for review. All CEs were adequately supported by substantiating information and had been appropriately scrutinised by the Cost Adviser. Additionally, all had been appropriately authorised in accordance with agreed UHB delegated limits, and only instructed by the Project Manager once UHB approval had been granted. However, delays were observed in the receipt of Project Issues Forms (PIFs) in Capital, Estates & Facilities (CEF), and in their authorisation, as below.	Potential risk of: • Changes may not be agreed within contractual timeframes. • Project time and cost may not be appropriately controlled.

CE Ref	PIF Ref	Value	Date of PIF issue by PM	Date received in CEF	Days between PIF issue and receipt by CEF	Date PIF approved by UHB	Days between PIF receipt and authorisation in CEF	Total days from PIF issue to authorisation
31	27	£19,267.78	23/3/22	25/3/22	2	29/3/22	4	6
35	-	£241,951.78	CE35 was reviewed as part of the test but was subsequently confirmed as not yet authorised.					
38	30	£12.510.97	6/5/22	16/5/22	10	16/5/22	0	10
41	28	£6,361.07	31/3/22	Not stamped	Not known	7/4/22	Not known	7
49	38	£13,694.86	24/6/22	30/6/22	6	6/7/22	6	12
60	42	£10,600.51	19/7/22	2/8/22	14	3/8/22	1	15

It is noted timeliness in PIF authorisation is an issue repeatedly raised in audits at the UHB and has also been highlighted by the external Project Manager in his progress reporting.

Recognising that, whilst delays have occurred in the process, these did not negatively impact contract delivery for the sample reviewed, the priority rating has been determined accordingly.

Recommendations		Priority
6.1a	The UHB / PM should review the reasons for delays in the PIF issue/receipt process and ensure any avoidable delays are minimised going forward.	**Low**
6.1b	PIFs should be approved in a timely manner on receipt in Capital, Estates & Facilities.	

Agreed Management Action		Target Date	Responsible Officer
6.1a	Agreed. This will be completed and further reviewed in the lesson learned.	January 2023	Project Director
6.1b	Agreed. The DocuSign system has recently been implemented, which will expediate the process of PIF approvals going forward.		

Appendix B: Follow up of previously agreed management actions

Previous matter arising 1.1: Governance – Project Board	
Original recommendation and management response	Original priority
The Project Director should provide written reports to the GPW Governance Board. **Management Response:** Agreed. Project monthly progress reports will be issued to GPW Governance Board as an appended paper for information.	**Low**
Current findings	**Residual risks**
A copy of the Capital Highlight Report has been submitted to the GPW Governance Board from April 2022 onwards. **Conclusion:** Closed.	N/A

Previous matter arising 2.1: UHB Approval to Accelerate FBC development	
Original recommendation and management response	Original 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. **Management Response:** 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.	**Medium**
Current findings	**Residual risk**
Recognising the project-specific nature of these recommendations, the position will be re-assessed if a similar situation arises at a future project subject to audit. **Conclusion:** Closed - to be considered at future projects.	N/A

Previous matter arising 2.2: UHB Approval to Accelerate FBC development	
Original recommendation and management response	Original priority
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. **Management Response:** Agreed. See 2.1b	**Medium**
Current findings	**Residual risk**
Recognising the project-specific nature of this recommendations, the position will be re-assessed if a similar situation arises at a future project subject to audit. **Conclusion:** Closed - to be considered at future projects.	N/A

Previous matter arising 3.1: Contract Management	
Original recommendation and management response	Original priority
Future Assurance Contracts should be in place before duties/works commence. **Management Response:** Recognising the legal advice received via NWSSP:SES, the UHB will seek to minimise the period between commencement of works and contract signature.	**Medium**
Current findings	**Residual risk**
Noting that the implementation of this recommendation was to be assessed at future projects, reference has been made to the recently audited UHL Endoscopy Expansion project (*draft report issued October 2022)*. At this project, it was confirmed that works and adviser contracts were in place prior to works / duties commencing. **Conclusion:** Closed.	N/A

Previous matter arising 3.2: Contract Management	
Original recommendation and management response	Original priority
Future Assurance Letters of Intent do not represent good practice and should only be used in exceptional circumstances. **Management Response:** 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.	**Low**
Current findings	**Residual risk**
The use of Letters of Intent will be considered at future projects, where appropriate. **Conclusion:** Closed - to be considered at future projects.	N/A

Previous matter arising 3.3: Contract Management	
Original recommendation and management response	Original priority
Future Assurance Contracts should be dated at the time of execution. **Management Response:** Agreed. Contracts to be dated at point of execution.	**Low**
Current findings	**Residual risk**
Noting that the implementation of this recommendation was to be assessed at future projects, reference has been made to at the recently audited UHL Endoscopy Expansion project (*draft report issued October 2022*). At this project, it was confirmed that the works contract was appropriately dated. **Conclusion:** Closed.	N/A

Previous matter arising 3.4: Contract Management		
Original recommendation and management response		Original priority
Appropriate document control arrangements should be implemented for key documents such as those with contractual implications. **Management Response:** Agreed. Major Capital Project folder structure has been reviewed for implementation on existing and future projects.		**Low**
Current findings		**Residual risk**
Recognising similar issues at other projects, the incoming Head of Capital has been tasked with implementing an improved filing structure across all projects. **Conclusion:** Outstanding.		Lack of clarity as to the extant contract documents.
Recommendation		**Priority**
Appropriate document control arrangements should be implemented for key documents such as those with contractual implications.		**Low**
Management response	**Target Date**	**Responsible Officer**
Agreed. We have commenced the process of reviewing our current filing structure, with a view to implementing a consistent document retention approach across projects.	March 2023	Head of Estates & Facilities

Previous matter arising 3.5: Contract Management		
Original recommendation and management response		Original priority
Management should continue to seek the early resolution of the Project Bank Account provision. **Management Response:** Agreed. Risk and Assurance are currently agreeing approach to execution of PBA joining deed.		**Low**
Current findings		**Residual risk**
Arrangements to implement the PBA were nearly concluded – however it was not yet in use at the time of review. **Conclusion:** Outstanding.		Non-compliance with WG requirements.
Recommendation		**Priority**
Management should continue to seek the early resolution of the Project Bank Account provision.		**Low**
Management response	**Target Date**	**Responsible Officer**
Agreed. The Team have been working to resolve the issues of the Project Bank Account and will continue to do so. The Team will also review the possibility of applying for an exemption on this contract due to the limited duration left and the difficulties already encountered.	January 2023	Project Director

Previous matter arising 4.1: Risk & Contingency Management	
Original recommendation and management response	Original priority
The UHB / Genomics Partnership's project risk register should be costed where appropriate. **Management Response:** 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.	**Low**
Current findings	**Residual risk**
The current project risk register was reviewed. Whilst risks remained uncosted, it is recognised that those risks with capital cost implications to the project budget had been captured on the construction risk register. Service risk costs, if they materialised, would be met from revenue budgets outside the project, and therefore it is not considered appropriate to incorporate these costs into the project risk register. **Conclusion:** Closed.	N/A

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:

 **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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Capital Systems Management
Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Auditors:	NWSSP: Audit & Assurance – Specialist Services Unit
Executive sign-off:	Catherine Phillips, Executive Director of Finance
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities (Project Director) Nicola Foreman, Director of Corporate Governance Stephen Gardiner, Head of Estates and Facilities Claire Salisbury, Head of Procurement
Committee:	Audit Committee

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

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

Executive Summary

Purpose

Post reporting of potential breaches, at capital schemes, to Standing Financial Instructions and Standing Order requirements, recommendations and an action plan were agreed to be implemented to mitigate the risk of the same reoccurring. The audit was undertaken to provide assurance on the application of the plan; and to identify any enhancements to existing operational procedures / working practices.

Overall Audit Opinion and Overview

The commitment, by all parties, to address the identified actions is apparent. The action plan was endorsed by the appropriate officers and appropriate action was taken whilst recognising that some required more engagement than current workforce availability could provide.

However, whilst a process for change management was defined, this was not consistently applied across teams; and, for two changes reviewed (total circa. £120k), not in accordance with the defined delegated limits.

Monitoring and reporting arrangements also require review to ensure their consistent application across all capital schemes; notably those managed by the different teams within the Capital, Estates & Facilities department.

Key matters arising, requiring management attention include:

- Application of the change management (Project Issues Form) process at all capital schemes.
- Review of the scheme of delegation applied to capital schemes.
- Review of the content, and consistency of use, of the highlight reports prepared for capital schemes; and
- Completeness of reporting to the appropriate forums.

Other recommendations, including completion of the outstanding / partial actions, are included within the detail of the report.

It is proposed that a further follow up audit will be undertaken during March/April 2023, testing further UHB projects, to ensure ongoing compliance with established procedures.

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	Action Plans	Reasonable
2	Capital Approvals	Substantial
3	Change Management	Limited
4	Contractual Arrangements	Reasonable
5	Delegated Limits	Reasonable
6	Monitoring and Reporting	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1	Appropriate arrangements should be put in place to address / complete the outstanding agreed actions.	1	Operation	Medium
2.1	Irrespective of the capital project management team, the application of management processes should be consistent across the Capital, Estates & Facilities department.	3	Operation	Medium
2.2	Changes should be approved in accordance with the approved scheme of delegation.	3,5	Operation	High
2.3	Management may wish to consider the implementation of a revised scheme of delegation for capital schemes funded by Welsh Government	5	Design	Medium
4.1	Monthly highlight reporting should be applied at all major capital projects	6	Operation	Medium
4.3	Supporting procedures should be developed to ensure Lead Executives receive relevant and timely assurance to facilitate their responsibilities	6	Design	Medium

1. Introduction

1.1 Potential breaches to Standing Financial Instructions and Standing Order requirements have been reported, by the Assistant Director of Procurement Services and Director of Corporate Governance, at capital schemes and expenditure at the University Health Board (the UHB). Particularly, issues associated with the procurement, governance and financial monitoring arrangements applied. The findings were submitted by the Director of Corporate Governance to the Board in August 2021; and an associated action plan was agreed to be implemented to mitigate the risk of the same reoccurring.

1.2 Management requested a review of the implementation of the agreed action plan; and the embedding and operation of revised working practices associated with the schemes managed within the Capital & Estates function, for which a sample of five schemes was selected:

Capital scheme	Funding route	Value
Gynaecology Treatment rooms	Covid Recovery Programme *(approved and funded by WG)*	£450k
Ophthalmology Mobile Theatres (UHW)	Covid Recovery Programme *(approved and funded by WG)*	£2,951k
Same Day Emergency Care (SDEC): Phases 1 & 2	Covid Recovery Programme *(approved and funded by WG)*	£3,517k
Rookwood Gym	All Wales Capital Programme *(included within existing Rookwood Relocation capital scheme)*	£594k
UHL Engineering Infrastructure	All Wales Capital Programme	£5,875k

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

- Non-compliance with the Standing Orders, Standing Financial Instructions and National Procurement Regulations.
- Non-compliance with established framework / contractual arrangements.
- Inappropriate planning and approval processes result in a lack of adequate control.
- Poor project governance and management arrangements put the objectives of the project at risk.

2. Detailed Audit Findings

Action Plan: Review of the action and implementation of the recommendations included within the UHB's agreed action plan.

2.1 A total of 22 actions were raised: nine general and 13 specific to the Capital Estates & Facilities department. Appendix B sets out the current status of the

agreed action plan; noting that fieldwork of the sampled capital schemes also reviewed ongoing implementation / embedding of the changed practices

2.2 18 of the actions have been concluded as complete. Three were concluded as partially addressed and one as outstanding (**MA1**), as follows:

- Action 3 –review of the Finance Committee papers post the agreed change date (November 2021) noted that there has been limited reference to the expected reportable points.
- Action CEF5 – a full review of the Capital Procedures Manual needs to be undertaken.
- Action CEF10 – Lead Executive receipt of assurance reports was not always evident (see **MA4**); and
- Action CEF13 – the suite of contract documents specific to the UHB require formal approval for use.

2.3 The commitment, by all parties, to address the identified actions is apparent. The action plan was endorsed by the appropriate officers and appropriate action was taken whilst recognising that some require more engagement than current workforce availability could provide. **Reasonable assurance** has therefore been determined noting that regular review will need to be undertaken to ensure maintained compliance with the agreed actions.

Capital Approvals: Review of the adequacy of the UHB capital approval processes in conjunction with the Standing Orders and Standing Financial Instructions and Capital Procedures Manual.

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

- Approval of capital schemes or business cases to progress, by the Board, up to £1m. Contracts over £1m required Welsh Government approval. *It is noted that business cases for capital schemes, greater than £1m, will be presented to Board for approval and this is outside of delegated limits; however, it is noted that at submission stage, there is no commitment to provide / receive funding therefore acceptable.*
- Appropriate procurement exercise to be undertaken in line with procurement legislation and regulations and the UHB's SFI's to ensure value for money and transparency.
- Approval of the award of a contract and signed by the relevant authority once the procurement exercise has been undertaken. The values are <£500k

(Chief Executive or Management Executive) and >£500k (Board or Chair's Action)

2.5 As per para 1.3, there are different funding routes for the sampled capital schemes, however, the expectation for each (at both UHB and funding body level) remains the same.

2.6 Capital scheme audits, undertaken across other NHS Wales Health Board's. has evidenced the evaluation and approval of Outline Business Cases and Full Business Cases at Board level prior to submission to Welsh Government. For all, the review of receipt of WG approval letters has concluded acceptance of the offer by appropriate officers i.e., Director of Finance and Chief Executive. It has been deemed that signing of acceptance of the approval letter, and the detail of the business cases, including the value of capital works for which contracts are to be entered into, is implied as agreement to commence the associated work (unless significant changes to the approved business case arise).

2.7 For the capital schemes considered at this review only one (UHL Engineering Infrastructure) followed the guidance as reported by the Head of Corporate Governance.

2.8 The Rookwood Gym works were included as a discrete line within the wider Rookwood Relocation FBC, for which the UHB identified, in its own review, as not being compliant with the approval processes.

2.9 For the Covid Recovery Schemes, retrospective approval from the Board was sought at the September 2021 meeting; following receipt of approval from WG nine days previously. However, it is clear from the paper presented to Board, noting the tight timescales for submission, Management Executives were advised of the application via the Chief Operating Officer. Noting the acceptance of such, through review of the Board minutes, and the mitigating actions taken, it is deemed that appropriate governance arrangements were demonstrated.

2.10 Approvals have also been considered in light of variations to contracts. For two of the capital schemes (Mobile Theatres & SDEC), a combined increase of circa £3.3m was noted. Evidence of procurement reports and Chair's actions was evidenced for both.

2.11 Non-compliance for the approval of Rookwood Gym works has already been reported by the UHB for the wider Rookwood project, therefore noting the above approval routes and mitigating actions, **substantial assurance** has been determined for the remaining sampled capital schemes.

Change Management: Review of the change control process applied to capital projects including the process for additional approvals and virement arrangements.

2.12 Section 2.3.1 of the Procedure Manual for Managing Capital Projects states that '*any changes proposed by the User Group Lead, after the brief has been frozen, will need to be strictly controlled via the Health Board Project Issues Form (internally) and subsequently with the contractor using the NEC3 Compensation Event process. As such, all requests must be costed and any programme/quality implications assessed before the Project Manager seeks approval of the Assistant Director, Capital Planning, Estates & Operational Services to proceed via the Project Issues Form process*'.

2.13 Of the capital schemes reviewed:

Compliance with change control process	
1 scheme	*No changes applied*
2 schemes	*Changes applied and were appropriately managed through the PIF process (including appropriate detailing of contingency).*
2 schemes	*Changes applied, however, no evidence of these being managed through the required process.*

2.14 At the two non-compliant schemes (Gynaecology Treatment Rooms and UHL Engineering Infrastructure), it was noted that, based on the technical nature of the scope of works, the Project Team was established from members of the UHB's Discretionary Capital Team rather than the Capital Team (who would normally lead/manage schemes of this value/nature). Whilst it is recognised that typically low-value projects are managed by the Discretionary Capital team and, therefore, may not necessitate the full range of controls as set out in the Procedure Manual, where larger projects are involved, management of the same should be undertaken in a consistent manner (**MA2**)

2.15 Noting the ongoing construction programme for the UHL Engineering Infrastructure project, management advised that the required process will be correctly applied. The project changes instructed to date, had been generated via a Project Manager Notification (PMN) – both for a value of circa £60k and approved by the Project Officer but with no evidence of more senior review on the budget / available contingency for the scheme (refer to ***Delegated Limits***).

2.16 Noting the above, **limited assurance** has been determined.

Contractual Arrangements: Review of the content of the agreed contract / framework arrangements and an assessment of compliance relevant to the stage of the capital project.

2.17 Lead contractor appointments for the sampled capital schemes were made through:

- Local Buildings Framework (3)
- Competitive Tender (1)
- NHS Shared Business Services (SBS) Framework (1)

2.18 Signed contracts / Service Level Agreements were evidenced for each appointment.

2.19 Where external Cost Adviser and/or Project Manager appointments were required at the schemes examined, all appointments were procured via an established framework (either local or national framework arrangements).

2.20 Compliance with agreed processes was assessed through a review of the Procurement reports prepared for each scheme. Where restrictions were noted i.e., direct award due to reasons of urgency, it was evident that the procurement team undertook due diligence to confirm the proposal being presented and approved accordingly.

2.21 There is an expectation for contracts to be in place prior to commencement of works / duties and this has been a recommendation theme (specifically for those schemes procured under the Designed for Life Framework) raised at a number of previous capital scheme audits [1].

2.22 None of the schemes sampled were procured from this Framework for further assessment to be made.

2.23 However, at four of the five schemes reviewed, all had the required contractual arrangements in place prior to the commencement of works. The exception being the Ophthalmology Mobile Theatres project where a in the contract completion of circa two months was observed (**MA3**).

2.24 In accordance with Corporate Governance guidance, only once a contract has been signed can a requisition be placed on the system for processing of contractual payments. For the schemes reviewed, this was achieved with one minor exception of a delay of two days.

[1] As reported at the *Development of Genomics Partnership Wales Final Internal Audit Report (issued April 2022)*, advice was sought from NWSSP:SES and the D4L Framework legal advisers as to the level of risk that the UHB would be exposed to, in the event of any dispute arising prior to stage-based contracts being executed. It was advised that whilst the Framework does provide some protection, thereby reducing the risk to the UHB, the signing of contracts post-commencement of works should be kept to a minimum

2.25 Compliance with established UHB guidance will continue to be assessed at all capital projects that are included within future Internal Audit/Integrated Audit plans.

2.26 Noting the above, for the actions taken to date and the review of the arrangements put in place for the sampled schemes, **reasonable assurance** has been determined.

Delegated Limits: A Review of the appropriateness of delegated authorised limits applied to capital projects.

2.27 For the contracts reviewed at para 2.17, all had been signed in accordance with the UHB's scheme of delegation.

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

- Project Manager £0-£25k
- Director of Planning £25k-£125k
- Chief Executive £125k-£500k
- Chair Above £500k

2.29 In addition to the above, the Director of Capital, Estates & Facilities has a delegated project limit for contract changes of £25k.

2.30 As per para 2.15, there was no evidence of the internal application of the above delegatory arrangements at two of the schemes examined i.e., Gynaecology Treatment Rooms and UHL Engineering Infrastructure, to ensure appropriate consideration against their individual allocated contingency (**MA2**).

2.31 A review of the schemes of delegation operating at other NHS Wales Health Board's notes that specific delegated authorised limits have been approved and applied at capital schemes funded by Welsh Government. These limits recognise the role of the Project Board, Senior Responsible Officer and other Executive membership and the requirements of the associated contract mechanisms. The UHB may wish to consider the implementation of similar arrangements to efficiently manage future capital schemes (**MA2**).

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

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

2.33 The expected reporting forums would include:

- Project Team and Project Board.
- Capital Management Group (CMG).
- Covid Recovery Forum [noting those projects which have been funded from Covid recovery monies].

2.34 The UHB's Capital Manual refers to highlight reporting requirements at various stages of the capital schemes i.e.,

Capital Manual reference	***Reporting expectation***
Para 1.8: Reporting – Project Highlight Reports	*Project Highlight Reports: on a monthly basis, the Project Manager reports to the Project Board on the status of current project stage.*
Para 2.5.8: Construction Stage	*The Project Manager should ensure a highlight report is completed for projects. The project shall note the progress and cost of the project, including details of contract delays etc.*

2.35 At the date of the audit fieldwork, project audits had concluded on two other UHB capital schemes (Genomics and Maelfa Wellbeing Hub); where it was reported that the Capital Highlight report format had recently been enhanced, to provide more detailed financial information to the appropriate forums i.e., at Project Team meetings.

2.36 Whilst at the sampled schemes the enhanced (or previous) Capital Highlight reports were not applied, the following was observed:

- At three Covid recovery schemes (fast-paced and short in duration) written weekly updates were provided to the Covid Recovery Forum detailing significant matters and/or risks. However, no financial project information was presented
- At one Covid project (SDEC), extensive weekly and bi-weekly reporting from the contractor plus weekly Covid Recovery updates. However, the content of these reports did not capture the wider project management issues such as contingency management that would typically be observed at larger capital schemes.
- At the Rookwood Gym scheme, financial information was presented through the reporting matrix at the Capital Management Group meetings.
- At the UHL Engineering Infrastructure scheme, noting its infancy at the date of fieldwork, only a contractor's progress report was available. Whilst this Welsh Government funded project is being managed by the Discretionary Capital team, there should be no deviation in the reporting expectations.

[Note: a separate audit of this scheme is scheduled as part of the 2022/23 IA audit plan where reporting will also be reviewed].

2.37 A review of the CMG papers confirmed high-level updates were received on each of the sampled capital schemes.

2.38 As per para 2.2, there was no evidence of detailed reporting to the Finance Committee as was expected from the agreed action plan.

2.39 The UHB has determined required project reporting arrangements, including alternatives where timing does not permit the standardised arrangements to be applied. However, it is evident that the established requirements are not currently being applied consistently at all UHB projects (**MA4)**. There is no debate that the internal Project Managers are fully versed in the details of their allocated schemes and the issues facing progression; and that these are discussed at an appropriate management level. However, to maintain the audit trail for dissemination of such information, continued application of the formalised reporting processes needs to be demonstrated

2.40 Recognising the level of reporting that has been observed at the schemes reviewed, **reasonable assurance** has been determined. However, it is acknowledged that the current inconsistencies need to be addressed.

Appendix A: Management Action Plan

<table>
<tr><th>Matter Arising 1: Completion of agreed actions (Operation)</th><th>Impact</th></tr>
<tr><td>As detailed within Appendix B, the implementation of four of the 22 agreed actions has been concluded as either outstanding or partially addressed:
<table>
<tr><th>Agreed Action</th><th>Current status</th></tr>
<tr><td>3</td><td>A review of the Finance Committee papers post the agreed change date (November 2021) noted that there had been limited reference to the expected reportable points.
The agreed workplan for the Committee includes the following:
<table>
<tr><th>Workplan</th><th>Frequency</th></tr>
<tr><td>Business cases</td><td>As and when
Deemed reasonable given the recognition there will not be one for every meeting.</td></tr>
<tr><td>IMTP</td><td>February</td></tr>
<tr><td>Capital Programme</td><td>Every other month</td></tr>
</table>
Noting that period of coverage of the papers reviewed (December to June 2022). It would be expected that at least one review of the capital programme would have taken place. This was not evidenced.</td></tr>
<tr><td>CEF5</td><td>A full review of the Procedure Manual for Managing Capital Projects needs to be undertaken, to encapsulate all the actions arising and processes / procedures implemented. It is</td></tr>
</table>
</td><td>Potential risk of:
• Non-compliance with the expected and established frameworks/ procedures.</td></tr>
</table>

	acknowledged, however, that the completion of this action has been impacted by availability of key officers
CEF10	Lead Executive receipt of assurance reports was not always evident; and there was inconsistency in the content of the reports prepared e.g., extent of financial information presented. Noting the same, the Lead Executive's key roles and responsibilities should be confirmed in writing (and accepted) to ensure the required assurances are received.
CEF13	A legal team was engaged to prepare a suite of contract documents specific to the UHB. At the date of fieldwork, whilst contractual proposals had been received by the UHB, they had not been formally approved for use.

Recommendations		Priority
1.1	Management should ensure appropriate arrangements in place to address / complete the outstanding agreed actions.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	3: The Capital Programme is due to come to the Finance Committee every other month. The 10 Year Capital Plan was presented to the Finance Committee in the September 2022 Private meeting due to the commercial details; and prior to that the Capital Plan Delivery was presented to Strategy and Delivery Committee in May 2022. Going forward there will be two further opportunities for the Finance Committee to review the Capital Programme once on 14 December 2022 and again on 22 February 2023.	Review of Capital Programme: Actioned since fieldwork Finance Committee discharging responsibilities in line with terms of reference: February 2023	3: Director of Corporate Governance

	CEF5: Agreed. Review has commenced but needs finalisation. CEF10: Agreed. Highlight reports now produced and consistency checked for information provided. Process to confirm responsibilities with Lead Executives being developed / reviewed. CEF13: Agreed. NEC3 document review completed. Process of updating to NEC4 commenced.	April 2023 March 2023 April 2023	CEF 5/10/13: Director of Capital, Estates & Facilities

Matter Arising 2: Change Management & Delegated Limits (Operation / Design)	**Impact**
Two of the schemes reviewed (Gynaecology Treatment Rooms and UHL Engineering Infrastructure) did not apply the PIF process – as required by the Procedure Manual for Managing Capital Projects; and as referenced in the agreed Action Plan for application to all schemes. The PIF process, when applying changes, is seen as a key internal control to ensure oversight and delegated approval of the utilisation of the project's contingency. Both schemes were managed by the Discretionary Capital team (within the wider Capital, Estates & Facilities department). It is expected that the controls, detailed within the manual, and the recommended actions (as per the plan) are applied at all capital schemes. AS a major All Wales Capital Project (AWCP) the UHL Engineering Infrastructure project should apply the defined major project controls. In the absence of PIFs, where changes had been applied, the lesser controls of Project Manager Notification (PMNs) had been applied instead. For the period reviewed, PMNs for two changes (£68k and £61k), had been applied at the UHL Engineering Infrastructure scheme and approved by the Project Officer i.e., without the required delegated authority.	Potential risk of: • Non-compliance with the Standing Financial Instructions; and Procedure Manual for Managing Capital Projects. • Non-compliance with the scheme of delegation. • Project budgets not effectively managed.

Recommendations		**Priority**
2.1	The consistent application of management processes across the CEF teams at all major capital projects (irrespective of the UHB team managing the schemes).	**Medium**
2.2	Changes should be approved in accordance with the approved scheme of delegation.	**High**

2.3	Management may wish to consider the implementation of a revised scheme of delegation for capital schemes funded by Welsh Government.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	Agreed. The implementation of Docusign for the PIF sign off process within the department, and the reinforcement of PIF process for the relevant required schemes.	December 2022	Director of Capital, Estates & Facilities
2.2	Agreed.	December 2022	Director of Capital, Estates & Facilities
2.3	Agreed. The scheme of delegation will be updated regarding PIFs to ensure there is clarity on the allocation of capital programme contingency up to £75k; and will be approved by the Board.	March 2023	Director of Corporate Governance

Matter Arising 3: Contract Approval (Operation)	**Impact**
The review of the contractual arrangements for the capital schemes sampled noted that: • the procurement process was compliant with SFI's. • a Request for Approval was in place and appropriately authorised for each; and • contracts and/or Service Level Agreements (SLAs) were in place for each contractor/adviser appointed. There was one exception to the above i.e., the Ophthalmology Mobile Theatres scheme. The SLA, for the provision of the modular buildings, was signed circa two months post completion of the enabling works; but in advance of the handover of the theatres to the UHB. Management advised that this scheme was emergency works and requirements were being confirmed as the project commenced; therefore, being unable to provide specifics for inclusion within the SLA. However, there were no mitigating actions implemented to manage the potential risks of the absence or appropriate contractual arrangements. The completion (and signing) of the SLA four days prior to formal handover is not considered acceptable. Recognising only one exception was noted at this review, and audit work completed at other UHB capital projects has reported improvements in the timeliness of the completeness of contract documentation, the priority rating has been determined accordingly.	Potential risk of: • Capital schemes progressing at risk without appropriate contractual cover in place.

Recommendations		**Priority**
3.1	Contracts should be in place prior to the commencement of capital schemes.	**Low**

Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed. The procurement report is prepared and authorised whilst the contract documentation is prepared. The order is raised once these are complete. With the implementation of Docusign the Contact will be included with the approval of the procurement documentation	At future schemes	Head of Procurement in consultation with Director of Capital Estates & Facilities

Matter Arising 4: Monitoring and Reporting: Highlight Reporting (Operation / Design)	**Impact**
Whilst there were no monthly highlight reports evidenced at the capital schemes sampled, mitigating reporting processes were observed. Reporting was in the form of e.g., weekly Covid Recovery updates, or monthly reporting via the CMG matrix, but neither report contained sufficient detail i.e., key project processes, financial information etc., to provide the required assurance to the relevant officers (Project Director and/or Lead Executive) (see ***Appendix B, Action CEF10***). It was also noted that not all Lead Executives, for the schemes, had attended CMG for the period reviewed.	Potential risk of: • Insufficient oversight and scrutiny of capital scheme activities, performance, and financial position against capital approval.

Recommendations		**Priority**
4.1	The required monthly highlight reporting should be applied at all capital projects.	**Medium**
4.2	Nominated project Lead Executives should be advised in writing of their responsibilities to the project, as required by the Action Plan.	**Low**
4.3	Capital, Estates & Facilities should develop supporting procedures to ensure the Lead Executives receive relevant and timely assurance to facilitate their responsibilities.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4.1	Agreed. For clarity, this refers to reporting for all major capital schemes.	December 2022	Director of Capital, Estates & Facilities
4.2	Agreed.	March 2023	
4.3	Agreed.	March 2023	

Appendix B: Current status of agreed action plan

Action		Lead	Timescale for completion	Current status
Capital Expenditure – Procurement and Governance Arrangements				
1	Provide training for key Board Members, Directors and staff involved in the management, procurement and oversight of capital schemes and expenditure focussing on: a) Procurement practice and regulations b) Standing Orders c) Standing Financial Instructions d) Scheme of Delegation and Earned Autonomy	Deputy Director of Finance & Head of Corporate Governance	By end of December 2021	***Complete*** Training was delivered at the Board Development session in December 2021.
2	Develop revised Standard Operating Procedure (SOP) to ensure compliance with Standing Financial Instructions and Procurement Regulations in relation to capital schemes, procurement, and governance.	Executive Director of Finance, Executive Director of Strategic Planning, Director of Corporate Governance	Complete - new process agreed with Executive colleagues and in place.	***Complete*** Confirmed the process has been agreed with the relevant parties.
3	Consideration be given to expanding the remit of Finance Committee to monitor expenditure of major capital schemes	Chair of the Board	By end of November 2021	***Partially addressed*** Updated terms of reference were presented to the November 2021 Finance Committee to incorporate the following: • Review of performance of business cases >£500k

Action		Lead	Timescale for completion	Current status
				• Review and monitor the IMTP financial plan and associated business cases over £500k and recommend approval to the Board. • Ongoing monitoring of the capital programme. However, review of the subsequent papers noted no reference to the above expected actions.
4	Ensure Executive Director is nominated to each capital scheme > £200k.	Executive Director of Finance	Immediate for new schemes > £200k	***Complete*** Whilst this was an agreed action, in considering the capital schemes that have been included Internal Audit plans, there has not been one where an Executive Director isn't named. For those capital schemes sampled at this audit, and for wider review of the reporting to Capital Management Group on all schemes, the same was concluded.

Action		Lead	Timescale for completion	Current status
5	Executive Lead appointed to capital scheme to ensure that due process is followed in relation to approval for schemes, procurement and signing of contract.	Executive Director	Immediate once appointed to scheme	***Complete*** This has been considered through review of the capital schemes sampled. No issues in relation to due process were noted.
6	Ensure all PIFs are amended to include details of contract, contingency spend and confirmation that it does not breach original value.	Director of Capital, Estates and Facilities	Immediate	***Complete*** Section 4 of the PIF form provides details of the movement in original contingency.
7	Ensure CAN's are published within 30 days of a contract award.	Director of Capital, Estates and Facilities	Immediate and will continue for all contracts now coming through.	***Complete*** Procedures have been put in place to ensure this is achieved. For the capital schemes reviewed, the contracts had been awarded via a Framework. It was confirmed, by Procurement, that CAN's are not issued when awarding contract through such means.
8	Ensure that contracts are signed off for all schemes.	Director of Capital, Estates and Facilities	Immediate	***Complete***

Action		Lead	Timescale for completion	Current status
				Contracts are in place for the sampled capital schemes. For existing schemes, this has been managed through reporting to the Capital Management Group where contract status is monitored for all schemes, subject to their stage in development.
9	CEF adhere to Procurement Contracts Regulations 2015, Standing Orders, Standing Financial Instructions and the Scheme of Delegation and Earned Autonomy.	Director of Capital, Estates and Facilities	Immediate	As per action (2).
CEF Capital Expenditure – Procurement and Governance Arrangements				
CEF 1	Identify a senior CEF manager to review the processes from inception of a project to completion with specific emphasis on key milestones for approval in line with the capital procurement processes and procedures.	Director of Capital, Estates and Facilities	Week commencing 13/09/2021	***Complete*** Responsibility for this review was charged to the Head of Discretionary Capital in consultation with other senior members of the CEF team. The development of the Capital Project Process Map addresses these mandatory deliverables for compliance.

Action		Lead	Timescale for completion	Current status
CEF 2	Review procurement and contract documentation for all live schemes to ensure compliance and, where necessary, seek retrospective approval.	CEF Business Manager, Procurement and Corporate Governance	End of October 2021	***Complete*** As above, and in consultation with the CEF Business Manager. A scheme contract tracker is in use setting out the details of the respective contractors, date of returned signed contract, when issued to Corporate for signing and expected officer(s) for signing. The status of contracts is also monitored through the monthly Capital Management Group meetings (included in the capital projects matrix presented). Retrospective approval was sought where required.
CEF 3	Develop a 'plan on a page' and checklist for all members of capital estates and facilities who undertake capital procurement as part of their job role.	Director of Capital, Estates and Facilities	Week commencing 13/09/2021	***Complete*** Capital Project Process Map in place which details the expectations of process for each of the key stages and mandatory deliverables associated with the same i.e., • Project initiation

Action		Lead	Timescale for completion	Current status
				• Early project stage completion • Contract • Live project process • Project reporting
CEF 4	Meet with all project leads who procure and manage capital projects to outline the procurement processes governance arrangements and the requirements of SFIs	Director of Capital, Estates and Facilities	Complete	***Complete*** Confirmed that meetings were held with all project leads responsible for both capital and estates schemes – the key issues and expectations for project management were addressed.
CEF 5	Review the capital procedures manual that was produced to provide guidance to the major capital and discretionary capital teams on key stages of project development including procurement and standing financial instructions to ensure it aligns to the current requirements.	Director of Capital, Estates and Facilities	By end November 2021	***Outstanding*** Whilst recognising the development as per (3) a full review of the Procedure Manual for Managing Capital Projects has not been evidenced. It is recognised that staffing issues will have impacted this, noting the departure of the Head of Capital Planning.
CEF 6	Provide training for all CEF staff involved with capital procurement with emphasis on the following: • Procurement practice and regulations	CEF Business Manager, Procurement and Corporate Governance	By end of October 2021	***Complete***

Action		Lead	Timescale for completion	Current status
	• Standing Orders • Standing Financial Instructions • Scheme of Delegation and Earned Autonomy			Training sessions have been delivered in relation to: • Procurement regulations; and • Governance in Capital Procurement.
CEF 7	Provide schedule of schemes to be tendered as part of the monthly capital management group report	Director of Capital Estates and Facilities	October 2021 (18/10/2021)	***Complete*** Review of the papers prepared for the Capital Management Group confirmed inclusion of schemes identified as a priority to progress to tender.
CEF 8	Arrange monthly meetings with procurement leads to ensure early engagement and agree the procurement routes and approvals to ensure compliance.	Interim Assistant Director of Capital Estates and Facilities	Closed	***Complete*** Routine meetings have been held, and continue to be held, between Procurement and the Head of Discretionary Capital.
CEF 9	Develop a revised project status report that includes details of approvals at the relevant stages, financial position for each project, including actual spend against planned and expenditure against contingency. The report should also include any client change (PIFs)	Head of Capital Planning	By end of October 2021	***Complete*** The monthly Project Progress Report has been enhanced to incorporate the required information. It was rolled out for use by the CEF project managers in February 2022; but is recognised that it will take a period of time to fully

Action		Lead	Timescale for completion	Current status
				embed and provide the complete suite of information required for all parties.
CEF 10	Provide the appointed Executive Lead for each capital scheme >£200k with an assurance report to include the financial position of the scheme, any changes design or client, procurement reports and contract status.	Project Lead	Closed	***Partially addressed*** See CEF9. It was not always evident that the appointed Executive Lead was in receipt of the report. Some don't sit on the Project Team / Project board / Capital Management Group; or, at the date of fieldwork, have an awareness that they are expecting to receive such reports. The content of the reports prepared also varied e.g., financial position presented.
CEF 11	Ensure all PIFs include the contingency sum, the accumulated spend to ensure that the PIF is affordable within the budget to avoid any breach of the value. PIFs are to be authorised in line with SFIs	Project Lead	22/10/2021	***Complete*** The PIF template form includes the required details to manage / monitor the contingency value against the proposed changes. For the sampled capital schemes, where PIFs had been

Action		Lead	Timescale for completion	Current status
				raised, compliance with approval was confirmed.
CEF 12	All contracts are to be signed prior to the issue of a requisition.	Project Leads	Closed	***Complete*** See CEF2, CEF4 and CEF6.
CEF 13	Review contract documents currently used by CEF for capital works and services to ensure that we reflect any specific requirements from the Health Board.	Head of Capital Planning	31/12/2021	***Partially addressed*** Solicitors were engaged to prepare a suite of NEC contract documents tailored to the UHB for use in the following circumstances: • To support appointment of Contractors via the UHB' Local Contractors Framework. • To support the appointment of Contractors and/or Consultants via open market conditions. • To support appointment of Consultants via the NHSSBS Framework. As at the date of reporting, they are not fully embedded in within the operations of CEF.

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:

 **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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UHL Engineering Infrastructure
Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Executive sign-off:	Abigail Harris, Executive Director of Strategy and Planning
Distribution:	Geoff Walsh, Director of Capital, Estates and Facilities (Project Director) Stephen Gardiner, Head of Estates and Facilities Tony Ward, Head of Discretionary Capital Gavin Evans, Project Manager Catherine Phillips, 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

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

Executive Summary

Purpose

The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Engineering Infrastructure Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Overall Audit Opinion and Overview

Reasonable assurance has been determined at this stage of the project.

At the date of the audit fieldwork (September/ October 2022) the Project Manager was reporting a delay to the project's completion of approximately nine weeks. This was due to a combination of factors, including the building subcontractor being delayed starting on site and structural redesign due to the originally appointed structural designer going into administration. There is a risk that timescales could be further extended due to open Early Warning Notices (EWN) and Project Managers Instructions (PMIs) associated with the lack of engagement with the medical gas supplier

Robust cost and project management arrangements controls were in place, with continual liaison and effective reporting to the relevant forums evident.

Contractual arrangements were appropriately approved; for both the main contractor and the UHB's advisers in line with the requirements determined within the approved Business Justification Case (BJC); with no amended procurement strategy approved.

Key matters requiring management attention, include:

- The need to determine any time and cost implications associated with the medical gas installation.
- The application of the change management (Project Issues Form) process. Note the change control mechanisms at this project had been reviewed as part of the capital systems review (published December 2022), and to avoid duplication, no recommendations have been re-raised within this report.

Other recommendations are detailed within the report.

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	Project Performance	Reasonable
2	Financial	Substantial
3	Technical	Substantial
4	Advisers	Substantial
5	Change Control	Limited
6	Quality	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
MA5	Application of the change management (Project Issues Form) process (*refer to Capital Systems Report, December 2022 for associated recommendation*).	5	Operation	High
6.1	Resolution to the outstanding issues concerning the medical gas installation.	6	Operation	Medium

1. Introduction

1.1 The audit reviewed the delivery and management arrangements in place to progress the upgrade of the electrical and medical gas infrastructure at University Hospital Llandough (UHL). This audit was commissioned in accordance with the agreed audit plan provided within the approved Business Justification Case (BJC) for this project.

1.2 The scope of works includes the complete replacement of existing distribution sub-station DSS4, with a new highly resilient sub-station in accordance with the latest Health Technical Memoranda. The current electrical system feeds the wards, operating theatres, high dependency unit etc; the medial gases also serve all wards and operating theatres. A failure of either service would have potential impact on patient safety.

1.3 The Welsh Government approved the BJC in October 2021, with the NEC option A contract to be utilised. Total agreed funding, including VAT, was £5,875k:

Costs	Total
Total Works Costs	£4,280k
Fees	£620k
Non-Works Costs	£546k
Risk Provision	£537k
VAT reclaim	(£108k)
Total Capital Cost	**£5,875k ***

the agreed funding includes an uplift in costs of £291k from the original BJC to take account of the current market conditions.

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

- Non-compliance with the Standing Orders, Standing Financial Instructions and National Procurement Regulations.
- Non-compliance with established framework / contractual arrangements.
- Inappropriate planning and approval processes result in a lack of adequate control.
- Poor project governance and management arrangements put the objectives of the project at risk.

2. Detailed Audit Findings

Project Performance: Consideration of performance against project objectives (e.g., time, cost, quality, benefit, critical success factors etc.)

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 areas under review are suitably designed and applied effectively.18 of the actions have been concluded as complete.

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

Time

2.3 The project commenced on site on 7th March 2022. At the time of the current review and as reported within the Project Manager's report (August 2022), the works were forecast to be delayed by approximately nine weeks i.e.:

- Planned Contract Completion: 4th November 2022.
- Current Anticipated Completion Date: 9th January 2023

2.4 The key factors for the reported delay include:

- the delayed start on site due to a subcontractor's inability to progress the works (attributed to a delay in funding approval); and
- the administration of the original structural engineering advisers, with a subsequent design review and update required by the new advisers.

2.5 It is acknowledged that the project programme will require further review once communication has been received from the supplier and the works for the medical gas new tank installation and replacement of existing tanks and base are confirmed. There were open EWN and PMIs surrounding this, that anticipate further delays to the programme and associated cost implications (see **MA6**).

Cost

2.6 At the date of fieldwork (October 2022), a forecast underspend of £30,632 was being reported; however, at the date of concluding the fieldwork, cost implications of the open EWN PMIs surrounding the medical gas supplier had yet to be formally affirmed.

Quality

2.7 The quality of the original structural design has been reviewed and challenged by the newly appointed structural design engineers (appointed following the original company being placed into administration). This has led to the redesign of structural elements which has impacted on the delivery of the project.

2.8 The adverse time (and potential cost) issues currently impacting on project delivery may be outside of the direct control of the UHB. Whilst noting the same, it has been recommended that a review of the issues be undertaken to determine any lesson that may be learnt and applied at future UHB projects (see **MA6**). Noting the same, **reasonable** assurance has been determined in respect of project performance at the current time.

Financial - Assurance that appropriate financial controls are applied at the project including approval mechanisms, monitoring and cost control, application of project bank accounts and the management of the project contingency etc.

2.9 The BJC for the project (total: £5.522m) was submitted and approved at the UHB Board meeting held in January 2021. However, project cost escalation/inflationary increases were identified, and additional Welsh Government approvals were provided in February 2022 to mitigate the cost escalation (total: £5.875m).

2.10 The NHS Wales Infrastructure Investment Guidance requires all projects over £2m in value to have a Project Bank Account (PBA). However, the implementation of the PBA had been delayed at the project (see **MA1**).

2.11 Monthly Project Manger's reports were produced for the attention of the Project Director, to assist with wider reporting within project governance structure. Within the Project Manager's report, the risk register was regularly updated. Noting the same, minor enhancements have been proposed (see **MA2**).

2.12 The October 2022 Project Managers report highlighted that 469k remained within the contingency, equating to 58% of the original allocation.

2.13 Project updates were provided, by the Project Director, to the monthly Project Team meetings and the quarterly Acute Infrastructure Sustainability Capital Programme Board. Monthly Capital Management Group updates were also noted (as required).

2.14 External project reporting was undertaken via Welsh Government dashboard reports which were submitted on a bi-monthly basis and included a breakdown the project's overall financial position.

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

Technical - Assurance that the appropriate contractual and programme management arrangements are applied together with, validation of the costs incurred to date.

2.16 The main contractor for the project was procured via an open tender process in accordance with the approved BJC.

2.17 The project operated within a well-defined governance structure, detailed within the Project Execution Plan (PEP). Whilst the PEP reflected the current stage of the project, minor enhancements have been proposed (see **MA3*)***.

2.18 The NEC 3 Option A contract has been completed at the Project; this option provides for a priced lump sum contract. The lump sum contract is then linked to a contract programme with an activity schedule, which were reviewed in line with the works programme.

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

Advisers – To ensure that appropriate adviser fee management arrangements are applied, together with associated monitoring, reporting and performance management arrangements.

2.20 The external Cost Adviser and Project Manager were appointed via a direct call off from the Shared Business Service (SBS) framework, with a Service Level Agreement (SLA) being signed by both parties. The application of the NEC consultancy services contract may have provided greater consistency with the main contract and enhanced roles and responsibilities. However, the SBS framework does not currently enable the use of the NEC consultancy services contract (see **MA4**).

2.21 The Capital & Estates team monitored and tracked advisers' payments to ensure regular invoicing and compliance with the financial limits determined at the project purchase order.

2.22 Noting the procurement process had followed due process, **substantial assurance** has been determined.

Change control – Assurance that appropriate change controls are applied, ensuring compliance with both NEC contractual requirements and UHB governance arrangements.

2.23 A register of changes is maintained on an ongoing basis by the Project Manager and reported within their monthly reports. From our sample of project changes totalling £198K, the Project Managers Notification to instruct the changes were issued prior to the being agreed by the UHB (see **MA5**). Noting the same to **limited assurance** being determined. Associated high priority recommendations have been made at the recently published Capital Systems report (December 2022), therefore we have not sought to replicate the recommendations at this review.

Quality - Assurance that adequate quality control and internal scrutiny arrangements are applied while the project progresses on site. Assurance that appropriate commissioning and handover arrangements are applied.

2.24 Monthly supervisors' reports were produced and incorporated with the established reporting mechanisms at this project. No significant matters had been raised; however, several small issues remain outstanding that were being monitored and actioned by the contractor.

2.25 Early procurement of equipment was undertaken in (March 2022) with appropriate vesting documentation received i.e., signed transfer of title forms.

2.26 There was however a lack of engagement with the Medical Gas supplier that has led to open EWN and PMIs (since January 2022) with no time and cost implications being determined (see **MA6**). We note that this issue has been highlighted through the projects reporting mechanism and to the UHBs Capital Management Group.

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

Appendix A: Management Action Plan

Matter Arising 1: Financial – Project Bank Account (Operation)	**Impact**
Welsh Procurement Policy Note (WPPN) 04/21 states that all Welsh Government construction and infrastructure contracts and any other 'appropriate contracts' valued at £2m or more which are delivered on behalf of Welsh Government Departments require a Project Bank Account (PBA), this is to be applied unless there are compelling reasons not to do so. Where such compelling reasons are identified, a decision report detailing those reasons must be completed and filed to allow for audit. There is no Project Bank Account (PBA) in place for this project and management has not confirmed a timescale for implementation. However, it is recognised that project payments are currently progressing through monthly valuation.	Potential risk of: • Non-compliance with Welsh Government policy.

Recommendations		**Priority**
1.1	Further work is required to ensure the Project Bank Account is established and operating in line with Welsh Government policy.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Agreed. Further discussion ongoing with Contractor to enable project bank account to be put in place for the scheme.	March 2023	Project Manager

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Matter Arising 2: Financial – Risk Register (Operation)			**Impact**
The risk register is included with the monthly Project Manager's report and is updated on a regular basis. The register represents a table of project risks that will allow individuals to track each identified risk and any vital information about it. The register was produced and scored in line with established methodologies i.e. scoring matrix, status of risk (Open/Closed). Further enhancements can be made to the risk register by assigning key individuals for managing risk i.e. the current register only indicates "Action By" either UHB or Advisers".			Potential risk of: • Inability to take action in a timely manner.
Recommendations			**Priority**
2.1	Individuals should be assigned as risk owners to aide effective management.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Agreed. Risk Register to be updated to include individual risk owners instead of organisation.	February 2023	Project Manager

Matter Arising 3 Technical – Project Execution Plan (Operation)	**Impact**
A Project Execution Plan (PEP) is a governing document that defines how a project is to be executed, monitored, and controlled. The PEP was reviewed by the UHB in March 2022, However, there were still some areas which needed to be reviewed / updated for the current stage of the project e.g.: • Key Performance Indicators (KPIs) - there is limited reference to how performance of the contractors and advisers will be monitored and reviewed. • Additional details surrounding the commissioning arrangements i.e. timescales, responsibilities etc. • The change management section indicates that the Project Issue Forms are not in use.	Potential risk of: • Inability to make decisions in a timely manner.

Recommendations		**Priority**
3.1	The Project Execution Plan (PEP) should be reviewed for accuracy and updated appropriately.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed. Project manager to review PEP and update any changes monthly.	February 2023	Project Manager

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Matter Arising 4: Adviser - Appointments (Operation)	**Impact**
The external Cost Adviser and Project Manager have been appointed via a direct call off from the Shared Business Service (SBS) framework; the key requirements of these roles are listed within the service level agreement. The main contractor appointment has been made under NEC Option A; the use of the SBS framework is in line with the approved BJC; however, we note that the formal NEC consultancy services contract may have afforded consistency/alignment with the main contract and provide greater details in terms of the roles and responsibilities for the advisers. Noting the appointment arrangements, best practice would provide the alignment of all contractual appointments e.g. adviser and contractor appointments under the NEC contractual frameworks. however, it is understood that the SBS framework does not permit deviations from the established arrangements. The benefits/risks of the preferred contractual mechanism should be provided within the contract strategy providing the opportunity for Board scrutiny, challenge, and approval.	Potential risk of: • Signing an inappropriate contract potentially leading to financial/legal disputes.

Recommendations		**Priority**
4.1	At future projects of the type, the Business Justification Case contract strategy should include e.g., contract/appointment considerations enabling more effective scrutiny.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed. To be reviewed for future projects.	At future projects	Director of Capital, Estates & Facilities

Matter Arising 5: Change Management	Impact
Section 2.3.1 of the Procedure Manual for Managing Capital Projects states that '*any changes proposed by the User Group Lead, after the brief has been frozen, will need to be strictly controlled via the Health Board Project Issues Form (internally) and subsequently with the contractor using the NEC3 Compensation Event process. As such, all requests must be costed and any programme/quality implications assessed before the Project Manager seeks approval of the Assistant Director, Capital Planning, Estates & Operational Services to proceed via the Project Issues Form process*'. A register of changes is maintained on an ongoing basis by the Project Manager and reported within their monthly reports. We have evidenced that the Project Managers Notification to instruct the changes were issued prior to the being agreed by the UHB However, Noting the High priority recommendations made at the recently published Capital Systems report (December 2022) which surrounds the change management processes at this project, we have not sought to replicate the recommendations again at this review.	Potential risk of: • Non-compliance with the Standing Financial Instructions; and Procedure Manual for Managing Capital Projects. • Non-compliance with the scheme of delegation.

Change Detail	Value (£)	Project Managers Notification Date	Project Issue Form Date
Uplift in business costs - change in contractor	120,000	22 February 2022	8 August 2022
Cost for Schneider Switchgear, Transformer and Busbar	67,701.96	26 January 2022	Not signed

Rerouting of Water and Gas Services	10,583.52	29 March 2022	16 June 2022

Recommendations		Priority
	N/A See capital Systems Report	**N/A**

Agreed Management Action		Target Date	Responsible Officer
	N/A See capital Systems Report		

Matter Arising 6: Quality – Medical Gas Supplier (Operation)	**Impact**
Multiple Project Manager reports had highlighted issues with the UHBs medical gas supplier; the October reports highlights the following: 1. *There has been a delay to planning and works for the Med Gas new tank installation and replacement of existing tanks and base which is at no fault of the Contractor. The supplier will not engage with either consultants or contractor so no works can be undertaken to the existing tanks until we have planning approval and completed the works to the new tanks and VIE line.* 2. *Lack of dialogue with the medical gas supplier remains a concern, with regard to planning and obtaining final quote from BOC"* This lack of engagement has been highlighted through the UHBs governance structures i.e. Project Team, Project Board and also at the Capital Management Group. The Project Director has also been actively involved is trying to resolve this lack of engagement. Audit notes that the planning application approval has now been received from the Local Authority, however, there are still open EWN on the change control register (May 2022) and an open PMIs (January 2022) with no time and cost implications being received.	Potential risk of: • The UHB may incur increased costs because of ineffective design. • The project design may not be fit for purpose.

Recommendations		**Priority**
6.1	The performance issue with the medical gas and equipment supplier will be resolved so that any time and cost implications can be assessed and factored into the project reporting mechanism.	**Medium**
6.2	A lesson learned exercise should be undertaken about how best resolve any similar issues in the future	**Low**

Agreed Management Action		Target Date	Responsible Officer
6.1	Agreed. The engagement issue with BOC has been resolved and has not currently had any implications on time or cost.	N/A	Director of Capital, Estates & Facilities
6.2	Agreed. A discussion will be completed with colleagues in procurement as to how future tenders include the need for early engagement associated with similar equipment, is factored in to tender documents.	March 2023	Project Manager

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 (time, cost and quality) and that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Core Financial Systems (Treasury Management)

Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Executive sign-off:	Catherine Phillips, Executive Director of Finance
Distribution:	Robert Mahoney, Deputy Director of Finance Helen Lawrence, Assistant Director of Finance - Financial Accounting and Services Rebecca Holliday, Head of Financial Services
Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Core Financial Systems – Treasury Management'.

Overview

The Treasury Management function has in place adequate systems and controls for managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. Accordingly, we have concluded Reasonable assurance overall.

We have made two medium priority recommendations which are inherently linked, relating to the strengthening of the Treasury Management Financial Control Procedure, which in turn would direct operational arrangements and the controls over Bankline, the online banking system.

We have made two further low priority recommendations concerning areas for refinement and further development, full details are included within Appendix A.

Report Classification

Reasonable assurance

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	Procedural guidance	Reasonable
2	Full year cash forecast	Substantial
3	Regular updates to the cash forecast are made and reviewed	Substantial
4	Receipts, payments, and cash balances	Reasonable
5	Transfers between Accounts	Substantial
6	Bank account reconciliations	Substantial
7	Recommendations from the review of Core Financials 2021/22	Substantial

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

Key Matters Arising

		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Strengthening of the Financial Control Procedure	1	Design	Medium
2	Bankline – access and controls	4	Operation	Medium

1. Introduction

1.1 Our audit review of the Core Financial Systems was completed in line with the 2022/23 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Given that previous Core Financials audits have received high levels of assurance, individual areas are now covered on an annual cyclical basis. In 2021/22 the audit covered general ledger and accounts receivable. Therefore, this year's audit focused on Treasury Management.

1.3 Treasury Management is concerned with the process of managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. There must be effective processes and procedures in place to ensure that all of the Health Board's financial obligations (e.g. the payment of employees and suppliers) can be met without interruption.

1.4 Treasury Management includes cash forecasting, cash flow management, receipting and banking controls.

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

Audit Risks

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

- Required payments cannot be made due to insufficient cash;
- Surplus cash is drawn down unnecessarily and not in line with Welsh Government requirements; and
- Previously identified issues are not effectively addressed.

2. Detailed Audit Findings

Objective 1: Procedural guidance is in place and is appropriate and up to date

2.1 Financial Services have developed a Financial Control Procedure, 'Treasury Management (Incorporating Cash Forecasting and Bank Account Controls)', (the 'FCP') to ensure that the Health Board has appropriate management and governance arrangements in place for cash forecasting and banking controls. The FCP is held electronically on SharePoint which can be accessed by Finance staff.

2.2 During the audit the FCP was reviewed in line with the Welsh Government Model Standing Financial Instructions (SFIs)[1], which have been adopted by the Health Board.

2.3 The SFIs require the Director of Finance to ensure that;

a. the Government Banking Service (GBS) is utilised for main Health Board transactions;

b. Separate accounts for non-exchequer funds;

c. Payments made from bank accounts do not exceed the amount credited to the account;

d. Accounts are not overdrawn;

e. Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds;

f. All bank accounts should be held in the name of the Health Board; and

g. The Director of Finance will prepare detailed instructions, that ensure sound controls over the day-to-day operation of the bank account, including; divisions of duties to minimise the risk of fraud & error, identification of signatories and reconciliation.

2.4 We reviewed the FCP against the requirements of the SFIs and found that in almost all instances the key areas were addressed. However, we found the FCP could be strengthened when reviewing point 'g.' above. *(Matter Arising 1 – Medium Priority)*

2.5 Furthermore, whilst we were able to identify guidance notes for preparing the monthly bank reconciliation, there were no up-to-date procedures on how to produce the monthly cashflow forecast, which is a key document in supporting the request for the monthly drawdown of funding from the Welsh Government. *(Matter Arising 1 – Medium Priority)*

Conclusion 1: A Financial Control Procedure covering the Treasury Management function is in place which outlines a number of processes, however the document could be strengthened to ensure greater alignment with the requirements of the Standing Financial Instructions adopted by the Health Board. (Reasonable Assurance)

[1] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/corporate-policy/s-corporate-policy/standing-financial-instructions-2021/

Objective 2 & Objective 3: A full year cash forecast is produced in a format consistent with the Financial Monitoring Returns. Regular updates are made and reviewed, with significant changes being appropriately reported

2.6 As part of the Monthly Monitoring Returns (MMR) to the Welsh Government the Health Board provides an updated monthly forecast which includes an actual cash flow for previous months and an updated forecast for the cashflow to the end of the year. We tested all cashflows submitted as part of the MMR up to month 6 and found forecasts had been produced, with the exception of the first month, where one was not required.

2.7 As well as the monthly cashflows, submitted as part of the MMR, the Treasury Manager is required to provide the Welsh Government with an estimate of the cash requirements for the following month, this is provided around the eighth of the preceding month, the table below is an example of the estimate requirement for April 2022, which was emailed to the Welsh Government on the 8th March 2022.

CARDIFF AND VALE UHB	
April 2022	**£**
FIS Capital forecast	10,000,000
Total Revenue forecast	128,240,000
Total FIS[2] forecast	**138,240,000**

2.8 The Welsh Government provide a timetable at the start of the year of when the above cash estimate is required, we sampled all cash estimates emailed to the Welsh Government by the Treasury Manager, from April to December and found all had been submitted on time apart from one which was one day after the deadline, as the Treasury Manager was waiting for information from Capital Accounting.

Conclusion 2 & 3: We were able to evidence that a full year cash forecast is produced in a format consistent with the financial monitoring returns. Regular updates are made to the cash forecast, which is regularly reviewed, with significant changes being appropriately reported to the Welsh Government. (Substantial Assurance)

[2] Financial Information Systems

Objective 4: Receipts and payments are accurately recorded, and cash balances are regularly reviewed to ensure that there are sufficient funds against forecasts with cash allocation requests appropriately requested and authorised

2.9 The Treasury Manager updates the cash flow daily and monitors the cash flow to ensure the Health Board has adequate cash to meet its daily requirements. As referred to above, the Treasury Manager submits a monthly cashflow forecast to the Welsh Government estimating the cash requirements. On around the twentieth of the month the Treasury Manager will submit a request for funds (this is done via an FIS form) to fund the following month's requirements. Currently the average monthly request is around £100m.

2.10 The estimated cash requirement going forward is calculated using a spreadsheet which identifies cashflows as they occur and forecasts future cashflows, it is maintained by the Treasury Manager and updated daily. It estimates future months cash requirements based on averages from previous months and known future spend.

2.11 We reviewed the bank balance on nineteen dates between April and October and confirmed that on each date the bank account was in credit. Seven of these dates were at the end of the month and all were in credit, within the five percent guidance advised by the Welsh government, to avoid holding large cash balances at month end.

2.12 The Health Board makes payments by BACs, CHAPs and to a much lesser degree by Payable Order (cheque). The payroll run is done through BACs payments and is not processed by Treasury Management. Accounts Payable is paid mostly by BACs but there are still some payments by Payable Order. Before the Accounts Payable run is processed approval is sought from the Treasury Management function to confirm the funds are available for that run.

2.13 In addition to the above payments the Treasury function is responsible for processing faster/urgent payments, payments to foreign companies and payments to other Health Bodies under Long Term Agreements. All these payments are processed using the Bankline electronic banking system. We tested a sample of foreign and faster payments and can confirm that for those sampled, all were verified to email requests and were processed accordingly.

2.14 There are currently four users set up to make payments on Bankline, none of these users have payment limits and all users can either input a payment or approve a payment. *(Matters Arising 2 – Medium Priority)*

2.15 As highlighted within objective one and matter arising one, there are opportunities to strengthen the FCP to align with requirements of the SFIs, which also impacts the operational arrangements we found in place. *(Matters Arising 2 – Medium Priority)*

2.16 We requested a copy of the Bank Mandate, but this was not held by the Treasury Management function. *(Matter Arising 3 – Low Priority)*

Conclusion 4: We were able to confirm that receipts and payments were accurately recorded, and cash balances were regularly reviewed to ensure that there were sufficient

funds against forecasts, with cash allocation requests appropriately requested and authorised. Payments from the account were supported by requests for payments and were appropriately authorised. We identified that the controls over the operational arrangements of Bankline required review, in alignment with a review of the FCP. (Reasonable Assurance)

Objective 5: Transfers are appropriately authorised.

2.17 The Health Board operates two bank accounts, the Exchequer account and the Charities account. Given the minimal number of accounts and the transfers between these accounts this area was not tested.

Conclusion 5: Transfers are minimal. (Substantial Assurance)

Objective 6: Bank account reconciliations are appropriately completed

2.18 The Health Board's Treasury Management FCP requires that the bank statement is reconciled to the Cash Book and the Ledger, this is undertaken on a daily basis by the Treasury Manager.

2.19 A schedule detailing the number and value of un-presented payable orders (cheques) is prepared and updated on a monthly basis. At month end the bank accounts are reconciled to the ledger as part of the closedown procedures and the reconciliations are checked by the Head of Financial Services. The check is confirmed by an email from the Head of Financial Services to the Treasury Manager and a copy of the email is saved with the reconciliation.

2.20 The audit reviewed all bank reconciliations between April and October 2022 and we can confirm that all had been undertaken and independently checked and that a copy of the email had been added to the reconciliation. The inclusion of the email for validation of the independent check does not prevent the spreadsheet being altered after it was checked. There are features available in Microsoft Word and Excel to use digital signatures. *(Matters Arising 4 – Low Priority)*

Conclusion 6: Daily and monthly bank account reconciliations to the ledger and cashbook are undertaken, which include a review of unpaid cheques and income not yet received in the bank account. This area could be improved by utilising Microsoft Office's ability to add a digital signature to reconciliations. (Substantial Assurance)

Objective 7: Recommendations from the 2021/22 Core Financials audit have been effectively implemented

2.21 The 2021/22 review of Core Financials reported substantial assurance overall, which identified two low priority recommendations. Low priority recommendations are considered a low risk to the Health Board. The most recent version of the Internal Audit Tracker presented to the Audit Committee on 6 September 2022 noted that both recommendations remained part complete.

Conclusion 7: We are satisfied that efforts are being made to take forward the recommendations from the previous review of Core Financials, acknowledging that the two recommendations were low priority and therefore of minimal risk to the Health Board. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Strengthening of the Financial Control Procedure (Design)	**Impact**
We reviewed the Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure and found that it could be strengthened. Specifically, section 7.3 of the Standing Financial Instructions refers to Banking Procedures and 7.3.1 (d) notes the following, *"Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy."* The FCP does not specify who should have access to the Health Board's online banking facility (e banking approvers), how the cards and Bankline card readers should be controlled and stored, or what role or seniority a signatory to the account must be. We also found there were no up-to-date procedures on how to produce the monthly cashflow forecast, which is a key process of the Treasury Management function used to identify the Health Board's cash requirements for the subsequent month. The process was last documented in 2011.	Potential risk of: • Lack of resilience; and • Misuse.

	Recommendation	**Priority**
1	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1	- Agreed to revise FCP to include the requirements of 7.3.1(d) also addressed in point 2 on management actions. - Agreed FCP to be updated to include control arrangements for access, inputting & authorisation of the online banking system. - Agree to update the process document for developing the monthly cashflow forecast.	February 2023 February 2023 May 2023	Rebecca Holliday, Head of Financial Services

Matter Arising 2: Bankline – access and controls (Operation)	**Impact**
We reviewed the access and control arrangements for the online banking system, Bankline and make the following observations of existing processes which could be strengthened: • There are currently four users set up to make payments on Bankline, none of which have payment limits and all users can input a payment or approve a payment. As highlighted in Matter Arising 1 above, the current arrangements conflict with the Health Board's adopted Standing Financial Instructions, which requires an appropriate payment approval hierarchy for e banking approvers; • To action a payment, an inputter and approver is required, a fifth user is in the process of being set up but has not yet been activated. We would support this to enhance resilience and cover for absences; • We noted an example where an employee had left the Health Board and returned their Bankline card reader and card to the Treasury Manager (an approver within the system), rather than an administrator of the system. The SFIs state that the Director of Finance should ensure that there are *"physical security arrangements in place for cheque stationery, e banking access devices and payment cards"*; and • The list of Bankline users held by the Treasury function was out of date and until Internal Audit requested the Bank's list of registered users, this information had not been requested. The Treasury function maintains its own list of Bankline users, this was reviewed and required an update. The Health Board was being charged for one user who had left, although minimal in value.	Potential risk of: • Treasury is unable to action payments; • Error; • Fraud; and • Lack of resilience.

** We note that the points raised above link with the gaps in the FCP, highlighted in Matter Arising 1, which if addressed in procedure would direct the operational arrangements.*			
Recommendation			**Priority**
2	To enhance the access and control arrangements of the online banking system, Bankline the following should be considered: - Consideration should be given to the operational arrangements of Bankline and how the requirements of the SFI are met regarding an appropriate payment approval hierarchy for e banking approvers; - To ensure segregation of duties between the administration and payment processes, Bankline administrators should receive cards and card readers from leavers, and should adequately destroy the card to reduce risk of misuse; - An up to date list of Bankline users should be held to include current users and their up to date job titles; and - We support the activation of a fifth user on Bankline to ensure there is adequate cover for absence.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	- Agreed – Payments via Bankline >£500k shall require a 2nd authoriser AfC band 8 or above. – FCP to be updated. - Agreed – FCP to be updated to ensure segregation of duties between the administration and payment process for Bankline. Also, the FCP to be updated with process for leavers and destroying of Bankline e-cards. - Agreed – An up to date list of Bankline users to be held. - Agreed – To activate an additional inputter if operationally possible within team.	February 2023	Rebecca Holliday, Head of Financial Services

Matter Arising 3: Bank Mandate (Operation)			**Impact**
To ensure control over the bank account it is important for the Health Board to maintain an up to date version of the Bank Mandate, which confirms who has authority to open and close accounts, add additional signatories and sign cheques. The Treasury Management function does not routinely hold a copy of the Bank Mandate, but a request was made through the audit and subsequently received.			Potential risk of: • Fraud; • Inefficiencies; and • Lack of clarity of signatories to the Health Board's bank account.
Recommendations			**Priority**
3	It is recommended that the Treasury Management function hold a copy of the Bank Mandate, which is reviewed periodically to ensure it is up to date and meets the needs of the Health Board.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Agreed – Bank Mandate to be reviewed on an annual basis.	March 2023	Rebecca Holliday, Head of Financial Services

~ *Continued over page* ~

Matter Arising 4: Digitisation Bank Reconciliation (Operation)			**Impact**
Whilst we were able to evidence that all bank reconciliations between April and October 2022 had been undertaken and independently checked, and that a copy of an embedded email confirmed this, there are opportunities to enhance the process. There is functionality within Microsoft Word and Excel to utilise the 'digital signatures' function, which would highlight if a document has been amended after verification, which could take place within current reconciliations.			Potential risk of: • Failure to identify post review changes to the bank reconciliation.
Recommendation			**Priority**
4	It is recommended that the Bank Reconciliation is signed off using Microsoft's digital signatures function.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	Agreed to bank reconciliation to be signed off using Microsoft's digital signature.	March 2023	Rebecca Holliday, Head of Financial Services

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*
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Assurance Mapping

Final Internal Audit Report (Advisory)

January 2023

Cardiff & Vale University Health Board

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Executive sign-off:	Nicola Foreman, Director of Corporate Governance
Distribution:	Aaron Fowler, Head of Risk and Regulation
Committee:	Audit & Assurance Committee

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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.

Executive Summary

Purpose

An advisory review to support the development of assurance mapping within the Health Board.

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 Health Board may wish to take forward. The opportunities outlined in this report (see Appendix A), if taken forward will enable the Health Board to fully embed the Assurance Strategy across the Health Board.

The Health Board's Assurance Strategy 2021-24 aligns to recommended best practice and the Assurance Map Template captures appropriate assurance and risk information. There is a defined governance structure underpinning the Assurance Strategy and an action plan is in place for its implementation. However, more medium-term actions are required to assist in embedding and implementing the Assurance Strategy within the Health Board

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 if:

1	The Health Board has developed a comprehensive Assurance Strategy informed by best practice, which has been approved by the Board;
2	The Assurance Strategy is supported by a robust governance structure and reporting arrangements for ensuring that the objectives are being progressed in a timely manner; and
3	The Health Board has agreed and clearly defined how it intends to apply and rollout the Assurance Strategy and develop the Assurance Map and has recognised the roles and responsibilities for implementation across the organisation.

Opportunities		Audit Objective
1	Review and revise the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to risk, governance and assurance best practice	1
2	Review and revise the current Assurance Map template so that the layout and content takes a risk based approach, which will assist in prioritising areas to take forward	1
3	Develop a formal action plan for implementation / review of the Assurance Strategy to include actions for the medium term, to ensure the strategy becomes fully embedded across the Health Board.	3

1. Introduction

1.1 Our advisory review of the 'Assurance Mapping' arrangements has been completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board ('the Health Board').

1.2 During 2020/21, the Director of Corporate Governance undertook a review of the Health Board's assurance systems and presented a report with the findings to the Audit Committee in April 2021.[1] The report noted that whilst the Health Board has numerous assurance systems and reporting mechanisms in place, these could be strengthened and improved to reach a higher level of maturity. The Board, through recommendation by the Audit Committee, noted the findings and approved the action for the Director of Corporate Governance to develop an Assurance Strategy which would aim to provide an overall view of assurances, identifying areas of duplication, and address assurance weaknesses.

1.3 This advisory review has been split into two phases:

- Phase 1 (July – August 2022): A desktop review of key documentation, including the Assurance Strategy, Audit Committee and Board papers; and
- Phase 2 (October - November 2022): Meeting with key staff as appropriate to determine the progress being made with the objectives set within the Assurance Strategy, such as the progress of developing assurance maps.

1.4 To conclude Phase 1 of the review we issued a Briefing Paper to management on 16 August 2022 to report on our advisory findings and opportunities for improvement / further development. The two part approach was intended to support management to progress the implementation of the Assurance Strategy and development of the assurance map. This advisory report includes the overall findings from Phases 1 and 2, which reflects on the actions management have taken since issuing them with the initial Briefing Paper.

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

Advisory Audit Risks

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

- The framework, direction of travel and objectives of the Assurance Strategy are not intrinsic to the Health Board and have not been developed in line with risk, governance and assurance best practice;
- Lack of awareness across the Health Board of the Assurance Strategy and limited/restricted view of the assurance systems in place;
- Weaknesses or duplication of assurance systems which are resource-intensive are not being identified and rectified; and
- Inadequate assurance mechanisms which impacts leadership, governance and decision making.

[1] https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/06-04-2021-audit-and-assurance-committee-pdf/ (Item 7.6)

2. Detailed Audit Findings

Objective 1: The Health Board has developed a comprehensive Assurance Strategy informed by best practice, which has been approved by the Board.

Assurance Strategy

Phase 1 Findings (issued to management on 16 August 2022):

2.1 The Assurance Strategy 2021-24, developed by the Director of Corporate Governance, was reviewed by the Audit Committee,[2] and approved by the Board in September 2021.[3]

2.2 We reviewed the content of the Strategy and were satisfied that the document comprehensively defines the assurance framework and its purpose, the types and sources of assurance systems, and their benefits. The Strategy clearly sets out the roles and responsibilities of all staff, to ensure that the Strategy is implemented and embedded within the Health Board's assurance framework.

2.3 The Strategy explicitly draws on best practice guidelines and principles published by recognised institutions within the governance and risk management field. The 'reference' section of the Strategy includes various links to content published from the Institute of Internal Auditors (IIA), the Institute of Risk Management (IRM), the HM Government – Orange Book, and the Good Governance Institute (GGI).

2.4 Whilst we recognise that the development of the strategy has been informed by best practice, we have noted that the Health Board has taken a different approach when embedding the 'Three lines of defence' model. The Health Board's model, taken from the Risk Management and Board Risk Assurance Framework Strategy, and the Assurance Strategy is as follows:

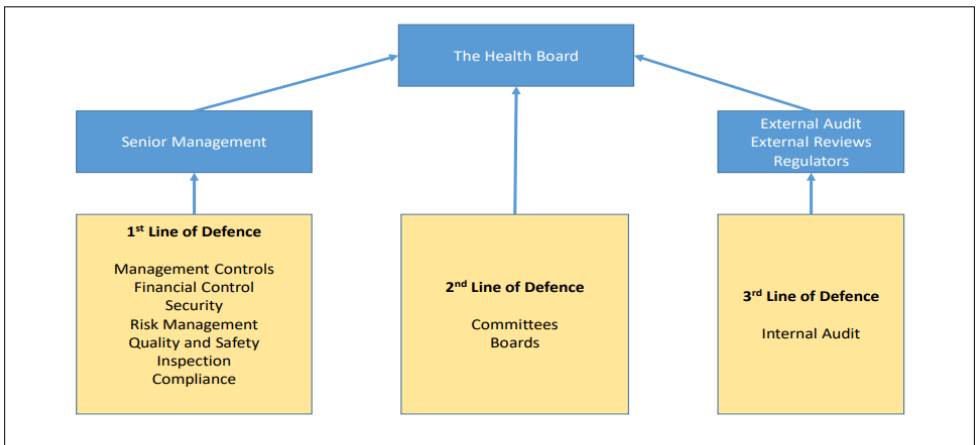


Figure 1: The Three Lines of Defence Model

2.5 The Health Board's above model implies that first line controls consist of management control mechanisms and the second line of Governing Bodies

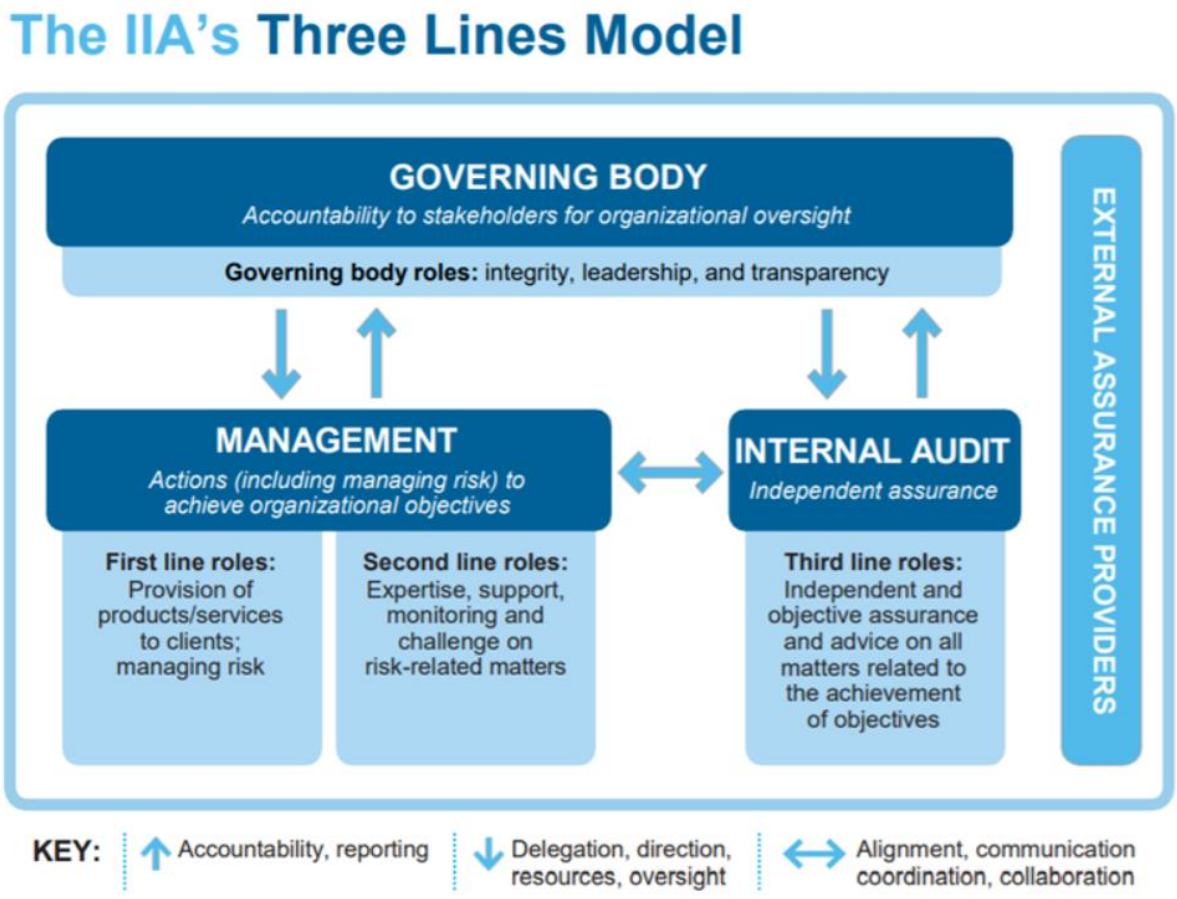
[2] https://cavuhb.nhs.wales/files/board-and-committees/audit-and-assurance-committee-2021-22/audit-committee-07-09-21-pdf/ (Item 7.6)

[3] https://cavuhb.nhs.wales/files/board-and-committees/board-2021-22/2021-09-30-final-boardbook-v5-pdf/ (Item 7.13)

(Boards and Committees). It also implies that second line controls have a direct reporting line to the Health Board bypassing Senior Management. The approach varies to the generally accepted model which also provides a different definition for first and second lines of defence, as below and illustrated in 2.6:

- Reporting lines – All three lines of defence have a reporting line into Senior Management, that report into the Governing Body (Board and Committees);
- First Line roles – Process owners who are responsible for day-to-day management of processes and risks; and
- Second Line roles - Defence systems and controls put in place to support management, typically assurance or compliance functions.

2.6 Below illustrates the published IIA's model:[4]



[4] https://www.theiia.org/globalassets/site/about-us/advocacy/three-lines-model-updated.pdf

2.7 To illustrate the lines of defence in further granularity, the below is an extract from a publication, 'Board Assurance: A toolkit for health sector organisations, from Baker Tilly'.[5]

Fig 3.4.2: Illustration of overall assessment of assurance

Area: Human resources Activity: recruitment

Process	1st line	2nd line	3rd line	Overall assurance
DBS checks	HR confirm	Finance check	Internal audit	Review annually
Qualifications	HR confirm	None	None	Monitor/action
References	HR confirm	None	None	Monitor/action
Practical skill assessment	HR confirm	Finance check	Internal audit	Action required

2.8 In advance of embedding the Assurance Framework, consideration should be given to aligning the 'lines of defence' to best practice. Currently there is minimal emphasis within the Health Board's model on the second line of defence and the role of assurance or compliance teams. *(Phase 1 - Opportunity 1)*

Phase 2 Findings:

2.9 Discussions with the Head of Risk and Regulation confirmed that progress has been made with the implementation of the Assurance Strategy 2021-24. The Risk and Regulation Team have reviewed and revised the content of risk and assurance documentation following the advisory points made in phase one of this review. The Head of Risk and Regulation provided copies of the following documentation, all of which were updated in October 2022:

- Risk Management and Board Assurance Framework Strategy 2022 (RM and BAF Strategy);
- Assurance Strategy 2021-24; and
- Assurance Map Template.

2.10 We can confirm that the RM and BAF Strategy 2022 and the Assurance Strategy 2021-24 now adopts the "Three lines Model" in line with best risk management and governance practice.

[5] https://nhsproviders.org/media/1182/board-assurance-a-tool-kit.pdf (Section 2.3: Assurance Mapping)

Assurance Map

Phase 1 Findings (issued to management on 16 August 2022):

2.11 We attempted to review other health organisations' Assurance Maps but found minimal information that had been published or available in the public domain.

2.12 We considered other public sectors and professional bodies, and compared the layout of the Health Board's Assurance Map template, with assurance maps publicly available from the following organisations / institutions:

- Institute of Chartered Accountants in England and Wales[6]
- Board Assurance: A toolkit for health sector organisations[5]
- Cardiff Council[7]
- Bristol Council[8]

2.13 Upon reviewing the Assurance Map template, appended to the Health Board's Assurance Strategy, we identified opportunities to enhance the layout and content. *(Phase 1 - Opportunity 2)*

Phase 2 Findings:

2.14 We noted significant improvements with the layout and content of the Assurance Map Template which is included as an appendix of the Assurance Strategy 2021-24. The template now takes a risk-based approach with RAG ratings for the sources of assurance, has clear links with the Corporate Risk Register and includes an assessment on the target/desired assurance level for each risk.

Conclusion 1: The Health Board's Assurance Strategy 2021-24 aligns to recommended best practice and has clearly adopted the "Three Lines Model" within the Risk Management and Board Assurance Framework Strategy. The Assurance Map Template, appended to the Assurance Strategy, has clear links to the Corporate Risk Register and captures the appropriate assurance and risk information.

Objective 2: The Assurance Strategy is supported by a robust governance structure and reporting arrangements for ensuring that the objectives are being progressed in a timely manner.

Phase 1 Findings (issued to management on 16 August 2022):

2.15 The Director of Corporate Governance is the nominated champion for the Assurance Strategy, providing support across the Health Board. We have been able to evidence the updates from the Director of Corporate Governance to the Audit Committee, and the Board on the implementation of the Assurance Strategy.

2.16 In April 2022 the Director of Corporate Governance provided an update report to the Audit Committee on the progress of taking forward the Assurance Strategy and the associated plan to develop a Health Board Assurance Map. One of the initial actions had been to develop a central register that would capture

[6] Assurance mapping: a vital tool | Assurance practical guidance | ICAEW (Accessed 22/07/2022)
[7] Assurance Mapping 2020-21 (moderngov.co.uk) (Accessed 22/07/2022)
[8] https://democracy.bristol.gov.uk/documents/s58748/13%20-%20Internal%20Audit%20Plan%20202122%20Appendix%201.pdf (Accessed 22/07/2022, Page 2 Appendix 1)

assurance evidence and information on assurance systems operating within each Clinical Board and Corporate Department. This was recognised as a significant piece of work.[9]

2.17 Following the April 2022 Audit Committee, the Chair's Report was presented to the Board in May 2022, which provided an update on the systems of assurance.

Phase 2 Findings:

2.18 The Director of Corporate Governance provided a further update on the implementation of the Assurance Strategy to the Audit Committee which met in November 2022[10]. At the meeting, members noted and approved the following:

- Progress of advisory points (opportunities for improvement / development) made by Internal Audit in phase one of this review; and
- An Assurance Strategy Action Plan (short term to February 2023).

2.19 The Director of Corporate Governance and the Head of Risk and Regulation proposed that a further Assurance Strategy Update would be presented in February 2023 and would include the updated Assurance Strategy 2021-24 and Risk Management and Board Assurance Framework Strategy 2022. The proposal was agreed by the Audit Committee.

2.20 Discussions with the Head of Risk and Regulations noted that to date, there has been limited engagement with other areas of the Health Board in relation to the implementation of the Assurance Strategy. The Head of Risk and Regulation confirmed that once the Assurance Strategy has been approved, assurance maps will be populated and reviewed with specific clinical areas and directorates on a risk basis.

Conclusion 2: There is a defined governance structure underpinning the Assurance Strategy. We have noted the updates that have been presented to the Audit Committee and Board, and that progress has been hampered by COVID-19 and winter pressures. Further engagement from clinical areas and directorates will be sought following the approval of the Assurance Strategy 2021-24 by the Audit Committee, which is expected at the February 2023 meeting.

Objective 3: The Health Board has agreed and clearly defined how it intends to apply and rollout the Assurance Strategy and develop the Assurance Map, and has recognised the roles and responsibilities for implementation across the organisation.

Phase 1 Findings (issued to management on 16 August 2022):

2.21 During October and November 2021, the Corporate Governance Team delivered 'one to one' explanatory briefings with an initial tranche of Clinical Boards and Corporate Departments. Following the delivery of the initial briefings it was decided that further work on progressing the Assurance Strategy would be temporarily suspended until Spring 2022, to avoid adding to the pressures on

[9] https://cavuhb.nhs.wales/files/board-and-committees/audit-assurance-committee-2022-23/2022-4-5-public-boardbook-v5-pdf/ (Item 7.4)

[10] https://cavuhb.nhs.wales/files/board-and-committees/audit-assurance-committee-2022-23/81122-audit-meeting-book-v3pdf/ (Item 7.7)

the Health Board from COVID-19 and reduced bed capacity during the winter period.

2.22 The Strategy draws on the need to create a central register of assurances (Assurance Directory) that details the value and type of assurance. The central register of assurance will provide the level of information needed to create systematic assurance maps for each function of the Health Board.

2.23 The Assurance Directory and the relevant assurance maps aim to provide the Board with an overview of all assurance systems in place. The oversight of these assurance tools is expected to identify duplication and areas of poor/limited assurance.

2.24 The Corporate Governance Directorate will be responsible for delivering education and training across the organisation on an on-going basis, ensuring that guidance follows best practice.

2.25 Whilst we are satisfied that the Strategy recognises the above actions, we noted that there is no formal action plan in place with assigned target dates for implementation of the actions. *(Phase 1 - Opportunity 3).*

Phase 2 Findings:

2.26 The Head of Risk and Regulation has developed an action plan for implementation of the Assurance Strategy, which was shared with the Audit Committee in November 2022. A review of the action plan confirmed that all actions have assigned responsibility with target dates which will be monitored as part of an 'Assurance Mapping Update Report' to the Audit Committee.

2.27 A review of the action plan noted that the focus is short term (up to February 2023) with limited reference to actions that will assist in embedding and implementing the Assurance Strategy within the Health Board, for example engaging with clinical areas and directorates, local completion of the assurance map template, and the monitoring of the assurance maps. These actions will assist the Health Board to identify areas of duplication and address weak sources of assurance as per the scope of the Assurance Strategy. *(Phase 2 - Opportunity 3)*

Conclusion 3: We can confirm that the Health Board has agreed and defined how it intends to implement the objectives of the Assurance Strategy within an action plan and has set responsibilities and target dates for implementing these. However, the action plan has a short term focus and does not currently list actions that need to take place to fully embed the Assurance Strategy across the Health Board.

Appendix A: Opportunities for improvement and development

Finding 1 (Phase 1): Three lines of defence approach not consistent with best practice	**Residual Risk**
Following our review of the Assurance Strategy we noted that the assurance approach taken by the Health Board in relation to the 'three lines of defence' varied from best practice guidelines. The Health Board's approach implies different reporting lines, and has a different definition for what should constitute for first and second lines of defence controls, illustrated through paragraphs 2.4 – 2.8 of this report.	The direction of travel and objectives of the Assurance Strategy are not intrinsic to the Health Board and have not been developed in line with risk, governance and assurance best practice.
Opportunity 1 (Phase 1)	**Priority**
Consideration should be given to reviewing and revising the Health Board's approach to the 'Three Lines of Defence' model, so that it aligns to risk, governance and assurance best practice.	**N/A – Advisory Review**
Opportunity 1 (Phase 2 position)	
Our review of the updated RM and BAF Strategy 2022 and the Assurance Strategy 2021-24 confirmed that they now adopt the "Three lines Model" in line with best risk management and governance practice. The opportunity identified in phase 1 is therefore complete.	

Finding 2 (Phase 1): Strengthen the Assurance Map template	Impact
Upon reviewing the Assurance Map template, appended to the Assurance Strategy, we identified the following areas for consideration and further enhancement: • The Assurance Map template only provides a colour grading (RAG) of the overall level of assurance being provided for each Corporate Directorate or Clinical Board. The three lines of defence are not RAG rated (as illustrated in 2.7 of this report). A RAG rating would easily identify weaknesses or gaps in the levels of assurance; • The Assurance Map does not include the required / desired overall level of assurance, which would assist in prioritising the areas to take forward and the sources of assurance. On a risk basis, not all areas are equal; • The Assurance Map does not incorporate identified risks, such as those included in the Board Assurance Framework (BAF) or Corporate Risk Register (CRR), which would assist in prioritising the Assurance Maps to progress; and • In accordance with the narrative of the Assurance Strategy, the third line of defence is referred to as independent assurance, the Assurance Map template refers to the third line as external assurance. The template should reflect the narrative of the Strategy.	The direction of travel and objectives of the Assurance Strategy are not intrinsic to the Health Board and have not been developed in line with risk, governance and assurance best practice.
Opportunity 2 (Phase 1)	**Priority**
The Health Board should consider reviewing and revising the current Assurance Map template, appended to the Assurance Strategy, so that the layout and content takes a risk based approach, which will assist in prioritising areas to take forward.	**N/A – Advisory Review**

Opportunity 2 (Phase 2 position)

We noted significant improvements with the layout and content of the Assurance Map Template, it now takes a risk-based approach with RAG ratings for the sources of assurance, has clear links with the Corporate Risk Register and includes an assessment on the target/desired assurance level for each risk.

The opportunity identified in phase 1 is therefore complete.

~ Continued over page ~

Finding 3 (Phase 1): Formal Action plan for implementation phase	Impact
The Assurance Strategy draws on the need to develop an Assurance Directory as a central register of assurance, in addition to Assurance Maps from across the Clinical Boards and Corporate Departments, which will be a sizeable task. There is no formalised action plan in place, with timescales of implementation to identify and track progress of embedding the Assurance Strategy. In conjunction with finding 2, a risk based approach may assist in informing the roll out of the Assurance Strategy, for example areas of risk captured in the BAF and CRR are likely to be areas that are prioritised.	The direction of travel and objectives of the Assurance Strategy are not intrinsic to the Health Board and have not been developed in line with risk, governance and assurance best practice.
Opportunity 3 (Phase 1)	**Priority**
Consideration should be given to developing a formal action plan with actions, designated responsibility and timescales for implementation / review of the Assurance Strategy.	**N/A – Advisory Review**
Finding 3 continued (Phase 2)	
The Assurance Strategy is now supported by a formal action plan with designated responsibility and timescales for implementation and this has been shared with the Audit Committee in November 2022. A review of the action plan noted that the focus is short term (up to February 2023) and there is limited reference to the actions that are necessary to fully embed the Assurance Strategy and the assurance mapping process across the Health Board to clinical areas and directorates.	
Opportunity 3 (Phase 2)	
The Assurance Strategy Action Plan should be further developed to include actions for the medium term, to ensure the strategy becomes fully embedded across the Health Board.	**N/A – Advisory Review**

Management Response	Target Date	Responsible Officer
Agreed – A longer term action plan will be shared at the February Audit and Assurance Committee for approval.	February 2023	Head of Risk and Regulation

Appendix B: Assurance opinion

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.

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New IT Service Desk System
Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Auditors:	Ken Hughes, Audit Manager Martyn Lewis, IT Audit Manager
Executive sign-off:	David Thomas, Director of Digital & Health Intelligence
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Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

A new IT service desk system has recently been implemented to address serious failings previously identified by both IT management and internal audit.

The purpose of the audit was to review the set-up and implementation of the new system, and to assess the extent to which the new system has been able to drive improvements.

Overview

The new Ivanti Management System has been successfully implemented, and this has addressed many of the issues previously identified. There are however some areas where further improvements are required. We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Procedural guidance needs to be developed for the monitoring and closing down of calls.
- Calls are not at present being effectively prioritised.
- System access controls need to be developed.
- Service Level Agreements and Key Performance Indicators need to be developed.

Report Opinion

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

Assurance summary[1]

Objectives		Assurance
1	Calls are recorded and managed	Reasonable
2	Calls are classified and prioritised	Reasonable
3	The system enables predefined calls and routing	Substantial
4	User access and privileges s controlled	Reasonable
5	Users have been trained and have access to procedures and user guides	Substantial
6	A contract for the system is in place	Substantial
7	Management information is available	Reasonable
8	The system facilitates problem & knowledge management	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Procedural guidance to be developed	1	Design	High
2	Prioritisation of calls	2	Operation	Medium
3	Control of system access and privileges	4	Operation	Medium
4	SLA's and KPI's	7	Design	Medium

1. Introduction

1.1 Our review of the set up and implementation of the new IT Service Desk system was undertaken in line with the 2022/23 Internal Audit Plan for Cardiff & Vale University Health Board (the Health Board).

1.2 The Health Board has recently purchased and implemented a new service desk system (Ivanti) which aims to better enable the help desk to manage calls and assist staff throughout the organisation. The system will also enable better management information and help drive improvements.

1.3 The audit also reviewed the progress made in implementing the agreed management actions from our previous Limited Assurance IT Service Management report issued in December 2021, and where applicable outstanding actions have been incorporated into the findings from this review.

2. Detailed Audit Findings

Objective 1: The system enables the recording of calls and allows tracking and management from logging to closure.

2.1 The Ivanti Service Management (ISM) system has a Self-Service Portal which allows Health Board staff to raise issues and requests with the IT department and get IT support. Health Board staff can still also raise a call by telephone or by sending an e-mail to the service desk.

2.2 Once a call has been logged on the ISM system it can be managed through the call status function which has a number of options. This enables the recording of updates and allows call tracking from logging through to closure when calls can be closed once the issue has been satisfactorily resolved.

2.3 Review of the system showed that key fields such as the users name, department, telephone number, location and line manager are mandatory when logging calls, and these can be populated by selecting from a drop-down menu.

2.4 All open calls and those set to 'Waiting for Customer' status should be monitored by the assigned owner and their supervisor. However, this is currently being done on an ad hoc basis resulting in high levels of open active calls dating back to April 2022 **(Matter Arising 1)**.

2.5 Although a range of SOP's have been developed, at the time of our audit there were no Standard Operating Procedures (SOP's) in place detailing how and when calls should be monitored, what actions should be taken and under what circumstances calls can be closed down **(Matter Arising 1)**.

Conclusion:

2.6 The new Service Desk system enables calls to be accurately recorded and monitored, although this is not presently being done in a systematic and consistent

way resulting in a backlog of open calls. We have provided reasonable assurance for this objective.

Objective 2: The system enables information capture and classification and prioritisation.

2.7 All calls to the Service Desk are classified as either an 'Incident' or a 'Service Request'. An incident is raised when assistance is required to resolve an issue, for example the user cannot log on to a particular system, or their laptop won't power up. A service request is where the user is requesting a service, for example new software to be installed, access to a network printer or a NADEX account for a new starter.

2.8 If the call is received by the service desk via email or telephone, the service desk will classify the call by recording it as either a Service Request or an Incident on the appropriate screen. If the user logs the call through the self-service portal and classifies it incorrectly, i.e., as a Service Request rather than an Incident, there is a process by which the service desk can correct the classification.

2.9 The system enables the service desk advisor or the self-service user to record all relevant information in respect of the incident in the Summary field which is free text. The call category must also be selected from a drop-down menu, for example Hardware, Software, Functionality, Log in Failure etc, and this enforces better data quality.

2.10 All key information such as the users name, job title, department, contact details and line manager's name is mandatory and must be completed. The urgency and impact of the incident can also be assigned form a drop-down menu. This then automatically assigns a priority rating from 1 to 5. For example, if Medium is selected for both the Urgency and Impact fields, the priority rating will be 3.

2.11 A report was run of all open Incidents as at the 07.11.22. This had a total of 470 calls, of which 461 were priority 3. Of the remaining calls, three were priority 1, three were priority 2, one was priority 4 and two were priority 5. The criteria used to assign the priority rating is therefore presently assigning the vast majority of calls the same priority rating **(Matter Arising 2)**.

Conclusion:

2.12 The new ISM system satisfactorily enables information capture, classification and prioritisation, although calls are not at present being effectively prioritised. We have provided reasonable assurance for this objective.

Objective 3: Predefined calls and routing are set up within the system.

2.13 A set of predefined calls have been developed and set up on the Ivanti system for the most common calls and incidents, and these enable them to be resolved on first contact. They are accessed through the service catalogue tab and cover common requests such as a new Nadex account, Internet Access request, new Paris Incident / Fault / Request etc.

2.14 Calls are then categorised from a look up menu on the Service Catalogue home screen, for example Most Popular, New Incident, Software, Printing.

2.15 Once a call template has been selected from the Service Catalogue, a list of possible solutions is automatically generated. This has a search option and also offers possible solutions from related articles within the FAQ, Knowledge and Announcement tabs.

Conclusion:

2.16 Predefined calls and call routing have been set up on the system, and these will be expanded and added to over time. We have provided substantial assurance for this objective.

Objective 4: User access is controlled with appropriate privileges granted.

2.17 The current IT Help Desk structure has 16 posts reporting to the IT Support Manager below which there are four hierarchical levels made up of a Service Desk Manager, an IT Service Desk Co-ordinator, three Senior Service Desk Analysts and 11 IT Service Desk Analysts.

2.18 The number of Service Desk Analysts is in line with those in post during our previous service desk audit, although at the time of our audit the Service Desk Manager post and two Service Desk Analyst posts were vacant. However, we were informed that recruitment to fill these posts is currently ongoing.

2.19 We were informed in discussions that a generic user profile has been developed for each level or role, and access is granted according to the post held. At the time of our audit, system access was being controlled by the ISM Project Manager who is responsible for setting up new users with access and where appropriate removing access from leavers.

2.20 A list of current users and their access levels was requested to enable audit to review the appropriateness of access privileges granted to enable the management of calls within the system, and to check all users were still employed within the IT Help Desk function. Whilst a list of users was provided, the information required to undertake the testing was not provided. It was however noted that there is no formal process in place to ensure that access for new users is formally approved, staff receive the appropriate level of access, and access is promptly removed from users that leave **(Matter Arising 3).**

Conclusion:

2.21 Whilst we understand that user privileges are granted according to the users' role, we have been unable to undertake any detailed testing in this area. Access to the system is currently being controlled by the ISM Project Manager but there is no formal approval process in place, and no process to ensure access is removed promptly from users that change their role or leave the organisation. We have provided reasonable assurance for this objective.

Objective 5: Users have had appropriate training and access to procedures and user guides.

2.22 The main system users are the service desk and other IT staff, although all Health Board staff are able to raise calls themselves via the self-service portal. We were informed that training was provided to service desk and other IT staff by the ISM Project Manager prior to the system going live. However, this involved 'on the job' training and consequently there are no records.

2.23 A Self-Service Portal User Guide has been produced, and this provides Health Board staff with guidance on how to create a new service request or log an incident. A range of user guides has also been produced for service desk staff. These include step by step guides on creating new incidents and requests and how to update records on the system. As noted previously these are incomplete and still in development.

2.24 The system also has a searchable help function that IT staff can use to get help on specific issues. Help and support is also currently provided by the ISM project manager.

Conclusion:

2.25 IT staff have received 'on the job' training from the ISM Project Manager who also provides help and support to staff on a day-to-day basis. A user guide has been produced for staff raising calls via the self-service portal, and a range of user guides has been produced by the ISM project manager. The ISM system has a searchable help function for use by service desk and other IT staff. We have provided substantial assurance for this objective.

Objective 6: A contract for the system and associated maintenance is in place.

2.26 The Ivanti helpdesk software is licensed not sold, and its use is covered by a User License and Services Agreement. This can be accessed via a link to the Avanti website and review of the agreement by audit did not identify any issues.

2.27 Support and maintenance, and in particular system updates and upgrades is covered by section 6 of the license agreement and is included in the purchase price of the software.

Conclusion:

2.28 Use of the system, support, maintenance, updates and upgrades are all covered by a User License and Services Agreement. We have provided substantial assurance for this objective.

Objective 7: The system enables the provision of management information that drives improvements.

2.29 The ISM system has a customisable dashboard for Incidents and a separate dashboard for Service Requests. The Incident dashboard provides a variety of information, for example the number of active incidents by 'owner'. The user can drill down on this to obtain a report detailing all the active incidents. The dashboard

can show the number of incidents by status and again the user can drill down on the numbers to get a line-by-line detailed report.

2.30 The dashboard is currently configured to also show the top 5 services with incidents, service by category average score, service by count and average score and incidents by owner / status.

2.31 We were informed by the IT Support Manager that they are currently in the process of developing KPI's for reporting purposes as agreed by management following our previous service desk audit, although this work has not yet been completed and is still ongoing. We also note that there are still no fixed Service Level Agreements in place with user departments **(Matter Arising 4).**

Conclusion:

2.32 There is a customisable dashboard that can report on service requests and incidents separately, and users can drill down on the numbers provided to obtain individual call details. A KPI report is currently being developed for reporting purposes. We have provided reasonable assurance for this objective.

Objective 8: The system enables problem management and knowledge management.

2.33 It was confirmed during testing that the ISM system has a 'Knowledge' module that can be accessed from the dashboard. This is in the process of being populated and at the time of our audit there were 67 articles which can be categorised, for example as Software, Error Message, Functionality, Locality Staff, Documents, Installation and How To.

2.34 As well as recording the issue, the system records details on how to resolve the issue or the answer to the problem. As noted previously, as well as a search function, suggested articles appear in a side pane when help desk staff raise new incidents or service requests.

Conclusion:

2.35 The ISM system can be configured to enable problem and knowledge management, and this is in the process of being populated. We have provided substantial assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Monitoring of Open Calls (Design)	**Impact**
A report was run from the ISM system of all active incidents as at the 07.11.22. Of the 470 active calls, 396 were still open. This does not include service requests. Of the 396 open calls, 258 had been open for more than 31 days. All calls are assigned to a specified owner within IT. Where calls require some action to be taken by the customer, both Incidents and Service Requests, their status can be set to 'Waiting for Customer'. A report was run of all calls with a 'Waiting for Customer' status as at the 15.11.22. This showed there were 210 calls waiting for a response from the customer, of which only 22 had been closed. Of the remaining 188 still open, 112 had been waiting for more than 31 days. It was also noted during testing that the target resolution date for calls is not a mandatory field, and this is not always being recorded. All open calls and those set to 'Waiting for Customer' should be monitored by the assigned owner and their supervisor. Whilst it is acknowledged that the Service Desk team is not at present fully staffed, this is currently being done on an ad hoc basis resulting in high levels of open active calls dating back to April 2022. Although a range of SOP's have been developed, there are no documented procedures or SOP's in place detailing how and when calls should be monitored, what actions should be taken and under what circumstances they can be closed down.	Calls are not resolved and closed promptly resulting in disruption to services provide by the Health Board.

Recommendations		**Priority**
1.1	A Standard Operating Procedure should be developed for the monitoring of open calls and calls set to 'Waiting for Customer' status. Customers with calls set to 'Waiting for Customer' status should receive two reminders, and these calls should be closed if the customer fails to respond after the second reminder.	**High**
1.2	Consideration should be given to making the target resolution date a mandatory field for all calls.	

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Agreed Management Action		Target Date	Responsible Officer
1.1	Service Desk Standard Operating Procedures have been created as part of the implementation. Standard reporting within the software has been configured to report Incidents and Service Requests which has passed baseline SLAs. Advanced reporting is currently being installed and configured using dynamic Microsoft Power Business Information reporting tools.	March 2023	IT Support Manager
1.2	Target resolution date is already configured within the system, as this is linked to the SLA. Inclusion of a target resolution date is difficult to predict for non-standard requests due to external factors, however, an indicative date will be included.	July 2023	IT Support Manager

Matter Arising 2: Prioritisation of Incidents (Operation)	**Impact**
The ISM system enables new Incidents to be assigned a priority rating from 1 to 5, where 1 is the most urgent. This is automatically assigned based on the Urgency and Impact levels selected from a drop-down menu when logging the call. For example, a call assigned Medium Urgency and Medium Impact will be assigned a Priority Rating of 3. A report was run of all open Incidents as at the 07.11.22. This had a total of 470 calls, of which the vast majority (461) were priority 3. Of the remaining calls, 3 were priority 1, 3 were priority 2, 1 was priority 4 and 2 were priority 5. Staff are therefore either using Medium Urgency and Impact for all calls, or the criteria used to assign the priority rating is automatically assigning the vast majority of calls as priority 3. If all calls are assigned the same priority level, there is no effective prioritisation of calls.	Incidents are not effectively prioritised and urgent calls take longer to resolve which has a negative impact on service delivery.

Recommendations		**Priority**
2.1	To enable Incidents to be effectively prioritised guidance should be developed for the use of Urgency and Impact levels when logging new Incidents. This should include clear definitions for each level and when they should be used, i.e. What does High, Medium and Low Impact and Urgency mean and when should these be used. The criteria used to automatically assign priority levels should also be reviewed to ensure calls are being effectively prioritised.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Further documentation will be created to ensure that Urgency and Impact of Incidents is clarified. Additionally, the automatic criteria for call priority will be detailed and documented.	March 2023	IT Support Manager

Matter Arising 3: System Access Controls (Operation)			**Impact**
We were informed in discussions with the Project Manager that a generic user profile has been developed for each level or role, and access is granted according to the post held. At the time of our audit, system access was being controlled by an Ivanti Consultant who is responsible for setting up new users with access and where appropriate removing access from leavers. A list of current users and their access levels was requested to enable audit to review the appropriateness of access privileges granted and to check all users were still employed within the IT Help Desk function. However, this has not been forthcoming. It was also noted during discussions that there is no formal process in place to ensure that access for new users is formally approved, staff receive the appropriate level of access, and access is promptly removed from users that change role or leave.			Unauthorised access to the system.
Recommendations			**Priority**
3.1	A process should be developed to formally approve access to the system and to allocate appropriate access privileges, and to remove access from users that change post or leave the organisation.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Due to the Service Desk being owned and managed by the CAV IT support function, access is only provided to administrative staff on a need only basis. This is after appropriate training has been provided. As part of the improved Started, Movers and Leavers process within CAVUHB access rights are removed when staff members leave their role or organisation. The ISM platform is licenced using concurrent licences which are reviewed frequently, this provides additional controls around access.	March 2023	IT Support Manager

Matter Arising 4: Service Level Agreements and Key Performance Indicators (Design)	**Impact**
Our previous audit of the IT service desk identified a lack of Service Level Agreements (SLA's) with user departments setting out the responsibilities and expectations of all staff. Our audit also identified a lack of Key Performance Indicators (KPI's) for the service desk. The management response stated that SLA's would be put in place and monitored when further resources allowed, and that KPI's would be created and reported on as part of the ISM implementation. An indicative deadline for the implementation of these actions was September 2022. However, at the time of our current audit there were still no SLA's in place. We were informed by the IT Support Manager that they were in the process of developing KPI's and a KPI Report, and that this work had been delayed whilst waiting for the implementation of the Ivanti reporting function which has now been completed.	The services provided do not meet the needs of the organisation.

Recommendations		**Priority**
4.1	The service levels provided should be formally agreed with each user department. As part of this process an agreement setting out the responsibilities and expectations of all staff should be defined. Key Performance Indicators for the IT service desk should also be developed and regularly monitored and reported at an appropriate forum within the Digital & Health Intelligence Directorate.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	A new Ivanti reporting server has been implemented within the last week. This server will be used to provide detailed, customised reports from Ivanti. KPI and SLA compliance reports will be created and reviewed within the next 3-6 months. These will also be fed formally into the Board via the digital and health intelligence sub-committee on a regular basis.	July 2023	IT Support Manager

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Access to In-Hours GMS Service Standards (PCIC Clinical Board)

Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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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

To review the processes and procedures in place for assessing GP practices achievement against the 'Access to In-Hours GMS Service Standards'

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Reporting lines from the Health Board's Access Forum do not currently reflect Welsh Government guidance, where updates are to be provided at Board level on a quarterly basis; and
- The operation of the Access Forum could be strengthened by reviewing the terms of reference, giving consideration to attendance and the required quoracy. The forum is a key mechanism of sharing best practice.

A further low priority recommendation is within the detail of the report, which is advisory in nature.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance and reporting structure	Reasonable
2	Engagement and support for GP practices	Reasonable
3	Monitors implementation of the Standards, with escalation of issues where necessary	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Welsh Government reporting requirements	1	Operation	Medium
2	Operation of the Access Forum	1 & 2	Operation	Medium

1. Introduction

1.1 The review of 'Access to In-Hours General Medical Services (GMS) Standards' within the Primary, Community and Intermediate Care (PCIC) Clinical Board was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board'). The audit had been deferred from the 2021/22 Internal Audit Plan.

1.2 Audit Wales undertook a review of primary care across all Welsh Health Boards, publishing the individual Cardiff and Vale University Health Board report in May 2019[1] and a national report in October 2019. The national report highlighted that, *"While the NHS and Welsh Government are taking a range of steps to strengthen primary care, change needs to happen at greater pace and scale to tackle longstanding challenges and ensure sustainability of these vital services."*

1.3 In March 2019, the Minister for Health and Social Services introduced the 'Access to In-Hours GMS Service Standards'[2] (the Standards), which set clear requirements on practices in terms of minimum expectations relating to access, including an increased digital offering. The Standards have since been amended from the initial 2019/20 guidance to take account of changes in working practice necessitated by the COVID-19 pandemic. Further amendments have now been made to reflect the GMS contract agreement between Welsh Government, NHS Wales and GPC Wales of 1 December 2021[3].

1.4 The 'Access to In-Hours GMS Service Standards' consist of eight clear measurables to be achieved by GP practices. Achievement of the Standards are assessed each financial year. The 57 GP practices in the Health Board area are required to submit evidence of achievement against each indicator to the Primary Care Information Portal, developed by Digital Health and Care Wales, at periods throughout the year (quarterly) and to confirm an end of year position as at31st March in order to receive financial payment at the end of June of the same year. The evidence submitted is used by the Health Board for verification purposes. The achievement payment is calculated using the contractors registered patient size. For context, the average payment awarded to practices that achieved all of the Access Standards in 2022 was £29,000.

Audit Risks

1.5 The key risks considered in the review are potential patient harm or poor patient experience arising from:

- Patients being unable to access GP services in a timely basis; and
- Non-compliance with the Access Standards.

[1] https://www.audit.wales/sites/default/files/1276A2019-20_CVUHB_Primary%20care_Eng_5.pdf
[2] https://www.audit.wales/sites/default/files/Primary-care-services-in-Wales-2019-eng_11.pdf
[3] https://www.gov.wales/sites/default/files/publications/2021-12/access-to-in-hours-gms-services-standards-amended-supplementary-guidance.pdf

Limitations to scope

1.6 This review covers access to 'in hours' GP services only.

2. Detailed Audit Findings

Objective 1: The Health Board has an appropriate governance and reporting structure over the monitoring of GMS performance, particularly the 'Access to In-Hours GMS Service Standards'

2.1 The governance and reporting structure over the monitoring of General Medical Services (GMS) contract performance is clearly documented in the Health Board's GMS Contract Monitoring Framework, which was approved by the internal GMS Panel in October 2020.

2.2 The Health Board has established an Access Forum in-line with Welsh Government guidance. The purpose of this forum is to oversee the implementation and monitoring of the Access Standards. It continued to operate during the COVID-19 pandemic.

2.3 Welsh Government guidance stipulates that Access Forums should, " *… report to the appropriate leadership group within the individual health board. Updates are to be provided at Executive and Board level on a quarterly basis".*[4]

2.4 We reviewed the Access Forum's Terms of Reference and found this aligned to Welsh Government guidance, outlining performance should be reported to both the Board and the Strategy and Delivery Committee every quarter. However, we found performance is not reported to either governance forum. When discussed with management it was highlighted that the Clinical Board's own Quality, Safety and Experience Committee receive quarterly updates, which has a reporting mechanism through to the Board's Quality, Safety and Experience sub-committee, should matters require escalation. (Matters Arising 1 – Medium Priority)

2.5 Whilst reviewing the Access Forum's Terms of Reference, we found it had not been reviewed since it was finalised in January 2020. Its own review requirements outline an annual review. (*Matters Arising 2 – Medium Priority*)

2.6 We reviewed Access Forum meetings for the period 2021-2022 and found it had met every quarter. However, one of these meetings was not quorate and key stakeholders were absent from a number of meetings. (*Matters Arising 2 – Medium Priority*)

Conclusion 1: We found the Health Board has established an Access Forum which monitors the implementation of the Access Standards. However, we identified some issues with its reporting lines, Terms of Reference and attendance. (Reasonable Assurance)

[4] https://www.gov.wales/sites/default/files/publications/2020-11/access-to-in-hours-gms-services-standards_1.pdf (Role of the Health Board)

Objective 2: The Health Board has engaged and supported GP practices in identifying and implementing improvements required to meet the Standards

2.7 The Health Board keeps practices up to date with Access Standards guidance via distribution of Welsh Government guidance which is sent out as received via practice manager email distribution. A shared working document is updated as and when required in-line with announcements from Welsh Government to further clarify requirements and expectations to practices. This is accessible to all GP practices via email. It should also be noted that practices receive Welsh Government guidance through other routes such as BMA/LMC.

2.8 Following the introduction of the Access Standards, the Health Board invited all GP practices to attend Access Workshops per locality. We reviewed the content of this training session and found it provided useful planning instructions on how to implement and achieve the Access Standards.

2.9 To assist in the achievement of a number of the Standards, the Health Board procured the eConsult system which allows practices to communicate with patients virtually, provides a digital triage platform, and allows patients to book consultations online. It is available for use by all practices and was renewed in March 2021 for a further 12 months.

2.10 At the time of our audit fieldwork, the Health Board were conducting Annual Practice Meetings which incorporate the Access Standards, but are not limited to this area. We found these meetings offered an opportunity to identify and implement improvements needed to achieve the Access Standards, as well as encouraging practices to share any examples of good practice to be shared at Access Forums. At the time of our audit fieldwork, it was the intention that all practices will have been met with by the end of December 2022.

2.11 Best practice is a standing agenda item at Access Forums. We found clear evidence of best practice examples being shared, including examples of successful projects and a digital access presentation.

2.12 As per it's Terms of Reference, the Access Forum should be attended by a Practice Manager representative for each cluster within the Health Board. There is an expectation that best practice examples shared at the Access Forum will be disseminated within each cluster by its Practice Manager representative. However, upon reviewing Access Forum attendance we found these representatives regularly failed to attend and would have therefore been unable to share best practice within their clusters as intended. (*Matters Arising 2 – Medium Priority*)

2.13 We contacted the three Practice Manager Representatives to obtain their views on the engagement and support from the Health Board around the Standards. The Health Board may want to reflect and consider the feedback received to take forward any potential learning. *(Matters Arising 3 – Low Priority)*

Conclusion 2: We found the Health Board reliably provides all GP practices with relevant updates relating to the Access Standards. The Health Board has provided practices with several platforms to identify areas of concern and enable improvement, including

individual meetings with practices. We received feedback from Practice Manager Representatives which has identified areas which the Health Board may wish to further explore to enhance the current offering of support and engagement. (Reasonable Assurance)

Objective 3: The Health Board monitors progress against implementing the above improvements and compliance with the Standards, with escalation of issues where necessary and prompt action taken to address lack of progress or non-compliance.

2.14 Due to the Access Standards not being mandatory, the Health Board cannot enforce compliance and so do not have a formal policy for escalating non-compliance.

2.15 The Health Board completes quarterly summary reports outlining compliance rates and areas of non-achievement by all GP practices against the Access Standards. These summary reports are shared at the Access Forum, the Primary Care Quality and Safety Committee, and the PCIC Clinical Board's Quality, Safety & Experience Committee.

2.16 Monitoring of the Access Standards is a standing agenda item at the Access Forum. We found evidence of non-achievement of the Standards being acted on by the Forum.

2.17 The Health Board proactively reminds all practices via email when evidence needs to be submitted to the National Access Standards Portal as proof of achievement, in-line with Welsh Government submission dates. These reminders are sent in good time prior to submission deadlines.

2.18 For 2021-22, two practices failed to achieve all of the Access Standards. We found these practices were repeatedly contacted by the Health Board to remind them to submit the required evidence in-line with the final submission dates. We found these communications to be timely, clear and supportive in nature.

2.19 To comply with the Access Standards, GP practices must submit evidence as proof of achievement to the National Access Standards Portal which is managed at a national level by Digital Health and Care Wales. Once GP practices have submitted evidence, the Health Board approves this if sufficient and appropriate to meet the Access Standards and this is updated as final by Digital Health and Care Wales. We reviewed this approval process and found it to be robust.

2.20 Following collation of submissions from all GMS practices by Digital Health and Care Wales, the Health Board receives a summary of achievement and payments to be made. This is cross-referenced with the evidence submitted by the GP practices and signed-off, in-line with the Quality Assurance and Improvement Framework by the UHB Primary Care Contracting Team. Payments are then made by NWSSP GMS Payments Team. We tested a sample of evidence submitted against payments made for period 2021-22 and found all were accurate.

Conclusion 3: We found the Health Board monitors compliance against the Access Standards on a quarterly basis. In instances of non-compliance, the Health Board will proactively contact practices to inform them of what outstanding evidence is required for them to achieve the Access Standards and receive payment. Furthermore, the Health Board operates in-line with Welsh Government GMS Access Standards guidance and the Quality Assurance and Improvement Framework when processing and approving GP practices achievement against the Access Standards. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Welsh Government reporting requirements (Operation)	Impact
Welsh Government guidance outlines the requirement that, *"Assessment of performance against the Access Standards will routinely feature at quarterly Quality & Delivery meetings, where the executive team will feedback on Access Standards achievements and ongoing progress"*.[5] The Access Forum's Terms of Reference reflects the guidance, stipulating, *"To report updates on progress to the UHB Executive and Board through the Strategy and Delivery Committee on a quarterly basis"*. It further outlines that Access Forum meeting dates should be aligned to the Strategy and Delivery Committee. However, we found performance against the Access Standards is not reported to either the Strategy and Delivery Committee or the Board. The Health Board completes quarterly summary reports which outline compliance and non-achievement of the Access Standards pertaining to each GP practice. We found these are only shared at Access Forums and the Clinical Board's own Quality, Safety and Experience Committee.	Potential risk of: • Non-compliance with the Access Standards

Recommendation		Priority
1	Management should revisit Welsh Government guidance to ensure Access Standards' performance and reporting requirements are met by the Health Board.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1	Access Standards guidance to be reviewed and appropriate corporate governance structure for reporting within the Health Board confirmed - Process for reporting established - TOR updated	February 2023	Sarah Griffiths, Head of Primary Care

[5] https://www.gov.wales/sites/default/files/publications/2020-11/access-to-in-hours-gms-services-standards_1.pdf (Role of the Health Board)

Matter Arising 2: Operation of the Access Forum (Operation)	**Impact**
We reviewed the Terms of Reference and attendance of four Access Forums meetings, for the period 2021-2022, and note the following: The Terms of Reference should undergo annual review according to its own review requirements, but we found no evidence of it being reviewed since it was finalised in January 2020. Whilst reviewing Access Forum attendance, we found one forum was not quorate. The Terms of Reference considers the Access Forum to be quorate with the following members in attendance, but we noted the absence of the Local Medical Committee representative at the December 2021 Access Forum: Director of Operations or delegate; Representative from the Primary Care Team; Locality Manager/Assistant Locality Manager; Community Health Council representative; Local Medical Committee Representative; and Practice Manager Representative. Further, we also note the absence of a member of PCIC management at three of the meetings reviewed, although their attendance does not impact on quoracy. As per the Terms of Reference, other membership at the Access Forum should include a Practice Manager representative from each cluster within the Health Board. There is an expectation that each Practice Manager representative shares examples of best practice, discussed at the forum, within their cluster. However, we found two of the Practice Manager representatives failed to attend one of the four forums reviewed, whilst one of the representatives failed to attend three of these four. Absence of these members is significant as GP practices rely on them to disseminate best practice examples to assist them in the implementation of the Access Standards. We note, Access Forum minutes are not shared with the practices but understand key best practice examples are shared via email when the Health Board deem them important.	Potential risk of: • Best practice examples not being utilised by all practices to aid achievement of the Access Standards

	Recommendation	**Priority**
2	The Access Forum's Terms of Reference should be reviewed and updated in accordance with its own requirements. As part of that review consideration should be given to those that make up quoracy of the forum, and the potential for deputy/alternative attendees for Practice Manager Representatives, and PCIC management when they are unable to attend.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
2	TOR to be reviewed, including essential membership to ensure quoracy.	February 2023	Sarah Griffiths, Head of Primary Care

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Matter Arising 3: Level of support offered to GP Practices (Operation)	**Impact**
Welsh Government Access to In-Hours GMS Services Standards guidance is limited in the information it provides on the level of support expected to be delivered by Health Boards. The guidance notes, *"The Health Board will have a supportive role in assisting practices with achievement of the standards",*[5] and gives no further instruction on the manner of how Health Boards should provide support. To gain a better understanding of the support being offered, we sought feedback from the three Practice Manager Representatives for each of the cluster areas. The feedback sought was directed at the Access Forum, and the Health Board's engagement with practices. We received feedback from two of the three Practice Manager Representatives. One representative spoke on behalf of the practices within their cluster, and one sought direct feedback from practice managers within their cluster. In summary, the feedback we received reiterated our own findings that the Health Board is consistent in reminding GP practices when submission deadlines for the Access Standards are approaching and chasing any late submissions. However, feedback indicated that the Health Board could be more proactive in offering support. Additional feedback indicated Health Board communications are too lengthy, a more succinct approach in communication seems to be favoured. It was also suggested that a return to face to face meetings, particularly for cluster meetings and practice visits, would benefit practices in their understanding of the Access Standards.	Potential risk of: • Non-compliance with the Access Standards

Recommendation		**Priority**
3	Consideration should be given to the feedback obtained through this review and whether any learning can be taken forward to further support GP practices to implement and achieve the Access Standards.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	Explore further the specific support required from practices using Practice Manager representative to identify from their constituent locality practices	April 2023	Sarah Griffiths, Head of Primary Care

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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Endoscopy Insourcing (Medicine Clinical Board)

Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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Executive sign-off:	Paul Bostock, Chief Operating Officer Hannah Evans, Managing Director of Non-Acute Services
Distribution:	Hannah Mastafa, General Manager, Medicine Clinical Board Louise Platt, Director of Operations, Medicine Clinical Board
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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.

Executive Summary

Purpose

Our audit focussed on the governance and operational arrangements in place to manage the Endoscopy Insourcing Contract.

Overview

We have issued reasonable assurance on this area.

In all but one instance we offer reasonable assurance against the audit objectives. We provide 'Limited' assurance for Objective 3 due to the lack of information made available to inform our audit testing.

In summary, the matters requiring management attention include:

- Consideration of the weekly points targets which have been fluctuating since the commencement of the new contract, including the achievability and monitoring arrangements;
- Strengthening the documentation held for key meetings, declaration of interest forms and CVs for all Remedy Healthcare Services (RHS) staff working on the contract;
- KPI's have not been developed for the contract, a requirement of the SLA; and
- The accuracy of payments made to the provider.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Governance Arrangements	Reasonable
2	Declarations of Interest	Reasonable
3	Provider Staff Suitability	Limited
4	Contract Performance Monitoring	Reasonable
5	Invoices and Payments	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Weekly Points Targets	1	Operation	Medium
2	Operational effectiveness of governance groups	1	Operation	Medium
3	Declaration of Interest Forms and Working Time Regulations Opt Out Forms	2	Operation	Medium
4	Validation of RHS Staff working on the contract	3	Operation	Medium
5	Lack of Key Performance Indicators	4	Design	Medium
6	Value for money	5	Design	Medium

1. Introduction

1.1 Our audit for the Medicine Clinical Board was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board'). The initial focus of the planned audit was of Quality, Safety and Experience within the Clinical Board. Since the Plan was approved by the Audit Committee, a revised focus has been given to the review of Endoscopy Insourcing arrangements, at the request of the former Chief Operating Officer.

1.2 The Health Board has entered into an insourcing agreement with Remedy Healthcare Services (RHS) for the provision of Endoscopy Services during the weekends at University Hospital Llandough (UHL). The service is operated on Health Board premises using staff provided predominantly by RHS, although the Health Board is required to provide two staff for each shift.

1.3 The financial value of the service is determined by the activity delivered, which is in the region of £35,000 per weekend, amounting to circa £1.8 million per annum.

1.4 The insourcing arrangements, which were awarded under a Framework Agreement, are covered by a Service Level Agreement (SLA). This details a description of the services to be provided and sets out accountabilities, roles and responsibilities for both parties.

1.5 The Internal Audit Plan approved by the Audit Committee notes the Chief Operating Officer (COO) as executive lead for this review. During the interim period, the Managing Director of Non-Acute Services was identified as the lead for this review.

Audit Risks

1.6 The risks associated with the review were as follows:

- The service is provided by inappropriately qualified or experienced staff leading to potential harm to patients and reputational damage;
- Health Board staff undertake additional non-NHS work through the insourcing arrangement and work excessive hours, and this has an adverse effect on their health and well-being and their NHS work; and
- Financial loss if the Health Board pays for services that are not of the required quality or are not received.

2. Detailed Audit Findings

Objective 1: There are appropriate governance arrangements in place which ensure that patient numbers (points) and patient mix are in line with the projected financial model.

2.1 The Service Level Agreement (SLA) in place sets out the objectives, stakeholders and service requirements for the contract. There are a range of endoscopy procedures that can be carried out, and each procedure has a points value, depending on the complexity and the average time taken to complete it. The SLA specifies a requirement for a minimum of 270 points per weekend for services at both UHL, using a four-room set up and UHW, using a two-room set up. However, services are at present only being provided at UHL.

2.2 The minimum points requirement per weekend for UHL was initially set at 25 points per room per session, a total of 200 points per weekend. On 27 June 2022 this had been reduced to 192 per weekend, made up of 96 points per 8 hour session (4 rooms x 24 = 96, for 2 days = 192). However, the points targets, which have been fluctuating since the start of the contract, had not been met in any week between the 4th/5th June and the 3rd/4th September 2022.

2.3 We were informed that the Health Board over books procedures (and points) to allow for patients that do not turn up or their procedure cannot be undertaken. The data provided to us showed that procedures were being slightly overbooked on some weekends, but in some cases, bookings were lower than the daily target. *(Matter Arising 1 – Medium Priority).*

2.4 An Insourcing Quality & Safety Governance Group has been set up to ensure contractual compliance with the contract. A Terms of Reference has been drawn up for the Group who intend to meet bi-monthly. There is a named 'Chair' and a further eight named members of the Group with both the Health Board and the service provider adequately represented.

2.5 The agenda, minutes and action log arising from their meeting held on the 12th May 2022 were reviewed, and a copy of the meeting notes and action log from the meeting held on the 14th July 2022 were requested. However, as at the end of September 2022 the minutes and action log from the July meeting had still not been written up and circulated. We were also informed that the meeting scheduled for September 2022 was cancelled due to the number of 'apologies' received. We note that no quorum for the group meetings is specified within the Terms of Reference *(Matter Arising 2 - Medium Priority).*

2.6 As well as the bi-monthly Governance meetings, there is a weekly wash-up meeting between the Health Board and RHS staff, and this includes a review of the points achieved and any issues that have arisen from the previous weekend. These are recorded in a weekly wash-up action log that is circulated by email together with a summary of the meeting.

2.7 A standing agenda has been developed for the meetings, but the email summaries do not always fully follow the agenda. It is also difficult to determine which weekend the summary is referring to as the dates are not included in the emails which are not always sent out promptly. Issues arising are not always being recorded with sufficient detail, for example staffing issues *(Matter Arising 2 - Medium Priority).*

Conclusion 1: There is an SLA in place between the Health Board and the service provider that details the contractual arrangements for the insourcing contract. However, the weekly points target has not been achieved in any week since the commencement of the contract. Our review of the current governance fora and the documentation to support them has identified that enhancements are required to strengthen the documentation and administrative arrangements. A more robust methodology should be developed to facilitate effective contract monitoring. (Reasonable Assurance)

Objective 2: Health Board staff engaged by the provider are supported by declarations of interest and carry out the work outside their NHS contract without working excessive hours.

2.8 The terms of the SLA require any staff that work for RHS that are already employed by the NHS or the commissioning Health Board to complete a Declaration of Interests form. The Health Board provides two staff to work on the contract each day, a Nurse Lead and a Decontamination technician. We were provided with staffing lists for the duration of the contract to date, and these showed there was a pool of 11 Health Board staff that had worked on the contract to date.

2.9 Testing identified that Declaration of Interest forms had been completed by all but one member of the Health Board's staff working on the contract. In addition, some of the forms had not been fully completed or signed by the line manager. *(Matter Arising 3 - Medium Priority).*

2.10 The UK's Working Time Regulations (WTR) limit the average number of hours most employees are allowed to work each week to 48 over a 17 week period. Employees can however opt out of the 48 hour average weekly limit by completing and signing an 'opt out' agreement.

2.11 The Health Board use a standard Opt Out form for staff that wish to work more than the average 48 hours per week. Ten of the eleven Health Board staff identified as working on the contract had completed and signed the standard WTR Opt Out form. For the one member of staff that had not completed an opt out form, it was unclear whether they are working in excess of the hours to require completion of an Opt Out form. *(Matter Arising 3 - Medium Priority).*

Conclusion 2: On the whole, Health Board staff engaged by RHS have completed a Declaration of Interest form, although the completeness of the forms requires improvement by management. Similarly, 'Working Time Regulations - Opt Out forms' were in place for the majority of staff, but the position was unclear for one member of staff engaged by RHS. The Health Board has a duty to ascertain if staff working in excess

of 48 hours per week are aware of the Regulations, and relevant staff members must acknowledge this by completing the Health Board's Opt-Out form. (Reasonable Assurance)

Objective 3: Staff proposed by the service provider are suitably qualified and experienced and staffing levels for all shifts are in line with the requirements of the SLA.

2.12 The SLA requires the contractor to make available the curriculum vitae (CVs) of all consultants and nurses prior to them commencing work on the contract. We were informed that when provided, these are checked and agreed by the Clinical Director. The contract requires RHS to provide one JAG accredited Endoscopist and four Endoscopy nurses for each day shift. The nurses are provided from a pool of 15 set up specifically for the contract.

2.13 The CVs presented to us did not represent all staff working for RHS on the contract. Although requested, we were also not provided with any documentation to confirm which RHS staff had worked on the contract each weekend *(Matter Arising 4 - Medium Priority).*

Conclusion 3: Due to the limited information made available to us we were unable to verify if the correct number of RHS staff had been present for each shift. We were also unable to verify whether there was an approved CV in place for all RHS staff working on the contract, particularly nurses. (Limited Assurance)

Objective 4: Performance of the service provider is monitored on an ongoing basis against the requirements of the SLA, and where this does not meet the required standards penalties are activated in line with the terms of the SLA.

2.14 Performance is monitored through bi-monthly governance meetings and weekly wash-up meetings. Each endoscopy procedure has a set points value based on the complexity and time taken to carry out the procedure. The SLA specifies the minimum points requirement that should be achieved each weekend. As noted under objective 1, the contractor had not achieved the points target for any of the weeks reviewed.

2.15 It was noted from the weekly wash up log and minutes of the Governance Group meetings that there should also be KPI's in place, as noted within the SLA. However, we were not provided with any information in respect of KPI's *(Matter Arising 5 - Medium Priority).*

Conclusion 4: Whilst performance is monitored through the bi-monthly governance meetings and weekly wash-up meetings we could not identify any key performance indicators, which is a requirement of the SLA. (Reasonable Assurance)

Objective 5: Invoices submitted by the service provider are accurate, timely and reflect the actual service provided. Invoices are verified and authorised prior to timely payment by the Health Board.

2.16 A flowchart has been produced for the processing of provider invoices. This requires that invoices are sent to the Service Manager and Endoscopy Manager in the first instance. The Service Manager then reviews the invoice against delivered activity.

2.17 The invoice is then forwarded to Endoscopy Admin who will raise a requisition within 48 hours of receipt (if no queries) and forward the invoice to NWSSP procurement.

2.18 The requisition will then be authorised by the Service Manager. Due to the value of the invoices, the order is then automatically sent for further authorisation to the Director of Operations to facilitate payment.

2.19 A report was obtained from Finance detailing all the payments made to RHS from the beginning of this financial year. The finance report shows that the Health Board is being invoiced for £34,104 per weekend plus an additional £900 per day which is in line with the costs payable as per the SLA and a variation agreed in July 2022.

2.20 There is no provision within the SLA to reduce payments where the points targets have not been met, unless this has been caused by RHS not providing sufficient staff. Should this occur the full invoice for that day would not be payable, although to date no payments have been withheld. We were informed that credit notes have been requested from RHS but to date these have not been received, and neither were they captured on the finance report we received. *(Matter Arising 6 - Medium Priority)*

2.21 It was noted that although invoices should be submitted by RHS on a weekly basis in accordance with the terms of the SLA, we were advised that this was not being done. This has resulted in finance having to accrue for outstanding invoices at month end. We were informed that the Health Board has been liaising with RHS to obtain invoices weekly.

2.22 At present, all the contract costs are being recovered from the Welsh Government as part of the COVID-19 Recovery Plan.

Conclusion 5: Invoices submitted by the contractor were found to be in line with the charges specified within the SLA, although they were not being submitted weekly by the contractor. There is a flowchart for the processing of provider invoices, which should result in payments only being made for activity delivered. However, we were advised that credit notes are due from RHS which would imply that the review of invoices prior to payment has not been effective. From a value for money perspective a review of the SLA should be considered and where the points targets have not been met there is the potential to reduce payments. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Weekly Points Target (Operation)	**Impact**
There are a range of endoscopy procedures that can be carried out, and each procedure has a points value, depending on the complexity and the average time taken to complete it. A review of the points achieved to date shows that the points targets have been fluctuating since the start of the contract. We reviewed the number of points booked with RHS each week from the 02/07/22 to the 25/09/22 so these could be compared to the weekly points targets and points achieved by RHS. The data provided confirmed that points targets are regularly not being met. Further information provided identified opportunities for greater monitoring of weekly bookings, targets and points achieved by RHS.	Potential risk of: • The service provider is not fully meeting their contractual requirements so the Health Board may not be receiving full value for money from the contract.

Recommendation		**Priority**
1	Management should undertake the following to strengthen the performance arrangements with RHS: • The weekend points target should be reviewed against the SLA and current performance levels to ensure it is realistic and achievable; and • Develop a more robust methodology to ensure that the points achieved by RHS are effectively monitored against the weekly points booked and points target to enable an accurate assessment of the contractor's performance.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	The weekly target for points / number of patients seen each day has been agreed between the operational and clinical teams in Cardiff and Vale UHB and RHS and agreed as realistic and achievable. RHS performance is monitored on a weekly basis at the weekly Wash-up calls.	Complete	General Manager

Matter Arising 2: Operational effectiveness of governance groups (Operation)	**Impact**
The service provided by RHS is overseen by a Quality and Safety Governance Group that meets bi-monthly, we make the following observations of the Group based on documentation received: • The Group's Terms of Reference does not include a quorum for meetings, so decisions could be taken by a minority that are not in the best interests of the Health Board or its patients; • We note that the meeting scheduled for September 2022 was cancelled due the number of apologies received; and • The group's administrative arrangements are in need of improvement. As at the end of September 2022 the meeting notes and action log for the meeting held on the 14th July 2022 had still not been written up and circulated. Similarly, we make the following observations of the 'Weekly Wash-up Meetings': • These meetings are summarised in an e-mail which is circulated to all relevant staff. A standing agenda has been developed for the meetings, but the email summaries do not always fully follow the agenda; • It is also difficult to determine which weekend the summary is referring to as the dates are not included in the emails which are not always sent out promptly; and • Issues arising are not always recorded with sufficient detail, for example staffing issues.	Potential risk of: • Poor decision making that is not in the best interests of patients or the Health Board.

	Recommendation	**Priority**
2	The governance arrangements for the Quality & Safety Governance Group, and Weekly Wash-Up meetings could be enhanced, specifically: • The Terms of Reference for the Quality & Safety Group should be updated to include a quorum for meetings; • Administrative arrangements for both forums should be improved to ensure that meeting notes are written up and circulated promptly after meetings; and • Consideration should be given to developing a template document for all weekly wash-up meetings. This should follow the agreed standing agenda and include the weekend dates.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
2	The audit recommendations have been actioned by the department. - The quorum has been added to the Terms of Reference for the both the Weekly Wash-up calls and the Quality and Safety Governance Meetings. A standing agenda remains in place for both meetings. - The minutes of the Quality and Safety Governance meeting held in July were delayed due to sickness within the directorate management team. Minutes and actions from other Quality and Safety meetings have been circulated in a timely manner. - A template document for the weekly wash up calls has been developed and is in use. The action log and notes of the meeting are circulated to attendees within 24hrs of meeting.	Complete	General Manager

~ *Continued over page* ~

Matter Arising 3: Declaration of Interest Forms and Working Time Regulations Opt Out Forms (Operation)	**Impact**
We found that Declaration of Interest forms had been completed by 10 of 11 Health Board members of staff identified as working on the RHS contract. However, seven of the forms had not been fully completed by the line manager and two had not been signed by the line manager. We were also provided with copies of 'Working Time Regulations - Opt Out forms' for the same 10 Health Board staff that have worked on the RHS contract to date, either as Nurse Lead or Decontamination technician. All the forms provided had been signed and dated. For the one member of staff that had not completed an Opt Out form, it is unclear whether or not they are exceeding the 48 hour average weekly limit.	Potential risk of: • Non-compliance with corporate governance requirements and Working Time Regulations.

	Recommendation	**Priority**
3	Management should ensure that Declaration of Interest forms, and where applicable Working Time Regulations Opt Out forms are fully completed and signed off by management for all Health Board staff that work on the RHS contract.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
3	The outstanding DOI form for one member of staff has now been completed. This member of staff would not require a WTD opt-out form as they do not work over hours. All DOI forms have been fully completed by the line manager.	Complete	Lead Nurse

Matter Arising 4: Validation of RHS Staff working on the contract (Operation)	**Impact**
In accordance with the terms of the SLA, RHS should provide the Health Board with CVs for all the staff that work on the contract. RHS provide four endoscopy nurses and one consultant for each 12 hour shift on a Saturday and Sunday. The nurses are provided from a pool of 15 nurses. We were informed that all CVs received are checked and agreed by the Clinical Director. RHS provided staff CVs for 23 consultants, but only three nurses. We were unable to obtain lists of the RHS staff working on the contract each weekend. However, as four nurses are required per shift, and given the pool of 15 nurses set up by RHS to work on the contract, it would appear that CVs have not been provided for all RHS nurses working on the contract.	Potential risk of: • The provider may use staff that are not suitably qualified on the contract leading to harm to patients.

	Recommendation	**Priority**
4	To ensure staff working on the RHS contract are suitably qualified and experienced, the following records should be available and held by management: • CVs from RHS for all staff working on the contract with evidence of review and approval; • Staff that have not provided suitable CVs should not be allowed to work on the contract; and • Records should be maintained of the names of RHS staff that have worked on the contract each day to verify that the correct number of staff have been provided.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4	All Operator CVs (consultants and nurse endoscopists) are reviewed by the clinical director before they are authorised to work as part of the insourcing contract. The directorate will ensure that these CVs are kept on file with evidence of authorisation. As with all Agencies that supply nurses to the Health Board, it is the responsibility of the agency to ensure that nurses are qualified for the role they are performing.	January 2024	Clinical Director

	The directorate already keeps a daily staff record of all RHS staff that work as part of the contract.		

Matter Arising 5: Key Performance Indicators (Design)	**Impact**
It was noted from review of the weekly wash up log and minutes of the Governance Group bi-monthly meetings that as well as the weekly points target, there should also be KPI's in place to monitor clinical performance. The SLA also requires the number of planned and actual endoscopy procedures carried out to be reported weekly / monthly. The Insourcing of Clinical Support Services SLA, notes *"KPI Reporting metrics to be discussed and agreed (Sample Endoscopy KPI Matrix provided) – reporting fortnightly".* So far we have been unable to determine whether this has been done or who monitors and reports on these. Consequently, we have been unable to determine whether performance targets are in place, and if these are relevant, up to date and are being met.	Potential risk of: • Poor performance by the contractor is not identified and addressed leading to patient harm.

	Recommendation	**Priority**
5	Key Performance Indicators should be developed to monitor the contractor's clinical performance.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
5 The Directorate team has requested that RHS provide a monthly clinical KPI report however this has been delayed partly due to the changeover in staff at RHS. The Directorate team has recently received a draft clinical KPI report from RHS and are working with the provider to finalise this report.	December 2022	General Manager

Matter Arising 6: Value for money (Design)	**Impact**
The financial value of the service is determined by the activity delivered, which is in the region of £35,000 per weekend, amounting to circa £1.8 million per annum. We note that there is no provision within the SLA to reduce payments where the points targets have not been met, unless this has been caused by RHS not providing sufficient staff. Should this occur the invoice for that day would not be payable. Whilst there was evidence that this had happened since the start of the new contract, to date no payments have been withheld or refunds received. We were informed that credit notes had been requested from RHS but to date these have not been received. At present, all the contract costs are being recovered from the Welsh Government as part of the COVID-19 Recovery Plan	Potential risk of: • Poor performance by the contractor is not identified and addressed leading to patient harm.

	Recommendation	**Priority**
6	It may be prudent to try and instigate an amendment to the contract (see section 6A of the SLA, Variation to Standard Specification) whereby the failure to achieve the agreed points each weekend would result in a proportional financial penalty, rather than the non-payment of invoices in full should the failure be caused by RHS not providing sufficient staff.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
6	The directorate team will consider an amendment to the contract to include proportional financial penalty where RHS is unable to achieve the full weekly points / patient target.	March 2024	General Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**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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Medical Records Tracking (Clinical Diagnostics & Therapeutics Clinical Board)

Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Committee:	Audit & Assurance Committee

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

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

Executive Summary

Purpose

To review the effectiveness of the mechanisms for tracking medical records both inside and outside of the Health Records department.

Overview

The report provides limited assurance for the tracking of acute (secondary care), medical records. Four high priority and two medium priority recommendations have resulted in the overall opinion.

Matters which require management attention include the out of date Records Management Policy (UHB 142) and Procedure (UHB 326). The documents refer to governance fora no longer in operation. Currently the Health Records department have no direct link into the Executive Medical Director, the executive sponsor of the Policy and Procedure. The author of the documents also sits outside of the Health Records department.

Further high priority recommendations have been made which relate to the security and storage of acute records, and the ability to track records from the patient management system to their physical location. The majority of issues associated with the tracking of records was a result of those held in a clinical setting or outside of Health Records.

We make two further medium priority recommendations which would enhance operational effectiveness.

We also highlight within Appendix A the barriers which are currently impeding digitalisation of medical records.

Report Opinion

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	Policy and Procedures	Limited
2	Governance arrangements	Reasonable
3	Operational arrangements	Limited
4	Risks and Incidents	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy and Procedure require review	1 & 3	Design	High
2	Health Records governance requires review	2	Design	High
3	Security and storage of medical records	3	Operation	High
4	Lessons learnt require formal tracking	4	Operation	Medium
5	Inaccuracies of medical records location	3	Operation	High
6	Operational effectiveness to be improved and harmonised	3 & 4	Operation	Medium

1. Introduction

1.1 The review of 'Medical Records Tracking' was completed in line with the Cardiff and Vale University Health Board (the "Health Board") 2022/23 Internal Audit Plan, and at the request of the Clinical Diagnostics and Therapeutics Clinical Board (the "Clinical Board").

1.2 The Health Board's Records Management Policy (UHB 142)[1] and Procedure (UHB 326)[2] set out the Health Board's commitments to comply with relevant legislation for the handling of all records it creates, including the Code of Practice on the Management of Records, under the Freedom of Information Act 2000.

1.3 The Health Board's Record's Management Procedure gives specific focus to the tracking and tracing of medical records, to ensure that manual records can be moved in a controlled manner. Specifically noting that, *"All patient case notes/health records should be tracked on the patient administration systems (PAS) and PARIS in line with the UHB's case note tracking procedure".*

1.4 The Health Board's 'Health Records department' is part of the Clinical Diagnostics and Therapeutics Clinical Board. The record libraries at University Hospital Wales hold in the region of half a million acute records, and University Hospital Llandough holds approximately 150,000 records. Further archived records are held off site.

1.5 The Internal Audit Plan, approved by the Audit Committee notes the Chief Operating Officer (COO) as executive lead for this review. During the interim period, the Managing Director of Non-Acute Services was the lead for this review.

Audit Risks

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

- There is a lack of clarity of roles and responsibilities due to out-of-date policy and procedures;
- Governance structures, roles and responsibilities may not be clear or operating effectively;
- Medical records are not adequately managed, leading to risks to patient safety and exposing the Health Board to reputation risk; and
- Learning from past incidents is not taken forward and addressed, resulting in reoccurring issues.

Limitation to scope

1.7 The audit focused on the tracking of acute health records, and not the appropriateness of the records or their completeness. Our focus was given to active health records and the ability to track them within Health Board settings. We did not test or visit off-site facilities.

[1] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/corporate-policy/r-corporate-policy/6-2-records-management-policy-january-2018-pdf/

[2] https://cavuhb.nhs.wales/files/policies-procedures-and-guidelines/corporate-policy/r-corporate-policy/records-management-procedure-igsc-8aug17-pdf/

Detailed Audit Findings

Objective 1: Policy and Procedures

- The Health Board has appropriate policies and procedures in place for the tracking of medical records, which are regularly reviewed and maintained; and
- Roles and responsibilities are clearly defined within the relevant policy and procedures.

2.1 The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) are available on the Health Board's website.[3] The procedure states that all staff should be aware of their individual record keeping responsibilities through generic and specific training and guidance, however on review we noted that both documents had passed their scheduled review date (Policy 2021, and Procedure 2020). *(Matter Arising 1 – High Priority)*

2.2 We were provided with the following local procedures and guidance, which cover specific processes:

- Procedures for Collecting, Tracking and Filing of Health Records (September 2022, v0.2);
- Procedure for the First Pull of Medical Notes, from File, for Out-Patient Clinics (September 2021, v0.2); and
- University Hospital Wales, Medical Records, Digital Health Records, Guidance – 2020.

Conclusion 1: The published Records Management Policy and Procedure which are currently held on the Health Board's website require review. Whilst the scheduled review date has passed, we found that management and organisational responsibility was outlined within the Procedure but there are elements of the documents which no longer reflect current processes such as the governance arrangements. Local procedures and guidance are in place for operational processes. (Limited Assurance)

Objective 2: Governance Arrangements

- There are appropriate governance structures in place, which provide effective oversight of the tracking of medical records; and
- The governance structure facilitates the escalation of assurance through to the Board.

2.3 We were informed by management at the commencement of the review that there are no forums outside of the Clinical Board that matters associated with the tracking of medical records can directly report into. This was apparent from review of the Medical Records Procedure which refers, under section 4 the 'Information

[3] https://cavuhb.nhs.wales/about-us/governance-and-assurance/policies-procedures-and-guidelines/corporate-policies/

Governance Assurance Framework' to groups no longer in operation. *(Matter Arising 2 – High Priority)*

2.4 In 2021 the Health Board responded to a complaint made to the Ombudsman, which highlighted issues where the medical record of a deceased relative could not be located. In response to the complaint, one aspect under consideration was, *"Undertake a review and enhance the governance arrangements for management of the health record in order to ensure that the governance arrangements are suitable and robust".* We found no documentary evidence to suggest this had taken place but acknowledge that this audit will provide some insight to inform a review. *(Matter Arising 2 – High Priority)*

2.5 Whilst we found that the governance arrangements for the tracking of medical records outside of the Clinical Board could be strengthened, the Clinical Board's structure does facilitate the escalation of assurance through to the Board. On the 15th June 2022 the Board's sub-committee, Quality, Safety and Experience Committee received the Clinical Board's Assurance Report.[4]

Conclusion 2: The Clinical Board structure provides a mechanism to escalate issues and offer assurance through to the Board's Quality, Safety and Experience sub-committee. However, there are no governance mechanisms outside of the Clinical Board, which were previously in place and detailed in the out of date Records Management Policy and Procedure. The Health Board has acknowledged that the governance of Health Records requires review, as outlined in a letter to the Ombudsman in 2021, but this is yet to come to fruition. Any revisions made to the governance arrangements should be instigated in tandem with the review of the Records Management Policy and Procedure. (Reasonable Assurance)

Objective 3: Operational Arrangements

- Medical records are adequately filed and easily retrievable onsite, whether held within a records library or within a clinical setting

2.6 We were given access to the health records libraries at University Hospital of Wales (UHW) and University Hospital Llandough (UHL) and provided with a tour in advance of commencing our audit testing. We subsequently made further visits and several observations were made, which may hamper the retrievability of records held within the libraries. *(Matter Arising 3 – Medium Priority)*

2.7 A patient's medical record may be supported by numerous files / devolved notes. Varying hospital visits and appointments may lead to several files being opened in alternative areas for a patient. The Records Management Procedure, albeit out of date, requires records and the information within them to be grouped in logical structure. We noted that medical records had volume numbers highlighted on the

[4] https://cavuhb.nhs.wales/files/board-and-committees/quality-safety-and-experience-committee-2022-23/2022-06-15-qse-papers-v2pdf/

front cover, however, we found that these are not being completed. *(Matter Arising 6 – Medium Priority)*

UHW

2.8 There are two filing systems in operation within the UHW medical records library:

- Terminal digit/unit number: An historic filing system, the last two digits of a patient's number is used as the filing reference.
- Location based filing: A relatively new system where files are stored in available spaces within the filing bays and tracked accordingly.

(Matter Arising 6 – Medium Priority)

2.9 The medical records library in UHW comprises six filing rooms, referred to as Closed Filing Room 1, Closed Filing Room 2, Closed Filing Room 3, Closed Filing - The lodge, Open Filing Room 4, and Open Xray overflow.

2.10 On a daily basis medical records staff retrieve medical records from clinical areas using a weekly timetable. The files are mainly held in medical secretary offices, and outpatient suites, for example Urology or Haematology.

UHL

2.11 All the libraries in UHL adopt the location-based filing system and a closed library for all eight filing rooms, made up of the Main Filing Room, Second Filing Room, Raddis Room, Xray Room, White Unit, Room 2, Room 5, and Hafen-Y-Coed Room.

2.12 At UHL, it is the responsibility of non-Health Records staff, principally medial secretaries to return the medical records once used in clinics.

- The transfer of medical records can be tracked on the patient management system

2.13 Medical records are tracked on the Patient Management System (PMS), with the exception of UHL mental health records which are tracked on the PARIS system. Records should be updated on PMS or PARIS whenever moved to an alternative location. The UHW team utilise a 'SearchRemarks' system to search for medical records in PMS, this is currently not in use at UHL. *(Matter Arising 6 – Medium Priority)*

2.14 We were informed that prior to COVID-19 spot checks were undertaken to verify the accuracy of the information in PMS to the physical location of a record, however, there are currently no proactive spot checks in place. *(Matter Arising 6 – Medium Priority)*

2.15 We carried out audit testing at UHW and UHL to identify if medical records can be appropriately tracked from the electronic system to their physical location (medical records libraries and clinical settings) and vice versa. We identified instances where we could not locate medical records, the majority of which were expected to be located outside of Health Records *(Matter Arising 5 – Medium Priority)*

- Medical records are stored in secure locations with authorised and controlled access to records at all times

2.16 As noted above, the majority of the medical records libraries have restricted access. The closed filing rooms are restricted to medical records staff, whilst the open filing rooms at UHW are accessible to staff following the required access activation process. The medical records libraries in UHW have digital locks and TDSI access while UHL have digital locks and key locks. During our site visits we observed instances at UHL where the security locks to access the libraries were not used as required. *(Matter Arising 3 – High Priority)*

2.17 During our site visits we also made observations regarding the storage of records, we found examples where areas of improvement could be made. *(Matter Arising 3 – High Priority)*

- To support continuous improvement, the potential impact of plans for the digitisation of patient records have been considered

2.18 We discussed with management the various tools and initiatives currently underway to move towards digitisation of patient records, which included the following:

- Clinical Information Triage (CIT) Programme – The programme is placed within Health Records, targeted at clinicians to reduce the need for paper records and a move towards digitised records. The programme relies on the willingness of clinicians to buy into the programme and participate, specifically those who undertake acute secondary care outpatient appointments.
- Clinical Outcome Module (COM2) – A clinical office module which allows clinicians to enter their notes electronically instead of paper notes. The CIT programme aligns with the efforts to increase the uptake of COM2. There have been two recent assessments of the functionality of COM2; an internal review, as well as an external one focused on functionality and user experience. We were informed by management that the findings have helped form a development plan for improving the usability of COM2 which Digital & Health Intelligence are taking forward. The findings also form part of the engagement and roll-out plan for increasing the uptake of COM2; a workstream sitting within the UHB's Outpatient Transformation Programme.
- Digital Health Records – Some clinics are fully digitised and have Digital Health Records (DHR).
- Clinical Portal - Scanned documents are held in the Health Board's clinical portal.

2.19 We considered the Health Board's Digital Strategy and the inclusion of the Electronic Patient Record, but we acknowledge that this stream is currently not funded which will impact the ability of the Health Records department to take

forward their digitisation initiatives. We note that the department appears to be lacking key equipment to progress, for example, the scanning machines in use at UHW and UHL were purchased approximately 10 years ago and there are no maintenance or support arrangements in place, neither are there contingency arrangements. *(Matter Arising 7 – Low Priority)*

2.20 As referred to under objective one, the Policy and Procedure associated with medical records are out of date and require review, particularly as the Health Board moves further towards digitisation and systems and processes evolve, for instance the hybrid use of digital and paper files requires clear direction by procedure. *(Matter Arising 1 – High Priority)*

Conclusion 3: Whilst there are systems in place for the management of medical records, improvements could be made. The operational arrangements should be directed by procedure, but as already highlighted the Records Management Procedure requires review. We also identified instances where the security and storage arrangements of health records could be strengthened. We attempted to locate a sample of health records, some of which could not be located. (Limited Assurance)

Objective 4: Risks and Incidents

- Emerging and existing risks relating to the tracking of medical records are adequately captured on the Clinical Board's Risk Register and escalated where appropriate

2.21 We reviewed the Clinical Board risk register, which is held in the corporate template. The Risk and Regulation Team confirmed that the Clinical Board have engaged as required to provide updates of their Clinical Board Risk Register.

2.22 We received minutes of the Clinical Board's Quality, Safety and Patient Experience sub-committee, which demonstrated that the risk register is presented for review and revision.

2.23 In June 2022, the Board's Quality, Safety and Experience sub-committee received an Assurance Report from the Clinical Board, which included risks which feature within the Clinical Board risk register.

2.24 On review of the Clinical Board risk register, two of the risks noted made specific reference to Health Records, specifically the potential 'Lack of access to the medical record including physical and digital storage' within the IT/Digital risk. Further, the potential of 'Health Records – inadequate storage capacity, security of the Health Record, potential for data loss, health and safety risks' within the Estates and Medical Equipment risk.

- Missing healthcare records are reported on Datix, and any learning from reported incidents are taken forward

2.25 We were advised by management that any instances of lost patient records would be addressed in accordance with the Incident, Hazard and Near Miss Reporting

Procedure (UHB 433). The Information Governance Department has access to Datix to view incidences for further action, monitoring of investigation and remedial actions. Where appropriate, the Head of Health Records would be made aware of relevant issues.

2.26 Our visit to UHW highlighted that a misfile log is maintained in an attempt to locate and identify the root cause of missing records. UHL does not hold a similar record. *(Matter Arising 6 – Medium Priority)*

2.27 We considered learning opportunities from reported incidences and specifically focused on the outcome of a complaint made to the Ombudsman where a patient's record was missing. Within the response, the Health Board listed a number of considerations to further minimise the loss of patient records, but further progress is still needed, which included a review of governance. *(Matter Arising 4 - Medium Priority)*

Conclusion 4: The Clinical Board's Risk Register is held in the corporate template and regularly reviewed. We noted the inclusion of risks relevant to the tracking of medical records. Incidences associated with missing healthcare records are to be dealt with under the Incident, Hazard and Near Miss Reporting Procedure (UHB 433). The Head of Heath Records confirmed that the team are notified or made aware of investigations where relevant, by the Information Governance Team. We considered opportunities for the Health Records department to learn from reported incidents and found this an area which could be strengthened, but acknowledge this is currently hampered by the lack of direction from policy and procedure, and the governance arrangements which are lacking. (Reasonable Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Policy and Procedure require review (Design)	**Impact**
The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) were both published in July 2018 and have been due for review since January 2021 August 2021 respectively. We note that a review of the Policy and Procedure is outside the remit of the Clinical Board, given the accountable executive detailed within the documents is the Medical Director. On review of the content of the documents it was evident that a review is required, for example the Procedure details the arrangements of the 'Information Governance Assurance Framework', which includes forums that are no longer operational. Further findings from this audit demonstrate that clarity is needed when the documents are next reviewed. Further, the Procedure refers to a 'Case Note Tracking Procedure' which we have been unable to locate.	Potential risk of: • There is a lack of clarity of roles and responsibilities due to out-of-date policy and procedures.

Recommendation 1		**Priority**
1	The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) require review.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Review of The Health Board's Records Management Policy (UHB 142 v3) and Procedure (UHB 326 v2) will be undertaken to reflect subsequent changes in national and local legislation and guidance, as well as operational practice, with view to updated versions being approved and available to Health Board teams and employees.	31 March 2023	To be determined following wider cross clinical board and corporate function discussions, led by the Director of Operations, Clinical Diagnostics & Therapeutics Clinical Board.

Matter Arising 2: Health Records governance requires review (Design)	**Impact**
There is currently no governance structure in place outside of the Clinical Board which provides direct oversight of the tracking of medical records or a means of escalating issues beyond the Clinical Board. The Records Management Procedure (UHB 326 v2) refers to the Information Governance Sub-Committee being the approver of the Procedure, which is no longer in existence, neither is the Medical Records Management Group (disbanded in 2019). Further, the Executive Medical Director is noted as the Accountable Executive within the Procedure but there is currently no governance fora in operation to offer assurance or to escalate issues associated with the tracking of medical records through to the Executive Medical Director. The Health Board has shown a commitment to reviewing the governance arrangements for the management of Health Records, as noted within a letter responding to the Ombudsman in 2021, but as yet there have been no revisions to arrangement since the letter was circulated.	Potential risk of: • Negligence and reputational damage.

	Recommendations	**Priority**
2	In alignment with the review of the Records Management Policy and Procedure, the governance arrangements should be redesigned to provide effective oversight of the tracking of health records, to ensure there is a line of sight to the accountable executive of the policy and procedure.	**High**

	Agreed Management Action	**Target Date**	**Responsible Officer**
2	The Health Board has a monthly Information Governance Sub-group chaired by the SIRO and attended by senior leaders including the Medical Director. Matters relating to the tracking of medical records can be escalated there. The group is linked to the Digital and Health Intelligence Committee (formerly the Information Governance Sub-Committee), and as such relevant points and actions will be raised accordingly	31 March 2023	To be determined following wider cross clinical board and corporate function discussions, led by the Director of Operations, Clinical

	at organisational governance fora. It is acknowledged that the mechanism for receiving points of escalation is often responsive in nature. Review of current governance arrangements related to medical records management will be undertaken with recommendations made, and subsequently enacted, to ensure a clearer line of sight to the accountable executive of related policy and procedures and related Heath Board.		Diagnostics & Therapeutics Clinical Board.

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Matter Arising 3: Security and storage of medical records (Operation)	**Impact**
We visited the Health Record Libraries at UHW and UHL and make the following observations which hamper the safe keeping of medical records and the adequacy of storing records: UHW • One top window permanently left open; • General filing observations: Some loose notes without files, large files and archive boxes requiring re-boxing, cramped files which are almost falling off the shelves, cramped and unorganised patient boxes; • Cluttered storage areas: Empty trolleys were randomly placed within the libraries, replacement water bottles for a water filter took up space, in addition to archived records held in a large cage; • Documents on the floor: Temporary storage prior to transfer to another site (archived boxes and maternity notes), RIP case notes (some placed in the centre of the room), also used and new stationery folders and box files; and • Facilities: previous water leakages* and stalactites. UHL • Access to libraries: Digilocks (keypad entry) installed but at the time of our visit was not in use, further a door was not key locked in the day; • Library access is less secure than at UHW where TDSI (an integrated access control system) is used; • Large ('fat') files on the floor; and • Leaks experienced*. * On discussion with library staff it was confirmed that water leaks have been experienced in 4 of the libraries (3 in UHW and 1 in UHL). Records are moved around to avoid damage and are monitored. Any signs of water leaks are reported to the Estates department. At the time of our visit, there were some incidences which had not been resolved.	Potential risk of: • Medical records are stored in secure locations with authorised and controlled access to records at all times.

Recommendation		Priority
3	Management should consider viable options to address the issues identified through our observations of security and storage arrangements of Health Records.	High

Agreed Management Action		Target Date	Responsible Officer
3	The department will develop a Security and Storage action plan addressing all points outlined. The plan will detail which elements the department is responsible for delivering and those requiring Clinical Board or Health Board support e.g. those requiring capital works. It will be submitted to the Clinical Diagnostics & Therapeutics Clinical Board, with review, support and oversight through its Quality, Safety and Patient Experience Sub-Committee programme.	28 February 2023	Directorate Manager, Patient Administration and Outpatients

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Matter Arising 4: Lessons learnt require formal tracking (Operation)	**Impact**
To inform a claims investigation, a medical record was requested but could not be located. Subsequently, the Health Board was required to undertake a review of the missing record and respond to the Ombudsman. A letter to the Ombudsman in November 2021 contained the following areas for consideration to further minimise the loss of patient records: *"1. Further digitisation of elements of the medical record (e.g.COM2) which will lead to recording and storage of the record electronically.* *2. Implementation of an app which links to the tracking database.* *3. Undertake a review and enhance the governance arrangements for management of the health record in order to ensure that the governance arrangements are suitable and robust.* *4. Develop a communications strategy to inform the organisation of their responsibilities with regards to safe storage of the medical record which will include a review of tracked notes and a records 'amnesty'* *5. Undertake a review of the record scanning solution as part of the digital mix"* At the time of our review it was evident that further work is needed to take forward the above considerations, linked to findings noted within this report which relate to governance and digitisation.	Potential risk of: • Learning from past incidents is not taken forward and addressed, resulting in reoccurring issues.

Recommendation		**Priority**
4	Management should formally track progress of taking forward lessons learnt to mitigate the risk of known issues recurring and to assist in identifying barriers that can be escalated for resolution.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	A Health Board 'Tracking of Medical Record Learning and Improvement Proposal' will be developed. This will incorporate the points outlined in the Ombudsman response November 2021. Learning and progress on improvement will be assessed through Clinical Board's Quality, Safety & Patient Experience meetings, with further oversight	3 March 2023	Directors of Nursing, and to be determined following wider discussion

	via the Health Board's Patient Experience function and governance structures, as well as the enhanced governance structures subsequently clarified through the delivery of recommendation 2.		

Matter Arising 5: Inaccuracies of medical records location (Operation)	**Impact**
Audit testing was undertaken at UHW and UHL to ascertain if a sample of medical records could be located. The testing was undertaken in two parts: • Part 1: From the patient management system to the physical location (Samples UHW 20, and UHL 10); and • Part 2: From the physical location to the patient management system (Sample UHW 20, and UHL 10). The responsibility for medical records only sits with the Health Records Department whilst within the libraries, once moved outside of these controlled areas the responsibility is with wider Health Board staff in clinical and other settings to adequately track and store records. We identified the following anomalies:	Potential risk of: • Medical records are not adequately managed, leading to risks to patient safety and exposing the Health Board to reputation risk.

	UHW	**UHL**
Part 1: PMS to physical location	7 (2 Health Records, and 5 Clinical setting) * See note below (1)	1 (Clinical setting)
Part 2: Physical location to PMS	1 (Clinical setting)	0

UHW: Seven (35%) of 20 sampled records selected from the PMS could not be located at the physical location. For *one of the 13 medical records found, support was needed from Health Records staff to locate due to the referencing used on PMS, which referred to a former reference system. One of the twenty records selected from the physical location to PMS had an incorrect location recorded on PMS.

UHL: One of the ten selected from PMS could not be located at the physical location. This was resolved by Health Records staff, where a clinical area had updated the system retrospectively when the record had already been returned to the Health Library.

Recommendation		Priority
5	Management should ensure staff are reminded of their responsibilities to return health records once used and the importance of updating PMS or PARIS following a change in location.	High

Agreed Management Action		Target Date	Responsible Officer
5	This will be taken forward as part of Agreed Management Action 4, specifically in relation to point 4 of Matters Arising 4. Departmental (Health Records), reinforcement of correct processes and good practice related to storage of medical records, will be undertaken prior to this.	31 March 2023 3 February 2023	As Recommendation 4 Head of Health Records

~ *Continued over page* ~

Matter Arising 6: Operational effectiveness to be improved and harmonised (Operation)	**Impact**
We reviewed the systems and controls in place to track medical records and make the following observations which may impede operational efficiency and effectiveness: • UHW currently has two filing systems in operation, location based tracking and terminal digit/unit number; • There is an option on the front cover of a medical record to select 'no. of this volume' of 'total no. of volumes' to assist in tracking medical records but this was not being populated; • We reviewed practices at UHW and UHL and found inconsistencies, for example UHW maintain a missing file log, but UHL do not. Further, UHW use 'SearchRemarks', a tool to search PMS for health records, but UHL do not; and • There was no evidence of random spot checks of health records to ensure that files are held where expected in accordance with the PMS system. We understand this took place prior to COVID-19.	Potential risk of: • Delay in accessing and storing medical records

Recommendation		**Priority**
6	Management should consider enhancing the operational efficiency and effectiveness to track medical records, based on our findings associated with the alternative filing systems in use, the indexing of records, the inconsistencies between UHL and UHW, and random spot checks on locations.	**Medium Priority**

Agreed Management Action		**Target Date**	**Responsible Officer**
6	The department will revise its related local Standard Operating Procedures to ensure consistency of practice across sites, particularly in relation to the points outlined. Emphasis will be placed on regular sample location and tracking checks and hierarchy of actions depending on findings. A specific plan to complete the progress made towards a universal filing system (location-based tracking), will be developed. This will link to the Security and Storage action plan aligned to Recommendation 3.	28 February 2023	Directorate Manager Patient Administration and Outpatients

Matter Arising 7: Barriers which prohibit the digitalisation of Health Records (Operation)	**Impact**
Whilst the Health Records directorate are attempting to progress various initiatives to move towards digitisation, aligned to the Health Board's Digital Strategy, it is questionable what progress can be made given the lack of funding available to take forward the Electronic Patient Record. There has been no investment or development within the PMS system to enhance the tracking of medical records for decades, which is problematic given the hybrid nature of some health records. The system does not facilitate the tracking of paper and digital records, which form one record. The lack of governance arrangements identified in Matter Arising 2, does limit the forums outside of the Clinical Board for Health Records to pursue digitisation aspirations. Further, the Health Records directorate appears to be lacking adequate scanning devices, existing scanners at UHW and UHL are approximately a decade old, with no maintenance agreements in place. There is no contingency plan in place should one of the devices breakdown.	Potential risk of: • Delay in accessing and storing medical records

	Recommendation	**Priority**
7	Following the implementation of recommendations 1 and 2 within this report, consideration should be given by management and the relevant governance forums of how the known barriers to digitisation can be addressed, if the Health Board aspires to digitise Health Records.	**Low Priority**

	Agreed Management Action	**Target Date**	**Responsible Officer**
7	An assessment and proposal document will be created outlining known and potential barriers to digitisation and how they can be addressed, linking to current Health Board strategies and programmes, and specifically to national and organisational Digital work plans and schemes.	31 July 2023	Director of Digital and Health Intelligence

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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Management of Locum Junior Doctors (Children & Women's Clinical Board)

Final Internal Audit Report

January 2023

Cardiff & Vale University Health Board

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

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

Contents

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Executive sign-off:	Paul Bostock, Chief Operating Officer Hannah Evans, Managing Director of Non-Acute 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.

Executive Summary

Purpose

To review the system for agreeing and booking locum junior doctors, including appropriate use of the Envoy system before offer of increased rates and cross checking of shifts against claims.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Locum Junior Doctors were working shifts prior to approval being granted by the Directorate;
- We identified instances where Locum Junior Doctors were paid in excess of the expected rate, although we could evidence approval of the higher rate;
- Examples were identified where Locum Junior Doctors worked in excess of the shift time request, for example no rest breaks were taken; and
- There were retrospective requests for bank shifts entered onto the Envoy system.

We sampled two Directorates and found that the four matters arising raised relate to Acute Child Health, and two of the matters arising also relate to Obstetrics and Gynaecology.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

	Objectives	Assurance
1	Locum Doctors are sourced through the Bank	Substantial
2	Clinical Board approval has been granted to work in an area of interest	Reasonable
3	Requests for Locum Junior Doctors are supported by justification and authorisation	Substantial
4	Rates will be in accordance with the current rates offered	Reasonable
5	Bank shifts are verified and authorised on the Envoy system	Reasonable
6	Accurate and timely reports on bank usage and costs are produced	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Prior approval of Locum Junior Doctors – Acute Child Health	2	Operation	Medium
2	Deviations from Directorate approved rates – Acute Child Health and Obstetrics & Gynaecology	4	Operation	Medium
3	Variations in shift length – Acute Child Health	5	Operation	Medium
4	Retrospective requests for bank shifts entered on the Envoy system - Acute Child Health and Obstetrics & Gynaecology	5	Operation	Medium

1. Introduction

1.1 Our audit review of 'Management of Locum Junior Doctors' (CVU 2223-35), within the Children & Women's Clinical Board was completed in line with the 2022/23 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board'), and at the request of the Clinical Board.

1.2 To meet the rapidly rising demand for healthcare services, the Health Board is always looking for talented medical and dental professionals to lend their support and join the Medical and Dental Managed Locum Bank. Locum junior doctors can benefit from easier options to take up additional shifts and broaden their experience of working in different departments. The Envoy application enables members of the bank to book available shifts and submit timesheets to facilitate payment.[1]

1.3 The Medical and Dental Managed Bank provides monthly management information to Clinical Boards. The reports include 'Invoiced Spend by Directorates' within the Clinical Boards. The July 2022 report stated that for the current financial year £101,325 had been spent on Bank usage within Obstetrics and Gynaecology, and £293,958 had been spent within Paediatrics which included £4,102 on Agency usage.

1.4 Prior to commencing the audit it was agreed with the Director of Operations for the Clinical Board that the sampled Directorates for this review would be Acute Child Health, and Obstetrics and Gynaecology.

1.5 The Internal Audit Plan, approved by the Audit Committee notes the Chief Operating Officer (COO) as executive lead for this review. During the interim period, the Managing Director of Non-Acute Services was the lead for this review.

Audit Risks

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

- Unnecessary engagement of bank or agency locums due to poor controls around the identification of need and requesting / authorising shifts;
- Poor controls over the accuracy of shifts claimed could undermine financial probity / control; and
- Financial loss due to unnecessary usage or incorrect payment of Locum Junior Doctors.

Limitations to scope

1.7 The focus of our audit work for this review was with the sampled Directorates and not within the Medical and Dental Bank, as we have recently carried out a separate audit in this area (CVU 2223-06).

[1] https://cavuhb.nhs.wales/jobs/managed-locum-bank/

2. Detailed Audit Findings

Objective 1: Locum Junior Doctors are sourced through the 'Medical and Dental Managed Locum Bank'

2.1 Locum Junior Doctors within Acute Child Health, and Obstetrics and Gynaecology are initially sourced from their existing internal staff by requesting whether they are able to undertake an extra shift. In addition, the Obstetrics and Gynaecology Directorate contact external staff that have previously worked within the Directorate to confirm whether they are able to undertake shifts. Both of these requests will be input onto the Envoy system detailing 'Candidate Identified' and the name of the Doctor.

2.2 In cases where the Directorates are unable to fill the shift, the Rota Coordinator inputs the vacant shift onto the Envoy system for the Managed Bank to attempt to cover the shift with Bank staff initially and thereafter Agency workers.

2.3 Our testing verified that all Locum Junior Doctors were sourced from internal staff or via the Medical and Dental Managed Locum Bank.

2.4 We were advised that since the introduction of the Medical and Dental Bank in 2021, measures have been put in place with Payroll to block any payment requests that come from outside of the payment feeder files sent via Medacs (the Managed Bank provider), which has been live since August 2021.

Conclusion 1: Locum Junior Doctors for both Directorates were sourced via internal staff or through the Medical and Dental Managed Locum Bank. (Substantial Assurance)

Objective 2: In advance of Locum Junior Doctors working in an area of interest, departmental / Clinical Board approval has been granted

2.5 In instances when a Junior Doctor contacts the Medical and Dental Managed Locum Bank to confirm that they want to work in a specific area, the Bank will email the area with a copy of the Doctor's CV to request approval. All the returned approval emails are maintained by the Bank on the MISL system (document management system).

2.6 We selected a sample of 40 Locum Junior Doctors, (22 Acute Child Health & 18 Obstetrics and Gynaecology) to ensure that the Directorate had approved the Doctor working in that specific area of interest. Approval had been obtained where required, however, it was identified that some Locum Junior Doctors had undertaken locum shifts prior to the approval being granted by the Directorate. *(Matter Arising 1 – Medium Priority)*

Conclusion 2: Directorate approval was provided for Locum Junior Doctors to work within the respective Directorates. However, there were instances whereby the Locum Junior Doctor had undertaken a shift prior to the approval being received by the Managed Bank. (Reasonable Assurance)

Objective 3: All Clinical Board / Directorate requests for Locum Junior Doctors are supported by documented justification and authorisation

2.7 The Rota Co-ordinators are responsible for producing the rotas in advance and identifying where there are resource gaps within the rotas. As detailed in objective 1, there is a system in place for filling the vacant shifts. All vacant shifts are recorded on the Envoy system detailing the reason for the vacancy.

2.8 The Obstetrics and Gynaecology Directorate Manager produced a 'Management of locum shifts process' document dated July 2022 outlining how locum shifts are allocated. We were advised that there are times when the Directorate are unable to fill a shift by a lower grade Locum Doctor so they will request a middle grade Locum Doctor to undertake the shift.

2.9 We selected a sample of 45 shifts (30 Acute Child Health & 15 Obstetrics and Gynaecology) that had been worked by a Locum Junior Doctor to ensure an appropriate reason for the vacant shift was recorded on the Envoy system. For the sample selected we were able to confirm that an appropriate reason for the Locum Junior Doctor was recorded on the Envoy system.

Conclusion 3: Our audit testing verified that there were appropriate reasons for the need to have Locum Junior Doctors covering vacant shifts within the two Directorates, which had all been recorded on the Envoy system. (Substantial Assurance)

Objective 4: Rates paid to individuals will be in accordance with the current rates offered, any deviations from the current rates are supported by the relevant approver

2.10 The General Manager for Acute Child Health advised that there are standard rates in place for Locum Junior Doctors within the Directorate, which we received by email confirmation. She further confirmed that in most cases the rates are maintained, however, there have been occasions whereby they have had to deviate from the standard rates and approval has to be obtained through the Clinical Board.

2.11 Within the Obstetrics and Gynaecology Directorate there are standard rates in place for Locum Junior Doctors, which are detailed within the 'Management of locum shifts process'.

2.12 We selected a sample of 45 Locum Junior Doctors (30 Acute Child Health & 15 Obstetrics and Gynaecology) to ensure that the rates paid were in line with the rates agreed within the Directorates. We identified nine instances which deviated from the Directorate rates, however, they had been approved. *(Matter Arising 2 – Medium Priority)*

2.13 Reasons were provided for the increase in rates, and Directorates are able to increase the rates as there is currently no centralised rate card. We were previously advised that the Health Board along with other Health Boards on the M4 corridor

are attempting to develop a rates card so that all Locum Doctors will be paid at the same rate, which is due in 2023.

Conclusion 4: There are rates determined within the two Directorates. However, from our testing we identified that there were deviations from these rates to ensure that vacant shifts were filled, and these had been approved. (Reasonable Assurance)

Objective 5: All completed bank shifts are verified and authorised on the Envoy system prior to payment at the correct rate

2.14 The Locum Junior Doctors are responsible for completing their timesheets on the Envoy system and on completion it is sent to the relevant approver within the Directorate. Following a check for accuracy, the timesheet will be approved on the Envoy system.

2.15 We selected a sample of Locum Junior Doctors that carried out shifts during a three month period to ensure that they had been approved in line with the signatory list and that approval had been actioned following the shift being worked. In all cases they had been approved appropriately following completion of the shift. However, it was noted that six shifts were greater in length than the original shift request. *(Matter Arising 3 – Medium Priority)*

2.16 Our testing further identified that 12 shifts were requested on the Envoy system retrospectively, the same issue was highlighted in a separate audit 'CVU 2223.06 - Medical and Dental Staff Bank'. *(Matter Arising 4 – Medium Priority)*

Conclusion 5: All shifts were recorded on the Envoy system, which were supported by completed timesheets that were approved for payment. However, we did identify minor instances where there were differences in the number of hours requested to the number of hours worked. Furthermore, we identified bank shifts that were requested on the Envoy system retrospectively, once the shift had been completed. (Reasonable Assurance)

Objective 6: Accurate and timely reports on bank usage and costs are produced and distributed to appropriate staff within the Clinical Board

2.17 The Deputy General Manager for Acute Child Health and the Medical Staffing Coordinator meet the Head of Workforce Solutions in Medacs (Medical and Dental Bank) on a monthly basis and discuss the reports that the Managed Service produces. Consideration will be given to any gaps in the rotas and any vacancies so that the Managed Service are aware of the shifts that will be requested. Actions and notes are taken from the meetings. There is a monthly Directorate Management Team meeting which is attended by staff within the Directorate and the Clinical Board Accountant, and they discuss the financial position including the spend on Locums.

2.18 On a monthly basis the Directorate Manager for Obstetrics and Gynaecology, Service Manager, Rota Coordinator and Clinical Director meet with the Head of

Workforce Solutions in Medacs to discuss the reports produced by the Managed Service. Similar to Acute Child Health, there is a monthly Directorate Management Team meeting which is attended by staff within the Directorate and the Clinical Board Accountant attends where the financial position is considered including any spend on Locums.

Conclusion 6: Both Directorates hold monthly meetings with the Medical and Dental Bank and reports are produced showing the number of Locums booked, reason for spend and savings. We could evidence that actions are taken from the meetings. Finance also produces monthly reports for the Directorates including any spend on Locums and meetings are held to discuss the reports. (Substantial Assurance)

Appendix A: Management Action Plan

Matter Arising 1: Prior approval of Locum Junior Doctors – Acute Child Health (Operation)	**Impact**
We selected a sample of 40 Locum Junior Doctors (22 Acute Child Health & 18 Obstetrics and Gynaecology) to ensure that the relevant Directorate had approved the Doctor working in that specific area and that approval had been provided to the Managed Bank. From our testing, we identified: • 22 of the sample did not require approval to work within the Directorates as they held substantive posts and all relevant checks had been previously undertaken; and • 18 of the sample required approval to work within the Directorates but we found eight had undertaken a shift prior to approval being obtained within the Acute Child Health Directorate.	Potential risk of: • Patient safety if the appropriate checks have not been undertaken.

	Recommendation 1	**Priority**
1	Management within the Acute Child Health Directorate need to ensure that they grant approval for a Locum Junior Doctor working within their respective Directorate prior to them carrying out any shifts.	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
1	CHFW: There are some occasions when there is short term sickness, that the vacant shift is put on Envoy retrospectively. This can be during weekends or out of hours when the medical staffing coordinator is not present. Approval is granted prior to the start of the shift by the clinical lead for junior medical workforce, however is not recorded on envoy until the next working day. The directorate management team will work closely with the lead for junior medical workforce to identify a process that will ensure all vacant shifts are recorded prior to any shift being worked when the rota coordinator is not in place (out of hours and at	April 2023	Dr Genevieve Thueux, Assistant Clinical Director for Workforce (Lead for Junior Medical Workforce) Victoria Taylor, Medical Staffing Coordinator Directorate Management Team

	weekends). The efficacy of this process will be regularly audited by the Directorate Management team and amended until it is sustainably embedded as business as usual.		

Matter Arising 2: Deviations from Directorate approved rates – Acute Child Health and Obstetrics & Gynaecology (Operation)	**Impact**

We reviewed the rates paid for 45 Locum Junior Doctors (30 Acute Child Health & 15 Obstetrics and Gynaecology) to ensure that they were being paid the correct rates as determined by the Directorates.

Our testing identified nine anomalies, although all had been approved on the Envoy system and had received appropriate sign off by senior management. When discussed with senior management, we were advised that the higher rates paid are driven by market forces and the availability of locum junior doctors. Whilst we note appropriate approval was granted, we have held this finding in the report for transparency of the challenges currently being faced by the Clinical Board.

Acute Child Health Directorate

Locum Junior Doctor Grade	Directorate hourly rate	Actual hourly rate paid	Number of anomalies
Grade FY1	£53	£70 *	1
Grade FY2	£59	£70 *	2

* We were advised by the Rota Coordinator that the Doctors received the £70 SHO rate as they were covering an ST1 (SHO) gap rather than an FY1 / FY2 gap.

Gynaecology and Obstetrics Directorate

Locum Junior Doctor Grade	Directorate hourly rate	Actual hourly rate paid	Number of anomalies
ST2	£60	£25.82 **	1
ST3	£70	£60 ***	2
ST5+	£70	£85 ****	3

Potential risk of:

- Financial loss due to unnecessary usage or incorrect payment of Locum Junior Doctors.

** We were advised that it is the responsibility of the Rota Co-ordinator to input the rate when they enter the shift onto the Envoy system, in this instance this did not happen and reverted to the default rate.

*** The Rota Co-ordinator confirmed that this was entered at a lower grade in the first instance, but where cover cannot be obtained, they go up to the next tier. It was further advised that it was an error not to have changed the rate.

The instances of underpayment have been taken forward by the Directorate for correction.

**** The Clinical Director confirmed that the locums were working on a senior tier on call and therefore £85 per hour was the correct rate.

	Recommendation	Priority
2	Management should ensure that the rates paid are in line with the Directorate approved rates, in instances where the rates paid do deviate from the recommended rates evidence should be retained to support these decisions. *We acknowledge that there will be a rate card introduced for the M4 corridor in 2023.*	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
2	Obstetrics and Gynaecology: Prior to locum shifts being offered to colleagues, the rate of pay will be confirmed with the Directorate Manager / Service Manager / Clinical Director by the rota-coordinator for assurances that those working shifts are told of the correct rates. If at any time rates of pay need to change, Clinical Board approval will be sought in writing.	January 2023	Rhodri John, Directorate Manager
	CHFW: Prior to a rate card being introduced, the directorate are working to agreed rates. In some instances where there have been difficulties covering the service a higher rate of pay has been authorised. This is to ensure safe staffing levels across the clinical areas. The team will ensure evidence is retained to support the agreed higher rate of pay and Clinical Board authorisation will be sought in writing.	January 2023	Clinical Lead / Directorate Management Team

Matter Arising 3: Variations in shift length – Acute Child Health (Operation)	**Impact**
We selected a sample of 45 shifts (30 Acute Child Health & 15 Obstetrics and Gynaecology) to ensure that the original shift request agreed with the actual number of hours worked. Our testing identified that six shifts fulfilled within Acute Child Health were greater in length than the original shift request, which ranged from 15 minutes to 45 minutes in excess of the request. The reasons provided are as follows:	Potential risk of: • Poor controls over accuracy of shifts claimed could undermine financial probity / control

Number of anomalies	Rationale
4	No break taken *
2	No reason was provided

* The Framework which covers the Managed Bank Service, incorporating Locum Junior Doctors, outlines the Health Board responsibilities as *"GM03 To ensure that breaks are deducted from and that Drs are encouraged to take appropriate rest-breaks".*[2]

We received a report from the Managed Bank Service, which highlighted 'Lost Break Savings' of £16,514.30 for the period April 2022 – August 2022 for the Acute Child Health Directorate. The amount is determined from reviewing shifts where no break has been deducted from a locum shift worked.

Recommendation		**Priority**
3	In instances where management are approving the payment of shifts in excess of the hours requested, management should ensure that appropriate reasons are provided for the additional time, and that staff are encouraged to take appropriate rest-breaks.	**Medium**

[2] Multidisciplinary Framework Agreement, 3.1 Schedule 2 – Specifications for Staff Bank Service

	Agreed Management Action	Target Date	Responsible Officer
3	CHFW: During high pressures on the wards there are occasions where staff are unable to take their rest breaks. Assistant Clinical Director for Workforce will remind all doctors of the importance to take their allocated break and record these as part of their worked shift.	March 2023	Dr Genevieve Thueux, Assistant Clinical Director for Workforce (Lead for Junior Medical Workforce)

~ Continued on next page ~

Matter Arising 4: Retrospective requests for bank shifts entered on the Envoy system – Acute Child Health and Obstetrics & Gynaecology (Operation)	**Impact**
We identified in a previous internal audit, 'CVU 2223.06 - Medical and Dental Staff Bank', that a number of Bank shifts had been entered on the Envoy system retrospectively. Within this audit, we undertook a similar test and identified that this was also an issue. We reviewed a sample of 45 shifts (30 Acute Child Health & 15 Obstetrics and Gynaecology) undertaken by Locum Junior Doctors and identified 12 anomalies (11 Acute Child Health & one Obstetrics and Gynaecology), as follows:	Potential risk of: • Poor controls over the accuracy of shifts claimed could undermine financial probity / control

Number of days post shift entered on the Envoy system	Number of Medical staff	Directorate
3	1	Acute Child Health
4	3	2 Acute Child Health 1 Obstetrics and Gynaecology
7	1	Acute Child Health
9	1	Acute Child Health
10	1	Acute Child Health
11	1	Acute Child Health
22	2	Acute Child Health
25	1	Acute Child Health
27	1	Acute Child Health

'Candidate identified' was recorded on the Envoy system for all of the above and therefore all Locum Junior Doctors had been obtained by the Directorate.

Recommendation		Priority
4	Rota-Coordinators need to ensure that all bank shifts for Locum Junior Doctors are entered onto the Envoy system prior to the shift being worked to facilitate accurate financial planning and reporting.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
4	Obstetrics and Gynaecology: Rota coordinator will remind all clinical leads to notify of any vacant shifts each month. This will ensure Envoy is up to date with any outstanding shifts prior to being filled. This will be regularly audited by the Directorate Management Team.	January 2023	Rhodri John, Directorate Manager
	CHFW: Rota coordinator will remind all clinical leads to notify of any vacant shifts each month. This will ensure Envoy is up to date with any outstanding shifts prior to being filled. This will be regularly audited by the Directorate Management Team	February 2023	Clinical Leads Victoria Taylor, Medical Staffing Coordinator

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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