

Public Audit & Assurance Committee

Mon 20 May 2024, 09:30 - 11:10

Microsoft Teams

Agenda

09:30 - 09:35 1. Preliminaries

5 min

1.1. Welcome & Introductions

Rhian Thomas

1.2. Apologies for Absence

Rhian Thomas

1.3. Declarations of Interest

Rhian Thomas


1.4. Minutes of the Committee meeting held: 06.02.2024

Rhian Thomas

 1.4 Public Audit & Assurance Minutes 06.02.24.pdf (12 pages)

1.5. Actions following meeting held: 06.02.2024

Rhian Thomas

 1.5 Action Log - Public Audit & Assurance.pdf (1 pages)

1.6. Any Other Urgent Business

Rhian Thomas

09:35 - 10:50 2. Items for Review & Assurance

75 min

2.1. Internal Audit Progress Report including:

35 minutes *Ian Virgil*

The full reports can be found under the [Supporting Documents](#) Folder.

- Core Financial Systems
- Financial Management within Clinical Boards
- UHL Endoscopy Development
- Information Governance
- Cyber Security
- Cancer Services
- Patient Safety Incident Management
- Mortality Reviews
- Risk Management / Board Assurance Framework

 2.1 Internal Audit Progress Report May 24 cover.pdf (2 pages)

 2.1a Internal Audit Progress Report May 24.pdf (24 pages)

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2.2. Audit Wales Committee Update Report:

20 minutes Wales Audit

- Primary Care Services -Follow-up Review (2022 Local Work)

- 📄 2.2 CVUHB Audit Committee Update (May 2024).pdf (12 pages)
- 📄 2.2a CVUHB Primary Care Follow-Up Report Final.pdf (33 pages)

2.3. Internal Audit Recommendation Tracking Report

5 minutes Matt Phillips

- 📄 2.3 Internal Audit Tracking Report - May 2024.pdf (3 pages)
- 📄 2.3a Internal Audit Tracker - May 2024 v2 IV.pdf (6 pages)
- 📄 2.3b Internal Audit Summary Tables - May 2024.pdf (6 pages)

2.4. Audit Wales Recommendation Tracking Report

5 minutes Matt Phillips

- 📄 2.4 Audit Wales Recommendation Tracking Report - May 2024.pdf (2 pages)
- 📄 2.4a Audit Wales Tracker - May 2024 master.pdf (1 pages)
- 📄 2.4b Audit Wales Recommendation Table - May 2024.pdf (1 pages)

2.5. Regulatory Compliance Tracking Report

5 minutes Matt Phillips

- 📄 2.5 Regulatory Compliance Tracking Report May 2024.pdf (4 pages)
- 📄 2.5a Reg Tracker for Committee May 2024.pdf (4 pages)

2.6. Procurement Compliance Report / Chairs Actions Review / Single Tender Actions

5 minutes Catherine Phillips / Claire Salisbury

- 📄 2.6 Procurement Audit Committee Report.pdf (9 pages)

10:50 - 11:10
20 min

3. Items for Approval/Ratification

3.1. Internal Audit Plan 2024/25

5 minutes Ian Virgil

- 📄 3.1 Internal Audit Plan 24-25 Cover.pdf (2 pages)
- 📄 3.1a CVUHB Internal Audit Plan 24-25.pdf (29 pages)

3.2. Audit Wales - 2024 Audit Plan

5 minutes Wales Audit

- 📄 3.2 2023-24 NHS Audit Plan (CVUHB).pdf (24 pages)

3.3. Counter Fraud Annual Plan 2023/24

5 minutes Gareth Lavington

- 📄 3.3 Counter Fraud Annual Report 23-24 Cover Sheet.pdf (3 pages)
- 📄 3.3a Counter Fraud Annual Report 23-24.pdf (14 pages)
- 📄 3.3b Appendix 1 - Counter Fraud Annual Report 2023-24.pdf (8 pages)

3.4. Counter Fraud Annual Plan Outline 2024/25

5 minutes Gareth Lavington

- 📄 3.4 Counter Fraud Annual Plan 2024-25 Cover Sheet.pdf (2 pages)

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11:10 - 11:10 **4. Items for Noting & Information**

0 min

4.1. Counter Fraud Progress Update

Gareth Lavington / Catherine Phillips

4.1 Counter Fraud Public Progress Report Cover Sheet.pdf (2 pages)

4.1a Counter Fraud Public Progress Report.pdf (9 pages)

11:10 - 11:10 **5. Agenda for Private Audit and Assurance Committee**

0 min

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

11:10 - 11:10 **6. Any Other Business**

0 min

11:10 - 11:10 **7. Review & Final Closure**

0 min

7.1. Items to defer to the Board / Committees & Review of Future Actions

Rhian Thomas

7.2. Date and Time of the next Committee meeting:

Rhian Thomas

2nd July 2024 at 9am via MS Teams

7.3. 10-minute break prior to the Private Meeting

11:10 - 11:10 **8. Declaration**

0 min

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

**Minutes of the Public Audit & Assurance Committee Meeting
Held On 6 February 2024 at 9:00am
Via MS Teams**

Chair:		
Rhian Thomas	RT	Independent Member for Capital and Estates and Committee Chair (CC)
Present:		
David Edwards	DE	Independent Member for ICT
Mike Jones	MJ	Independent Member for Trade Union
John Union	JU	Independent Member for Finance
In Attendance:		
Rachel Gidman	RG	Executive Director of People and Culture
Murray Guard	MG	Audit Manager Internal Audit
Mark Jones	MJ	Audit Manager – Audit Wales
Lucy Jugessur	WW	Interim Deputy Head of Internal Audit (IDHIA)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist (LLCFS)
Robert Mahoney	RM	Deputy Director of Finance
Urvisha Perez	UP	Audit Lead - Audit Wales
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Huw Richards	HR	Auditor – Internal Audit
Heledd Thomas	HT	Senior Auditor – Audit Wales
Ian Virgil	IV	Head of Internal Audit (HIA)
Observers:		
Glynis Mulford	GM	Risk & Regulation Officer
Frankie Thomas	FT	Head of Corporate Governance
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Ceri Phillips	CP	UHB Vice Chair
David Thomas	DT	Director of Digital & Health Intelligence

Item No	Agenda Item	Action
AAC 24/02/001	Welcome & Introduction The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 24/02/002	Apologies for Absence Apologies for absence were received. The Committee resolved that: a) Apologies were noted.	

<p>AAC 24/02/003</p>	<p>Declarations of Interest</p> <p>The Committee resolved that:</p> <p>a) No Declarations of Interest were noted.</p>	
<p>AAC 24/02/004</p>	<p>Minutes of the Meeting Held on 7 November 2023</p> <p>The Minutes of the Meeting Held on the 7 November 2023 were received.</p> <p>The Committee resolved that:</p> <p>a) The draft minutes of the meetings held on 7 November 2023, were held to be a true and accurate record of the meeting.</p>	
<p>AAC 24/02/005</p>	<p>Actions– Following Meeting held on 7 November 2023</p> <p>The Actions were received.</p> <p>The Director of Corporate Governance provided an update on the policies plan noting that all policies had been provided to the relevant Executive Assistants (EAs) so that they could take them to their Executive and Directorates for review.</p> <p>The Committee resolved that:</p> <p>a) The Actions were discussed and noted.</p>	
<p>AAC 24/02/006</p>	<p>Internal Audit Progress Report</p> <p>The Internal Audit Progress Report was received.</p> <p>The Head of Internal Audit (HIA) advised the Committee that he would take the report as read and highlight key areas which included:</p> <ul style="list-style-type: none"> • Section 2 noted that 5 audits had been scheduled to come to the Committee in February 2024 but deadlines were not met and the reasons for that delay was outlined within the report. • Section 3 noted that 8 audits had been finalised since the previous meeting of the committee with scores which included: <ul style="list-style-type: none"> - Mental Health Clinical Board Governance arrangements – Reasonable Assurance - Capital Systems – Reasonable assurance - Infection Prevention & Control – Reasonable assurance - Technical Continuity – Reasonable assurance - Estates Condition – Limited assurance - HealthRoster System – Limited assurance - Alcohol Standards – Limited assurance - Shaping Our Future Wellbeing – Future Hospitals Programme – Advisory. 	

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- Section 4 noted the delivery of the 2023/24 Internal Audit Plan which stated that there were a total of 35 reviews within the 2023/24 Internal Audit Plan and the overall progress was outlined within the paper.

The HIA advised the Committee that a summary position identified that Internal Audit were about halfway through with delivering the plan with the remainder either in progress or agreed and scheduled to be delivered.

- Key Performance Indicators – It was noted that 2 KPIs that Internal Audit monitored delivery against were at amber status and would be fed back to the Committee at a future meeting.
- Section 5 noted the proposed changes to the 2023/24 plan which included
 - The addition of an audit, the Eye Care Digitisation Process audit which had been agreed by the Executive Director of Finance (EDF)
 - The removal of 2 audits, Business Continuity Planning and Shaping Our Future Hospitals Programme, 23/24 audit both agreed by the Executive Director of Strategic Planning (EDSP)
- Section 6 noted the development of the 24/25 Internal Audit Plan where it was identified that meetings were being held with the Health Board's Executive Directors to discuss potential areas for inclusion within the 2024/25 Internal Audit Plan.

The CC noted that there was still a lot of work to get through before the end of the financial year and asked how confident the HIA was that it could be completed.

The HIA responded that there was a pressure to get reports finalised but noted the support from the Corporate Governance team and Executives helped to hit the relevant deadlines.

He added that there was sufficient resourcing in place to deliver against the plan.

- Section 7 provided the Committee with the final report summaries for each audit identified in section 3 and further detail was provided:
 - Mental Health Clinical Board Governance arrangements - The audit was provided with a reasonable assurance, with four recommendations, 1 high, 2 medium and 1 low.
 - Capital Systems – The audit was provided with a reasonable assurance and the audit noted that project information was generally well organised and readily available for review. Improved reporting was observed at the sampled projects

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including to the Capital Management Group (CMG) – with improved executive attendance at the same.

- Infection Prevention & Control – The audit was provided with a reasonable assurance with 1 high, 3 medium and 1 low recommendation
- Technical Continuity – The audit was provided with a reasonable assurance which reflect the fact that the Health Board hardware was security hosted and there was extensive use of virtualisation to enable resilience of that hardware.

The Independent Member – ICT (IMICT) advised the Committee that he had not received assurance on the timeframes of the work required around the recommendations and asked if any dates could be provided as the recommendation stated the risks should be added to the risk register as opposed to completing the work to eliminate the risks.

The HIA responded that from Audit Manager perspective, he was comfortable that there had been progress in the development of other sites and noted that it was his understanding that they were well progressed with that and that the recommendation was to ensure the risk would be included on the risk register and within that, the timescales would be identified.

He added that it could be confirmed that the next meeting and was referred to the Digital & Health Intelligence Committee which would be meeting on 28th May 2024.

- Estates Condition – it was noted that the NHS in Wales faced unprecedented challenges with balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The Audit Manager for Internal Audit (AMIA) advised the Committee that the latest nationally reported data (2021/22) for the Health Board confirmed a total backlog maintenance requirement of £152m – although the capital investment requirement to clear the backlog maintenance was likely to be materially higher.

He added that the audit sought to evaluate the arrangements put in place by the Health Board to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

It was noted that the key to understanding the challenge would be the quality of the baseline data which was acknowledged within the Health Board's Board Assurance Framework (BAF) whilst noting that the health Boards current estates condition baseline data was developed from a

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2017 condition survey which had been updated annually by desktop review.

The AMIA advised the Committee that a tendering exercise was currently being progressed to survey the estate and to establish an updated baseline.

- HealthRoster System - The audit was provided with a limited assurance with significantly high priority recommendations which were outlined within the report.

The Executive Director of People & Culture (EDPC) welcomed the audit and noted that the Health Roster system came into the Organisation in September 2023 and noted that she would collaborate with the Executive Nurse Director to ensure the recommendations took priority.

- Alcohol Standards - The audit was provided with a limited assurance with 6 high recommendations and 1 medium which were outlined in detail.

Shaping Our Future Wellbeing – Future Hospitals Programme – it was noted that the Health Board had received positive feedback from Welsh Government (WG) on their Shaping Our Future Wellbeing – Future Hospitals Programme, Programme Business Case (PBC).

The Auditor for Internal Audit (AIA) advised the Committee that at the time of the review, the Health Board was in the process of establishing arrangements to develop a Strategic Outline Case (SOC).

He added that the stage was being progressed at risk, noting WG endorsement of the PBC or confirmation of SOC funding had not yet been received.

It was noted that the review was advisory in nature and provided proactive advice on the proposed governance arrangements to see the Programme through the activities outlined within the report to the next key juncture.

The CC advised the Committee that sufficient Executive representation would be required at future Committee meetings to respond to limited assurance reports.

The Committee resolved that:

- a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit report were considered.
- b) The proposed adjustments to the 2023/24 plan were approved.

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AAC
24/02/007

Audit Wales Update to include Structured Assessment.

The Audit Wales Update to include Structured Assessment was received.

The Audit Lead - Audit Wales (ALAW) advised the Committee that exhibit 2 summarised the status of Audit Wales' current and planned performance audit work and noted she would take the report as read.

Key points included:

- All-Wales thematic on workforce planning arrangements – it was noted that the work examined the workforce risks that NHS bodies were experiencing and were likely to experience in the future. It examined how local and national workforce planning activities were being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.
- Structured Assessment 2023 – Core – it was noted that the structured assessment work was designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources and it was noted that the 2023 Structured Assessment reviewed:
 - Board and committee cohesion and effectiveness
 - Corporate systems of assurance
 - Corporate planning arrangements
 - Corporate financial planning and management arrangements.

It was noted that exhibit 3 provided information on other relevant examinations and studies published by the Auditor General in the last six months which could be read by the Committee.

The ALAW advised the Committee on further detail around the Structured Assessment work and noted that the report set out the findings from the Auditor General's 2023 structured assessment work at Cardiff and Vale University Health Board and was designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

She added that overall, Audit Wales found that the Health Board had maintained effective arrangements to ensure good governance and had adopted a refreshed long-term strategy which included:

- Corporate approach to planning
- Board transparency, effectiveness, and cohesion
- Corporate systems of assurance
- Corporate approach to managing financial resources

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	<p>The ALAW advised the Committee that there were still opportunities to further enhance public transparency of board business, as well as review the effectiveness of the new committee structure.</p> <p>The CC added that recommendation 7 within the report highlighted that enhanced recommendation tracking could be undertaken and noted that it had been discussed earlier in the meeting around the relevant Committees of the Board receiving the audits that received limited assurance.</p> <p>The Director of Corporate Governance (DCG) responded that he would bring a report to the July Committee meeting to feedback on the response to the recommendations outlined within the Structured Assessment.</p> <p>The Committee resolved that:</p> <p>a) The Audit Wales Update was noted.</p>	DCG
<p>AAC 24/02/008</p>	<p>Review of Workforce planning Arrangements</p> <p>The Review of Workforce planning Arrangements were received.</p> <p>The ALAW advised the Committee that the report received outlined the Health Boards strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements.</p> <p>It was noted that the Health Boards People Plan was clearly focused on addressing workforce challenges in the short and medium term, but more attention was needed on addressing long-term risks.</p> <p>The Committee was advised that the Health Board was working effectively with internal and external stakeholders to find shared solutions to current and future workforce challenges.</p> <p>The ALAW added that the Health Board had clear intent to improve workforce planning capability but should ensure it had the resources to support delivery of its People Plan.</p> <p>She added that the report found that the newly established People and Culture Committee was starting to receive timely and comprehensive workforce performance reports, but the Health Board needed to strengthen the focus on the impact of People Plan actions.</p> <p>It was noted that six recommendations had been made and that the management response was received alongside the report.</p> <p>The EDPC advised the Committee that she had welcomed the report and was happy with the content provided.</p>	

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	<p>She added that to add assurance, a paper would be received by the Executives the following Monday to discuss the People & Culture Committee and the resource required to be even more effective.</p> <p>The Committee resolved that:</p> <p>The Review of Workforce planning Arrangements report was noted</p>	
<p>AAC 24/02/009</p>	<p>Review of the Risk Management System verbal update</p> <p>The Review of the Risk Management System verbal update was received.</p> <p>The Head of Corporate Governance (HCG) advised the Committee that the Corporate team had explored risk management system options as the Health Board needed to utilise a system to manage the risks across the Organisation.</p> <p>She added that there was an option to use a system already in place with Clinical Boards which had received positive feedback called the Audit Management and Tracking tool (AMaT).</p> <p>It was noted that conversations were ongoing with the AMaT team around how a risk management module of AMaT could look.</p> <p>The HCG added that the Corporate team were also engaging with the Clinical Boards and attending the Clinical Board reviews to understand where risks were being discussed and managed at local levels which would help with the development of the AMaT module.</p> <p>She concluded that further updates would be shared with the Committee where appropriate.</p> <p>The Committee resolved that:</p> <p>a) The verbal update on the Review of the Risk Management System was noted.</p>	
<p>AAC 24/02/010</p>	<p>Procurement Compliance Report / Single Tender Actions</p> <p>The Procurement Compliance Report / Single Tender Actions report was received.</p> <p>The EDF advised the Committee that she would take the routine report as read and drew the Committees attention to page 7 of 8 which showed the variance from the Health Boards Single Tender Actions (STAs) and Single Quotation Actions (SQAs) which had halved over the past 12 months, however non-compliant breaches had doubled.</p> <p>She added that this was due to the improvement work undertaken by the Procurement Team on behalf of Shared Services and had been widening their net to make sure that all non-pay expenditure was captured where</p>	

	<p>appropriate and that where the work continued, the Team would work alongside the service users to understand why there were in a position to have breached the compliance and then processes put in place so that it would not continue.</p> <p>The Independent Member – Finance (IMF) noted that one of the breaches outlined within the report had been dated for 10 months and asked why it was still outstanding.</p> <p>The EDF responded that the 10 months was in relation to a research trial in which the Health Board gained income which sometimes was in conjunction with universities but it had not been affected through procurement.</p> <p>She added that at a point in time, the Health Board would have looked to pay invoices which is when the Procurement Team would have become aware of the issues and it had been ongoing for 10 months before being identified.</p> <p>The EDF concluded that when areas do not need to routinely use the Health Boards procurement process, they should still apply procurement rules and follow correct procedures.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) The contents of the report were noted. b) The contents of the report were approved. 	
<p>AAC 24/02/011</p>	<p>Audit Wales Annual Report</p> <p>The Audit Wales Annual Report was received.</p> <p>The Audit Manager – Audit Wales (AMAW) advised the Committee that he would take the report as read and noted that it summarised all of the reports that the Committee had already received and noted that they were now in the public domain.</p> <p>The Committee resolved that:</p> <p>The Audit Wales Annual Report was noted.</p>	
<p>AAC 24/02/012</p>	<p>Timetable for the Production of the 2023-2024 Annual Accounts and Annual Report</p> <p>The Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report was received.</p> <p>The HCG apologised to the Committee because the timetable was not attached to the report received and noted that it had now been circulated via email to Committee members and would be added to the papers.</p>	

	<p>She added that the Corporate Governance team proposed to bring a draft report to the Committee at its May 2024 meeting with the final report being received in July 2024 for recommendation to the Board.</p> <p>The AWAM advised the Committee that Audit Wales had written out to NHS bodies in Wales setting out the proposed timetable for 2023/24 and noted the accounts and report would be certified on 15th July 2024.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> a) The proposed timetable and approach for the Annual Report 2023-24 was reviewed. b) The contents of the proposed timetable and approach was approved and it was agreed that that work would continue within the proposals to deliver the timely preparation of the Annual Report. 	
<p>AAC 24/02/013</p>	<p>Counter Fraud Progress Update</p> <p>The Counter Fraud Progress Update was received.</p> <p>The Lead Local Counter Fraud Specialist (LLCFS) advised the Committee that he would take the report as read and highlighted some areas which included:</p> <ul style="list-style-type: none"> • Promotion and Awareness and Educational Activity - Two market place corporate induction events had been attended, with 12 presentations provided to new starters. It was noted that Counter Fraud would remain a standing item on the corporate induction agenda. <p>International Fraud Awareness Week – The event took place as usual in October 2023 and during the course of the week various support material was issued. Awareness and advice was provided via the counter fraud digital platform on a daily basis which addressed the following areas:-</p> <ul style="list-style-type: none"> - Expenses and allowances - Festive Fraud - Salary Overpayments - Working elsewhere - Fraud under the magnifying glass <ul style="list-style-type: none"> • E-Learning – it was noted that since the launch in April 2023, 52 members of the Health Board had completed the e-learning module. • Fraud Prevention Notice – 1 was issued by the Counter Fraud Authority during the reporting period which was in relation to the festive period. 	

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	<ul style="list-style-type: none"> • Risk Assessments – 2 risk assessments had been started in relation to prevention work but were not completed at the time of the meeting and so would be reported back once completed. • Referrals – 28 referrals had been received which showed that the awareness was out in the Organisation. Of those 28, 7 new formal investigations had started leaving the Health Board with 13 open cases with 8 being legacy salary issues. • National Fraud Initiative – with the latest figures provided, no issues had been found which required formal investigation and the LLCFS was confident that the team would be able to complete all the matched by the next Committee meeting. <p>The CC asked that when employment was terminated due to false references, were there clear guidelines on what could be shared with other Organisations.</p> <p>The LLCFS responded that in relation to the investigations being undertaken, they could be shared widely with other NHS Organisations because there was a section in the data protection act that allowed the Health Board to share that information.</p> <p>The Committee resolved that:</p> <p>a) The report was noted.</p>	
<p>AAC 24/02/014</p>	<p>Thematic Engagement Exercise – Good Practice</p> <p>The Thematic Engagement Exercise – Good Practice information was received.</p> <p>The Lead Local Counter Fraud Specialist (LLCFS) advised the Committee that he would take the report as read noting that the Counter Fraud team had received a visit from the Counter Fraud Authority (CFA) in late 2023 where the purpose of that visit was to highlight good practice and to also check upon compliance ratings that had been provided.</p> <p>We had a visit from counter fraud authority in late 2023, the purpose of the visit was to highlight good practice but also check upon compliance ratings that I had provided.</p> <p>He added that during the CFA visit, it also identified that the uptake of the Fraud Awareness e-Learning package provided on the ESR platform was extremely low within the Health Board and so he had arranged a meeting with the DCG and HCG to discuss the use of the AMaT system to potentially track the fraud risks and to add the fraud risk assessments to the recommendation trackers.</p> <p>The EDPC advised the Committee that she would be happy to review the e-learning data as it was clear that compliance had to be increased.</p>	

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	<p>The EDF added that the Health Boards induction programme would be a good starting point for that discussion.</p> <p>The Committee resolved that:</p> <p>a) The considerations raised in the report were discussed with a view to identifying solutions to the concerns raised.</p>	
	<p>Agenda for Private Audit and Assurance Committee</p> <p><i>i. Counter Fraud Progress Update (Confidential – ongoing investigations)</i></p> <p><i>ii. Health Board Salaries Overpayment Update</i></p>	
AAC 24/02/015	<p>Any Other Business</p> <p>No Other Business was discussed.</p>	
AAC 24/02/016	<p>Items to be deferred to Board / Committee</p> <p>The CC noted that the audits should be received by the relevant Committees.</p>	
	<p>Date and time of next committee meeting</p> <p>Tuesday 2nd April 2024 at 9am via MS Teams</p>	

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

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions					
AAC 24/02/006	Internal Audit Progress Report – Technical Continuity	Internal Audit to provide assurance on timescales for the recommendations received	Ian Virgil	07.05.2024	COMPLETED Update to be given in May 2024. <i>On Forward Plan</i>
AAC 24/02/012	Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report	Draft Annual Report to be received at May meeting	Matt Phillips	07.05.2024	COMPLETED Update to be given in May 2024. <i>On Forward Plan</i>
AAC 24/02/007	Audit Wales Update	Management Response to the Structured Assessment	Matt Phillips	02.07.2024	COMPLETED Update to be given in July 2024 <i>On Forward Plan</i>
Actions referred to Board / Committees					
AAC 24/02/006	Internal Audit Progress Report – Technical Continuity	Audit to be received by the Digital & Health Intelligence Committee	Ian Virgil / David Thomas	28.05.2024	COMPLETED Update to be given at DHIC meeting in May 2024 <i>On Forward Plan</i>

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Report Title:	Internal Audit Progress Report			Agenda Item no.	2.1
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	20/05/24
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	X
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Internal Audit				

Main Report

Background and current situation:

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

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

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

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

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

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

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

The following reports have been finalised since the February 24 meeting:

- Core Financial Systems (Asset Register Management) (Substantial Assurance)
- University Hospital Llandough Endoscopy Development (Reasonable Assurance)
- Information Governance (Reasonable Assurance)
- Patient Safety Incident Management (Reasonable Assurance)
- Follow-up: Cyber Security (Reasonable Assurance)
- Financial Management within Clinical Boards (Reasonable Assurance)
- Mortality Reviews (Reasonable Assurance)
- Cancer Services (Reasonable Assurance)
- Risk Management / Board Assurance Framework (Reasonable Assurance)

The full copies of the final reports are included as separate items within the agenda.

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

Recommendation:

The Audit & Assurance Committee are requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

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

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

Risk: Yes/No

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

Safety: Yes/No

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

Financial: Yes/No

Workforce: Yes/No

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

Legal: Yes/No

Reputational: Yes/No

The progress report provides an update on the delivery of the Internal Audit plan for 2023/24, which includes audits that provide assurance around reputational risks.

Socio Economic: Yes/No

Equality and Health: Yes/No

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

S. Saunders/Nathan
 17/05/2024 21:26:07

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee May 2024

NWSSP Audit and Assurance Services



GIG
CYMRU
NHS
WALES

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



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

Saunders,Nathan
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1. Introduction

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

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

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

2. Assignments with Delayed Delivery

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



Audit	Current Position	Draft Rating	Reason
Temporary Staffing Costs	Draft Report	Limited	Report not agreed and finalised in time for submission to the Committee.
Medical Records Tracking (CD&T) Follow-up	Draft Report	Reasonable	Delay in completion of fieldwork due to waiting for information from management.
Decarbonisation	Draft Report	Limited	Report not agreed and finalised in time for submission to the Committee.
Management of Health Board Policies Follow-up	Draft Report	Reasonable	Management requested delay in commencing fieldwork due to work on Covid enquiry.
Eye Care Digitisation Programme	Draft Report	Reasonable	Delay in completion of fieldwork due to waiting for information from management.
PCIC CB Governance	Work in Progress		Delay in progressing fieldwork due to other priorities on Internal Audit resources.

3. Outcomes from Completed Audit Reviews

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

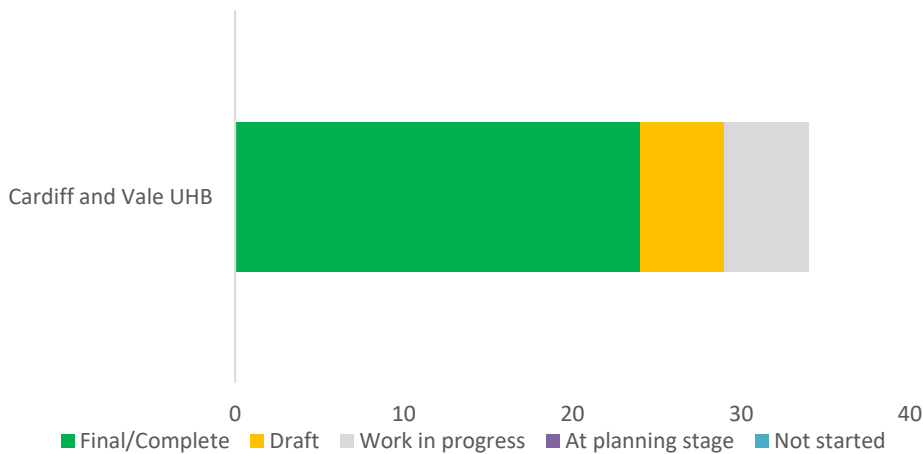
The Executive Summaries from the final reports are provided in Section six. The full reports are included separately within the Audit Committee agenda for information.

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FINALISED AUDIT REPORTS	ASSURANCE RATING	
Core Financial Systems (Asset Register Management)	Substantial	
University Hospital Llandough Endoscopy Development	Reasonable	
Information Governance		
Patient Safety Incident Management		
Follow-up: Cyber Security		
Financial Management within Clinical Boards		
Mortality Reviews		
Cancer Services		
Risk Management / Board Assurance Framework		

4. Delivery of the 2023/24 Internal Audit Plan

There are a total of 34 reviews within the 2023/24 Internal Audit Plan, (including the change highlighted below), and overall progress at this stage of the year is summarised below.



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

In addition, the remaining five audits are currently work in progress.

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.

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Appendix A also includes details of the three audits from the 2022/23 plan that had not been sufficiently progressed to be included within the Head of Internal Audit Opinion for 2022/23. The outcomes from these audits will feed into the 2023/24 Opinion.

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

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

5. Changes to the 23/24 Internal Audit Plan

The following audit has been identified for deferral from the plan:

- UHW Tertiary Tower – Proposed for deferral to the 24/25 plan due to delays with the progression of the scheme on site.

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6. Final Report Summaries

6.1 Core Financial Systems (Asset Register Management)

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for Asset Register Management.

Overview

We have issued substantial assurance on this area.

- A financial control procedure and supporting guidance booklet are in place.
- Asset register transactions are correctly stated and adequately supported.
- An annual asset verification exercise is completed.
- Monthly reconciliations to the financial ledger are completed.
- Only two low priority recommendations / advisory points have been raised which are within the detail of the report.

Report Opinion

Substantial



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

Low impact on residual risk exposure.

Trend



2020/21

Assurance summary¹

Objectives	Assurance
1 Asset Register Financial control procedure	Substantial
2 Up to date asset registers	Substantial
3 Asset register management systems are updated to record additions, movements and disposals	Substantial
4 Assets are periodically verified	Reasonable
5 Assets are accounted for including valuation, depreciation and indexation	Substantial
6 Asset management system is reconciled to the financial ledger	Substantial

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

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6.2 University Hospital Llandough Endoscopy Development

Purpose

The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Development project, and the performance against its key delivery objectives i.e., time, cost, and quality. This second review of the project covered the period from October 2022 onwards.

Overall Audit Opinion and Overview

At the time of the current review, the project remained within the approved budget allocation. However, a significant number of design changes had impacted contingency funds. Savings made elsewhere within the project have ensured a balanced financial position had been maintained.

Project changes had been managed via both the NEC contractual requirements and the UHB's Project Issues Form (PIF) process, with appropriate approvals in place in line with the Scheme of Delegation.

Contractual completion had been delayed by thirteen weeks; however, this was not expected to have an undue impact on existing service delivery.

The significant matters arising at the project include:

- The need to undertake a post-completion review of the design and change processes applied, to learn lessons for future projects;
- The application of contract conditions (at future projects) in accordance with the applied form of contract; and
- The development of a performance framework for monitoring of contractor and adviser performance at future projects.

Reasonable assurance has been determined at this review.

Report Classification

Trend

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.



2022/23

Assurance summary ¹

Assurance objectives	Assurance
1 Project Performance	Reasonable
2 Validation of Management Action	Limited
3 Financial Assurance	Reasonable
4 Technical Assurance	Reasonable
5 Change Control	Reasonable
6 Equipping	Reasonable
7 Quality Assurance	Reasonable

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

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Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	The risk register should be reviewed to determine any further potential impact to the project budget (and associated need for approval of additional funding).	3	Operation	Medium
4.1	Capital & Estates should liaise with NWSSP Accounts Payable on the matter of late payments.	4	Operation	Medium
5.1	On project completion, a review should be undertaken into the design / change process applied, with any lessons learnt for application at future projects.	5	Design	Medium
6.1	The UHB and external Project Manager should support the timely execution of the change management processes.	5	Operation	Medium
7.1	The warranty arrangements for the main equipment should be confirmed, with retention of associated documentation.	6	Operation	Medium
8.1	A performance management framework should be developed to support the monitoring and reporting of Contractor and adviser performance.	7	Design	Medium

Future Key Assurance Matters ²		Assurance Objective	Control Design or Operation	Recommendation Priority
2.1	At future projects, the contract conditions applied should conform with the form of contract applied.	3	Operation	Medium
7.2	At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board.	6	Operation	Medium

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

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6.3 Information Governance

Purpose

The overall objective of this audit was to review the resourcing, capacity, and resilience of the Information Governance structures to achieve compliance with GDPR and FoI requirements.

The purpose of the review was to provide assurance to the Audit Committee that a process is in place for ensuring that the organisation complies with the legislative requirements relating to Information Governance.

Overview


We have issued **reasonable** assurance on this area.

The medium priority matters to be considered by management include:

- IG workplans do not capture improvement and development activities; and
- Lack of IG Leads / Champions within the Health Board to support the IG team.

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

Report Opinion

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

Assurance summary¹

Objectives	Assurance
1 Sufficient resources are in place to enable all IG duties to be undertaken effectively.	Reasonable
2 An appropriate structure is in place to ensure all areas are engaged and comply with IG requirements.	Reasonable
3 An appropriate reporting framework is in place for IG.	Substantial

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

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6.4 Patient Safety Incident Management

Purpose

The overall objective of the audit was to review the arrangements in place within the Health Board for the identification, recording, investigation, and management of incidents and learning lessons.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Health Board’s Incident, Hazard and Near Miss reporting policy and procedure have been updated but both require minor amendments to be made to them;
- The Health Board’s National Incident Tool Kit requires finalising and being made available for staff; and
- Key stages within the incident reporting cycle are not being completed within reasonable timelines and evidence is not always in place within Datix to support actions taken and lessons learned.

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 The Health Board has an incident management policy and procedures in place which aligns to the Welsh Government policy. The guides are accessible to staff and training is in place for staff.	Reasonable
2 Patient safety incidents (including nationally reportable incidents) are identified and captured, investigated, quality assured, approved and responded to within required timeframes.	Reasonable
3 Monitoring and reporting take place at appropriate forums within the Health Board.	Substantial
4 National Reportable Incidents (NRI) and where applicable local reportable incidents action plans are in place for lessons learnt from patient’s safety incidents and learnings and reports are shared across the Health Board.	Substantial

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Amending of Health Board Incident, Hazard and Near Miss reporting Policy and Procedure	1	Design	Medium
2	Finalise and availability of National Incident Tool Kit Guidance	1	Design	Medium
3	Evidence to support adherence to incident management requirements	2	Operation	Medium

6.5 Follow-up: Cyber Security

Purpose

The overall objective of this audit is to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Cyber Security (2223-24) review that was reported as part of our 2021/22 work programme.

Overview of findings

Good progress has been made to address the recommendations contained within the original report.



A Cyber Security Improvement plan was developed and implemented in November 2023 and presented to the Digital Health and Intelligence Committee in February 2024.

Terms of Reference for the CAV Cyber Security Meeting and Cyber Security Sub-Group have been implemented and action logs and meeting minutes have been maintained.






We note that two recommendations remain in progress.

- Whilst the Cyber Security Improvement Plan has been developed, it lacks assigned officers and a timetable for implementation.
- Our review of Cyber reports to the Digital Health and Intelligence Committee noted that KPI's have not yet been developed.

Follow-up Report Classification

	Follow up: Most high priority recommendations implemented and progress on the medium priority recommendations.	Trend  2022/23
-----------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------

Progress Summary

Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1 Lack of Cyber Security Improvement Plan	High		Low
2 Cyber security monitoring	High		Closed
3 Cyber Security Improvement reporting	Medium		Closed
4 Performance Measures / KPI's	Medium		Medium
5 Data back-ups and restores	High		Closed

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6.6 Financial Management within Clinical Boards

Purpose

The overall objective of the audit was to review the processes operating within the Clinical Boards around financial management, budgetary control and delivery of savings.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Ensuring budget holders regularly access the financial system available to them.
- Ensuring that Clinical Boards identify and deliver savings schemes to deliver their delegated savings targets.

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Assurance summary¹

Objectives	Assurance
1 Sufficient, relevant and reliable information available to Clinical Board budget holders.	Reasonable
2 Clinical Boards work collaboratively with their Finance Business Partners.	Substantial
3 Clinical Board's Financial position presented and discussed.	Substantial
4 Clinical Board's have developed agreed achievable savings plans for 2023/24	Reasonable
5 Implementation of agreed savings plans are monitored, reported and acted upon.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Budget holders not accessing financial reports	1	Operation	Medium
3	Savings Plans 23/24 not being identified and achieved	4, 5	Operation	Medium

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6.7 Mortality Reviews

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for Mortality Reviews.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- An overarching policy and procedure has not yet been developed by the Health Board due to the All- Wales Learning from Mortality Review Model Framework not yet being finalised;
- There is currently a backlog of cases referred back to the Health Board by the Medical Examiner Service which are awaiting internal review and closure. The Health Board aims to clear the backlog by March 2024; and
- There are a number of key priorities that need to be implemented by the Health Board in order to further develop the mortality review processes.

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 The Health Board has appropriate policies and procedures in place setting out the mortality reviews process	Reasonable
2 Robust processes are in place for interacting with the Medical Examiner Service	Reasonable
3 Cases referred back to the Health Board by the Medical Examiner are subject to appropriate review in each Clinical Board	Reasonable
4 Adequate review and reporting and to ensure lessons are learned	Reasonable

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Policies and procedures	1, 2	Medium
2	Review of cases not up to date	3	Medium
3	Implementation of Key priorities for the Learning from Mortality Group in 2024	2, 3 & 4	Medium

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6.8 Cancer Services

Purpose

Review the effectiveness of the structures and processes in place to provide sustainable cancer services that deliver the single cancer pathway standards.

Overview

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

- Further clarity on the remit, roles and responsibilities of clinical boards and the Cancer Services Team.
- Improve the visibility of suspected cancer patients entering pathways.
- Undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.
- Secretarial support is advised for documenting the Executive Cancer Board business.
- Define the risk management process for the Cancer Services team.

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

Report Opinion



Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary¹

Objectives	Assurance
1 Roles and responsibilities	Reasonable
2 Governance Arrangements	Reasonable
3 Improvement trajectories and action plans	Substantial
4 Performance metrics	Substantial
5 Monitoring and reporting	Reasonable

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

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
1	Clarity on roles and responsibilities	1 Operation	Medium
2	Visibility of patients on Suspected Cancer Pathways	1 Operation	High
3	Executive Cancer Board business is not minuted	2 Design	Medium
4	Define risk management arrangements for the Cancer Service Team	2 Design	Medium

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6.9 Risk Management / Board Assurance Framework

Purpose
 The overall objective of the review was to determine and evaluate the ongoing development, implementation and application of the Health Boards Risk Management and Board Assurance processes.

Overview
 We have issued reasonable assurance on this area.



The Health Board has an up-to-date Risk Management Strategy and supporting Procedures in place, with effective Board Assurance Framework and Corporate Risk Register processes in operation. Overall, we note that the majority of the risk management processes are consistently applied throughout the Health Board operations.

The matters requiring management attention include:

- Testing identified numerous gaps of information including owners of risks not being detailed on the Clinical Boards/ directorates and departmental risk register.
- Possible delays in risk escalation to the Corporate Risk Register.

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

Report Opinion

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

Assurance summary¹

Objectives	Assurance
1 Strategy and Framework	Substantial
2 Identification and classification	Substantial
3 Risk registers	Reasonable
4 Risk ownership and management	Reasonable
5 BAF, CRR & risk escalation	Reasonable
6 Monitoring and Review	Reasonable
7 Recommendation implementation	Substantial

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

Key Matters Arising

No	Objective	Control Design or Operation	Recommendation Priority
2	Risk ownership and register update	3 & 4	Medium
3	Escalation of Risks to the Corporate Risk Register	5	Medium

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ASSIGNMENT STATUS SCHEDULE

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

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
<i>Estates Assurance – Estate Condition</i>	4	Finance	Q1		Final Report	Limited	February
Mental Health Clinical Board Governance Arrangements	24	COO	Q1		Final Report	Reasonable	February
<i>Capital Systems</i>	3	Finance	Q2		Final Report	Reasonable	February
Technical Continuity	13	Digital & Health Intelligence	Q2		Final Report	Reasonable	February
Alcohol Standards	21	Public Health	Q2		Final Report	Limited	February
Health Roster System	9	People & Culture	Q2/3		Final Report	Limited	February
Infection Prevention & Control	30	Nursing	Q3		Final Report	Reasonable	February
Financial Management within Clinical Boards	2	Finance	Q2		Final Report	Reasonable	May
Patient Safety Incident Management	29	Nursing	Q2		Final Report	Reasonable	May
Mortality Reviews	33	Medical	Q2		Final Report	Reasonable	May
Core Financial Systems (Asset Register Management)	1	Finance	Q2/3		Final Report	Substantial	May
Information Governance	14	Digital & Health Intelligence	Q3		Final Report	Reasonable	May
Follow-up: Cyber Security	15	Digital & Health Intelligence	Q3		Final Report	Reasonable	May
Cancer Services	23	COO	Q3		Final Report	Reasonable	May
Risk Management / Board Assurance Framework	5	Corporate Governance	Q4		Final Report	Reasonable	May
Temporary Staffing Costs	7	People & Culture / Finance	Q3		Draft Report	Limited	July

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Medical Records Tracking (CD&T) Follow-up	27	COO	Q3		Draft Report	Reasonable	July
Decarbonisation	19	Strategic Planning	Q4		Draft Report	Limited	July
Management of Health Board Policies Follow-up	35	Nursing	Q4		Draft Report	Reasonable	July
Eye Care Digitisation Programme	38	Finance	Q4		Draft Report	Reasonable	July
PCIC Clinical Board Governance	25	COO	Q2		Work in Progress		July
IMTP Development Process	16	Strategic Planning	Q3		Work in Progress		July
Implementation of People & Culture Plan	8	People & Culture	Q4		Work in Progress		July
Performance Reporting	11	Digital & Health Intelligence	Q4		Work in Progress		July
Maternity Care – Ockenden Review	31	Nursing	Q4		Work in Progress		July
<i>Development of Integrated Audit Plans:</i>							
• UHL Endoscopy Development	34	Strategic Planning	Q2		Final Report	Reasonable	May
Reviews removed from the plan							
ISO Accreditation within ALAC	32	Therapies	Q1	Q2	The external accreditation review has been completed with a positive outcome, so no value in completing our planned audit. Removal agreed with the Director of Therapies and Health Science. Agreed by September AC.		
Medicine CB – Acute Model / Same Day Emergency Care	26	COO	Q3		The COO requested deferral to Q1 of the 24/25 plan to allow further time for the developments to be embedded. Agreed by September AC.		

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Business Continuity Planning	17	Strategic Planning	Q3		Proposed for deferral to the 24/25 plan due to the sickness absence of the lead manager. Deferral has been agreed with the Executive Director of Strategic Planning. Agreed by February AC.		
Shaping Our Future Hospitals Programme	20	Strategic Planning	Q4		Proposed for removal from the plan as the Programme is not currently progressing. Removal has been agreed with the Executive Director of Strategic Planning. Agreed by February AC.		
UHW – Tertiary Tower	37	Strategic Planning	TBC		Proposed for deferral to the 24/25 plan due to delays with the progression of the scheme on site. To be agreed by May AC.		

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REPORT RESPONSE TIMES

Audit	Rating	Status	Draft issued	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Recommendation Tracking	Substantial	Final	25/07/23	15/08/23	11/08/23	11/08/23	G
Pentyrch Surgery Development – Site Evaluation Process	Advisory	Final	08/09/23	29/09/23	21/09/23	21/09/23	G
Leadership and Management Training and Development	Advisory	Final	21/09/23	12/10/23	02/10/23	03/10/23	G
Refresh of the Health Board's Strategy	Limited	Final	29/09/23	20/10/23	06/10/23	09/10/23	G
PARIS System	Reasonable	Final	28/09/23	19/10/23	02/10/23	09/10/23	G
Quality, Safety & Experience Governance	Advisory	Final	17/08/23	8/09/23	12/10/23	13/10/23	R
Surgery CB - Consultant Job Plans (22/23)	Limited	Final	10/08/23	31/08/23	16/10/23	17/10/23	R
Urgent and Emergency Care – Welsh Government Six Goals Programme	Substantial	Final	12/10/23	22/11/23	19/10/23	19/10/23	G
Follow-up: Chemocare IT System	Reasonable	Final	26/09/23	17/10/23	23/10/23	24/10/23	R
Capital Systems	Reasonable	Final	21/09/23	06/10/23	06/10/23	25/10/23	G
HealthRoster System	Limited	Final	12/10/23	02/11/23	16/11/23	16/11/23	R
Shaping Our Future Wellbeing – Future Hospitals Programme	Advisory	Final	16/10/23	06/11/23	17/11/23	17/11/23	R
Mental Health Clinical Board Governance Arrangements	Reasonable	Final	02/11/23	23/11/23	21/11/23	28/11/23	G
Alcohol Standards	Limited	Final	15/11/23	01/12/23	22/12/23	21/12/23	G
Infection Prevention & Control	Reasonable	Final	02/01/24	23/01/24	22/01/24	22/01/24	G
Technical Continuity	Reasonable	Final	12/12/23	05/01/24	24/01/24	24/01/24	R
Estates Assurance – Estate Condition	Limited	Final	11/09/23	02/10/23	24/01/24	24/01/24	R
University Hospital Llandough Endoscopy Development	Reasonable	Final	30/11/23	21/12/23	26/02/24	26/02/24	R
Information Governance	Reasonable	Final	09/02/24	01/03/24	28/02/24	29/02/24	G

Audit	Rating	Status	Draft issued	Responses & exec sign off required	Responses & Exec sign off received	Final issued	R/A/G
Core Financial Systems (Asset Register Management)	Substantial	Final	21/03/24	15/04/24	27/03/24	04/04/24	G
Patient Safety Incident Management	Reasonable	Final	04/03/24	25/03/24	05/04/24	05/04/24	R
Follow-up: Cyber Security	Reasonable	Final	14/03/24	08/04/24	04/04/24	05/04/24	G
Mortality Reviews	Reasonable	Final	09/02/24	01/03/24	24/04/24	24/04/24	R
Financial Management within Clinical Boards	Reasonable	Final	04/03/24	25/03/24	23/04/24	24/04/24	R
Cancer Services	Reasonable	Final	12/03/24	04/04/24	30/04/24	01/05/24	R
Risk Management / Board Assurance Framework	Reasonable	Final	08/04/24	30/04/24	30/04/24	01/05/24	G






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KEY PERFORMANCE INDICATORS

Indicator Reported to Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2023/24	G	April 2023	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 2023/24	A	84% 31 from 37	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	94% 29 from 31	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	54% 14 from 26	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	96% 25 from 26	80%	v>20%	10%<v<20%	v<10%

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Assurance Ratings

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

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

Date issued: May 2024

Document reference: 4206A2024

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

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

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About this document

- 1 This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board. We are presenting our 2024 Audit Plan to the Committee in May 2024.
- 2 We also provide additional information on:
 - Other relevant examinations and studies published by the Auditor General.
 - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
- 3 Details of future and past Good Practice Exchange (GPX) events are available on our [website](#).

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Financial audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2023-24 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2023-24 Annual Report and Accounts.	We started our audit planning in March 2024.	On 11 July 2024. To be considered by the Audit and Assurance Committee, followed by the Board. The Auditor General is scheduled to certify the audited Annual Report and Accounts on 12 July.

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Performance audit update

5 Exhibit 2 summarises the status of our current and planned performance audit work.

Exhibit 2 – Performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Primary Care Services - Follow-up Review (2022 Local Work)	Chief Operating Officer	In 2018, we conducted a review of primary care services, specifically considering whether the Health Board was well placed to deliver the national vision for primary care as set out in the national plan. We made several recommendations to the Health Board. This work will followed-up the Health Board's progress against these recommendations.	Complete – report in today's papers.	May 2024
Structured Assessment 2024 – core	Director of Corporate Governance	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review:	Planning	November 2024

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		<ul style="list-style-type: none"> • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements. 		
Review of Unscheduled Care	Chief Operating Officer	<p>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.</p> <p>The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1).</p> <p>We also plan to review progress being made in managing unscheduled care</p>	<p><u>Blog and data tool</u> published in April 2022</p> <p>Part 1 – Regional report being drafted.</p> <p>Part 2 – Fieldwork underway</p>	<p>July 2024</p> <p>November 2024</p>

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).		
Structured Assessment 2023 Deep Dive – review of cost savings arrangements	Executive Director of Finance	Given the significantly challenging financial position across NHS Wales, this review is examining the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Reporting	September 2024
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Director of Digital and Health Intelligence	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Planning	To be confirmed
Planned Care review	Chief Operating Officer	This work will follow on from the national report on <u>tackling the planned care backlog</u> .	Planning	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		<p>Whilst the exact focus of this work is still to be determined, it is likely to consider:</p> <ul style="list-style-type: none"> • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and <p>Use of the additional Welsh Government financial allocations to improve waiting lists.</p>		
Review of eye care services (2024 local work)	Chief Operating Officer	<p>Following on from our report on orthopaedic services last year, we will review the Health Board's speciality with the highest level of waits - eye care services.</p> <p>We will assess the Health Board's services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. Scoping work will be completed in due course, but we expect to include both community and acute eye care services within the scope of this work.</p>	Planning	To be confirmed

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Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<u>Supporting Ukrainians in Wales</u>	March 2024
<u>From firefighting to future-proofing – the challenge for Welsh public services</u>	February 2024
<u>Board Effectiveness Follow-up - Betsi Cadwaladr University Health Board</u>	February 2024

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. Links to the documents on our website are provided.

Exhibit 4 – Audit Wales corporate documents

Title	Publication Date
<u>Annual Plan 2024-25</u>	April 2024

- 8 There are no relevant Audit Wales consultations currently underway.

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

Primary Care Follow-up Review – Cardiff and Vale University Health Board

Audit year: 2022

Date issued: March 2024

Document reference: 4096A2024

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

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Summary report

Introduction

- 1 Primary care is the first point of contact for the majority of people who use health services in Wales. It encompasses a wide range of services, delivered in the community by a range of providers, including General Practitioners (GPs), Pharmacists, Dentists, Optometrists, as well as other professionals from the health, social care, and voluntary sectors.
- 2 In 2018-19, the Auditor General reviewed primary care across all Health Boards in Wales, with a particular focus on general practice. That work focussed on strategic planning, investment, workforce, oversight and leadership, and performance. Our [2018 Review of Primary Care](#) at Cardiff and Vale University Health Board found that primary care was a growing priority, with the Health Board making progress towards delivering its ambitious plans, with workforce pressures being less acute than in some areas. However, our review also found that primary care performance was mixed, and a number of difficult challenges remained.
- 3 The landscape for primary care in Wales has changed since our original review in 2018. Welsh Government has published its long-term plan for health and social care - [A Healthier Wales](#). The plan highlights primary care's crucial role in helping to realise the ambition of creating a seamless whole system approach with services designed around people, based on their needs, supporting them to stay well and not just providing treatment when they become ill. This means that more services traditionally provided in a hospital setting are shifted into the community to provide care at home or closer to home to take pressure off hospitals and reduce the time people wait to be treated.
- 4 The [Strategic Programme for Primary Care](#)¹ set out its programme aims which are designed to support the delivery of the primary care contribution to 'A Healthier Wales'. These are being taken through six workstreams of work which health boards are expected to then implement at a local level:
 - focussing on 'ill-health' prevention and wellbeing;
 - developing 24/7 access to services;
 - exploiting data and digital technologies;
 - strengthening workforce and organisational development;
 - improving communications and engagement; and
 - developing 'cluster-level' vision and enabling service transformation.
- 5 In February 2023, the National Primary Care Board, which oversees the Strategic Programme for Primary Care, identified that this work is progressing at a varying pace within each health board area. Alongside this, there are wider concerns

¹ The Strategic Programme for Primary Care is the all-Wales primary care response and contribution to 'A Healthier Wales'.

around the capacity of central Primary Care Services Teams within health boards to deliver organisational priorities, as well as Board-level visibility and focus on primary care.

- 6 Welsh Government has also embarked on an ambitious programme of contract reform across General Medical Services, Dentistry, Community Pharmacy, and Optometry to:
 - ensure primary care services are sustainable;
 - improve patient access to primary care services;
 - reinforce the focus on quality and prevention;
 - enable cluster working to plan and deliver services; and
 - strengthen the workforce.
- 7 Primary care services were severely impacted by the COVID-19 pandemic. Whilst the immediate public health emergency has subsided, primary care providers continue to face challenges as they seek to restore, recover, and reconfigure their services to meet the needs and expectations of the public in a post-pandemic world.
- 8 Our review has focussed primarily on assessing the extent to which the Health Board has implemented our 2018 recommendations. However, we have also undertaken some additional work to assess the extent to which:
 - the Health Board’s central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs; and
 - the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board’s primary care services.
- 9 The methods we used to deliver our work are summarised in **Appendix 1**.

Key messages

- 10 Overall, we found **the Health Board is progressing work to improve strategic planning, cluster maturity and leadership. However, central primary care services capacity remains stretched, and more work is required to establish a financial baseline and strengthen its approach for evaluating and mainstreaming new ways of working. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, reporting on delivery of plans, patient experience, and primary care performance and outcomes needs strengthening.**

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Implementation of previous audit recommendations

- 11 We found that **the Health Board has addressed actions relating to strategic planning and is also prioritising and strengthening alignment of cluster maturity and cluster lead training and development. However, despite shifting some resources from secondary to primary care, progress has remained slow, and a financial baseline has not yet been established. The Health Board also needs to strengthen arrangements for evaluating and mainstreaming new ways of working within primary care clusters.**
- 12 The Health Board's arrangements for considering regional population growth within its key strategic plans are effective. Whilst it does not have an overarching primary care strategy, the Primary, Community, and Intermediate Care (PCIC) Clinical Board is developing an annual delivery plan which sets out primary care strategic objectives aligned to regional and national priorities. The Health Board engages well with the public and stakeholders when developing strategic plans.
- 13 The Health Board has successfully shifted resources for some services from secondary to primary care, but progress remains slow. It has also struggled to establish a baseline understanding of the true cost of primary care.
- 14 The Health Board is successfully evaluating, mainstreaming, and publicising some new ways of working and is improving its arrangements for sharing learning. However, there are opportunities to strengthen these arrangements further.
- 15 The Health Board is progressing work to align cluster maturity. It is taking steps to review cluster membership and attendance at meetings and is strengthening development of cluster leads. However, the Health Board is struggling to appoint to some cluster lead vacancies, which could inhibit further progress in embedding the arrangements and present resilience and sustainability risks across clusters.

Board-level visibility and focus on primary care

- 16 We found that **primary care is reflected in key Health Board's strategies and plans. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, there are opportunities to strengthen reporting around the delivery of primary care plans, the experiences of patients accessing primary care services, and primary care performance and outcomes.**
- 17 Primary Care is a component of the Health Board's strategic plans, which clearly align to national priorities. The Health Board's PCIC Clinical Board delivery plan for 2024-25 sets out several short-term annual priorities. However, the absence of medium term (3 to 5 year) priorities presents risks to the Health Board's achievement of its long-term strategic objectives for primary care.
- 18 Board members engage with primary care leaders and staff thus demonstrating a commitment to the primary care agenda. Whilst matters affecting primary care are not fully embedded in Board and committee business, primary care is still visible at

these meetings, featuring in a range of Health Board reports with reasonable oversight and scrutiny of the information presented.

- 19 There continues to be a limited number of primary care performance measures included within the Health Board's Integrated Performance Report, with a lack of performance data and commentary on progress potentially inhibiting effective understanding and monitoring of primary care performance.
- 20 The Health Board's arrangements for monitoring progress of primary care plans through the IMTP / Annual Plan progress updates could be improved by providing a dedicated report on progress to deliver the PCIC Clinical Board's strategic objectives. There are also opportunities for the Health Board to be clearer on outcome-based measures to help understand what impact or difference it is making and whether it is resulting in improved outcomes and experiences for patients.

Capacity and capability to deliver local and national priorities

- 21 We found that **whilst the Health Board has increased the number of roles within its Central Primary Care Team, capacity remains stretched due to increasing workloads associated with local and national priorities. There are good arrangements in place to support the development of staff within the team, but succession planning arrangements require strengthening.**
- 22 The Health Board's PCIC Clinical Board have clear lines of accountability to the Chief Operating Officer, who is supported by an effective management structure. The Health Board has increased the Primary Care Team's capacity, but increasing workloads associated with both local and national priorities are stretching some senior leadership staff, impacting on their ability to respond to and manage day-to-day operational and business needs.
- 23 The Health Board is supporting staff with training and development across PCIC services. However, we found limited evidence that it has succession plans within the Primary Care Services Team, presenting some risks to the resilience of the team.

Recommendations

- 24 The status of our 2018 audit recommendations is summarised in **Exhibit 1**.

Exhibit 1: status of our 2018 recommendations

Implemented	Ongoing	No action	Superseded	Total
	11	-	-	14

- 25 As a result of this follow-up work, we have made new recommendations for the Health Board to address which are set in out **Exhibit 2**. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 2: recommendations

Recommendations

Investment in primary care

R1 The Health Board should:

- 1.1. Calculate a baseline position for its current investment and resource use in primary and community care.
- 1.2. Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.

New ways of working

R2 The Health Board should:

- 2.1 Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;
- 2.2 Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;
- 2.3 Subject to positive evaluation, begin to fund new models from mainstream funding; and
- 2.4 Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce the demand for GP appointments.

Primary care clusters

R3 The Health Board should:

- 3.1 Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.
- 3.2 Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups.

Recommendations

Strategic approach to primary care

- R4 The Primary, Community, and Intermediate Care Clinical Board Delivery Plan should include medium-term (3 to 5 year) priorities to support delivery of the Health Board's longer-term strategic objectives for primary care.
-

Board oversight and visibility

- R5 The Health Board should:
- 5.1 Ensure that the contents of Board and committee performance reports adequately cover primary care;
 - 5.2 Increase the frequency of primary care performance reporting to Board and committees; and
 - 5.3 Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients.
-

Annual reporting

- R6 Following the implementation of the Primary, Community and Intermediate Care Delivery Plan, the Health Board should produce an annual Primary Care Report setting out its achievements during the previous year, with the first report reflecting the period 2024-25.
-

Succession planning

- R7 The Health Board should strengthen succession planning arrangements for its Primary Care Services Team to ensure greater resilience and business continuity in terms of skills, expertise, and knowledge.

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Detailed report

Implementation of previous audit recommendations

- 26 We considered the Health Board's progress in implementing our 2018 audit recommendations. These focus on:
- strategic planning (2018 Recommendations 1 and 2);
 - investment in primary care (2018 Recommendations 3a and b);
 - new ways of working (2018 Recommendations 4a, b, c, and d); and
 - primary care clusters (2018 Recommendations 5a, b, and c).
- 27 Recommendations relating to oversight of primary care at Board and committees (2018 Recommendations 6a, b, and c) are discussed later in this report.
- 28 Overall, we found that **the Health Board has addressed actions relating to strategic planning and is also prioritising and strengthening alignment of cluster maturity and cluster lead training and development. However, despite shifting some resources from secondary to primary care, progress has remained slow, and a financial baseline has not yet been established. The Health Board also needs to strengthen arrangements for evaluating and mainstreaming new ways of working within primary care clusters.**

Strategic planning

- 29 We considered whether the Health Board has revisited its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff (2018 Recommendation 1). We also considered whether the Health Board has developed the necessary consultation and communication plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans (2018 Recommendation 2).
- 30 We found that **the Health Board's key strategic plans consider the impact of population growth, alongside risks and actions, to meet population need. We also found that the Health Board has effective arrangements for communicating and engaging with the public and stakeholders on primary care plan development, activity, and service changes.**
- 31 The Health Board has effective arrangements for considering regional population growth in key strategic plans. It has used the [Cardiff and Vale of Glamorgan Population Needs Assessment 2022](#) to inform its long-term strategy – ('[Shaping our Future Wellbeing](#)'), its [Annual Plan 2023-24](#), and its [Local Public Health Plan 2020-23](#). These plans clearly demonstrate how the Health Board is considering population growth and taking action to meet the needs of its population. For example, the long-term strategy sets out a priority to align the Health Board's workforce to the demographic profile of the population by 2035, and the Annual Plan acknowledges that while population growth trends have slowed, it is

continuing to grow. The Health Board's Growth and Capacity Review², which was used to inform its Estate Strategy refresh, also sets out plans for significant population growth alongside capacity and funding risks to meet population needs. The review includes a forward action plan with specific actions and a responsible officer to mitigate these risks.

- 32 Whilst the Health Board does not have a dedicated Primary Care Strategy, the Primary, Community and Intermediate Care (PCIC) Clinical Board is developing an Integrated Delivery Plan for 2024-25. The Delivery Plan sets out proposed strategic objectives aligned to relevant Health Board, national, and regional priorities³. The strategic objectives include associated priority objectives, implications, risks, and milestones for their delivery with several of these focussing on meeting population need through improved service sustainability.
- 33 Primary Care Clusters and Pan Cluster Planning Groups also use the Cardiff and Vale of Glamorgan Population Needs Assessment to inform decision making and develop plans to respond to areas of population need. **We therefore consider 2018 Recommendation 1 to be implemented.**
- 34 The Health Board has effective arrangements in place to ensure public engagement in primary care plan development, activity, and service changes. Our 2023 Structured Assessment report comments positively on the extensive public engagement undertaken by the Health Board whilst refreshing its long-term strategy, 'Shaping Our Future Wellbeing', which focuses on preventing ill health, tackling inequality, and providing 'care closer to home'. In addition, the PCIC Clinical Board has established a Primary Care Communication Activity Steering Group using Welsh Government funding. This group is responsible for supporting local communication activity within primary care, specifically the Primary Choice campaign, which aims to promote the expanding multi-disciplinary team model and roles within primary care to the public. The Health Board also has a strong working relationship with the new citizens' voice body, Llais Wales⁴, and actively engages with it when planning and communicating service changes within primary care clusters. **We therefore consider 2018 Recommendation 2 to be implemented.**

Investment in primary care

- 35 We considered whether the Health Board has calculated a baseline position for its current investment and resource use in primary and community care (2018

² The Local Development Plan Growth and Capacity Review informs the Health Board's 2019 Primary Care Estates Strategy and provides a position on planned population growth, general practice capacity and key issues, risks, and a forward plan.

³ These include: 6 goals for urgent and emergency care; primary care contractor services sustainability; community and specialist services sustainability; and whole system / clinical pathway improvement.

⁴ From 1st April 2023, 'Llais' replaced the seven Community Health Councils.

Recommendation 3a). We also considered whether the Health Board has reviewed and reported, at least annually, its investment in primary and community care to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care (2018 Recommendation 3b).

- 36 We found **that the Health Board is shifting some resources from secondary to primary care, but progress remains slow. However, the development of a long-term financial model should help the Health Board to establish a clear financial baseline position for primary care to enable it to support the shift in resources and evaluate and demonstrate the progress it is making.**
- 37 The Health Board has struggled to establish a financial baseline to understand the 'true cost' of primary care. However, it is demonstrating strategic intent and has successfully transferred some resources from secondary to primary care, for example, staff and funding for musculoskeletal services, and mental health services. However, in general, progress has been slow due to several challenges and barriers that will need to be overcome before further progress can be made. These include: the continuing focus on improving secondary care performance measures; the impact of the COVID-19 pandemic; financial constraints; the prolonged evaluation and evidence gathering process (see **paragraph 41**); and the complexities of moving investment funding between services.
- 38 Positively, the Health Board is currently developing a long-term financial model to achieve financial sustainability in future years. As part of this work, it is exploring how it can focus its resources on primary, community, and preventative care to achieve savings in the long-term. This should also help it to establish a clear financial baseline position to determine the true cost of primary care against which it can evaluate and demonstrate the progress it is making in shifting resources. **We therefore consider 2018 Recommendations 3a and 3b to be ongoing. They have now been replaced by 2024 Recommendation 1.1 and 1.2.**

New ways of working

- 39 We considered whether the Health Board has:
- worked with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models (2018 Recommendation 4a);
 - centrally collated evaluations of new ways of working and share the learning by publicising the key messages across all clusters (2018 Recommendation 4b);
 - subject to positive evaluation, began to fund new models from mainstream funding rather than the primary care development fund (2018 Recommendation 4c); and
 - worked with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce the demand for GP appointments (2018 Recommendation 4d).

40 We found that **whilst the Health Board is evaluating, mainstreaming, and promoting some new ways of working, these arrangements are not yet fully embedded within primary care clusters which hinders further progress.**

41 The Health Board has successfully evaluated and mainstreamed (using core funding) some new ways of working, such as its Musculoskeletal and Mental Health Service models. However, it has not yet fully embedded its evaluation arrangements within primary care clusters resulting in inconsistent approaches to evaluating new ways of working. There is good evidence that the Health Board is sharing learning and key messages nationally and locally using cluster peer review, accelerated cluster development reviews, locality meetings, and the Clinical Services Group. However, it still needs to establish a systematic and consistent approach for centrally collating evaluations, sharing learning, and publicising key messages across clusters. In **paragraph 37**, we comment on the challenges and barriers it will need to overcome to enable further investment in primary care and therefore make further progress to mainstream new ways of working. **We therefore consider 2018 Recommendations 4a, 4b and 4c to be ongoing. They have now been replaced by 2024 Recommendations 2.1, 2.2., and 2.3.**

42 The Health Board has good arrangements in place to promote new ways of working. In **paragraph 34** we comment on the role of the Health Board's Primary Care Communication Activity Steering Group and the Primary Choice campaign. Our work found that the Health Board uses accessible language and terminology and different communication methods to engage with the public. However, it still needs to strengthen the arrangements by increasing public awareness of how to access the appropriate first point of contact for their needs. **We therefore consider 2018 Recommendation 4d to be ongoing. It has now been replaced by 2024 Recommendation 2.4.**

Primary care clusters

43 We considered whether the Health Board has:

- reviewed the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary (2018 Recommendation 5a).
- reviewed the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups (2018 Recommendation 5b).
- Encouraged all cluster leads to attend the Confident Primary Care Leaders course (2018 Recommendation 5c).

44 We found that **the Health Board is progressing work to align primary care cluster maturity, review cluster membership and attendance at meetings, and strengthen training and development for Cluster Leads. However, it is**

struggling to appoint to several Cluster Lead roles which could inhibit progress in embedding these arrangements and present resilience and sustainability risks across clusters.

- 45 The Health Board's emerging PCIC Clinical Board Delivery Plan for 2024-25 identifies alignment of primary care cluster maturity as a key priority. The plan identifies milestones spanning 2023-24 and 2024-25 to ensure the Health Board strengthens its support for clusters. These include completing a cluster peer review to inform development needs and maturity assessment of clusters, building capacity through its community care programme, and strengthening cluster planning and delivery.
- 46 The Health Board has also recently established Pan Cluster Planning Groups and as mentioned in **paragraph 41**, appointed Cluster Development Managers to strengthen the planning, commissioning, and delivery of services across primary care clusters. However, it is too early to evaluate the effectiveness of these arrangements. **We therefore consider 2018 Recommendation 5a to be ongoing. It has now been replaced by 2024 Recommendation 3.1.**
- 47 In April 2022, the national Strategic Programme for Primary Care issued model terms of reference for cluster meetings which formally extended membership to include social care leads and third sector representatives. The terms of reference also included representation from other areas such as Public Health Wales, mental health services, and medicines management. Clusters were also given the option to include other members as required although patient representation was considered not to form part of the core membership. Instead, this was suggested to be covered through the establishment of patient engagement and participation forums where relevant at a local level. The Health Board is currently reviewing cluster membership to identify gaps in the existing arrangements, and wider cluster membership as it identifies more partners. **We therefore consider 2018 Recommendation 5b to be ongoing. It has now been replaced by 2024 Recommendation 3.2.**
- 48 The Health Board is taking some positive steps to strengthen leadership training for Cluster Leads. Since our previous work, the Confident Primary Care Leaders course has changed its focus to Aspiring Practice Managers, with national discussions taking place with respect to developing a national leadership development programme for primary care. In its absence, the Health Board is supporting PCIC Clinical Board staff, including Cluster Leads, to attend several leadership programmes and training courses provided by the Health Education and Improvement Wales (HEIW) 'Gwella Leadership Platform' and Academi Wales. The Health Board is also establishing a PCIC Academy to provide additional education and training support within the PCIC Clinical Board. We comment on this further in **paragraph 70. We therefore consider 2018 Recommendation 5c to be implemented.**
- 49 Despite this investment and additional plans to strengthen Cluster Lead training and development through the Accelerated Cluster Development Programme, there

are several vacancies among Cluster Lead roles which present resilience and sustainability risks across clusters. The Health Board is currently developing a Strategic Workforce Plan for Primary Care which sets out several priorities for addressing recruitment and retention of staff across all primary care settings, including clusters.

Board-level visibility and focus on primary care

- 50 We considered the extent to which the Board and / or its committees regularly consider matters relating to the planning, performance, risks, and opportunities associated with the Health Board's primary care services.
- 51 We expected to see the following:
- Primary care is reflected in Health Board strategies and plans and reflect the ambitions of 'A Healthier Wales.'
 - Primary care features in the terms of reference and workplans of the Board and relevant committee(s).
 - The Health Board ensures primary care is regularly considered at Board and committee meetings and features within papers and reports from wider elements of the Health Boards business, e.g., finance, risk, and relevant service reports.
 - The Health Board considers publishing a dedicated annual report on primary care.
- 52 We also considered whether:
- The contents of Board and committee performance reports adequately cover primary care (2018 Recommendation 6a).
 - The Health Board has increased the frequency of primary care performance reporting (2018 Recommendation 6b).
 - The Health Board has ensured that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and outcomes for patients (2018 Recommendation 6c).
- 53 We found that **primary care is reflected in key Health Board's strategies and plans. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, there are opportunities to strengthen reporting around the delivery of primary care plans, the experiences of patients accessing primary care services, and primary care performance and outcomes.**
- 54 Primary Care is sufficiently reflected in the Health Board's long-term strategy and 2023-24 Annual Plan. These plans are clearly aligned to the ambition of 'A Healthier Wales', and place a strong emphasis on providing care closer to home. As mentioned in **paragraph 32**, the Health Board is developing a PCIC Clinical Board Delivery Plan for 2024-25. Whilst this plan sets out several short-term

annual priorities to respond to urgent issues, the absence of medium-term priorities potentially presents a risk to the Health Board's achievement of its long-term strategic objectives for primary care **(2024 Recommendation 4)**.

- 55 Board members proactively engage with primary care leaders and staff thus demonstrating a clear commitment to the Health Board's primary care agenda. For example, the Vice Chair has chaired accelerated cluster development meetings and shared learning with the Board at meetings. Also, both the Chair and Vice Chair attend routine meetings with the Director of Operations and other senior leaders bi-monthly and monthly respectively, to discuss primary care performance and plans.
- 56 However, matters relating to primary care are not fully embedded within routine Board and committee business. Other than some focus on monitoring of performance information across commissioned services, including primary care and primary care contracts, neither the terms of reference nor workplans for committees refer to primary care. The Health Board, therefore, should consider strengthening these key documents to ensure continued focus on this element of its business.
- 57 Despite this, primary care is still visible at Board and committees with reasonable scrutiny and oversight of the information presented. During 2021-22, the Board Assurance Framework (BAF) included a principal risk relating to the sustainability of primary and community care services. However, in September 2023, it was incorporated into a broader strategic risk relating to the provision of sustainable urgent and emergency care as close to home as possible. Whilst we found this approach to be broadly satisfactory, the Health Board will need to ensure that it still actively considers and manages key strategic risks facing primary care through its corporate and operational risk management arrangements.
- 58 The PCIC Clinical Board routinely presents an Assurance Report to the Health Board's Quality, Safety, and Experience (QSE) Committee which provides assurance over key elements of the Clinical Board's quality and safety performance, updates on community pharmacy, General Medical Services, dental service sustainability, and key risks for committee consideration. Overall, we found the report to provide appropriate level of information for effective scrutiny and assurance.
- 59 Primary care also features within papers and reports from wider elements of the Health Board's business. For example, the PCIC Clinical Board update to the People and Culture Committee on values-based appraisal, and statutory and mandatory training compliance in March and July 2023. Routine finance reports to the Finance and Performance Committee also reference primary care in the context of savings schemes delivery, and cashflow forecast. The Health Board also completed a deep dive into General Dental Services provision and intends to report to the November 2023 Finance and Performance Committee.
- 60 The Board and Finance and Performance Committee routinely consider the Health Board's Integrated Performance Report which sets out primary care performance

against Health Board priorities, Annual Plan commitments, and the NHS Wales Performance Framework Measures. However, there continues to be a limited number of performance measures relating to access to primary care services and reports do not effectively reflect either primary care sustainability risks or wider primary care plans. Whilst the update provides an overview of in-month / period performance, sufficient data does not always accompany the primary care measures to enable effective monitoring of performance trends against the targets. It also does not provide sufficient clarity on the actions needed to improve performance, or the impact of actions taken. There are also opportunities for the Health Board to be clearer on outcome-based measures and reporting to help to understand what impact or difference it is making. **We therefore consider 2018 Recommendations 6a and 6b to be ongoing. They have been replaced by 2024 Recommendations 5.1 and 5.2.**

- 61 We note regular reporting at Clinical Board level on primary care business unit risks, performance, and delivery of plans. For example, an IMTP annual planning update, Primary Care contractual changes, primary care deep dives, and Executive review updates. Whilst some of this information is integrated into reports at committee level, there does not appear to be a dedicated report to the Board or relevant committee(s) on progress to deliver the PCIC Clinical Board's strategic objectives. There are also opportunities to strengthen reporting in relation to the improved outcomes and experiences of patients in primary care. **We therefore consider 2018 Recommendation 6c to be ongoing. It has been replaced by 2024 Recommendation 5.3.** The development of an annual PCIC Delivery Plan provides an opportunity to produce a primary care annual report in future years, setting out progress made against the PCIC Clinical Board's strategic objectives (2024 Recommendation 6).

Capacity and capability to deliver local and national priorities

- 62 We considered the extent to which the Health Board's central Primary Care Services Team has the appropriate capacity and capability (in terms of knowledge, skills, and experience) to deliver local and national priorities, as well as to manage day-to-day operational and business needs.
- 63 We expected to see the following:
- The Health Board's central Primary Care Services Team is appropriately structured with clear lines of accountability and reporting to the relevant senior manager(s).
 - The Health Board regularly assesses and allocates appropriate resources (including procuring external support as necessary) to its central Primary Care Services Team to ensure it can effectively manage day to day business operations and ongoing transformational change.

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- The Health Board regularly keeps resource levels within its central Primary Care Services Team under review.
- The Health Board identifies and supports the training, learning, and development needs of its central Primary Care Services Team on an ongoing basis to ensure an appropriate mix of skills, experiences, and abilities.
- The Health Board has suitable succession planning arrangements in place for its central Primary Care Services Team to ensure continuity and minimise the risks associated with loss of skills, knowledge, and experience.

64 We found that **whilst the Health Board has increased the number of roles within its Central Primary Care Team, capacity remains stretched due to increasing workloads associated with local and national priorities. There are good arrangements in place to support the development of staff within the team, but succession planning arrangements require strengthening.**

65 The Health Board's PCIC Clinical Board has clear lines of accountability to the Chief Operating Officer who has delegated authority for PCIC services and is a member of the Board. The role covers the entirety of the Health Board's clinical / operational services. Whilst this brings the advantage of a 'whole system' overview of service delivery, some of those we interviewed felt that the absence of a dedicated Board-level director role raises challenges around explaining and understanding complex issues and risks that may arise in primary care. Nevertheless, the Chief Operating Officer is supported by an effective management structure including the PCIC Clinical Board Clinical Director, Interim Director of Operations, and Head of Primary Care.

66 The Primary Care Services Team sits within the PCIC Clinical Board structure and is managed by the Assistant Director of Primary Care. The team's sub-structure encompasses two elements focussing on primary care contracting and dental and optometry. Since our previous review, the Health Board has made some changes to the existing establishment and skill mix within the team. It has introduced a Head of Dental and Optometry role and increased capacity by creating several new roles at Pay Bands 5, 6 and 7, spanning both primary care contracting and dental and optometry. These new roles are helping provide additional support for:

- General Medical Services sustainability;
- contract reform implementation and management;
- performance monitoring, governance, and assurance of primary care contracts;
- management of the dental centralised waiting list; and
- immunisations.

67 It is positive that the Health Board has provided additional capacity to the Primary Care Services Team, but increasing workloads associated with both local and national priorities are stretching some senior leadership staff, potentially impacting on their ability to respond to and manage day-to-day operational and business

needs. The Health Board's executive review process provides a mechanism for senior leadership to discuss resource and capacity concerns. In addition, the Health Board's strategic workforce plan for primary care aims to address capacity issues across all primary care settings.

- 68 The Health Board has reasonable arrangements to support staff training and development across PCIC Services. It uses staff appraisals to identify training and development need, and actively encourages staff to access Health Board facilitated training. Managers and senior leaders can also access external opportunities, such as the Institute of Leadership and Management (ILM) accredited programmes, and the Health Education and Improvement Wales (HEIW) 'Gwella Leadership Platform'. The PCIC Clinical Board is also actively developing coaching skills amongst its staff to help facilitate staff development through mentoring and shadowing opportunities.
- 69 Whilst there have been some internal promotions to leadership roles, we found limited evidence of succession planning within the Primary Care Services Team. This not only presents some short-term risks where existing staff are unable to cover unexpected absences, but also longer-terms risks in terms of resilience and business continuity following the loss of key skills, expertise, and knowledge (**2024 Recommendation 7**).
- 70 Positively, the Health Board's is establishing a PCIC Academy which will consider and co-ordinate training and education for a broad range of professionals working within primary and community services to deliver several priorities and strengthen succession planning arrangements, including:
- Building workforce sustainability through education and training;
 - Understanding and integrating new roles;
 - Maintaining excellence and develop careers;
 - Supporting development of multi-professional services; and
 - Developing experiences and opportunities.
- 71 The draft strategic workforce plan for primary care also sets out several priorities for improving access to education and training, leadership and succession, and workforce supply and shape.

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Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	<p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none">• Minutes and papers from Board and relevant committee meetings, including public and private Board meetings, PCIC Clinical Board minutes, Cluster Meeting minutes, Executive Review meetings, public Quality, Safety & Experience Committee meetings.• CAV 24/7 performance dashboard.• New primary care operational performance management dashboard.• The Health Board's Self-Assessment document and accompanying briefing paper.• GMS Service Sustainability Progress report.• 2022-25 Integrated Medium-Term Plan Update – Quarter 4.• Cardiff & Vale UHB Annual Report 2021-2022.• Cardiff & Vale UHB Annual Plan 2023-2024.• Cardiff & Vale UHB Long-term 'Shaping our Future Wellbeing' Strategy to 2035.• Cardiff & the Vale Population Needs Assessment 2022• Developing the PCIC Clinical Board Delivery Plan 2024-25 – September 2023 Update.• PCIC Clinical Board Assurance Report – July 2023
Interviews	<p>We interviewed the following:</p> <ul style="list-style-type: none">• Chief Operating Officer;• Vice Chair of the Board;• Primary, Community and Intermediate Care Clinical Board – Director of Operations; and• Primary, Community and Intermediate Clinical Board – Head of Planning.

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Element of audit methods	Description
Focus Groups	<p>We undertook focus groups with:</p> <ul style="list-style-type: none"> • Staff from the Health Board’s Communications team, including the Director of Communications and the Head of Communications. • Staff from the Health Board’s Corporate, Strategy, Planning & Performance functions, including the Director of Integrated Health & Social Care and the Executive Director of Strategic Planning. • Staff from the Health Board’s Primary, Community & Intermediate Care functions, including the Primary, Community, and Intermediate Care Clinical Board – Clinical Director, the Director of Nursing PCIC, the Assistant Director of Primary Care and the Primary, Community and Intermediate Care Clinical Board – Head of Finance.
Observations	<p>We observed the following meeting:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Committee

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Appendix 2

A summary of progress against our 2018 recommendations

Exhibit 4 sets out the recommendations we made in 2018 and our summary of progress.

Exhibit 4: summary progress against 2018 recommendations

Recommendations	Progress
<p>Strategic planning</p> <p>R1 The Health Board has developed an ambitious plan for primary care, but the plan does not consider the impacts of projected population growth as a result of housing developments in Cardiff. The Health Board should therefore revisit its primary care plan to ensure it includes specific actions to meet the needs of the projected population growth in Cardiff.</p>	<p>Implemented – see paragraphs 31 to 33</p>
<p>Investment in primary care</p> <p>R2 The Health Board’s plans for primary care have been developed with only limited consultation and collaboration with some key groups of stakeholders. The Health Board should therefore develop the necessary consultation and communications plans to ensure meaningful public and stakeholder engagement in any further development / refinement of its primary care plans.</p>	<p>Implemented – see paragraph 34</p>
<p>Investment</p> <p>R3 While the Health Board recognises that it needs to shift resources from secondary to primary and community settings, it cannot demonstrate that this shift is happening. The Health Board should:</p>	

Recommendations	Progress
<ul style="list-style-type: none"> a) Calculate a baseline position for its current investment and resource use in primary and community care. b) Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care. 	<p>Ongoing – see paragraphs 38 to 39</p> <p>Ongoing – see paragraphs 37 to 38</p>
<p>New ways of working</p> <p>R4 Whilst the Health Board is taking steps towards implementing some new ways of working, more progress is required to evaluate the effectiveness of these new models and to mainstream their funding. The Health Board should:</p> <ul style="list-style-type: none"> a) Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models. b) Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters. c) Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund. d) Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce demand for GP appointments. 	<p>Ongoing – see paragraph 41</p> <p>Ongoing – see paragraph 41</p> <p>Ongoing – see paragraph 41</p> <p>Ongoing – see paragraph 42</p>

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Recommendations	Progress
<p>Primary care clusters</p> <p>R5 Variation was found in the maturity of primary care clusters. The Health Board should:</p> <ul style="list-style-type: none"> a) Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary. b) Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase representation from local authorities, third sector, lay representatives and other stakeholder groups. c) Ensure all cluster leads attend the Confident Primary Care Leaders course. 	<p>Ongoing – see paragraph 46</p> <p>Ongoing – see paragraph 47</p> <p>Implemented – see paragraph 48</p>
<p>Oversight of primary care</p> <p>R6 Scope was found to improve the way in which primary care performance is monitored and reported at Board and committee level. The Health Board should:</p> <ul style="list-style-type: none"> a) Ensure the contents of its Board and committee performance reports adequately cover primary care. b) Increase the frequency with which Board and committees receive performance reports regarding primary care. c) Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care, and the extent to which those plans are resulting in improved experiences and <p>Saunders Nathan 17/05/2024 21:26:07</p>	<p>Ongoing – see paragraphs 55 to 60</p> <p>Ongoing – see paragraph 55 to 60</p> <p>Ongoing – see paragraph 61</p>

Recommendations	Progress
outcomes for patients.	

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Appendix 3

Organisational response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	<p>Investment in primary care</p> <p>The Health Board should:</p> <p>1.1 Calculate a baseline position for its current investment and resource use in primary and community care.</p> <p>1.2 Review and report, at least annually, its investment in primary and community care, to assess progress since the baseline position and to monitor the extent to which it is succeeding in shifting resources towards primary and community care.</p>	<p>During 2024/25 we will develop our baseline assessment of investment and resource into Primary & Community Care, which will be used as the basis in which resource shift (system efficiency and effectiveness) can be calculated year on year.</p>	<p>Quarter 4, 2024</p>	<p>PCIC Clinical Board Director, PCIC Director of Operations, PCIC Deputy Director of Operations, Assistant Director - Head of Finance</p>

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R2

New ways of working

The Health Board should:

- 2.1 Work with the clusters to agree a specific framework for evaluating new ways of working, to provide evidence of beneficial outcomes and inform decisions on whether to expand these models;
- 2.2 Centrally collate evaluations of new ways of working and share the learning by publicising the key messages across all clusters;
- 2.3 Subject to positive evaluation, begin to fund new models from mainstream funding; and
- 2.4 Work with the public to promote successful new ways of working, particularly new alternative first points of contact in primary care that have the potential to reduce the demand for GP appointments.

This work is already underway locally.

The National Accelerated Cluster Development (ACD) Programme facilitates Primary Care Clusters, made up of health and care professionals, to work across service boundaries to influence the development of services for their patients.

The plan of the Pan-Cluster Planning Groups (PCPG), covering both Cardiff and Vale regions, will progress work during the 2024 planning cycle to inform whole system efficiency and effectiveness opportunities from the lens of Primary Care, informed by current legacy/recurrent cluster delivered schemes with a strong evidence base for scalability.

A paper is to be provided to Cardiff and Vale Senior Leadership Board in May 2024, setting out the work of Clusters and Pan Cluster Planning Groups to date.

Development sessions are planned during Quarter 1 2024 to develop resources to further support evaluation and to further establish Cluster and Pan Cluster Planning Groups as part of the UHBs planning architecture.

Quarter 4, 2024

PCIC Clinical Board Director, PCIC Director of Operations, PCIC Deputy Director of Operations, Assistant Director - Head of Finance

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		<p>New models/schemes to be prioritised for investment will then be identified for inclusion within the Health Board's planning process for the 2025/6 annual plan. Evaluations will continue to be requested as part of approving/renewing Cluster proposals and held centrally via a SharePoint resource.</p> <p>We continue to utilise 'Primary Choice' as our main branding and concept to help the public understand the range of skills and services available to them within Primary Care, led by a Communication Activity Steering Group.</p> <p>During 2024/25, we will cascade service-based information on a Cluster by Cluster basis to share information about the level and range of services available to them within their community.</p>		
<p>R3</p>	<p>Primary care clusters</p> <p>The Health Board should:</p> <p>3.1 Review the relative maturity of clusters, to develop and implement a plan to strengthen its support for clusters where necessary.</p> <p>Review the membership of clusters and attendance at cluster meetings to assess whether there is a need to increase</p>	<p>This will continue to be an ongoing piece of work. Clusters will engage in the National ACD programme of work to inform assessment of maturity across Wales via Cluster Peer review process and self-assessment matrix. A review of Cluster membership will be undertaken by Cluster Leads each year in line with peer review process activities.</p>	<p>Quarter 3, 2024</p>	<p>PCIC Deputy Director of Operations, PCIC Deputy Clinical Board Director working with Cluster Leads and</p>

	<p>representation from local authorities, third sector, lay representatives and other stakeholder groups.</p>	<p>Clusters are supported through a monthly operations group meeting to discuss risks, issues actions or decisions needed to support in line with the requirements of the ACD programme and expected operational arrangements, with actions/escalations taken to support further progress. Progress against ACD measures continue to be monitored nationally also.</p> <p>Cluster Leads engage nationally via an All-Wales Cluster Leads Group and Health Board leads engage in a National Action Learning group to share learning and/or best practice approaches.</p>		<p>Locality Managers</p>
<p>R4</p>	<p>Strategic approach to primary care</p> <p>The Primary, Community, and Intermediate Care Clinical Board Delivery Plan should include medium-term (3 to 5 year) priorities to support delivery of the Health Board’s longer-term strategic objectives for primary care.</p>	<p>We will use our ‘Operational’ plan to inform our longer-term strategy and priorities for Primary and Community Care services. The narrative in the operational plan will change to reflect our longer-term priorities and ambitions, supported by an in-year delivery plan.</p> <p>This will be shaped/informed by;</p> <ul style="list-style-type: none"> • Strategic Programme for Primary Care • Health Board Strategy - Delivering in the Right Places 	<p>Quarter 3, 2025</p>	<p>PCIC Clinical Board Director, PCIC Director of Operations, PCIC Deputy Director of Operations – Working with Strategy and Planning, Director of Health & Social Care Integration</p>

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		<ul style="list-style-type: none"> • 6 Goals for urgent & Emergency Care • 5 Goals for Planned Care • Regional Partnership Board (RPB) Area plan – Starting Well, Living Well and Aging Well. • Population Needs Assessment • Cluster and Pan Cluster Planning priorities <p>During 2024/25 we will develop our baseline assessment of our services and investments into Primary & Community Care. We will work across our partners and systems to describe our vision for Primary and Community Care services.</p>		
R5	<p>Board oversight and visibility</p> <p>The Health Board should:</p> <p>5.1 Ensure that the contents of Board and committee performance reports adequately cover primary care;</p> <p>5.2 Increase the frequency of primary care performance reporting to Board and committees; and</p> <p>5.3 Ensure that reports to Board and committees provide sufficient commentary on progress in delivering Health Board plans for primary care,</p>	<p>A plan is in place to increase primary care reporting at Board Level. A review of the current reporting is underway, which will build upon the data and information shared regularly at Operational Delivery Group and Executive Review meetings, to ensure the Board and other committees are robustly sited upon Primary Care performance, as part of the system.</p> <p>This will coincide with a review of the Clinical Board operating arrangements and strengthening of our Business Assurance Framework, ensuring the right structures and systems exist.</p>	Quarter 3, 2024	Chief Operating Officer, PCIC Clinical Board Director, PCIC Director of Operations, PCIC Deputy Director of Operations

	and the extent to which those plans are resulting in improved experiences and outcomes for patients.			
R6	<p>Annual reporting</p> <p>Following the implementation of the Primary, Community and Intermediate Care Delivery Plan, the Health Board should produce an annual Primary Care Report setting out its achievements during the previous year, with the first report reflecting the period 2024-25.</p>	Plans are already in place to develop an end of year report during Quarter 1 2024. This concept will be further built on during 2024 and embedded as a process for 2025 onwards.	Quarter 1, 2025	Director Operations, Clinical Board Director, Deputy Director of Operations
R7	<p>Succession Planning</p> <p>The Health Board should strengthen succession planning arrangements for its Primary Care Services Team to ensure greater resilience and business continuity in terms of skills, expertise, and knowledge.</p>	<p>We will use opportunities during 2024/25 to identify the baseline knowledge, skills and competencies required within Primary Care Services Teams, followed by an assessment of current education and training provision available. Once the gap is established, working with our Local Primary Care Academy, we will develop an induction and training programme for Primary Care Service teams based on;</p> <ul style="list-style-type: none"> • New to Primary Care services • Transitioning to Primary Care Services 	Quarter 2, 2025	Director Operations, Deputy Director of Operations

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To note the Strategic Workforce Plan for Primary Care (due to be published April 2024) has also identified this as a priority so local plans may need to be adapted to meet national direction/programme of work.

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

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Report Title:	Internal Audit Recommendation Tracker Report			Agenda Item no.	2.3
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	20.05.2024
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	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 Internal Audit by means of an internal audit recommendation tracking report (“the Tracker”).

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, 2022/23 and 2023/24.

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 totals 156.

Ninety-eight recommendations, reported as either Partially Complete or as No Action were recorded in the Tracker at the November 2023 Committee meeting which have been carried forward to the May 2024 meeting. Twenty-two of these recommendations that had been completed were removed from the Tracker.

Following completion and submission to the November 2023 Committee meeting, fifteen new Internal Audit Reports were added to the Tracker:

1. Refresh of the Health Board’s Strategy
2. Welsh Government Six Goals Programme
3. PARIS
4. Chemocare Follow-up
5. Surgery Clinical Board Consultant Job Plans
6. Leadership and Management Training and Development
7. QSE Governance Advisory
8. Mental Health Clinical Board Governance
9. Capital Systems Management
10. Infection, Prevention and Control
11. Technical Continuity
12. Estates Condition
13. Implementation of Health Roster System
14. Alcohol Standards
15. SOFI Governance Review

Of the 156 recommendations listed within the Tracker, 37 are recorded as completed, 77 are listed as partially complete and 42 are listed as having no action taken or reported since the last Committee meeting.

A full review of all outstanding recommendations has been undertaken since the November 2023 Committee Meeting. Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

Updates on the following outstanding recommendations for 2019/20 and 2020/21 are as follows:

- **Medical Staff Study Leave** – the implementation date has been moved to 1.09.2024
- **Data Quality Performance Reporting (single cancer pathway)** – an update has been reported to the May 2024 meeting
- **Infrastructure Network Management** – this report has been superseded by a new audit review and removed from the Tracker.

It should be noted that the narrative within Column L (Executive Update) of the 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 - 2023/24 (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
Internal Audits 2022/23	6	18	3	2	29
Internal Audits 2023/24	7	11	5	5	28

Attached at Appendix 2 are summary tables which provide an update on the 20 May 2024 position as of the 15 April 2024.

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:

- Note the tracking report for tracking audit recommendations made by Internal Audit.
- Note and be assured by the progress which has been made since the previous Audit and Assurance Committee Meeting in November 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	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	
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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 may be 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

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority Rating	Recommendation	Agreed Management Action	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Executive Update for May 2024: 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.	Comments from Risk and Regulation Team and (Internal Audit comments in Red)
2023-24	31.03.24	Implementation of Health Roster System	R1/9	Low	The review of the Rostering Procedure UHB 339 should be finalised, approved and the updated procedures should be disseminated to all relevant staff.	The e-rostering procedure was considered at the Employment Policy Sub Group (EPSG) meeting in October. The meeting membership is trade union representatives and People & Culture Team representatives. The group did not approve the procedure as they felt it needed further review to reflect the culture that we want to create, i.e. flexibility, good work life balance, high engagement and retention. The revised procedure will include the link to the Rostering Principles, Safe Care Guidance and Nurse Staffing Framework, highlighted below. The procedure is being considered by EPSG in December 2023.	Director of People and Culture Executive Nurse Director		C	Following further meetings with the EPSG and further changes made the Roster Policy was published in Jan 2024 and is scheduled for review Nov 2024.	Agree that this action is now complete.
2023-24	31.03.24	Implementation of Health Roster System	R2/9	High	Arrangements should be put in place to ensure that rosters are created, approved and published in line with the roster timetable.	The Corporate Nursing Team (working with the e-rostering team) are producing monthly reports for Roster Managers, Senior and Lead Nurses. The reports contain information on rosters that have not been approved or not approved in accordance with the rostering timetable. Recently these reports have been sent to Clinical Board DoN requesting that more focus is placed on the importance of publishing the roster 6 weeks in advance. Compliance will be monitored monthly via the Rostering KPI dashboard.	Director of People and Culture Executive Nurse Director	Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards	C	Monitoring data reports are being produced by the Corporate Nursing Team and are being issued monthly to the DoNs. The e-rostering team also monitor compliance with rostering KPIs and regularly send notifications to Managers to prompt them to sign off the rosters in a timely manner.	Agree that this action is now complete.
2023-24	N/A	Implementation of Health Roster System	R3/9	Medium	A review of the HealthRoster system should be undertaken to ensure that the user privileges for Roster Managers and Senior Management are correct and allow for appropriate segregation of duties in line with the Rostering Procedure.	HealthRoster privileges/permissions have been reviewed and updated to ensure the Roster Manager cannot create and approve a roster. The new permissions hierarchy includes: first approver - Roster Manager and second approver - Senior Nurse	Director of People and Culture Executive Nurse Director	Paul Jones, Head of E-Rostering	C	This work is completed. We have also reviewed all Senior Nurse access who are required to cover Out of Hours support to Rostering areas.	Would not agree that this is complete based on the issues identified within our current Temporary Staffing Costs audit.
2023-24	31/03/2024	Implementation of Health Roster System	R4/9	Medium	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	The e-rostering team have just undertaken roster reviews with approx. 45 ward areas, this was an in-depth review which took 50 days in total. The team are working with Roster Managers daily to ensure the rules and parameters they need are built into the HealthRoster system. The aim is to build confidence in the function, change behaviours and increase the number of rosters that are created using the auto-roster functionality. The improvement will be monitored monthly through the KPI dashboard. The e-rostering Leads (3x band 6) are aligned to CBs to ensure that Roster Managers have the appropriate level of support to use the system to its full potential, including auto rostering.	Director of People and Culture Executive Nurse Director	Paul Jones, Head of E-Rostering and Roster Managers, Clinical Boards	C	The e-rostering team have undertaken reviews with areas that are using HealthRoster. Areas identified as suitable for SafeCare were prioritised, followed by all other nursing areas. A total of 264 roster reviews were identified •205 reviews have been completed •38 scheduled to be reviewed •27 areas yet to attend /fail to respond •34 do not need reviewing. The e-rostering team are reporting monthly key rostering metrics and focusing support on areas where improvements are required. We will continually review and monitor to ensure areas improve and comply.	Agree that this action is now complete.
2023-24	31.03.2024	Implementation of Health Roster System	R5/9	Low	Staff should be reminded that annual leave requests should be processed within the HealthRoster system to ensure that all requests and approvals are supported by a full audit trail	The e-rostering team as part of the ongoing training and support to Roster Managers are reminding Roster Managers of the importance that their team need to request annual leave through the Healthroster system rather than by other mechanisms. This message is also being reinforced by the Clinical Board, DoN and the Corporate Nursing Team. The number of annual leave requests made through the HealthRoster system will be monitored monthly, if the % does not increase this will be escalated to the DoN and to NPG.	Director of People and Culture Executive Nurse Director	Directors of Nursing, Clinical Boards Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager	C	We are monitoring the usage of A/L requests entered via HealthRoster system – current usage is 45% of requests made via HealthRoster for the 24/25 period. The current system – Employee Online (EOL) which staff use to make requests including A/L requests – is being replaced with a new system LOOP. This is being implemented across the UHB from June 24 and aimed for completion Dec 2024. We are hoping this will make it easier for staff to make requests - as well as continuing promotion of HealthRoster as the main input of A/L	Should this be part complete given the further actions they've highlighted?
2023-24	31.01.2024	Implementation of Health Roster System	R6/9	Low	Consideration should be given to exploring alternative ways to integrate live data from ESR to HealthRoster system ensuring that annual leave entitlements within the HealthRoster system are correct and up to date.	Whilst there is no direct interface between ESR and HealthRoster currently available (a service request is being submitted) there is an A/L entitlement report available in ESR that we can adapt and be manually uploaded into HealthRoster. The work will involve cross referencing the data between both ESR and HealthRoster, but the end achievement will be to load a monthly file into Healthroster using the manual import file in ESR.	Director of People and Culture Executive Nurse Director	Mike Mullan, Head of People Analytics Paul Jones, E-Rostering Manager	PC	The Agreed Management Action is currently being implemented with a view to providing an accurate starting annual leave entitlement for staff using HealthRoster for the new annual leave year commencing 1st April 2024. A monthly update process, using data from ESR, will be adopted in HealthRoster thereafter. An initial file will be produced in May 2024 with all A/L entitlements from ESR and following a period of testing we will then commence the regular monthly uploads.	
2023-24	31.03.24 31.03.24 31.03.24	Implementation of Health Roster System	R7/9	High	Arrangements should be put in place to ensure that staff balances are being managed adequately to ensure that staff are working their contracted hours and are not owing or being owed excessive hours.	Embedding an effective rostering culture is one of the UHB's top priority and the system will support drive the efficiency. Corporate Nursing, People & Culture and Clinical Boards have worked together to reach an agreement on how we will support managers to embed effective rostering principles and achieve this priority: • Monthly e-rostering reports were piloted in October, every DoN has received a report for their Clinical Board, detailing every member of staff who has an owing time balance between 24 and 100 hours. Lead Nurses are validating this data and rostering the outstanding hours as appropriate. Progress will be monitored on a quarterly basis. • For time balances owed over 100 hours the E-Rostering Team are undertaking regular reviews of rosters. Any staff member that owes over 100 hours will be discussed and validated with the Roster Manager. Changes will be made in the system to correct the balance and any genuine time balances will be rostered by the Roster Manager. • A Rostering Dashboard has been created that provides high level data in relation to rostering KPIs. This will be developed into a more intuitive tool once the DataHub has been implemented. The dashboard will help monitor the agreed KPIs and will provide assurance that effective rostering is being embedded into the UHB and efficiencies are being achieved through the HealthRoster system.	Director of People and Culture Executive Nurse Director	Directors of Nursing, Clinical Boards Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager Paul Jones, E-Rostering Manager	C	Regular monthly reports are being provided by the Corporate Nursing Team of the Time Balances- the e-rostering team are working with those areas that have been highlighted with excessive time balance issues e.g. Data entry errors, Joiners & leavers, Contract Hrs changes, Absences not recorded correctly etc.	Agree that this action is now complete.
2023-24	31.03.2024	Implementation of Health Roster System	R8/9	High	Arrangements should be put in place to ensure that Roster Managers are finalising shifts in a timely manner.	A monthly report is sent to Roster Managers to inform them how many unverified shifts they have outstanding, any outstanding shifts are escalated to the DoN 3 days and 1 day before the payroll is run. It has been agreed with the Executive Director of Nursing that any shifts that have not been verified in time will not be processed for Payroll, this has been communicated to all Roster Managers. Unverified shifts are no longer a KPI that the Health Board intends to use. The number of unverified shifts will be closely monitored by the e-rostering team and if it becomes problematic it will be escalated to DoNs, Corporate Nursing team and the EDoN	Director of People and Culture Executive Nurse Director	Paul Jones, Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards	PC	A Monthly report continues to be sent to Roster Managers of all unfinalised shifts and is escalated to DONS up to 3 days prior to the payroll being run. Shifts that are not finalised are cancelled. Despite the reports we are still having to dedicate resources to chase the managers in updating their rosters.	Would not agree that this is complete based on the issues identified within our current Temporary Staffing Costs audit.
2023-24	31.03.2024	Implementation of Health Roster System	R9/9	High	Arrangements should be put in place to ensure that there is appropriate and timely oversight of the Safecare tool, and that Senior Management/Roster Managers are ensuring that Nurses in Charge are updating patient acuity data.	SafeCare has been rolled out to approximately 67 ward areas with training taking place in February and March 2023. Staffing meetings have now been introduced and take place twice daily to review staffing levels on SafeCare and to share risk across the whole of the UHB.	Director of People and Culture Executive Nurse Director	Emma Davies, Senior Nurse for Nurse Staffing Act Directors of Nursing, Clinical Boards	C	There are 98 areas that are live on Safecare which include Mental Health, Maternity in addition to the 258 wards (Nurse Staff Act areas) A new redeployment matrix has been recently introduced as part of a recent system upgrade to simplify the redeployment process.	Agree that this action is now complete.

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority Rating	Recommendation	Management Response	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for November 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	31.05.2023	Cyber Security	R1/5	High	1. The team should prioritise and focus on the development of a Cyber Security Improvement Plan as required by the NIS Regulations. 2. A realistic timetable should be drawn up for the development and implementation of a Cyber Security Improvement Plan.	1. Accepted. The Cyber Security Improvement Plan remains a priority on our workplan. 2. The UHB had this program of work earmarked for the new Cyber Security Manager post but this appointment unfortunately fell through during the late stages of the recruitment process. Work was due to begin early March 2023. We will re-prioritise this work to begin in April 2023.	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	SUPERCEDED
2022-23	30.04.2023	Cyber Security	R2/5	High	A formal terms of reference should be drawn up and approved for both the CAV Cyber Security Meeting and the Cyber Security Sub-Group. The Terms of Reference should include details of the membership and Chair of each group, the frequency of meetings, quorum, reporting lines and if applicable their decision-making process. The make-up of the CAV Cyber Security Group should be reviewed with consideration given to including clinical board representation. The meetings of both groups should be recorded in meeting notes or minutes. An Action Log should be maintained by the Cyber Security Sub-	Accepted	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	SUPERCEDED
2022-23	30.06.2023	Cyber Security	R3/5	Medium	The position in respect of the development and implementation of a Cyber Security Improvement Plan or Cyber Security Workplan should be regularly reported to the Digital Health and Intelligence Committee.	Accepted. The next committee paper will include an update on the Cyber Security Improvement Plan.	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	SUPERCEDED
2022-23	30.06.2023	Cyber Security	R4/5	Medium	Cyber security performance measures and key performance indicators should be developed and reported to the Digital Health and Intelligence Committee on a regular basis.	Accepted. The next committee paper will ensure cyber security KPIs are included.	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	SUPERCEDED
2022-23	N/A	Cyber Security	R5/5	High	A record should be kept of all system restores from back-up's, the reason the restore was undertaken and whether or not the restore was successful. It is acknowledged that the number of systems in use within the Health Board generates a large amount of data for storage, and the team is carrying a number of vacancies. However, the integrity of backed up data for systems that have not been subject to ad hoc restores should be periodically tested.	Partially accept. The UHB does keep a record of all ad-hoc restores. This is typically >200 pa. However, whilst this doesn't test all backed up data, following a similar WAO recommendation in 2013, the UHB made following assessment: A preliminary assessment has been undertaken of increased resource requirements necessary to enable test-restore on all clinical systems. Indicative costs as follows: i) Backup and Test-Restore 6 monthly - £250k equipment plus 3 additional WTE resource ii) Backup and Test-Restore monthly - £500k equipment plus 7 additional WTE resource iii) Additional commitment of typically 3 (for 3 to 5 days) Service Department staff to test restored systems during test period (equates to circa 10 man days for twice yearly restore and 60 man days for monthly restore). The proposed actions in relation to recommendation 4 should be noted in this context, since additional investment in the virtual server farm will provide most, although not complete, mitigation of risk of back up. In the 10 years since this report, we anticipate that these figures will now be 2 to 3 times higher. Additionally, we don't believe that any UHB, including DHCW routinely test restores due to the cost incurred and risk to data.	N/A	N/A	NA	SUPERCEDED

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority Rating	Recommendation	Management Response	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for November 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.
2023-24	Q1 2024/2025	Cyber Security	R1/4	Low	A realistic timetable should be developed, and accountable officer(s) assigned to progress the Cyber Security Improvement Plan.	WE do recognise progress has been slower than we would like. It is widely reported over many years empirically that recruiting to cyber roles is highly competitive with the public sector often struggling for capable resources as pay points are lower, hence we have spent 12 months running numerous unsuccessful recruitment campaigns including the use of agency to no avail. Our most recent campaign however was successful after we increased the payscale for an appointee to Band 8a (from Band 7). The Cyber Security Lead is due to commence in post on the 14th May 2024. The improvement plan was largely written in the context of the critical system assessed in 2022 (PMS). PMS is currently migrating to a new environment and once migrated, currently scheduled for April 2024, a number of recommendations will be addressed. This, in addition to the Cyber Security Lead position being filled, will allow us to make some good headway into this action plan.	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	
2023-24	May-24	Cyber Security	R4/4	Medium	Key cyber security figures relating to server patching and perimeter controls should be consistently recorded, upon which performance measures and indicators can be developed and regularly reported to the Digital Health and Intelligence Committee.	There have been numerous attempts made to reflect key performance indicators into the Cyber Security Digital Health and Intelligence Committee report. Standard performance indicators are difficult to measure and whilst we have consistently reported legacy Operating System figures, this doesn't truly represent our cyber security position. This will improve as we complete Performance Measures and Metrics The February 2024 committee paper did report on a number of cyber metrics but this was more for awareness than a representation of performance. We can ensure we continue to report on legacy server OS and include metrics/indicators for other measures for future committees.	Director of Digital & Health Intelligence	Head of Information Governance & Cyber Security	NA	

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Financial Year Fieldwork Undertaken	Agreed Implementation Date	Audit Title	No of Recs	Priority	Opportunity	Management Response	Executive Lead	Operational Lead	Please confirm if complete (c), partially complete (pc), not actioned (na)	Management Response / Executive Update for February 2022: 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.
2023-24	31.10.2023 31.12.2023 - 30.04.2024 30.04.2024	Leadership and Management Training and Development	R1/4	N/A	The Leadership Framework should be aligned with the principles and objectives stated within the Health Board IMTP and the People and Culture Plan. Management should ensure collaborative engagement with Health Board senior management and staff ensuring a broad coverage of all Service Boards and Clinical Board services that include Medical staff groups.	The People and Culture Directorate are currently refreshing priorities and objectives in light of the current Shaping Our Future Wellbeing refresh, the challenging financial and workforce pressures, and in collaboration and partnership with Clinical and Service Boards IMTP development. The themes of the People and Culture Plan, which are established to reflect the national picture, will continue to be used to frame this work. Part of this work will involve the engagement and participation necessary to co-design the UHBs Leadership Framework. This will be with Clinical Boards, Service Boards, Trade Union Partners, Staff Networks, staff groups, external partners (e.g. HEIW), and through opportunities including: • Information and insights obtained via the implementation of the Culture and Leadership Programme • As above – NHS Wales Staff Survey • Leadership Summit events, workshops and focus groups • Attendance at Network meetings, Senior Leadership Board, CB executive Reviews, Feedback from HoPC Framework to be agreed via People & Culture Committee and Board. (To date it is important to note that programme design has been developed based upon evidence-based national principles (e.g. HEIW Leadership Principles for Health and Social Care), collaborative working with Canterbury and via Amplify events, and previous frameworks including the NHS Wales Management Competencies.)	Director of People & Culture	Deputy Director of People & Culture, Assistant Director of People Resourcing Assistant Director of OD, Wellbeing and Culture Assistant Director of OD, Wellbeing and Culture		
2023-24	30.09.2023 - 31.12.2023 30.04.2024	Leadership and Management Training and Development	R2/4	N/A	All future programmes should be planned and compiled from inception to completion via a project management methodology that ensures the effective capture and delivery of ideas from all interested parties across all Clinical Boards and their respective staffing groups	Although a 'project management methodology' approach was not evident, it is important to note that the delivery of programmes was planned to ensure appropriate capability and capacity to deliver. The 'rolling programme' of the two management development programmes was identified as a priority following a period of limited development during the pandemic, and the support required for those in management positions (both newly appointed and longer term). The resulting waiting lists and demand continues to be influenced by this. Work is already underway to develop a programme management approach to the design, delivery and evaluation of Leadership and Management Development. This includes: Support to the Head of ECOD and wider ECOD Team from the Change Hub to develop an appropriate programme planning approach. Engagement in Leadership Framework as in Finding 1	Director of People & Culture	Assistant Director of OD, Wellbeing and Culture		
2023-24	30.04.2024	Leadership and Management Training and Development	R3/4	N/A	Clinical Boards should be engaged with regularly to ascertain what future leadership and management training courses/programmes can be provided based upon their respective staff needs. Additionally, engagement should also be sought on a periodic basis to identify potential improvement changes to existing programmes available.	As part of the programme design, leadership principle review and ongoing culture and leadership programme work across the UHB, challenges will be identified in delivering effective leadership management development, but also opportunities, which may include changes in delivery models and methods. Management recognise that additional resources may be required, and this may include: • Staffing • External delivery / support • Training / upskilling of existing staff This will be confirmed as part of the commitment to the leadership principle development, engagement across the UHB, and via benchmarking and evidenced based research. The ECOD Team have recently changed in structure and leadership, and opportunities for greater whole team involvement in leadership and management development is being explored as the capacity and skills of the team changes. This includes opportunities while developing roles such as the following (please note this is not a complete list): ECOD Manager for Digital Learning ECOD Manager for Wellbeing and Engagement ECOD Manager for Coaching and Talent Management Senior ECOD Manager – Nursing and Midwifery Opportunities to develop programmes in partnership with other areas is also part of the leadership Framework engagement, e.g. Medical Education, PCIC AcademyIt is important to note the appointment into the Digital Learning post which will assist in developing a broader means of delivery and approach. (e.g. webinars; TEDtalks; VR; Simulation etc)	Director of People & Culture	Assistant Director of OD, Wellbeing and Culture Head of ECOD		

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2023-24	30.06.2024 31.12.2023 31.03.2024 31.03.2024	Leadership and Management Training and Development	R4/4	N/A	Clinical Boards should be engaged with regularly to ascertain what future leadership and management training courses/programmes can be provided based upon their respective staff needs. Additionally, engagement should also be sought on a periodic basis to identify potential improvement changes to existing programmes available.	The CBs will be engaged with to develop and shape the Leadership Framework (as per detail under other sections). The ECOD team have informal mechanisms currently of engaging with CB Senior Teams, namely through attending DoNs Meetings, DoOps Meetings etc. The Programme Management approach with explicitly include a more formalised approach to engagement including mechanisms by which programmes can be designed, planned and implemented. Since the review was undertaken, and with a new leadership structure embedding into ECOD, we are already seeing more engagement with CBs in some areas through the Directors of Ops. Once leadership framework has been developed, the UHB will be in a better place to undertake a leadership and management TNA – which will be undertaken at CB level. This will help identify areas of strength, areas for development, and gaps in provision. The work commencing on the Culture and Leadership Programme will also feed into the ECOD Team and identify areas for support, development and competencies requiring attention. Evaluation of leadership and management development will follow the Kirkpatrick model, and engagement with the CBs SMTs will be integral and built into this approach under the programme structure. It is important to note, that need will also be shaped by engagement with Board Members, Executive Team, SLB, Trade Unions and other stakeholders.	Director of People & Culture Assistant Director of OD, Wellbeing and Culture Head of ECOD			
2023-24		Quality, Safety and Experience Governance	R1/2		The Organisational Learning Committee should be established as soon as possible with appropriate terms of reference that detail: • definition(s) of organisational learning (short, medium, and long-term); • the role of the Committee and its aim and purpose; and • frequency and membership of meetings and quorate requirements etc.	Work is underway to discuss the purpose and scope of this meeting with a number of corporate bodies within the UHB including planning. A draft term of reference will be presented to the October 2023 Quality Safety and Experience Committee in November 2023 with a view to convene the first meeting in Quarter 4 of the financial year.		Assistant Director of Quality and Patient Safety		
2023-24		Quality, Safety and Experience Governance	R2/2		The terms of reference for the CEC and the CSG require review and updating.	The terms of reference for the Clinical Effectiveness Committee have been updated and circulated for review and will be signed off at the meeting on the 29th September 2023. The terms of reference for the Clinical Safety Group will be reviewed and a draft will be presented for comment at the meeting on 10th November 2023 and signed off at the subsequent meeting in January 2024.		Assistant Director of Quality and Patient Safety		
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R1/9		There should be a review of the level of Programme governance activities required, and the viability of progressing with the aim of developing a SOC, until wider concerns over affordability / funding models have been addressed: to be approved at Board / SOFH Committee level.	Agreed. This will be informed by the outcome of the clinical review and attendance at WG IIB. Executives met with WG at the beginning of September to understand likelihood of funding. There is currently no line of sight to funding but have been invited to an IIB on 13/11/23. Programme Boards and Project Boards have been stood down. The outcome of discussions with WG along with the Nuffield report should drive a review of next steps and Governance (including frequency) and the assistance of the Corporate Governance team will be requested. This said, communication from WG was pointing to funding before the NHS Wales cost pressures changed messaging to be less certain of funding the SOC. The SRO and PD had been keen to maintain rhythm of governance within C&V and the need for SOFH to be progressed given unsustainable estate condition. The members of the Programme Board attended monthly meetings reliably, however given the prolonged uncertainty, it is agreed the time has come to review. It should be mentioned that the team were not seeking to commence the SOC, rather plan and prepare the ground for the SOC once funding landed.	Director of Planning		NA	The team is currently being disbanded
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R2/9		Noting the current wait for funding, it is timely to evaluate terms of reference and governance structures to ensure each forum is appropriately focused.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB. The SOC production is considered a project and was being reported into the Programme Board. As the only project, it was the only Project Board. It is acknowledged that it is in the programme's early stages and the only group meeting, the Project Board was also covering more general ground by updating stakeholders on matters.	Director of Planning		NA	
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R3/9		The above review may include consideration of reinstatement of the SOFH Committee, or utilisation of an existing Committee, to provide periodic scrutiny and oversight of programme activities.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB.	Director of Planning		NA	
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R4/9		A Programme / Project -specific Scheme of Delegation should be developed.	Agreed	Director of Planning		NA	
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R5/9		The workstream governance structure should be clearly and consistently presented in key governance documents.	Agreed. The observation is understandable. The inconsistency reflects work that was in flight when documents were provided for the audit - where the PID hadn't caught up with the sub-documents having been updated	Director of Planning		NA	
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R6/9		Working groups should be clearly defined, with terms of reference in place to identify memberships, governance arrangements etc. These should be distinct from normal UHB operations, to ensure the Programme receives the necessary focus and to support clear monitoring and reporting performance	Agreed. Terms of reference were developed for workstreams and presented at the May project board during/post the audit review. Given the expectation of funding, it was prudent to plan the SOC to be efficient with time so we were relying on existing leaders to spare the time to assist and participate. In the absence of confirmed funding, there has been limited time colleagues have been able to commit alongside the 'day-job.' Receipt of funding would have enabled the recruitment of dedicated resource for SOFH (and SOFCS) work. Our approach did see planning progressing at differential paces and in the future needs either dedicated time from matrixed resources or dedicated resources from the workstreams assigned to the programme. To be considered as part of the governance and resource review recommended in this report.	Director of Planning		NA	

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2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R7/9	There should be a detailed review of the resources required as the UHB moves through the Programme, from SOC, to OBC and onwards, using an activity-based resource schedule. Resource schedules should be agreed with key departments and individuals to ensure risks and limitations are fully understood. Where funding bids are adjusted downwards, reporting to key forums should be clear as to the gaps this will leave in skills / capacity and the associated risks to programme delivery.	Agreed. Our plans did acknowledge the pre-requisites of the Clinical Model and Estate baseline work as early pre requisites. The approach to understanding the estate condition has changed, with the SOC initially expected to rely on existing data. More recently, with a potential for consideration of a do minimum option, we recognise there is a need to update this data to accurately reflect current risks. When funding was looking likely to arrive, preparing to procure an external advisor was work that was decided could start. Preparing for this exercise was right at the time and was happening in parallel with planning. This procurement work is now on hold and no tender will or can be progressed without a plan being complete and committed to along with a clear line of sight to funding. The point about a low level of resource request is noted and has been a subject of ongoing internal discussions since submission. We will consider our options upon the imminent receipt of a report from the Nuffield Trust on the clinical model described in our PBC. Indications from Nuffield are that resources applied so far to SOFH and SOFCS has been on the low side. The complexity of the transformation has also been mentioned by the Nuffield during their review and await their formal opinion in their report. Given the urgent need to replace our infrastructure, it had been a long-held ambition that a SOC would be attempted to be produced within 12 months. This is a reasonable ambition given the high-level detail WG were requesting and to avoid the risk of drift. Setting a time bound ambition is common practice. The plan wasn't in a position at the time of the review to be executed as it needed more work. Firm plans being produced prior to execution was the intent. It was our intent to 'outsource' the production of work such as the Economic Case (which is a function of the Strategic Case). With C&V plans more certain, e.g. knowing when a signed off CSP would be available, procuring a partner to help produce content for which we don't have skills could have commenced and they would bid the timeline and the steps. This would have completed the plan.	Director of Planning		NA
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R8/9	The team should move forward with development of a Communications Plan as soon as possible.	Agreed	Director of Planning		NA
2023-24	Post attendance at IIB and receipt of feedback from WG.	Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	R9/9	Governance forums should receive clearly distinguishable highlight / flash reports focusing on the assigned responsibilities of the reporting forum. Workstream highlight reports should be enhanced to clearly present performance information and associated risks	Agreed	Director of Planning		NA

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

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

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												
Overdue over 6 months under 12 months												
Overdue more than 12 months							2					
No date set												
Total					2		2					

Total number of recommendations outstanding as of 23 October 2023 for financial year 2019/20 is 2 which is the same position as in November 2023.

Saunders, Nathan
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Key: C – Complete PC – Partially Complete NA – No Action

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

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					3		3					
Total					3		3					

Total number of recommendations outstanding as of 15 April 2024 is 3 although two of these have been superseded as a new review has been undertaken.

Saunders, Nathan
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Key: C – Complete PC – Partially Complete NA – No Action

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

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached												
No date agreed												
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		2					
Total					2		2					

Total number of recommendations outstanding as of 15 April 2024 is 2.

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

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2022/23 (May 2024 Update)

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA
Date not reached												
No date agreed			1			7						
Overdue under 3 months							3					
Overdue by over 3 months under 6 months										1		
Overdue over 6 months under 12 months			3				16	3		3	4	1
Overdue more than 12 months			3			7	22			1	3	1
Total	7		7		58	14	41	3	14	5	7	2

Total number of recommendations outstanding as of 15 April 2024 is 79 with 19 actions complete for this period.

Saunders, Nathan
17/05/2024 21:26:07

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

INTERNAL AUDIT REPORT RE

Recommendation Status	High	C	PC	NA	Medium	C	PC	NA	Low	C	PC	NA	No Ratings	C	NA
Date not reached								2							
No date agreed						1				2					9
Overdue under 3 months		3	3	5		1	1	6		3	1	2		1	1
Overdue by over 3 months under 6 months		1	4	1		4	2	5		2	2	2			
Overdue over 6 months under 12 months				5											
Overdue more than 12 months											1				
Total	22	4	6	11	22	6	3	13	15	7	4	4	11	1	10

COMMENDATIONS FOR 2023/24 (May 2024 Update)

Total number of recommendations outstanding as of 15 April 2024 is 70 (18 of which are listed as complete) compared to the position in November 2024.

Saunders, Nathan
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Key: C – Complete PC – Partially Complete NA – No Action

Saunders, Nathan
17/05/2024 21:26:07

Report Title:	Audit Wales Recommendation Tracking Report			Agenda Item no.	2.4	
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	20.05.2024	
		Private	<input type="checkbox"/>			
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Risk and Regulation Officer					
Main Report						
Background and current situation:						
<p>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”).</p>						
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:						
<p>There have been no new recommendations added to the Tracker since the November 2023 Committee meeting. Out of the 19 recommendations carried forward from November 2023, 5 are reported as complete, 7 have been partially completed, and 7 are reported as having no action taken.</p> <ul style="list-style-type: none"> • Six recommendations are 1+ year’s overdue with one showing no date specified • Fourteen are 6+ months overdue • Two are greater than 3+ months but less than 6 months. • One is less than three months • Five of the recommendations remain on target to be completed on the agreed implementation date although a number of these have not been updated for this meeting. 						
Reports Superseded						
<p>Two reports listed below have been removed from the tracker because they have been superseded by updated Audit Reports:</p> <ol style="list-style-type: none"> 1. Audit of Accounts Report Addendum 2021/22 2. Structured Assessment 2022 						
<p>Since November 2023, a review of all outstanding recommendations has been conducted with executive and operational leads for each recommendation. This work will be reported to the Audit and Assurance Committee on a quarterly basis to provide updates on the status of recommendations. Between each instance of reporting to Committee the Risk and Regulation team will also continue meeting with Audit Wales Colleagues to verify progress made against recommendations included within the Tracker.</p>						
<p>The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in 19/20, 20/21 and 21/22 as at 20 October 2023.</p>						
Recommendation:						

The Audit and Assurance Committee Members are asked to:

- (a) Note and receive assurance from the progress which has been made in relation to the completion of Audit Wales recommendations.

To 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		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	
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Impact Assessment:

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

Risk: Yes

By maintaining an up to date Audit Wales Recommendation Tracker, the Health Board mitigates the risk that it may be subject scrutiny and supports the ongoing achievement of best practice recommendations.

Safety: N/A

Financial: N/A

Workforce: N/A

Legal: N/A

Reputational: N/A

Socio Economic: N/A

)
Equality and Health: N/A

Decarbonisation: 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)	Executive Update May 2024 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	Year end 2022/2023	Structured Assessment 2023	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	PC	September 2023: Band 5 appointed, releasing capacity for the 2 x cyber analysts to utilise existing proactive monitoring tools Penetration tests being conducted on an adhoc basis
2022/23		Structured Assessment 2023	R1/7	Well-being Objectives Whilst the Health Board's new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations. The Health Board, therefore, should: a) consider incorporating additional priorities that encompass all aspects of sustainable development, particularly those that relate to the environment; and b) set out how each individual well-being objective aligns to the national well-being objectives and the well-being objectives of its partners.		Director of Corporate Governance		NA	
2022/23		Structured Assessment 2023	R2/7	Accessibility of public Board meetings In order to enhance public transparency of Board business, the Health Board should improve public access to Board meetings by: • livestreaming and recording public Board meetings; and • making the recordings available on the Health Board's website shortly after each meeting.		Director of Corporate Governance		NA	
2022/23		Structured Assessment 2023	R3/7	Public accessibility of governance documents We found a number of outdated or unavailable governance related documents on the Health Board's website for example Standing Orders and Standing Financial Instructions. The Health Board should review its website, ensuring the latest versions of governance documents and papers are available.		Director of Corporate Governance		NA	
2022/23		Structured Assessment 2023	R4/7	New committee structure effectiveness review As part of its 2023-24 Board and committee effectiveness review, the Health Board should review the effectiveness of its new committee structure. The review should pay particular attention to whether: • the committee structure supports sufficient oversight of the refreshed strategic objectives; • committee terms of reference and workplans adequately cover all aspects of Board business; • there is merit in instigating a regular meeting for committee chairs; • there is an appropriate training and development for new committee chairs and new committee members; and • officers and Members have the capacity and resources to support more frequent committee meetings.		Director of Corporate Governance		NA	
2022/23		Structured Assessment 2023	R5/7	Hearing patient stories Currently the Quality, Safety, and Experience Committee does not receive patient stories. The committee should start every other meeting with a patient story to usefully set the tone for the remaining meeting and to ensure that members hear about patient experiences and related learning.	All meetings include a patient/ family/ staff/ carer story as part of the Clinical Board assurance report	Executive Nurse Director	Assistant Director of Patient Experience	C	Completed
2022/23		Structured Assessment 2023	R6/7	Improving performance reporting The Health Board has improved its Integrated Performance Report (IPR). Whilst we recognise it is a new and evolving report, we have found potential to enhance it by: • strengthening its links with the Annual Plan Delivery Report to ensure the relationship between some of the delivery milestones and key performance indicators is clearer; • having a more consistent focus on actions being taken to tackle underperformance in both the IPR and its cover report; • being clearer about whether the metrics in section two of the IPR are on target or not; • being consistent in providing reasons why data charts are unavailable in section two of the IPR, instead of leaving the section blank; and • providing benchmarking data (where available) to show how the Health Board compares to other health bodies		Chief Operating Officer		PC	An update to the structure assessment will be provided to the July Audit Committee. Additionally there is an internal audit plan for 2024/25 covering performance reporting. Further detail will be provide in July
2022/23		Structured Assessment 2023	R7/7	Enhancing recommendation tracking The Health Board has good recommendation tracking arrangements but there are opportunities to enhance them further to support learning and improvement. The Health Board should: a) formally refer recommendations and/or audit and review reports to relevant committees for deeper scrutiny, with the committees reporting back to the Audit and Assurance Committee for assurance, and b) develop a report for the Audit and Assurance Committee pulling together common themes, issues and learning from the internal, external and regulatory compliance reports.		Director of Corporate Governance		NA	

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Audit Wales Recommendations 2019/20 – 2023/24 (May 2024)

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	4		1					5		5
Clinical Coding Follow-up from 2014			1						1	1
Estates Follow-up Review			1						1	1
Review of Quality Governance Arrangements		2	1			1			2	3
Structured Assessment 2023	1	5	2				8			8
Total	5	7	7			1	8	5	5	19

According to the table above, no recommendations have been added to the Tracker since last reported at the Committee in November 2023. The total number of recommendations is currently 19, with 5 actions reported as complete. Seven actions are partially completed and 7 have no recorded update since the last Committee meeting. Five outstanding actions were more than a year behind schedule. Five recommendations are more than six months overdue, 8 recommendations are more than three months old with one less than three months.

Saunders Nathan
17/05/2024 21:26:07

Report Title:	Regulatory Compliance Tracking Report		Agenda Item no.	2.5		
Meeting:	Audit and Assurance Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	20.05.2024	
		Private	<input type="checkbox"/>			
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Risk and Regulation Officer					

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 is 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.

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.

Welsh Health Circulars

In addition, the updates below are also shared in relation to the Health Board's Management of Welsh Health Circulars (WHCs) A separate Tracker document is held for the monitoring of WHC's and is managed by the Team.

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 Red: Blue Green: Orange Yellow: Red	Comments
2021006	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 2023 Committee meeting the following Circulars have been added to the tracker and triaged to executive colleagues for action:

- 2023/009 COVID-19 Vaccination of Children aged 6 months – 4 years in a clinical risk group
- 2023/010 Certification of Vision Impairment in Primary and Community Care
- 2023/032 Amendments to Model standing Orders and Model Standing Financial Instructions NHS Wales
- 2023/035 Updates of guidance on clearance and management of healthcare workers living with a bloodborne virus (BBV) and a reminder of health clearance for Tuberculosis
- 2023/038 Healthy Start eLearning Course
- 2023/039 Independent Authorisation of Blood Component Transfusion (IABT) – 2023 - 2026
- 2023/040 The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)
- 2023/041 Refresh of the Rare Disease Action Plan 2022-26
- 2023/043 Vaccination of Healthcare Staff to Protect Against Measles
- 2023/044 Change to the Influenza (flu) Vaccination Programme 2023-2024
- 2023/045 Recording Dementia Read Codes
- 2023/046 All Wales Control Framework for Flexible Workforce Capacity
- 2023/047 Influenza Vaccines and Eligible Cohorts for the 2024 – 2025 season
- 2023/048 2024-25 Health Board Revenue Allocation
- 2024/001 Changes to the way individuals who are at highest risk from COVID-19 access lateral flow tests from COVID-19 treatments
- 2024/002 Standards for Competency Assurance of Non-Medical Prescribers in Wales
- 2024/004 Sterile Preparation of Medicine in NHS Wales
- 2024/005 Private Obesity Surgery and the Welsh NHS
- 2024/006 The National Clinical Guidelines for Stroke
- 2024/008 Vaccination of Children to Protect Against Measles
- 2024/009 COVID-19 Spring Booster 2024
- 2024/010 NHS Welsh Sustainability Conference and Awards: New date
- 2024/011 Changes to Welsh Government Dietary Advice for Young Children
- 2024/012 Nursing Preceptorship and Restorative Clinical Supervision: Position statement

As of the 19 April 2024 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.

Regulatory Tracker

To note, the All Wales Medical Genomics Service has informed the Corporate Governance Department of their resignation from UKAS Accreditation as the laboratory is currently facing a number of significant challenges. This has been escalated within the organization.

The Regulatory Tracker attached to this report is up to date as of the 19 April 2024 and will continue to be updated throughout the organisation and reported to the Committee on a bi-meeting basis.

Following the November 2023 Committee Meeting a total of 7 completed entries have been removed from the register. Three further entries have been reported as complete since the November 2023 Committee Meeting.

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 are requested to:

- (a) To review the updates shared and to take assurance from 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	
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Impact Assessment:

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

Risk: Yes

By maintaining an up to date Regulatory Recommendation Tracker the Health Board mitigates the risk that it may be subject to legal or regulatory penalty.

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 it's legal requirements.

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Saunders, Nathan
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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. 4 of the 9 Recommendations have been completed - 5 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. 4 of the 13 Recommendations have been completed - 9 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	Update: 18/10/2023 - 14 outstanding actions, 1 over target. Audit carried out 03&04/10/2023 awaiting new report. Outstanding actions to be carried forward onto new report.		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	16/01/23 16 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. Reply to the audit with actions submitted 17/2/23. Awaiting if actions accepted by Auditor.		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 Hygiene Ratings	Health Board Wide	6.07.2021 - 14.09.2023	Unannounced inspection	Executive Director of Finance	Health and Safety Committee	Head of Catering Services	N/A	25 Food Hygiene Ratings of 4 and 5 was achieved with no major contraventions	31.07.2021 - 14.10.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		C
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Unit, Woodland House	17.08.2023	Unannounced inspection	Executive Director of Finance	Health and Safety Committee	Head of Catering Services	N/A	A Food Hygiene Rating of 4 was achieved with no major contraventions	30.09.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		PC
Capital Estates and Facilities	Catering and Hospitality	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Units, UHW	12.05.2022	Unannounced inspection	Executive Director of Finance	Health and Safety Committee	Head of Catering Services	N/A	A Food Hygiene Rating of 4 and 5 was achieved with no major contraventions	23.06.2023	An update will be shared at the October Health and Safety Committee meeting providing assurance to the Health Board.		PC
CAPITAL EXPENDITURE INTERNAL REVIEW														
CLINICAL CODING														
CD&T	Clinical Coding	DHCW	Clinical Coding	24.06.2022	Clinical Coding Audit	Chief Operating Officer	Digital Health Intelligence Committee	Directorate Manager, Health Records	N/A	A total of 5 recommendations were made regarding clinical coding practice within the Health Board.	N/A	Meeting held with Endoscopy to review the deficiencies in the documentation. The meeting concluded that the format of the endoscopy reports cannot be amended. Item to be re-reviewed and added to the Clinical Coding Improvement plan being developed with the support from the Shaping Change Team.		PC
ECT ACCREDITATION														
FIRE AND RESCUE SERVICES														

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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)
Mental Health	Capital and Asset Management	Fire and Rescue Services	Mental Health HVC and Vale MH Services, Barry Hospital	14.04.2021	Regulatory 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. Legal proceedings remain ongoing.		PC
Medicine	Capital and Asset Management /UHW - Ward A4	Fire and Rescue Services	UHW Ward A4	29.09.2021	Regulatory 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 Article 21: Training	31.03.2023	Measures have been agreed with and implemented by senior managers of the UHB's Estates Service Board. Consequently 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 timescale, 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 likely to take place in early February.		PC
HEALTH EDUCATION AND IMPROVEMENT WALES														
HEALTH INSPECTORATE WALES														
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	9 of the 13 recommendations have completed. The remaining 4 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	15 of the 16 recommendations are reported as complete . An education plan is being developed to respond to the final recommendation.		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	9 recommendations are reported as complete. The remaining 12 recommendations are reported as partially complete with progress being made against sub-recommendations which are reported as complete.		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 recommendations were made relating to improvement of Staffing and operational procedures and guidelines.	N/A	7 of the 9 recommendations are reported as complete. The remaining two 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 recommendations were made relating to improvement of Staffing and operational procedures and guidelines, including Welsh Language Standards.	N/A	7 of the 8 recommendations are reported as complete.		PC
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.		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. During the meeting on 05/01/2023, the Head of H&S signed a voluntary statement in relation to information previously sent to them in February 2022. Further meeting with HSE 01/02/2023 and Head of Estates and Facilities provided a voluntary statement relating to an information request from the HSE. No further update		PC

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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)
Executive	Health Board wide	HSE	Health Board Wide	14-15/11/2023					18.04.2024	The HSE have recommended a UK wide NHS intervention programme started in 2018 which focused on the control of musculoskeletal injuries and Violence and Aggression against staff. They met with the CEO, Executive Director of People and Culture and the Head of H&S on 29/09/2023 in order to obtain an understanding of the UHB's approach at a corporate level and this will be followed up with interventions to operational areas on 14th and 15th November 2023. These covered: 1. Triage rooms, relatives / contact rooms and Majors Unit - Emergency Unit 2. Suitable and Sufficient risk assessments 3. Monitoring and review 4. Compliance and mandatory training 5. Use of emergency alarms - safe operating procedure 6. Advice		Closed after re-inspection on 18.04.2024		C
Public Health Wales	HSE has written to PHW and recorded here for information	HSE	PHW	19.08.2022					1.04.2023	HSE investigated a dangerous occurrence notified under RIDDOR at PHW microbiology laboratory. They conducted an inspection 17/01/2023 and PHW are required to provide a response by 01/04/2023	open ended	H&S and CEF have been kept informed of progress. Visit took place 17th January 2023 Complete - No further concerns for CAUVHB.		C
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 Accountability. 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 to complete outstanding recommendations. Updates are shared at the Digital Health Intelligence Committee. No progress reported since the April 2023 Committee meeting.		NA
JOINT ACCREDITATION 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-accreditation notice - There are ongoing discussions with the executive board regarding a new facility for BMT / Haematology as the service will not achieve re-accreditation post the next inspection cycle. A capital planning project team has been established to develop the business case to support the development of a refurbished facility for the service. No progress reported since the April 2023 committee meeting.		PC
MEDICAL GENETICS														
MHRA														
CD&T	Pharmacy SMPU and UHL	MHRA	Pharmacy SMPU	12.10.2021 9.05.2023	Good manufacturing practice (GMP) and good distribution practice (GDP)	Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC and 2 years	8 Recommendations 3 majors and 5 others	16/12/2021 and 31.03.2024	1 action outstanding but partially completed Type 1 letter Significant issues: Unresolved Air Handling Unit and facility issues to meet requirements of the regulator		PC
CD&T	RadioPharmacy / Medical Physics	MHRA	Radiopharmacy / Medical Physics	3.10.2023		Executive Medical Director	QSE Committee	Clinical Director of Pharmacy and Medicines Management	TBC	1 Critical deficiency comprised off 44 actions required	31.12.2023	Type 4 letter and referral to IAG due to Senior and Executive management had not exercised adequate oversight to ensure that the facility, equipment and processes were appropriately designed, qualified and validated in support of Aseptic product manufacturing		PC
NATURAL RESOURCES WALES														

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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)
OFFICE FOR NUCLEAR REGULATION														
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES														
RESEARCH AND DEVELOPMENT														
UKAS														
WELSH WATER														
WSAC														
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	01.11.2024	85% target met in individual standards and 90% overall target met - 95.22% overall compliance score achieved	01.11.2024	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. There are no updates to report to the November meeting		PC
Surgery	Audiology	WSAC	Audiology - Adult Rehabilitation	22.11.2022	Audiology - Adult Rehabilitation	Executive Director of Therapies and Health Science	QSE Committee	Lorraine Lewis	22.11.2025	85% target met in individual standards except for one and 90% overall target met - ~ 94% overall compliance score achieved	22.11.2025	4 recommendations made relating to standards 1.a.5, 1.c.6, 5.d.3 and 6.b.1, one of which is reported as completed. There are no updates to report to the November meeting		PC
WEST MIDLANDS QRS														

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Report Title:	Procurement Compliance Report		Agenda Item no.	2.6
Meeting:	Audit Committee	Public		Meeting Date:
		Private	X	
Status <i>(please tick one only):</i>	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.

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ASSESSMENT AND ASSURANCE**Non-Compliant Activity (21)**

This is activity where departments have engaged suppliers without Procurement involvement and therefore, have incurred a direct breach of SFI's.

Description Title	Value at Risk Excl VAT	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action/Status
Development and Implementation of a "Single Item Treatment" Form	£6,200.00	N/A	1 month	Surgery and Dental	Service did not engage with Procurement	Closed - No ongoing requirement
Vocera Software Maintenance and Support Services	£22,731.76	N/A	12 months	Mental Health	Service did not engage with Procurement	In Progress - Procurement arranging contract
Development and Feasibility of Trak Digital Self-Management Physiotherapy Intervention for People with Common Musculoskeletal Conditions in the Primary Care Setting Compared to Usual Care	£10,815.23	N/A	10 months	C,D&T	Service did not engage with Procurement	Closed - No ongoing requirement
Additional Schools Exercise Programme Animation	£8,240.00	N/A	One off services	Executives	Service did not engage with Procurement	Closed - No ongoing requirement
Asist Training	£4,500.00	N/A	One off training	Executives	Service did not engage with Procurement	In Progress - Procurement arranging contract
One Wales Mm Platform Rebate Fee	£5,500.00	N/A	6 months	PCIC	Service did not engage with Procurement	Closed - No ongoing requirement
Subscription to the Safety Incident Response Accreditation Network	£9,435.00	N/A	3 years	Mental Health	Service did not engage with Procurement	Closed - No ongoing requirement
Edge Training and Consultancy	£5,244.00	N/A	One off purchase	Mental Health	Service did not engage with Procurement	Closed - No ongoing requirement
MH Team Manager Development Programme	£10,500.00	N/A	One off purchase	Mental Health	Service did not engage with Procurement	Closed - No ongoing requirement
Shared Lives Proposal for Cardiff and Vale	£9,000.00	N/A	One off purchase	Mental Health	Service did not engage with Procurement	Closed - No ongoing requirement
Postgraduate Diploma in Dermatology	£5,520.00	N/A	1 month	Medicine	Service did not engage with Procurement	Closed - No ongoing requirement
Invoice to Professor	£6,659.90	N/A	2 weeks	Specialist	Service did not engage with Procurement	Closed - No ongoing requirement

Radiometer Service Contract	£6,880.00	N/A	12 months	C,D&T	Service did not engage with Procurement	Closed - Added to Procurement contracts workplan for compliant renewal at expiry
GMP Inspection Fee	£6,880.00	N/A	One off purchase	C,D&T	Service did not engage with Procurement	Closed - No ongoing requirement
Mental Health Secure Patient Transport	£7,817.50	N/A	1 month	Mental Health	Service did not engage with Procurement and was unaware that there was no formal agreement in place with this supplier.	In Progress - Procurement arranging contract
Delivery of the Whole School Approach to Emotional and Mental Wellbeing in Respect of Salary Costs to Emotional and Mental Wellbeing	£21,110.50	N/A	6 months	Executives	Service did not engage with Procurement	In Progress - Procurement arranging contract
Portertrac Licence	£25,600.00	N/A	12 months	Capital Planning, Estates and Facilities	Service did not engage with Procurement	Closed - Added to Procurement contracts workplan for compliant renewal at expiry
Attendance Fees for Optometrists Training	£5,740.00	N/A	One off training	Surgery and Dental	Service did not engage with Procurement	Closed - No ongoing requirement
Deprivation of Liberty Safeguards	£160,548.61	N/A	12 months	Executives	Service did not engage with Procurement	In Progress - Procurement arranging contract
Microsoft Azure Services	£12,000.00	N/A	6 months	Executives	Service did not engage with Procurement	In Progress - Procurement arranging contract
Professional Services - Solution Design & Customization, System Integration, Installation, Training	£10,000.00	N/A	One-off purchase	C,D&T	Service did not engage with Procurement	Closed - No ongoing requirement
Car Hire	£5,664.76	N/A		PCIC	Service did not engage with Procurement	In Progress - Procurement arranging a new contract
Catering for Ramadan Event	£8,000.00	N/A		PCIC	Service did not engage with Procurement	Closed - No ongoing requirement

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Contracts value breached/ extended at risk as a result of emergency/unforeseen circumstances (1)

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
Counselling Support Sessions	£21,168.00	June 2024	6 months	PCIC	63 additional clients needed to be included, which was unforeseen and an SQA was not completed in time prior to the 1st of the additional clients being treated.	Closed – Renewal will include additional capacity to avoid this re-occurring.

Other Non-Compliant Activity (11 Return)

This section details activities which were out of the Department/Health Board’s control as a result of any of the following;

- Emergency activity
- Unforeseen/Unplanned circumstances
- Exemptions

Title	Value at Risk	Contract Expiry	Length at Risk/Breach	Clinical Board	Reason	Action /Status
Legal Fees (Civitas Law)	£13,800.00	N/A	One off services	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
Legal Fees (St Johns Chambers)	£45,275.00	N/A	One off services	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
Legal Fees (Blake Morgan)	£35,601.60	N/A	One off services	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
Medical Education Academic Course Fees	£10,000.00	N/A	6 months	Executives	Service was processing on quarterly invoicing which were under £5k SFI's	Closed – Contract SLA put in place with Organisation
Replacement of NVR in HYC	£29,999.00	N/A	One off purchase	Capital Planning, Estates and Facilities	Emergency Replacement	Closed – Emergency replacement
Replacement of CRI External Gas Main	£28,234.00	N/A	One off purchase	Capital Planning, Estates and Facilities	Emergency Replacement	Closed – Emergency replacement
Purchase of Trenza Stent	£5,225.00	N/A	Emergency purchase	C,D&T	The stent was used in an emergency on a patient due to no other	Closed – emergency requirement

					alternatives being available.	
Dialysis Nursing Support	£39,330.04	N/A	2 months	Specialist	Agreement exceeded anticipated value due to additional support shifts required	In Progress – New contract being put in place to continuing requirement
Legal Fees (Temple Garden Chambers)	£6,062.50	N/A	One off services	Executives	NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment	Closed – Legal requirement
ICU Roof Leaks	£10,107.00	N/A	Emergency Works	Capital Planning, Estates and Facilities	ICU Emergency Roofing works at UHL	Closed – Emergency works
Emergency security cover at CRI	£27,600.00	N/A	Emergency hire	Capital Planning, Estates and Facilities	Assault on members of staff which required security personnel 24/7	Closed – Emergency

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 – (1 Return)

The report outlines all SQA/STA (1 Return) requests during the period the 1st January 2024 to 30th April 2024.

Clinical Board	Supplier	Name of Project	Retrospective Value of Contract Excl VAT	STA Type
Specialist	Miltenyi Biotec UK	Consumables and Maintenance of CliniMacs Prodigy	£54,190.83	Sole Supplier of Goods or Services

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 (26) requests during the period the 1st January 2024 to 30th April 2024. 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
Children and Women	Thornbury Nursing Services	Specialised Continuing Healthcare Package	£490,000.00	Urgent Operational Requirement
Capital Planning, Estates and Facilities	Assura PLC	Purchase of Intellectual Property right for the Design Development of Pentyrch Doctors Surgery	£150,000.00	Proprietary items, i.e. Trademarked, patented
C,D&T	Cardiff University	WREN Computing System Hosting Service	£65,282.82	Sole Supplier of Goods or Services
Surgery	Dekomed	Maintenance of Sterilisation Machines (DSDU+PCDU)	£28,530.00	Sole Supplier of Goods or Services
C,D&T	Genial Genetics	Shire Maintenance and Support Plan	£25,860.00	Sole Supplier of Goods or Services
C,D&T	Rees Scientific	Annual Revalidation of Rees Temperature Monitoring System (Haematology & Biochemistry)	£70,482.24	Sole Supplier of Goods or Services
Medicine	Vyaire	Maintenance of 2 Lung Function Machines	£16,797.60	Sole Supplier of Goods or Services
Specialist	ICNARC	Participation in the Case Mix Programme	£50,000.00	Sole Supplier of Goods or Services
C,D&T	Coleman-Milne	Purchase of Vehicle for Mortuary	£58,474.80	Urgent Operational Requirement
C,D&T	Horiba	Pentra 400C Maintenance Contract	£18,123.04	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Terra Firma	Full Geotech Survey for Rookwood	£30,319.25	Sole Supplier of Goods or Services
C,D&T	Ibex Medical Analytics	Provision of an Artificial Intelligence Solution Supporting Diagnostic Cellular Pathology	£15,000.00	Sole Supplier of Goods or Services
C,D&T	ARCCA - Cardiff University	WREN Computing Hosting System	£50,000.00	Sole Supplier of Goods or Services
Surgery	Therma Solutions	Equipment for PICCOS Trials	£7,200.00	Sole Supplier of Goods or Services
Capital Planning, Estates and Facilities	Openview	Installation of a networked CCTV system to be installed onsite at Riverside and viewed at UHW Security Hub	£32,299.06	Sole Supplier of Goods or Services
Executives	Qbtech Ltd	Provision of Qb Test to support ADHD diagnosis	£85,000.00	Sole Supplier of Goods or Services
Executives	Hospital Finance Managers Association	Annual HFMA London Conference	£7,964.72	Sole Supplier of Goods or Services

Executives	Hospital Finance Managers Association	Annual Subscription to the Bitesize Foundation courses	£12,500.00	Sole Supplier of Goods or Services
Executives	Hospital Finance Managers Association	Annual HFMA Wales Conference	£7,176.00	Sole Supplier of Goods or Services
PCIC	Roath House Surgery	Provision of General Medical Care into His Majesty's Prison (HMP) Cardiff	£187,610.00	Sole Supplier of Goods or Services
C,D&T	Aalto Scientific	Weqas foetal fibronectin EQA programme	£16,217.50	Sole Supplier of Goods or Services
Medicine	Echosens Ltd	Maintenance of Echosens Fibroscanners	£25,780.00	Sole Supplier of Goods or Services
Executives	Oracle Corporation UK Ltd	Goldengate for Distributed Applications and Analytics licenses	£56,829.26	Sole Supplier of Goods or Services
C,D&T	Perkin Elmer AES (UK) Ltd	Annual maintenance contract for NexION 5000 and NexION 2000 ICP-MS	£35,696.00	Sole Supplier of Goods or Services
C,D&T	Waters Limited	Maintenance of Wedinos Laboratory Equipment	£32,891.04	Sole Supplier of Goods or Services
C,D&T	DQD Engineering	PWS Distribution System Annual Maintenance Contract	£28,328.75	Sole Supplier of Goods or Services

Non-Compliant Activity / Contract Breach Summary

The below summary details all Boards who have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year	2022/23			2023/24			2024/25 (YTD)	
	Non-Compliant Breaches	Exemption	Covid-19	Non-Compliant Breaches	Exemption	Covid-19	Non-Compliant Breaches	Exemption
AWMGS	1	0	0	1	0	0	0	0
Children and Women	2	0	0	3	0	0	0	0
Capital Planning, Estates and Facilities	3	2	1	2	3	0	1	4
Clinical, Diagnostics and Therapies	2	0	0	11	4	0	4	1
Executives	8	5	0	21	9	0	5	5
Medicine	2	1	0	1	0	0	1	0
Mental Health	0	0	0	2	1	0	6	0
PCIC	0	0	0	2	0	0	1	0
Specialist	3	1	0	10	1	0	1	1
Surgery and Dental	9	1	0	10	0	0	2	0
TOTALS	31	10	1	63	18	0	21	11

Please note that in February 2021, the reporting of non-compliant activity was split into the above criteria to reflect accuracy in reporting the justifications behind certain breaches i.e., emergency works.

STA/SQA's by Department

Clinical Board	2022/23		2023/24		2024/25 (YTD)	
	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	3	3	0	0	0	0
Children and Women	3	1	4	0	1	0
Capital Planning, Estates and Facilities	15	2	2	0	3	0
Clinical, Diagnostics and Therapies	26	2	23	0	11	0
Executives	23	1	13	2	5	0
Medicine	4	0	0	0	2	0
Mental Health	3	0	1	0	0	0
PCIC	11	3	3	0	1	0
Specialist Services	11	1	3	0	1	1
Surgery Services and Dental	11	0	5	1	2	0
Grand Total	117	13	54	3	26	1

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report
- **APPROVE / AGREE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	Long term	Integration	Collaboration	Involvement	
------------	-----------	-------------	---------------	-------------	--

Impact Assessment:

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

Risk:

As outlined in the above section

Safety:	
As outlined in the above section	
Financial:	
As outlined in the above section	
Workforce:	
As outlined in the above section	
Legal:	
As outlined in the above section	
Reputational:	
As outlined in the above section	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders, Nathan
17/05/2024 21:26:07

Report Title:	Internal Audit Plan 2024/25			Agenda Item no.	3.1
Meeting:	Audit Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	20/05/24
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance <input type="checkbox"/>	Approval <input checked="" type="checkbox"/>		Information <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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.

It is a requirement of the Public Sector Internal Audit Standards that an Internal Audit Plan and Charter is prepared on an annual basis and presented to the Audit Committee for approval.

The work undertaken by Internal Audit will be completed in accordance with the Plan, which has been prepared following a detailed planning process and is subject to Audit Committee approval. The plan sets out the program of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards.

The Internal Audit Charter has been updated as at April 2024 and sets out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers.

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

The Internal Audit plan for 2024/25 has been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents.

Individual planning discussions were held with each of the Executive Directors, the Chief Executive, Chairman and Chair of the Audit Committee to inform development of the plan.

An initial version of the plan was shared with the Senior Leadership Board for review and comment, and to inform prioritisation of the potential audits to ensure that the plan can be delivered within the available resources.

The plan covers the whole of the 2024/25 audit year but will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Boards evolving risks and changing priorities and therefore provide effective assurance.

Recommendation:

The Audit Committee is requested to:

- **Approve** the Internal Audit plan for 2024/25.
- **Approve** the Internal Audit Charter as at April 2024.
- **Note** the associated Internal Audit resource requirements and Key Performance Indicators.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	<input checked="" type="checkbox"/>	6. Have a planned care system where demand and capacity are in balance	<input checked="" type="checkbox"/>
2. Deliver outcomes that matter to people	<input checked="" type="checkbox"/>	7. Be a great place to work and learn	<input type="checkbox"/>

3. All take responsibility for improving our health and wellbeing	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	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

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

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

Risk: Yes/No

Development and delivery of the Internal Audit plan provides the Health Board with a level of assurance around the management of a series of risks covered within the specific audit assignments.

Safety: Yes/No

The Internal Audit plan for 2024/25 includes a number of audits which will provide assurance around controls and processes relating to patient safety.

Financial: Yes/No

The Internal Audit plan for 2024/25 includes a number of audits which will provide assurance around financial controls and processes.

Workforce: Yes/No

The Internal Audit plan for 2024/25 includes a number of audits which will provide assurance around workforce issues.

Legal: Yes/No

The Internal Audit plan for includes a audit which will provide assurance around compliance with legal requirements.

Reputational: Yes/No

The Internal Audit plan for includes a number of audits which will provide assurance around potential reputational issues.

Socio Economic: Yes/No

Equality and Health: Yes/No

The Internal Audit plan for 2024/25 includes a number of audits which will provide assurance around equality and health issues.

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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Annual Internal Audit Plan

Internal Audit Charter

May 2024

Cardiff and Vale University Health Board

Saunders Nathan
17/05/2024 21:26:07



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



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[Disclaimer notice - please note](#)

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

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

1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP and the NHS Wales Joint Commissioning Committee (NWJCC) (the new Joint Committee for Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU)) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for NWJCC) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation’s goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation’s governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation’s governance, risk management, and control arrangements which afford suitable priority to the organisation’s objectives and risks;
- improvement of the organisation’s governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation’s risk assessment and maturity;
- the organisation’s response to key areas of governance, risk management and control;
- the previous years’ internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, such as the duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending

changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit and Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Directors of Corporate Governance and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

- 1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up: this is follow-up work on previous limited and unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NWSSP, DHCW and NWJCC.
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit and Assurance Committee and the Quality, Safety and Experience Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW and NWJCC;
- work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executive Directors and Independent Members to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Health Board's Senior Leadership Board to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit and Assurance Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan

to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

The audit of major capital programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective approved business cases with the associated plans funded via the Welsh Government's capital allocations. The following programme/project audits are scheduled to be progressed during 2024/25:

UHW Lift Replacement Programme

UHW/UHL - Mortuary Refurbishment

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6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit (Cardiff and Vale University Health Board)
Audit and Assurance Services
NHS Wales Shared Services Partnership

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Risk Management / Board Assurance Framework	1	BAF & CRR	Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	Director of Corporate Governance	Q4
Scheme of Delegation	2	BAFF Risk 14	Potential advisory review of the effectiveness and operation of the Health Boards scheme of delegation. To include review of how decisions are taken by Clinical Board Directors.	Director of Corporate Governance	Q3
Legal Services	3		Review of the current processes operating within the Health Board around the use of legal services. Including current levels of expenditure, funding arrangements and how decisions to engage legal services are taken and approved.	Director of Corporate Governance	Q2
Health & Safety	4		Review of the current progress in delivery against the action plan that was developed following an external review of	Executive Director of People & Culture	Q1

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			the Health & Safety arrangements in 2021.		
Occupational Health Services	5	BAF Risks 9 & 11	Review of the current structure and robustness of the service and processes in place to ensure effective delivery against KPIs and targets.	Executive Director of People & Culture	Q4
Implementation of Health Roster System Follow-up	6	BAF Risk 11	Follow-up review of the 2023/24 Limited Assurance audit. We will need to agree an appropriate time within the year to undertake the follow-up.	Executive Director of People & Culture	TBC
Business Continuity Planning (Deferred from 23/24 plan)	7		Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity, emergency planning and resilience across all areas and services. Provide assurance around the development of plans and that effective communication, training and testing of plans is undertaken.	Executive Director of Strategic Planning	Q1
Hosting of the Substance Misuse Area Planning Team and Board	8		Review of the processes around fatal substance misuse / drug poisoning deaths. How does the process work, including the operation of the review panel?	Executive Director of Strategic Planning	TBC

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Procurement & Contract Management	9	BAF Risk 14	To provide assurance that the Health Board has appropriate procurement and contract management arrangements in place. Review of Health Board arrangements along with the interaction and assurance received from NWSSP Procurement Services.	Executive Director of Finance	TBC
Core Financial Systems	10	BAF Risk 14	Annual review of controls in place to manage key risk areas across the main financial systems. Focus on General Ledger / Accounts Receivable.	Executive Director of Finance	Q2 / Q3
Charitable Funds	11	BAF Risk 14	Review the processes in place within the Health Board to ensure that Charitable Fundraising is appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.	Executive Director of Finance	Q3
Capital Systems	12	BAF Risk 12	A review of the refresh of the UHB's local contractor framework(s); to include e.g. the letting and award of the new framework contracts, adequacy of management, reporting and performance management arrangements, compliance with established award criteria and	Executive Director of Finance	Q3/4

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			adequacy of the associated contractual arrangements applied etc.		
Estates Assurance – Energy Management	13	BAF Risk 12	Increased energy tariffs are acknowledged as a key risk, so there is an increased need to ensure appropriate energy management and control arrangements are applied. Energy Management will be the focus of all UHB/Trust estates assurance reviews across NHS Wales during 2024/25, enabling the production of a national summary report on conclusion.	Executive Director of Finance	TBC
Estates Condition Follow-up	14		Follow-up review of the 2023/24 Limited Assurance audit. We will need to agree an appropriate time within the year to undertake the follow-up.	Executive Director of Finance	TBC
Safeguarding	15	BAF Risk 1	Review and evaluate the adequacy of the systems and controls in place within the Health Board in relation to safeguarding. Include a review of progress against actions from the Joint Inspection of Child Protection Arrangements (JICPA) review	Executive Nurse Director	Q1

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Concerns / Complaints / Putting Things Right (Duty of Candour)	16	BAF Risk 1	Review of the processes in place for management of concerns / complaints to ensure compliance with Putting Things Right regulations and the Duty of Candour.	Executive Nurse Director	Q2
Interventions Not Normally Undertaken (INNU)	17		To provide assurance that there are effective arrangements and processes in place to support consistent application of INNU across the Health Board.	Executive Director of Public Health	Q1
Smoking Cessation	18	BAF Risk 8	Review of the processes and actions being taken by the Health Board to achieve public health targets in relation to smoking cessation. Include a focus on processes to support patients within the Health Board's hospitals who are smokers.	Executive Director of Public Health	Q2
Alcohol Standards Follow-up	19		Follow-up review of the 2023/24 Limited Assurance audit. We will need to agree an appropriate time within the year to undertake the follow-up.	Executive Director of Public Health	TBC
Data Quality Strategy	20		Potential advisory audit supporting the development of the Health Board's Data Quality Strategy.	Executive Director of Digital	Q2 / 3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Departmental IT System	21	BAF Risk 15	Review controls in place to manage a local IT system. Potentially review the development of the Health Board's LDT local data repository.	Executive Director of Digital	Q1
Office 365 benefits realisation	22	BAF Risk 15	Review of the current roll-out and utilisation of Office 365 functions within the Health Board to determine if maximum benefit is being received from the investment.	Executive Director of Digital	Q4
Planned Care Programme	23	BAF Risk 7	Review development of controls and actions around the Planned Care programme. Specific area of focus for the review to be agreed with the COO.	Chief Operating Officer	Q3/4
Waiting List Management	24	BAF Risk 7	Review of the process operating within the Health Board to ensure effective management of patient waiting lists. Include a focus on RTT waiting lists.	Chief Operating Officer	TBC
Medicine CB – Acute Model / Same Day Emergency Care (Deferred from 23/24 plan)	25	BAF Risk 6	Review of the arrangements in place for development and delivery of the Acute Position Model / Same Day Emergency Care. To establish if they effectively delivering the changes required.	Chief Operating Officer	Q3

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
CB – Governance Arrangements (CB to be agreed)	26		Review of the structure and Governance arrangements within the Clinical Board. To include review of the processes around financial management, budgetary control and delivery of savings.	Chief Operating Officer	Q1
Surgery CB – Governance Arrangements	27		Review of the structure and Governance arrangements within the Clinical Board. To include review of the processes around financial management, budgetary control and delivery of savings.	Chief Operating Officer	Q2
Surgery CB Consultant Job Plans Follow-Up	28		Follow-up review of the 2023/24 Limited Assurance audit. We will need to agree an appropriate time within the year to undertake the follow-up.	Chief Operating Officer	TBC
Consent Process	29	BAF Risk 1	Review of the consent to examination and treatment process operating within the Health Board to establish the level of compliance with the All-Wales Consent Policy.	Medical Director	Q1
Records Management	30		Review of the arrangements and processes in place within the Health Board for the management and storage of records.	Medical Director	Q3

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
			To include a review of plans for the scanning and digitisation of patient records.		
Therapies and Health Sciences Agency and Locum staff	31	BAF Risk 9	Review of the processes and controls in place for the usage of agency and locum staff within the Therapies and Health Sciences services.	Executive Director of Therapies	Q2
Follow-up – Recommendation Tracking	N/A	N/A	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Director of Corporate Governance	Q4
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	32	BAF Risk 12	In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the health board to “assess the risk profile of the scheme and provide appropriate levels of review”. A small provision of days is included within the 2023/24 plan to enable us to work with the health board to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.	Executive Director of Strategic Planning	See IAAPs

Please note: The national audits undertaken at DHCW, NWSSP and NWJCC.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2023/24 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

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Appendix C: Internal Audit Charter

1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Cardiff and Vale University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
 - Senior Management means the Chief Executive as being the designated Accountable Officer for Cardiff and Vale University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cardiff and Vale University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:

-
- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
 - the appropriate assessment and management of risk, and the related system of assurance;
 - the arrangements to monitor performance and secure value for money in the use of resources;
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

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- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
- 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
- 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
- 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

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6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
 - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

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- ensuring effective co-ordination, as appropriate, with external auditors; and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

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assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

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relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
 - d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
 - e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
 - f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic

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➤ Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
 - The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the

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organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

- 14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2024

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Cardiff and Vale University Health Board – Audit Plan 2024

Audit year: 2023-24

Date issued: May 2024

Document reference: 4153A2024



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

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About Audit Wales

Our aims and ambitions

Assure



the people of Wales that public money is well managed

Explain



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

Inspire



and empower the Welsh public sector to improve



Fully exploit our unique perspective, expertise and depth of insight



Strengthen our position as an authoritative, trusted and independent voice



Increase our visibility, influence and relevance



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

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Introduction

I have completed much of my planning work.

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

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2024.

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



Adrian Crompton

Auditor General for
Wales

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Audit of financial statements

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

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

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

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

Performance audit work

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

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

My performance audit work is designed to comply with auditing standards set out by the International Organisation of Supreme Audit Institutions (INTOSAI). This is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

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Your audit at a glance



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

My audit planning has identified the following risks:

The current significant financial statement risks include:

- management's override of the controls in place; and
- not meeting the statutory financial duty to break even over the three years to 31 March 2024.

Other areas of audit focus include:

- the valuation of the Health Board's estate;
- the accuracy and completeness of the remuneration report disclosures, relating to members and senior officers;
- the remuneration of any senior officers that is above the Welsh Government's approved pay bands;
- the accuracy and completeness of the related party disclosures; and
- the extent of any property containing reinforced autoclaved aerated concrete (RAAC), and any impact on the accuracy and completeness the accounting.



My performance audit will include:

- Structured Assessment – core.
- Structured Assessment – deep dive review of investment in digital systems to support service resilience and transformation.
- All-Wales Thematic Review – managing demand for urgent and emergency care.
- Local work – review of eye care services



Materiality

Materiality

£18.6 million

Reporting thresholds (triviality):

Main materiality	£930,000
Related parties	£500
Remuneration report	£50

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Financial statements' materiality



Materiality £18.6 million

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

Materiality is calculated using:

- an estimate, being the 2022-23 expenditure of £1.861 billion (this will be updated on receipt of the 2023-24 accounts); and
- a materiality percentage of 1%.

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality, including for the lower materialities below).



Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

- Remuneration report i.e. each person's¹ disclosed remuneration, per the remuneration report categories (except for the pension benefits) - £1,000, or lower if a misstatement results in the wrong remuneration-banding being disclosed for an individual;
- Related party disclosures, £10,000; and
- Outturn against the revenue and capital resource limits, £1.

¹ Senior managers and members.

Significant financial statements' risks

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

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
<p>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 240.32-33].</p>	<p>I will:</p> <ul style="list-style-type: none"> • 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 I may add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.
<p>There is a significant risk that the Health Board will fail to meet its first statutory financial duty to break even over a rolling three-year period; against its revenue and capital resource limits.</p> <p>The reported <u>revenue</u> position at month 12 is a year-end deficit of £16.4 million for 2023-24, which would result in a deficit of some £43 million for the three years to 31 March 2024.</p> <p>The reported <u>capital</u> position at month 12I is a year-end surplus of £72,000 for 2023-24, which would result in a surplus of £201,000 for the three years to 31 March 2024.</p> <p>The current financial pressures increase the risk that management judgements and estimates could be biased in an</p>	<p>I will:</p> <ul style="list-style-type: none"> • monitor the Health Board's financial position for 2023-24 and the cumulative three-year position to 31 March 2024. • consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2024. • undertake cut-off testing around the year-end; and classification testing across revenue and capital expenditure. <p>If the Health Board fails to meet the three-year resource limit for revenue and/or capital, I would expect to qualify my regularity opinion on the 2023-24 financial statements. I would also expect to place a substantive</p>

Significant risk	Our planned response
effort to meet key financial targets such as its agreed control totals for 2023-24.	report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.

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Other areas of focus

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

Exhibit 2: other areas of focus

Audit risk	Our planned response
<p>I audit some of the disclosures in the remuneration report to a far lower level of materiality, as set out on page 9. The disclosures are therefore more prone to material misstatement. In some of my past audits I have identified material misstatements in the remuneration report, which the Health Board corrected. I therefore judge the 2023-2024 disclosures to be at risk of misstatement. There is also the regularity risk that the Health Board remunerates a senior officer(s) above the Welsh Government's approved pay bands, but without the Welsh Government's formal approval for any salaries that exceed its bandings.</p>	<p>I will examine all entries in the remuneration report to verify that they are materially accurate, and that remuneration is at the appropriately Welsh Government approved levels.</p>
<p>I also audit the disclosure of related party transactions and balances to a far lower level of materiality. In some of my past audits I have identified omitted or incorrect disclosures, which the Health Board corrected. I therefore judge the 2023-2024 disclosures to be at risk of misstatement.</p>	<p>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.</p>
<p>Valuation of land and buildings The value of land and buildings reflected in the balance sheet and notes to the accounts are material estimates. Land and buildings are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity depending on the specialist and management assumptions adopted and changes in these can result in material changes to valuations.</p>	<p>My audit examinations will include:</p> <ul style="list-style-type: none"> • review the information provided to the valuer to assess for completeness. • evaluate the competence, capabilities and objectivity of the professional valuer. • test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are

Assets are required to be revalued every five years (last done for 2022-23), but values may also change year on year and there is a risk that the carrying value of assets reflected in the accounts could be materially different to the current value of assets as at 31 March 2024, particularly in the current economic environment.

reasonable, and the revaluations have been correctly reflected in the financial statements; and

- test the reconciliation between the financial ledger and the asset register.

Reinforced Autoclaved Aerated Concrete (RAAC) is a material used in construction in many buildings between the 1960s and 1990s. Its presence has been confirmed in a range of public sector properties across the United Kingdom, including hospitals. Its existence can affect the value of properties, remedial costs and/or future remedial liabilities, and the potential cessation of use.

I will be reviewing the actions taken by the Health Board to establish whether any of its properties contain RAAC; and if they do the extent of professional examinations and reporting of affected properties.

As part of this work, I will also consider the governance and reporting within the Health Board on this issue.

My review is mainly aimed at:

- establishing that the valuation of property assets is materially correct; and
- that any material costs, whether incurred, or are liabilities at 31 March 2024, have been captured and accounted for correctly.

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Financial statements' audit timetable

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

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2024 Audit Plan	March to April	April 2024
Audit of financial statements work: <ul style="list-style-type: none"> • Audit of Financial Statements Report • Opinion on the Financial Statements • Audit of Financial Statements Addendum Report 	May to mid-July 2024 May to mid-July 2024 August 2024	Mid-July 2024 Certification is scheduled for 12 July 2024 Early September 2024

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Planned performance audit work

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

Exhibit 4: key dates for delivery of planned outputs

Area of work	Scope of the work	Planned timescales
<p>Structured Assessment - core</p>	<p>Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.</p> <p>My core 2024 structured assessment work will review the following areas:</p> <ul style="list-style-type: none"> • Board and committee cohesion and effectiveness. • Corporate systems of assurance. • Corporate planning arrangements; and • Corporate financial planning and management arrangements. <p>My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.</p>	<p>Fieldwork to commence between June and August 2024 with reporting by the end of October 2024.</p>
<p>Structured Assessment - deep dive review of investment in digital systems to support service resilience and transformation</p> <p style="font-size: small; transform: rotate(-45deg); position: absolute; bottom: 10px; left: 10px;">Saunders, Nathan 17/05/2024 21:26:07</p>	<p>In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency. This work was deferred from</p>	<p>Fieldwork to commence during the spring of 2024 and reporting by the end of December 2024.</p>

Area of work	Scope of the work	Planned timescales
	<p>2023, following my decision to replace the work with a review of the Health Board's approach to financial efficiencies.</p>	
<p>All Wales thematic review of urgent and emergency care – managing demand for urgent and emergency care</p>	<p>In my 2020 audit plan for the Health Board, I set out my intention to undertake work to examine arrangements to manage demand for urgent and emergency care services, as part of my wider work focused on these services.</p> <p>Due to the COVID-19 pandemic, I deferred this work to allow NHS bodies to respond to the pandemic, with a plan to bring the work back online once the impact of the pandemic had subsided and my work on patient flow out of hospital was completed. I am now able to take forward my work on managing demand for urgent and emergency care. The work will be undertaken during 2024 and will be funded from this year's audit fee.</p> <p>Consequently, I have decided to refund the Health Board the fee paid for this work as part of my 2020 audit plan.</p> <p>My 2024 urgent and emergency care work will focus on:</p> <ul style="list-style-type: none"> • The robustness of plans to manage the demand on urgent and emergency care services; • The effectiveness of arrangements to encourage and enable people to access the right care, in the right place, at the first time; and • The effectiveness of arrangements to monitor the performance of urgent and emergency care services and apply lessons learnt to improve the services further. 	<p>Fieldwork commenced in February 2024 and reporting by the end of September 2024.</p>

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Area of work	Scope of the work	Planned timescales
<p>Local project work – review of eye care services</p>	<p>My audit team will also undertake performance audit work that reflects issues specific to the Health Board. Following on from my report on orthopaedic services last year, my team will review the Health Board’s speciality with one of the highest level of waits – ophthalmology.</p> <p>My team will assess the Health Board’s services to ensure they are delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs. In planning the work my team will consider the potential to include aspects of community service provision within the scope of this work.</p> <p>In my 2023 Audit Plan for the Health Board, I set out my intention to follow-up the recommendations I made in my 2019 clinical coding follow-up review. However, through our planning work, we have noted some improvement in clinical coding performance. I have therefore decided to refund the Health Board the fee paid for this work as part of my 2023 Audit Plan. My team will, however, keep a watching brief on performance in this area and, if necessary, reintroduce this piece of work within our local programme of work at the Health Board.</p>	<p>Fieldwork to commence during the autumn of 2024 and reporting by the end of March 2025.</p>

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Fee and audit team

In January 2024 we published our [Fee Scheme](#) for the 2024-25 year as approved by the Senedd Finance Committee. My fee rates for 2024-25 have increased by an average of 6.4% as a result of unavoidable inflationary pressures and the ongoing need to invest in audit quality.

I estimate your total audit fee will be £465,673, being an 6.4% increase on last year's fee.

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

Our financial audit fee is based on the following assumptions:

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

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2024 (£) ²	Actual fee for 2023 (£)
Audit of Financial Statements³	285,714	268,528
Performance audit work:		
• Structured Assessment (including deep dive)	101,685	85,622
• All-Wales thematic review	44,156	46,180
• Local projects	34,118	37,332
Performance work total	179,959	169,134
Total fee	465,673	437,662

² The fees shown in this document are exclusive of VAT, which is not charged to you.

³ There will be a separate audit plan and fee estimate for the audit of the 2023-24 charity account.

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

Exhibit 6: my local audit team

Name	Role	Contact details
Dave Thomas	Engagement Director and Audit Director (Performance Audit)	dave.thomas@audit.wales 02920 320585
Gareth Lucey	Audit Director (Financial Audit)	gareth.lucey@audit.wales 02920 829398
Mark Jones	Audit Manager (Financial Audit)	mark.jones@audit.wales 02920 320631
Darren Griffiths	Audit Manager (Performance Audit)	darren.griffiths@audit.wales 02920 320591
Rhodri Davies	Audit Lead (Financial Audit)	rhodri.davies@audit.wales 02920 320637
Urvisha Perez	Audit Lead (Performance Audit)	urvisha.perez@audit.wales 02920 320610
Alexandra Ross	Senior Auditor (Financial Audit)	alexandra.ross@audit.wales 02920 320659

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

I will update you of any new circumstances that arise during the audits.

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Audit quality

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

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD* and our Chair, acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2023](#).

Our People



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

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

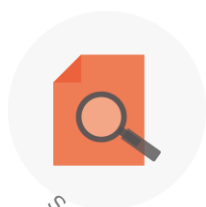
Arrangements for achieving audit quality



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

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

Independent assurance



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






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

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our <u>Good Practice</u> work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our <u>newsletter</u> which provides you with regular updates on our public service audit work, good practice, and events.
	our <u>publications</u> which cover our audit work completed at public bodies.
	information on our <u>forward performance audit work programme 2023-2026</u> which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various <u>data tools</u> and <u>infographics</u> to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our [Annual Plan 2024-25](#) and [Our Strategy 2022-27](#).

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We welcome correspondence and telephone calls in Welsh and English.

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

Report Title:	Counter Fraud Annual Report 2023-24		Agenda Item no.	3.3
Meeting:	Audit Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:
		Private	<input type="checkbox"/>	
Status <i>(please tick one only):</i>	Assurance	Approval	<input checked="" type="checkbox"/>	Information <input checked="" type="checkbox"/>
Lead Executive:	Catherine Phillips			
Report Author (Title):	Gareth Lavington - Counter Fraud Manager			

Main Report

Background and current situation:

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud**. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector.

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

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

The report also highlights how LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects summarised. The NHS CFA measures compliance as follows: **Green – fully compliant; Amber – partially compliant; Red – non-compliant.**

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

Agreed and approved by Executive Director Finance.

At the start of the year 500 days were planned for. 373 days have been provided to Cardiff and Vale UHB in this fiscal year. The reduction in these days has been the result of a number of issues: The department was understaffed for a period of time; Cardiff and Vale UHB Counter Fraud Team provides a service to a total of five organisations (CAVUHB, DHCW, HEIW, Velindre, PHW). Due to the dynamic nature of reactive fraud investigation, and the resulting risk and deterrence activity that follows, resources can be drawn away to a particular organisation for a significant amount of time. This will clearly then impact upon the allocation of resources to the other organisations.

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

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

Recommendation:

The Board / Committee are requested to: approve the report as an accurate assessment of the work undertaken during the year and a measure of compliance with the standards set out by the NHS CFA.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	<input checked="" type="checkbox"/>	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	<input checked="" type="checkbox"/>
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	<input checked="" type="checkbox"/>	Long term	<input checked="" type="checkbox"/>	Integration		Collaboration	<input checked="" type="checkbox"/>	Involvement	<input checked="" type="checkbox"/>
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Impact Assessment:

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

Risk: Yes

Loss of public funds which has an effect on patient care

Safety: No

Financial: Yes

Loss of public funds which has an effect on patient care

Workforce: Yes

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes

Use Statutory legislation to conduct investigations

Reputational: Yes

All negative publicity undermines public confidence

Socio Economic: Yes/No

N/A	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date: April 2024 DoF

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NHS
WALES

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

NHS WALES
Cardiff and Vale University Health Board

Annual Counter Fraud Report
01/04/2023 - 31/03/2024

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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Introduction

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

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

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

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

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

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

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect

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to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care).

Summary of Compliance

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

The section below highlights how LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects summarised. The NHS CFA measures compliance as follows: **Green – fully compliant**; **Amber – partially compliant**; **Red – non-compliant**.

(A similar breakdown of the actions undertaken by the LCFS team in direct measurement against the Standard requirements for 2023-2024 will be recorded in the NHS CFA Functional Standard Return. This is due for completion by 31st May 2024. This document will be completed by the Counter Fraud Manager and is required to be submitted to the Director of Finance and the Audit Committee Chair for sign-off prior to submission to the NHS CFA.)

- **Requirement 1: Accountable Individual and Audit Assurance**

Overall governance of Counter Fraud is led by the Executive Director of Finance (EDoF). The Local Counter Fraud Specialist (LCFS) has ensured to notify the EDoF of any referrals received and regular updates are provided throughout the investigation process. Additionally, the LCFS has extended this exchange of information to ensure that where appropriate, senior people services members have been briefed where aspects of a Counter Fraud investigation may overlap with that of a disciplinary concern. During the course of the year regular updates and meetings have taken place between the LCFS and EDoF, Head of Internal Audit, the Counter Fraud Champion and other senior managers.

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

GREEN

- **Requirement 2: Counter Fraud Bribery and Corruption Strategy**

The organisation has a Counter Fraud, Bribery and Corruption Policy. This was reviewed and updated in 2023 to ensure accuracy and that it remained consistent with current legislation and practice and was fully aligned to the NHS CFA strategy. The policy is available to staff via the Intranet and has been promoted through fraud awareness work throughout the year. Further work will be carried out in the year ahead to ascertain if possible to make the relevant documents more visible. The LCFS team this year has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

GREEN

- **Requirement 3: Fraud, Bribery and Corruption Risk Assessment**

The LCFS' team have continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy changes and updates which aims to strengthen the wider practices of the organisation in reducing the risk of fraud through poor policy or governance controls. Throughout the year the team has carried out risk profiling work in relation to the organisation. Over one hundred and fifty inherent fraud risks to all NHS Organisations have thus far been identified by the NHS Counter Fraud Authority. These are not all relevant to all organisations. Twenty-Seven (27) inherent fraud risks have been identified as being directly relevant to Cardiff and Vale UHB. A report of this Risk Profile has been provided to Audit Committee (February 2023). Work has continued in carrying out comprehensive fraud risk assessments into these areas. The

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Organisational Fraud Risk Profile will remain a 'living' document. Further to the inherent risks known, specific risks are also added to the profile as they arise as a result of investigation or external reporting e.g. Thematic Exercise, Fraud Prevention Notice, Local Intelligence Report. Where local risks have been identified, assessment work has been carried out accordingly.

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

It is only possible to report this area as partially compliant, as assurance has not been gained that the risk management policy of the organisation is being followed in respect of the addition of these risks to risk registers. All other areas of this work are fully compliant with the NHS CFA requirements and the Audit Committee can take assurance that further work has commenced in relation to this. Liaison has been sought and arranged with the corporate governance team in order to review the current system with the aim of ensuring reported fraud risk is recorded and responded to appropriately. Improvement into this work stream continues.

AMBER

- Requirement 4: Policy and Response Plan

The Health Board has a Counter Fraud Policy in place, which promotes the NHSCFA Fraud and Corruption Reporting Line and online reporting tool. The Counter Fraud Policy is supported by the Counter Fraud Procedure and response plan providing relevant information to all members of the organisation of the routes to take when reporting and investigating fraud and the responsibilities of the relevant stakeholders involved in the process. This is further supported by the Welsh Government Directions that provide a legal basis for the Counter Fraud provision to the organisation. Issues

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relating to bribery and fraud are also referenced within the Standards of Behaviour Framework Policy. Staff awareness is monitored through the use of staff survey.

GREEN

- Requirement 5: Annual Action Plan

An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document has approval / agreement and sign off from the EDoF and has been submitted to Audit Committee for approval. Progress of the LCFS teams work will be reported periodically at the Audit Committee. Due to the nature of Counter Fraud work the plan remains flexible and subject to change throughout the year as new risks and requirements are identified, and investigation referrals received.

GREEN

- Requirement 6: Outcome Based Metrics

Throughout the year the locally managed data systems introduced in 2022 have been maintained and updated in order to provide accurate measurement of all work carried out by the department. These new systems supplement existing systems such as ESR, CLUE case management, NFI, and all Wales statistical reporting. These are constantly reviewed and statistics produced (examples are shown at Appendix 1). Review and measurement has taken place in areas including, awareness and promotion, investigation and referral, risk, joint working, strategic planning, sanctioning, and financial loss and recovery. The system introduced has been successful in documenting results that inform direction and, where necessary, modifying work streams throughout the year. The collection and review of these figures identifies areas of work that are proving effective and areas that may require improvement. The data collection also aims to identify areas of emerging risk that require immediate focus and action.

GREEN

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- Requirement 7: Reporting Routes

Staff and contractors have been made aware throughout the year of the reporting routes available to them. In the last year these included direct contact with the team via email, phone and in person, the use of the online NHS CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers. These are further supported by the maintenance and promotion of local tools including QR coding, generic email address and Interactive Referral forms. They have been publicised by way of the Intranet system, the Counter Fraud Intranet Suite, placement of posters at key venues, Fraud Pop Up stalls, screen saver messaging, all staff News emailing and via awareness sessions. This will continue throughout the upcoming year.

All instances of fraud reporting have been initially assessed and those that are furthered to formal investigation have been recorded on the case management system (CLUE) and reviewed accordingly.

GREEN

- Requirement 8: Reporting Identified Loss

The Counter Fraud team has reported all incidents of suspected fraud and financial crime using the CLUE case management system. This reporting tool is used to record all investigations, sanctions, financial recoveries and losses and preventions and also has a mechanism to record system weakness and Local Proactive Exercise work. This system is supervised by NHS CFA and all information has been used to inform progress reporting to Audit Committee and CFS Wales. All identified loss to fraud is reported within this Annual report and in the Functional Return submitted to the NHS CFA.

GREEN

- Requirement 9: Access to trained investigators

At the time of reporting the team is fully staffed. The team is made up of a Counter Fraud Manager who acts as the Senior Investigating Officer; a Deputy Counter Fraud Manager; and, two Local Counter Fraud Specialists. All are experienced criminal investigators joining the organisation from a policing background. The two LCFS are currently undertaking their accreditation to achieve Accredited Counter Fraud Specialist (ACFS) status.

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The absence of this does not impair their ability to conduct investigation as their previous police investigation qualifications are directly transferable. Throughout 2023-2024 the team was significantly (25%) understaffed but this issue has now been resolved.

GREEN

- Requirement 10: Undertake Detection Activity

Where anomalies have been identified through counter fraud work e.g. investigations, the CF team strives to carry out proactive activity to assess whether there are any weaknesses present and remedial action required. A number of Local Proactive Exercises (LPE) have been undertaken this year with a view to detecting offences or identify process and/or system weakness. (More information provided at Section 9.)

A PPV programme is undertaken by the organisation and the Counter Fraud Manager attends quarterly meetings. Direct reports are submitted to counter fraud, and where appropriate an investigation/local proactive action will be started in relation to outlier information. Data mining has also been undertaken within the context of the NFI database and all investigations carried out in relation to the 2022-2023 exercise have now been opened and successfully closed or remain 'under investigation'. The team have responded to all fraud prevention notices and Intelligence bulletins issued by the NHS CFA and local bulletins issued by other external bodies. The Counter Fraud Team also attends each Local Intelligence Network (LIN) meeting to keep apprised of emerging trends in relation to drug misuse activity in the community that may have an impact on the organisation. All referrals to the team have been fully investigated. All actions taken by the Counter Fraud team in relation to work in this area have been reported accordingly on CLUE inclusive of any recoveries/preventions made.

GREEN

- Requirement 11: Access to and Completion of Training

All wales fraud awareness training has remained available to all staff throughout the year via ESR. This module remains non-mandatory training.

Regular awareness sessions are provided to all new starters via Corporate Induction and at the request of departments. A counter fraud newsletter has been published bi-monthly in order to keep staff apprised.

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Counter Fraud team staff have attended all sessions of formal training provided by NHSCFA and a number of webinars from NHS CFA have also been undertaken in relation to update training into areas such as risk assessment and CLUE implementation. The deputy Counter Fraud Manager has successfully achieved accreditation from the Chartered Institute of Public Finance and Accountancy (CIPFA) in the area of Fraud Risk Management. Accreditation courses are currently being undertaken by the two LCFS.

GREEN

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

The organisation has in place policies and registers in compliance with this requirement. The register of Conflicts / Declarations is managed by the Director of Corporate Governance and where appropriate liaison with Counter Fraud can be sought. Counter Fraud has access to the register for the purposes of investigation.

GREEN

Allocation of Resources

At 31st March 2024 **373 days** of Counter Fraud work have been completed against the agreed 500 days in the Counter Fraud Annual Work-Plan for the 2023/24 financial year as shown below. The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; interviewing suspects; preparing case files for the Crown Prosecution Service and maintaining the Fraud Risk provision. The days provided are less than planned. This has been due to under staffing for a protracted period of time the overall days available to the organisation being reduced as a result.

Strategic Requirements 40 Days

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

Proactive Work 125 Days

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(inclusive of fraud awareness and promotion activity, digital platform support work, detection work including PPV review, system weakness reviews and reporting, local proactive work, and National Fraud Initiative work.)

Reactive Work 208 Days

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

Summary of Costs

Total Costs	£ 139,122.00
--------------------	---------------------

Breakdown of Investigative work areas

At 1st April 2023 a total of **8** legacy investigations were open and being investigated by the team.

During the course of this financial year a total of **159** new referrals have been received by the team. A total of **61** cases were promoted to formal investigation. A breakdown of areas of referral and investigation and benchmarked figures year on year is provided at Appendix 1.

Sanctions and Recoveries

During the financial year the the following sanctions and recoveries have taken place.

Disciplinary Sanctions	12
Criminal Sanctions	1
Professional Sanction	0 (2 ongoing)
Financial loss attributed to fraud related activity	£3,476.69

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Financial Recoveries attributed to fraud loss	£3,476.69
Financial Prevention Figure *	£3,189.16
Financial Loss – non-fraud	£97,649.25
Financial Recovery – non-fraud	£97,649.25
Financial Prevention – non-fraud*	£21,003.00

* as defined by NHS CFA formula.

Fraud Awareness

During the course of 2023-2024 a fraud awareness has been delivered as listed below

Corporate Induction –03 events (23 presentations)

Bespoke - 03 events

Webinar - 10 events

Fraud pop Ups - 03 events

These sessions are supported by the opportunity for staff to undertake the E learning module on ESR and the Share point digital Counter Fraud site.

End of year figures are not available for ESR eLearning uptake at time of reporting.

Fraud Risk Assessments

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

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

- Impersonating a medical professional
- Out of Hours GP Omnicell drug storage
- Working elsewhere- agile and remote working
- Retention of salary overpayments
- Staff governance in the Integrated Medicine Directorate
- Capital and Estates Procurement
- Working elsewhere whilst sick
- False reporting of sickness

Local Proactive Exercise (LPE)

The following LPE's have been undertaken/commenced into the following areas.

- Finance Agency Worker – sub contracting – IBURN response
- Working elsewhere during contracted hours – FPN response
- Companies fraudulently registering at NHS properties
- Mandate fraud – FPN response
- Impersonating medical professionals – FPN response
- Secondary employment skilled worker visa – IBURN response
- Fraudulent Jobs offers at SMPU
- Fraudulent Invoices – IBURN response
- CEO Impersonation Fraud – FPN response
- CV and Theft related issues – IBURN response

Lines of Reporting

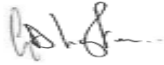
CEO	– Suzanne Rankin
Executive Director of Finance	– Catherine Phillips
Counter Fraud Manager	– Gareth Lavington
Deputy Counter Fraud Manager	– Henry Bales
LCFS	– Steven Betty
LCFS	– Jacob Parkinson

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Declaration

I declare that the Counter Fraud work carried out on behalf of Cardiff and Vale Health Board for the year 2023/2024 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Head Counter Fraud:
Gareth Lavington



Date: 02/04/2024

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Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Annual Counter Fraud Report

01/04/2023 - 31/03/2024

APPENDIX 1

Performance Charts

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

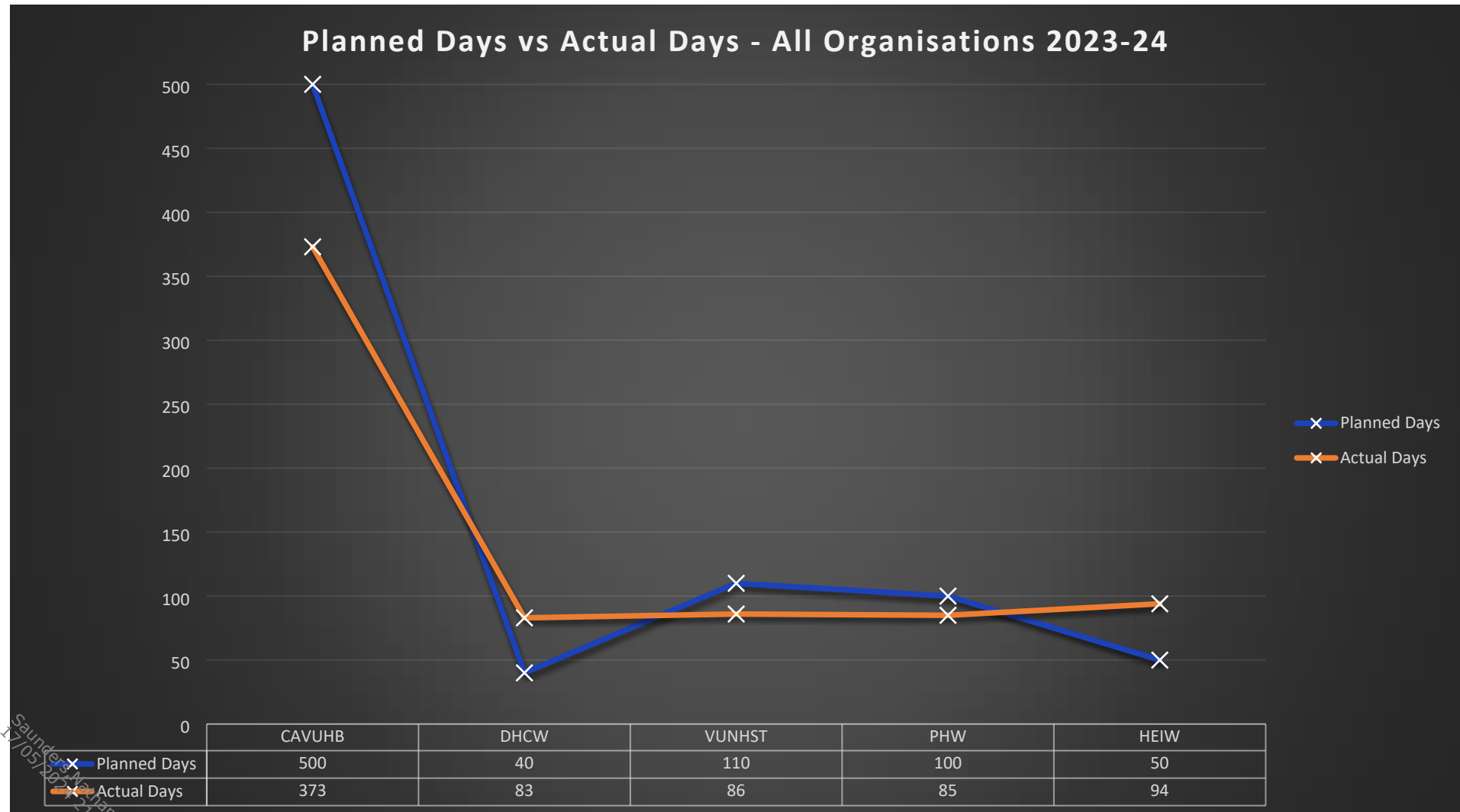
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Figure 4 – CAV - Referrals and Investigations Year on Year	6
Figure 5 – Thematic Areas of Investigation (All Organisations) 2022-23.....	7
Figure 6 – Thematic Areas of Investigation (All Organisations) 2023-24.....	8

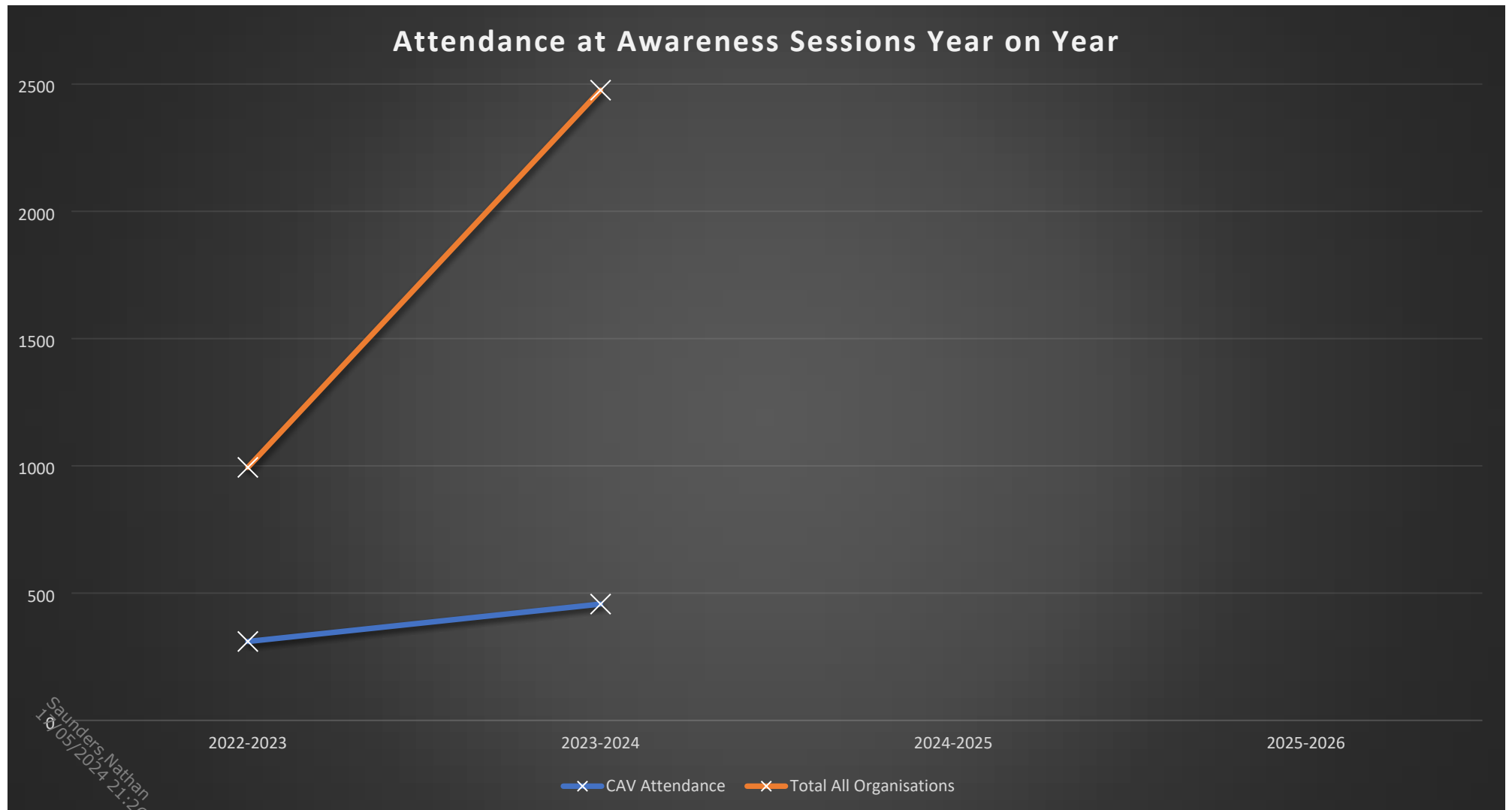
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Figure 1 – Planned Days vs Actual Days Provided by Counter Fraud Team – 2023-24 (All Organisations)



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Figure 2 – Attendance at Awareness Sessions Year on Year



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Figure 3 – All Organisations - Referrals and Investigations Year on Year

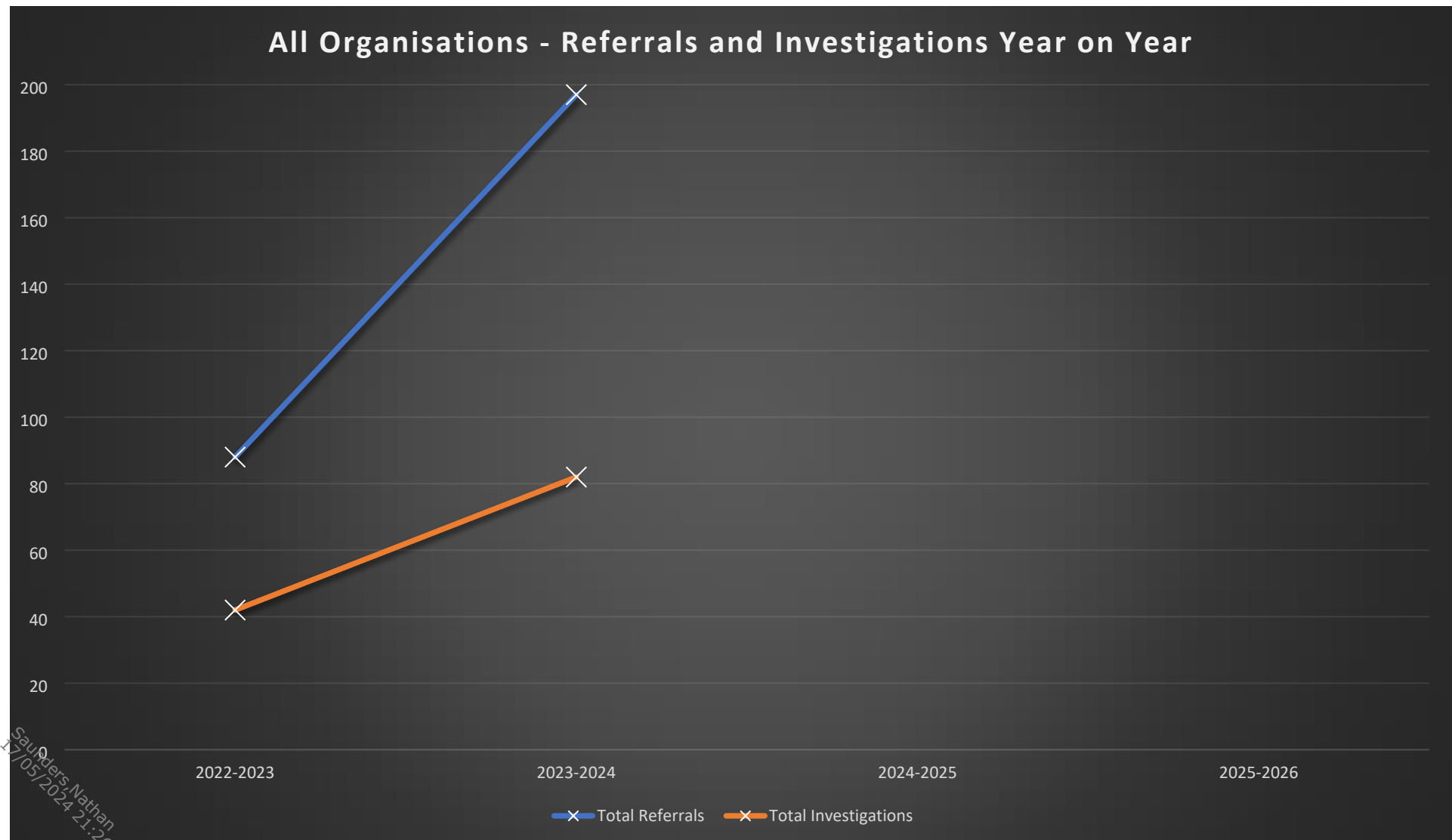
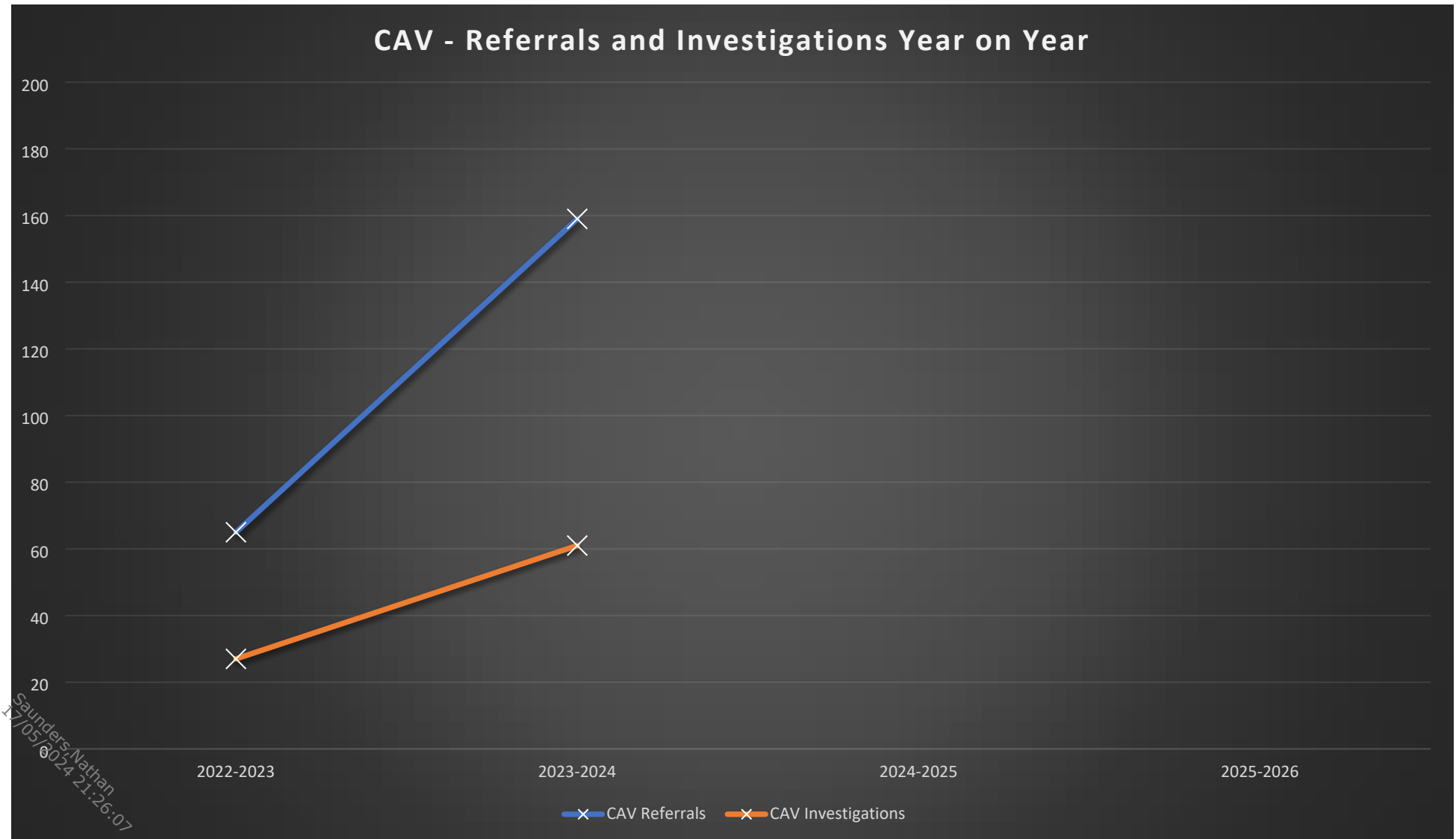
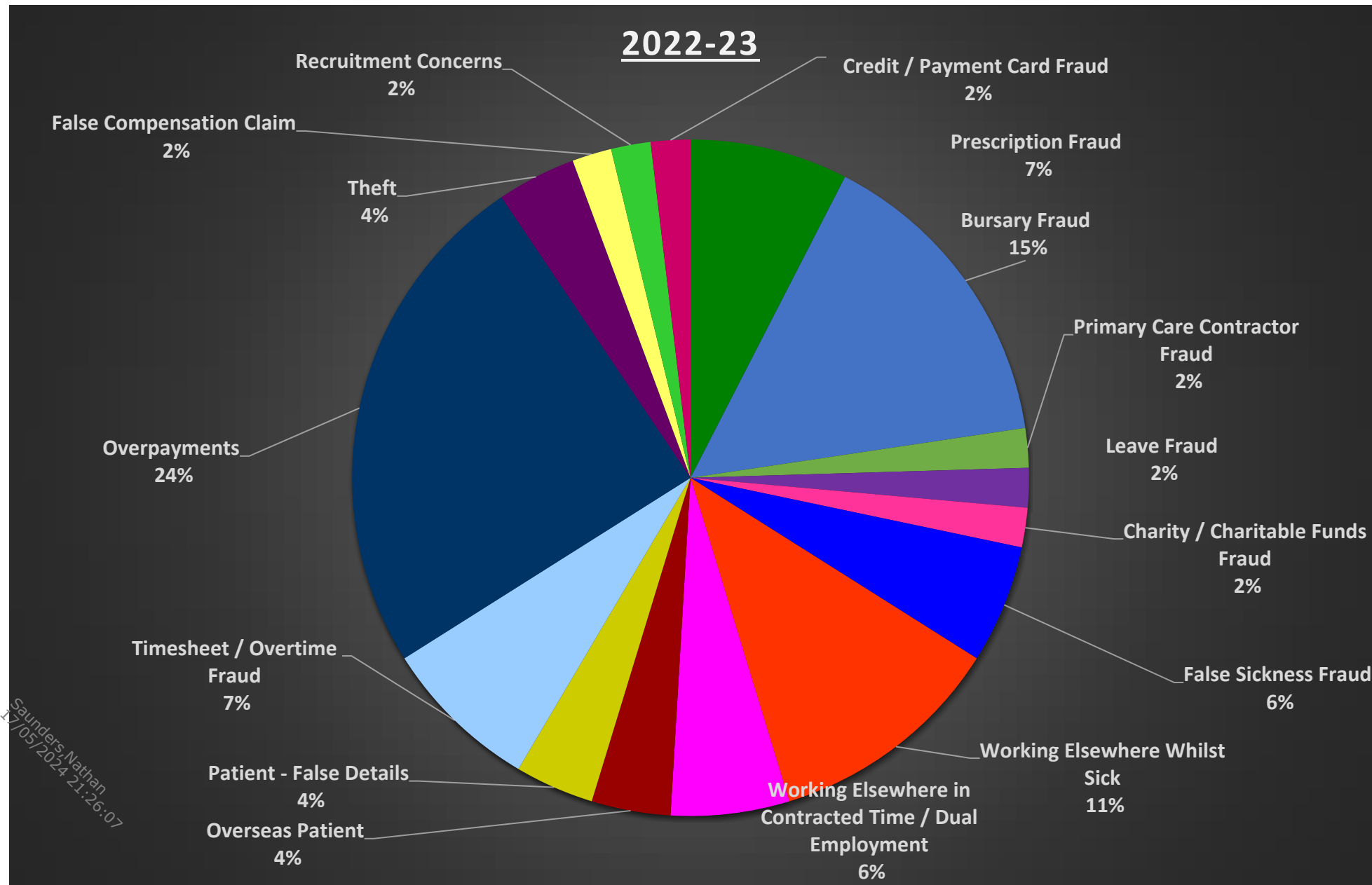


Figure 4 – CAV - Referrals and Investigations Year on Year



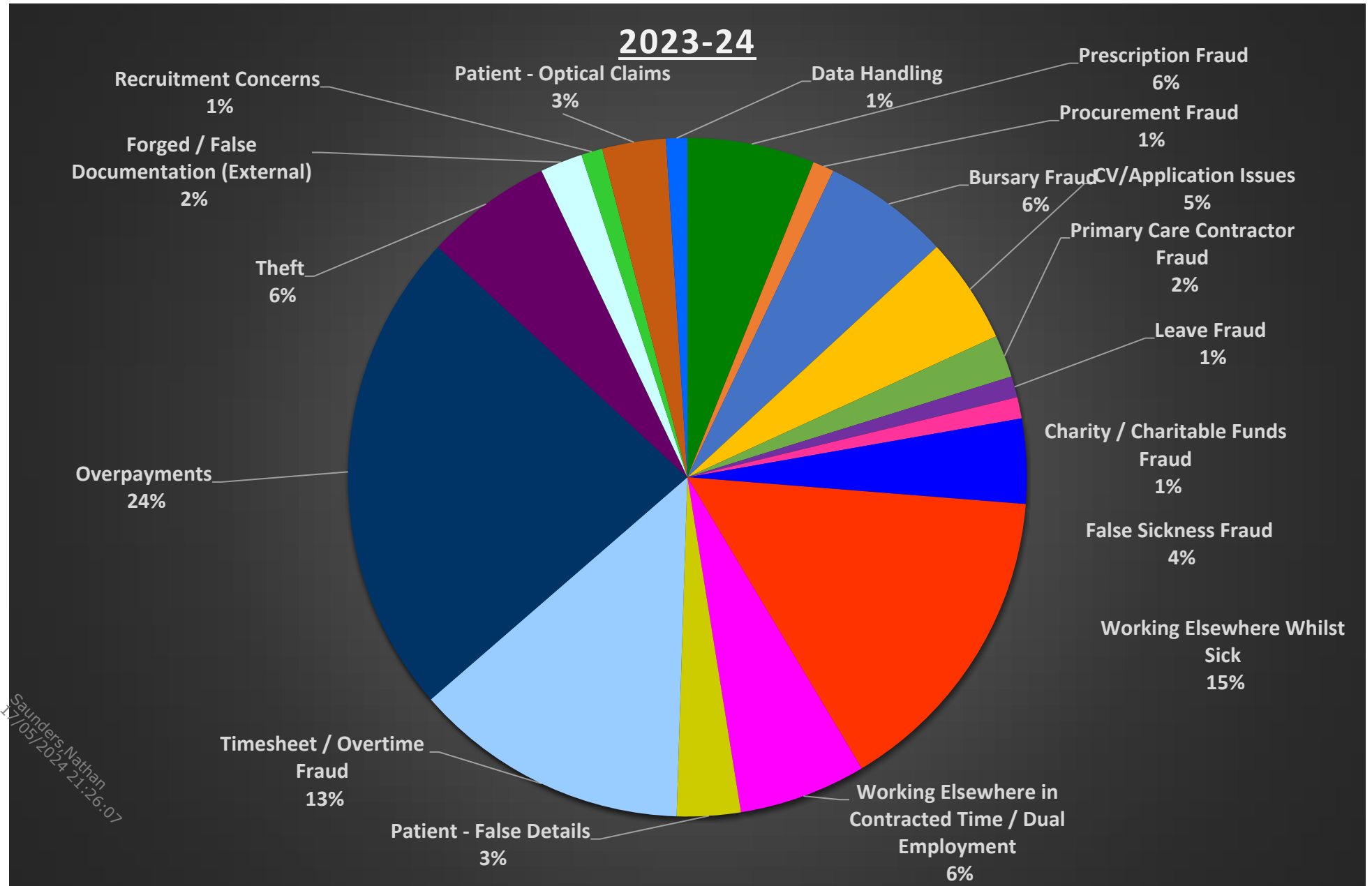
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Figure 5 – Thematic Areas of Investigation (All Organisations) 2022-23



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Figure 6 – Thematic Areas of Investigation (All Organisations) 2023-24



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Report Title:	Counter Fraud Annual Plan 2024-2025		Agenda Item no.	3.4
Meeting:	Audit Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:
		Private	<input type="checkbox"/>	
Status <i>(please tick one only):</i>	Assurance	Approval	<input checked="" type="checkbox"/>	Information
Lead Executive:	Catherine Phillips			
Report Author (Title):	Gareth Lavington Counter Fraud Manager			

Main Report

Background and current situation:

1. SITUATION

The NHS Counter Fraud Authority requires that an Annual work plan is created in relation to the counter fraud work to be carried out by counter fraud teams for their organisations. The workplan must directly align with Government Functional Standard GovS 013: Counter Fraud. This plan adheres to that principle and provides an overview of the areas of work that will be carried out on behalf of the organisation for 2024/2025.

2. BACKGROUND

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud**. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services. The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and has a duty to ensure the effective implementation of the NHS Counter Fraud Requirements. Local Counter Fraud Teams must adhere to these requirements and report their work against them. As a result, an Annual Workplan identifying how these requirements will be met is produced and submitted to DoF and Audit Committee for their approval.

The proposal is that the report is reviewed and approved.

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

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

Recommendation:

The Board/Committee are requested to: Review, discuss and approve the Plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	R	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	R
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	R	Long term	R	Integration		Collaboration	R	Involvement	R
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Impact Assessment:

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

Risk: Yes

Loss of public funds which has an effect on patient care

Safety: No

Financial: Yes

Loss of public funds which has an effect on patient care

Workforce: Yes

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes

Use Statutory legislation to conduct investigations

Reputational: Yes

All negative publicity undermines public confidence

Socio Economic: Yes/No

N/A

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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University Health Board

NHS WALES CARDIFF AND VALE UNIVERSITY HEALTH BOARD

COUNTER FRAUD PLAN 2024/2025

Gareth Lavington
Manager Counter Fraud
Cardiff and Vale UHB

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

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Catherine Phillips

Date: 21/02/2024

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WORKPLAN 2024-2025

Background

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud**. The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and has a duty to ensure the effective implementation of the NHS Counter Fraud Requirements. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is 31/05/2025. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. The Counter Fraud manager will provide a grading of compliance in relation to all areas of the functional standards through self-assessment. (Green, Amber or Red). This will be supported internally with the completion of the Annual Report that will align with the same methodology. The Counter Fraud Manager will complete these reports and they will be shared with the Executive Director of Finance and the Audit and Assurance committee.

In order to achieve the standard set by the NHSCFA, Cardiff and Vale University Health Board adheres to the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales. These directions require that each NHS body employs a dedicated, professionally accredited team of NHS Local Counter Fraud Specialists (LCFS). To ensure that the Health Board's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the Counter Fraud

Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided below formulates Local Counter Fraud arrangements for Cardiff and Vale University Health Board for 2024-2025. The tasks outlined will be considered and reviewed throughout the year as the need arises. The plan is intended to provide targets for the year but due to the nature of the work in countering fraud it will remain a living document and subject to change. The effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan will directly mirror GovS:13 Standard (Counter Fraud) in order to maintain consistency with the NHSCFA Counter Fraud Bribery and Corruption Strategy and other NHS bodies. This in turn supports the objectives set by the Welsh Government.

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

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

Any fraud risks which are identified by the LCFS will be recorded in line with the local Risk Management Policy and nationally via the CLUE case management system, and, where appropriate, they will be shared with the Internal Audit department and reported to the Director of Finance and Audit Committee. The aim is to provide assurance that the fraud risk is being suitably managed and is **owned by the appropriate department**. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices, together with identified **inherent** risks to all NHS organisations. Information received from external sources will be assessed and investigated and any risks identified as pertinent to the organisation will be subject to formal assessment and any necessary remedial action. To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued up to date risk assessment advice and training.

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A dedicated risk matrix scoring system and template have been designed and implemented that comply with Cabinet Office methodology for the purpose of recording and reporting upon fraud risk.

Outcomes/Results

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

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

Resource Provision

Resource Provision for CAVUHB	Days Planned 24 / 25
Counter Fraud Manager directly employed by Organisation	100
LCFS directly employed by Organisation	380
Total	480

Resource by Activity

Activity	Days Planned 24 / 25
Proactive	240
Reactive	240
Total	480

With the move to the GovS:13 (NHS Requirements) taking place and old 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account now obsolete, the methodology to be adopted in planning resource time by activity area is simplified into Proactive and Reactive areas. Generally *Proactive* work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises, and risk assessment. Reactive work will involve formal investigation into referrals received.

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

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Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>1: Accountable individual</p> <p>NHS Requirement 1A:</p> <p>A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken.</p> <p>The accountable board member is responsible for ensuring that nominations to the NHSCFA for</p>	<p>Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed.</p> <p>CFM to produce the Cardiff and Vale University Health Board (CAVUHB) Counter Fraud Annual Workplan which is to be agreed with the DoF and ratified by the Audit Committee.</p>	<p>Q1/2/3/4</p> <p>Q4 (23/24)</p>

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>the accountable board member, audit committee chair and counter fraud champion are accurate.</p> <p>NHS Requirement 1B:</p> <p>The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation.</p> <p>The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation.</p> <p>Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA</p>	<p>CFM to provide quarterly progress reports to Dof and Audit Committee.</p> <p>Checks to be carried out by CFM that nominations to NHS Counter Fraud Authority (NHSCFA) are correct, up to date and in order.</p> <p>Where necessary and appropriate Counter Fraud Manager (CFM) will seek to hold regular one to one meetings with the Audit Committee Chairperson, Independent members and the Counter Fraud Champion.</p> <p>In addition to this CFM to attend pre-audit committee meetings with non-executive Audit Committee and Board Members.</p> <p>Counter Fraud to remain a standing agenda item at Audit Committee. Counter Fraud Manager to provide</p>	<p>Q1/2/3/4</p> <p>Q4 (23/24)</p> <p>As required</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation.</p> <p>The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.</p>	<p>written and oral reports to this forum, annually and progressively throughout the year.</p> <p>Counter Fraud Manager (CFM) will address and report to Director of Finance (DoF) and Audit Committee any matters arising from NHSCFA in relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises.</p> <p>CFM to liaise with internal partners, such as Internal Audit, HR, Communication Department to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision.</p> <p>CFM to complete annual report and submit to Audit Committee. CFM to complete NHSCFA Functional Standard return. CFM to ensure that Audit Committee Chair and Director of Finance have oversight of the</p>	<p>Q1/2/3/4</p> <p>As required</p> <p>Q1 (24/25)</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	CF Functional return in order to provide assurance that it aligns with the information reported within the Annual Work report presented to Audit Committee in Q1.	Q1 (24/25)
<p>2: Counter fraud bribery and corruption strategy</p> <p>NHS Requirement 2:</p> <p>The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks.</p>	<p>CFM to ensure that work planned for in the Annual Counter Fraud Plan and that work carried out is aligned to the NHS CFA strategy and that the objectives are being met.</p> <p>CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>
<p>3: Fraud bribery and corruption risk assessment</p> <p>NHS Requirement 3:</p>	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. All risks identified to be assessed and remedial action taken and reported	Throughout the year and dynamically as the needs arise

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body).</p> <p>For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.</p>	<p>to key stakeholders. All matters arising to be reported to DoF and AC by way of periodic counter fraud progress reporting. If immediate action is required due to the nature and impact of the identified risk then this will be undertaken and reported to DoF as necessary.</p> <p>Fraud risk assessment profile to be maintained and managed by the deputy Counter Fraud Manager targeting all areas of inherent Fraud Risk to the organisation and providing a timescale of intended work. Proposed action plan/and work carried out to date to be submitted to Audit Committee for approval/noting alongside Annual Report at the Q1 24/25 Audit Committee meeting. This report will also provide up to date information in relation to locally identified and emerging risks and the work undertaken to mitigate them.</p>	<p>Q1(24/25)</p>

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>The maintenance of the Fraud Risk Profile will aim to evaluate, evidence and measure the effectiveness of counter fraud risk assessment work.</p> <p>Work to be carried out in conjunction with the Corporate Governance Team in order to further a reporting mechanism (Audit Tracker) to assist in ensuring that reported risks are responded to and are placed on local risk registers where necessary.</p> <p>Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year informed by post-investigation work, local risk assessment and CFA Fraud Prevention Notices and national exercises.</p> <p>Areas identified as priorities for LPE work to be carried out in 24/25 at the time of reporting are:</p> <ol style="list-style-type: none"> 1. Consultants/SAS vs Declarations of Interest vs Private Work vs Job Planning 	<p>Q1</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>2. Impersonation of medical professionals – focus upon agency staff</p> <p>3. Software downloads by staff</p> <p>All risk work undertaken will aim to comply with the local risk management policy and the Counter Fraud Manager will endeavour to have identified fraud risk added to local risk registers throughout the organisation.</p> <p>The CF team will assist and action any NHSCFA thematic exercises in relation to risk as they arise and report outcomes to DoF and Audit Committee.</p>	
<p>4: Policy and response plan</p> <p>NHS Requirement 4:</p> <p>The organisation has a counter fraud, bribery and corruption policy and response plan (the</p>	<p>Brand new Counter Fraud Policy designed, developed and implemented in 23/24 and remains in date.</p> <p>Counter Fraud team to promote awareness of the policy at presentations and through newsletters.</p>	<p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team.</p>	<p>CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.</p>	<p>Q3</p>
<p>5: Annual action plan</p> <p>NHS Requirement 5:</p> <p>The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).</p>	<p>CF Manager to complete annual Counter Fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed time period.</p> <p>CF Manager to ensure the plan is agreed by DoF, ratified by Audit Committee.</p> <p>CF manager to provide quarterly reports to Audit Committee.</p> <p>CF manager to provide quarterly statistics to Counter Fraud Service Wales to appraise Welsh Government of work undertaken and costs of service.</p>	<p>Q4 (23/24)</p> <p>Q1</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	CF manager to provide annual report measuring the effectiveness of the plan.	Q1 (24/25)
<p>6: Outcome-based metrics</p> <p>NHS Requirement 6:</p> <p>The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system.</p> <p>Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.</p>	<p>The new contact, enquiry and reporting methods now in place benefit from the automatic facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team throughout the year. Where necessary regular review will be used to inform change. In addition to this, regular review of referral and investigation trends will be made to ensure that any areas of weakness are identified at the earliest opportunity in order that remedial action can take place. Maintenance and use of the following resources already successfully implemented will be utilised and improved where necessary :-</p> <p>CLUE Management System</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>



Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>Interactive feedback forms</p> <p>Interactive Staff Surveys</p> <p>Fraud Risk Profile</p> <p>Risk Management Policy</p> <p>Locally developed outcomes database</p> <p>Electronic Staff Record</p> <p>CFS Statistics</p> <p>Microsoft Share point</p> <p>All investigations will be recorded and managed on the CLUE case management system and reported to Audit Committee via the quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.</p> <p>All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to Audit Committee via the Annual Report. This Data will also</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>be shared with the Counter Fraud Service Wales and the NHS CFA.</p> <p>Statistical report of work areas drawn from newly implemented local database to be provided in Annual Report. (To provide work benchmarked year on year)</p>	<p>Q1 (24/25)</p>
<p>7: Reporting routes for staff, contractors and members of the public</p> <p>NHS Requirement 7:</p> <p>The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system.</p>	<p>New reporting routes put into place during the course of 2022/2023 that compliment national routes of reporting continue to be fully maintained and successful. These will be continually 'advertised' throughout the year and awareness will be drawn to them via all routes available. Continued liaison with the communications team will assist in achieving this.</p> <p>CF Fraud team will continue throughout the year promoting their identity and presence. This will be undertaken by way of the continued development of the Share point Intranet Site, and throughout</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.</p>	<p>structured awareness and training sessions, and pop up stalls at key locations.</p> <p>Ongoing review of the effectiveness of the work undertaken (live database of metrics) and where necessary remedial action to take place dynamically throughout the year.</p> <p>Continued promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA to take place at all fraud awareness events.</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>
<p>8: Report identified loss</p> <p>NHS Requirement 8:</p> <p>The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case</p>	<p>CF team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting.</p> <p>CF Manager to ensure via review that all members of CF team are suitably trained and qualified to access the CLUE case management system and maintain up</p>	<p>Q1/2/3/4</p> <p>Q2/Q4</p>



Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises</p>	<p>to date knowledge and permissions in relation to the system.</p> <p>CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated.</p> <p>CF manager to oversee and direct live investigations on CLUE as the dedicated Senior Investigation Officer.</p> <p>CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting.</p> <p>CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and reported to DoF and Audit Committee at progress updates and at year end in Annual report and NHS CFA Functional Return.</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>9: Access to trained investigators</p> <p>NHS Requirement 9:</p> <p>The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account.</p> <p>The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.</p>	<p>The organisation currently employs/has access to provision from, four fully accredited, nominated and qualified LCFS. All members work on a full-time basis. All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. CF manager to review all staff levels of training and arrange remedial action where necessary.</p> <p>Two new staff members are currently not Accredited. This will be actioned by end Q2 it is aimed that accreditation will be gained.</p> <p>All staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and NHS CFS Wales. CF team will undertake continuing</p>	<p>Q1 /Q3</p> <p>Q2</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>professional development opportunities associated with role throughout the year as they become available.</p> <p>All staff to maintain full compliance with mandatory training/e learning as measured on the ESR system.</p> <p>CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to relevant IT systems.). Review of staff awareness/compliance in relation to Information Governance to take place.</p> <p>CF team to continue to have access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention and</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<p>storage of evidential data in line with legal requirements.</p> <p>All training and development to be recorded and annual staff appraisals to be carried out and objectives set.</p>	<p>Q4</p>
<p>10: Undertake detection activity</p> <p>NHS Requirement 10:</p> <p>The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption.</p>	<p>CF team to undertake national exercise work as it is published by NHS CFA throughout the year.</p> <p>CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Health Boards and Special Health Authorities.</p> <p>CF team will undertake Local Proactive exercises in response to locally identified risk if appropriate in order to detect offences/system weakness.</p>	<p>Q1/2/3/4</p> <p>As required</p> <p>As required</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.</p>	<p>CF Team to undertake the 2023-2024 National Fraud Initiative exercise in relation to Payroll data</p> <p>CF team to foster and maintain a close working relationship with Contractor Services ensuring a flow of intelligence from primary care, PPV, dental and optical teams with the aim of identifying areas of weakness and to assist in any investigations as the result of the identification of outlying information.</p> <p>CF team will engage with internal and external partners e.g. internal and external audit, in order to ensure that any outlying data is reported and acted upon accordingly.</p>	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p>
<p>1: Access to and completion of training</p>	<p>CFM to continue to work towards making Fraud Awareness Training module mandatory. In the</p>	<p>Q1/Q2</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>NHS Requirement 11:</p> <p>The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work.</p> <p>Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.</p>	<p>absence of this CFM to develop new strategies to encourage uptake.</p> <p>CFM to continue to work towards ensuring that Fraud Awareness training remains a standing item of agenda at all corporate inductions.</p> <p>CF team to maintain a promotion strategy in relation to the new module through effective communication to staffing cohorts.</p> <p>CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to</p> <ul style="list-style-type: none"> • Digital banners on organisation intranet site • Regular publishing of Counter Fraud news items via Counter Fraud Newsletter 	<p>Q1/2/3/4</p> <p>Q1/2/3/4</p> <p>Q1/2/3/4</p>

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	<ul style="list-style-type: none">• Regular messaging across available social media systems• All staff email bulletins to advise of fraud alerts• Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation including primary care• The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate in order to provide face to face contact with staff and public promoting the work of the team and its function <p>CF team to fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide and to the general public. Review of team competence to be carried out.</p> <p>CF team to fully participate in International Counter Fraud Week initiative.</p>	Q3

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Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
<p>12: Policies and registers for gifts and hospitality and COI.</p> <p>NHS Requirement 12:</p> <p>The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested</p>	<p>CFM to liaise with Corporate Governance Team to ensure policies are current.</p> <p>CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters.</p> <p>CF manager to provide a presence and input into relevant policy review, and to record and document changes.</p> <p>CF team to complete National Fraud Initiative exercise in relation to payroll versus Company Director matches to test effectiveness of declarations of interest policy.</p>	<p>Q1</p> <p>Q1/2/3/4</p> <p>As Required</p> <p>Q1/2/3/4</p>

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Report Title:	Counter Fraud Progress Report			Agenda Item no.	4.1
Meeting:	Audit Committee	Public	x	Meeting Date:	07/05/2024
		Private			
Status <i>(please tick one only):</i>	Assurance	x	Approval	Information	x
Lead Executive:	Catherine Phillips				
Report Author (Title):	Gareth Lavington				
Main Report					
Background and current situation:					
<p>The Counter Fraud Progress report seeks to provide assurance to members of the Audit Committee that the Counter Fraud work being undertaken is satisfactory, robust and compliant with NHS Counter Fraud Authority requirements.</p> <p>The report provides information around key areas of work including, fraud awareness and learning, fraud risk assessment, investigation and reactive work, and promotional activity.</p>					
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:					
Progress made against the Annual Counter Fraud Plan Promotional /Educational Activity Summary of Investigations Prevention activity National Fraud Initiative work					
Recommendation:					
The Board / Committee are requested to: note the report					
Link to Strategic Objectives of Shaping our Future Wellbeing:					
<i>Please tick as relevant</i>					
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance			
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn		x	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology			
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us		x	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives		x	
Five Ways of Working (Sustainable Development Principles) considered					
<i>Please tick as relevant</i>					
Prevention	x	Long term	x	Integration	x
				Collaboration	x
				Involvement	x
Impact Assessment:					
<i>Please state yes or no for each category. If yes please provide further details.</i>					
Risk: Yes/No					

Fraud is a risk to all organizations. Within the NHS should fraud occur then this can have financial and reputational impacts and ultimately negatively affect patient care.

Safety: Yes/No

Financial: Yes/No

All fraud occurring in the organization has a financial loss to the organization.

Workforce: Yes/No

Reduction of available staff during investigations and sanctions; demotivation

Legal: Yes/No

Reputational: Yes/No

As at Risk

Socio Economic: Yes/No

Equality and Health: Yes/No

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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Caerdydd a'r Fro
Cardiff and Vale
University Health Board

NHS WALES

Counter Fraud Progress Report

01/01/2024-31/03/2024

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

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1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the Cardiff and Vale University Health Board's Local Counter Fraud Specialists on behalf of the Health Board.

This report relates to activity for the reporting period 01/01/2024-31/03/2024.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2023-2024, and the NHS CFA functional standards. The below activity has taken place -

- i. Continued maintenance and development of a comprehensive local activity database which is vital in maintaining a detailed and accurate record of work undertaken and activity reported in order to inform areas of future work.
- ii. Continued maintenance of Counter Fraud digital platform – **Members of the Audit Committee are encouraged to visit the site at the link/QR code here**

[Counter Fraud - Home \(sharepoint.com\)](#)



Promotion and Awareness and Educational Activity

Corporate Induction– Two market place corporate induction events attended with 12 presentations provided to new starters. Counter Fraud remains a standing item on the corporate induction agenda.

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Fraud Pop Ups- One further session held at Y Gegin, UHW, to engage with staff and provide support and sign posting material.

E- Learning – Verbal update at meeting.

Newsletter – One further Newsletter produced and published to Counter Fraud Share point pages.

Prevention

Local Bulletins/Alerts – (0)

IBURN (intelligence bulletin) – (2)

1. Bulletin relating to an individual who is suspected of committing multiple frauds across public sector organisations. Suspect obtains roles by false pretences hiding previous history of fraudulent behaviour and offending and carries on multiple role simultaneously. Relevant checks made and the subject under investigation has had no contact with CAVUHB in any of their alias names.
2. Bulletin relating to the issue of false invoices to NHS organisations from a fake company. Relevant checks made and no contact with CAVUHB has been made. Intelligence passed on to Cyber Security team in order that blocks put in place in relation to the identified rogue email addresses and domain names. That has been carried out.

FPN – (Fraud prevention notice) – (1) – Notice issued in relation to CEO/DoF/CFO/COO unsolicited request fraud – based upon information obtained that this methodology is currently being used to obtain payments from finance teams using the pressure of the request purporting to be from a senior member of staff. Advice and support materials issued accordingly.

Referrals

During this reporting period there have been a total of 54 referrals made to the team. 39 of these referrals have been investigated and informally resolved with 15 promoted to formal investigation as below.

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Investigations

A total of 15 new formal Investigations have been commenced this period. A summary of the investigations for 23-24 are provided below. At the time of reporting 15 investigations remain open and are being investigated by the team. Summary of 23/24 investigations to date is provided below.

INV/22/00730	False On Call Claims	CARRIED OVER - 24/06/2022	04/12/2023	Dismissed and recovery of 36 with cci
INV/22/01558	False Bereavement	CARRIED OVER - 25/10/2022	04/07/2023	Subject has been dismissed for Gross Misconduct following Disciplinary Hearing. Financial Recovery made of £520.61
INV/23/00079	Staff Over Payment	CARRIED OVER - 10/01/2023		
INV/23/00096	Overpayment of Salary - Non Starter	CARRIED OVER - 12/01/2023		
INV/23/00113	Suspected Overtime Fraud (EW)	CARRIED OVER - 13/01/2023		
INV/23/00263	Working elsewhere during HB Hours	CARRIED OVER - 06/02/2023	02/05/2023	No fraud identified, all avenues of investigation completed under available powers.
INV/23/00412	Patient letters to different address	CARRIED OVER - 28/02/2023	04/07/2023	Reported in good faith, no offences identified.
INV/23/00415	Working whilst sick / NFI match	CARRIED OVER - 27/02/2023	23/06/2023	Case transferred to National Investigations Team NHSCFA - outcome awaited
INV/23/00646	Theft of Cyclizine	03/04/2023	02/05/2023	Evidence of theft to the value of £11.33, passed evidential test however did not pass public interest test for criminal prosecution. Subject work with organisation terminated.
INV/23/00648	Overpayment Of Salary - Career Break	03/04/2023	01/06/2023	Non Fraud Recovery £10,847.74. Subject on career break out of the country, civil recovery only.
INV/23/00702	Overpayment / On-Call Banding error	06/04/2023	18/05/2023	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/23/00737	Salary Overpayment Following Termination	18/04/2023	16/01/2024	Financial recovery made - £7511.08
INV/23/00764	Salary Overpayment Following Termination	21/04/2023	04/07/2023	Non fraud recovery - £5,525.37. Subject no longer employed by organisation.

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INV/23/00824	Salary Overpayment Following Termination	02/05/2023	04/07/2023	Non Fraud recovery - £2,967.57. Subject no longer employed by organisation.
INV/23/00825	Salary Overpayment for Sick Pay	02/05/2023		
INV/23/00826	Salary Overpayment Reduction in Hours	02/05/2023	16/01/2024	Repayment Plan Commenced - £6293
INV/23/00827	Salary Overpayment Following Termination	02/05/2023	16/01/2024	Civil Recovery only - £18877.97
INV/23/00828	False Reference - Bank Worker	02/05/2023	18/05/2023	Subjects recruitment with the organisation was terminated. Intelligence shared with counter parts across Wales regarding Subject.
INV/23/00884	Overpayment of Salary - Career Break	10/05/2023	21/11/2023	Overpayment repayment commenced
INV/23/00896	Overpayment of Salary - Late termination	11/05/2023	04/07/2023	Non Fraud Recovery - £6,589.22. Subject no longer in employment
INV/23/00991	CV Issues	23/05/2023	30/05/2023	Investigation complete, no issues found
INV/23/01060	Falsified managers signature on training form	02/06/2023	14/07/2023	Internal Disciplinary sanction / closed
INV/23/01204	Suspicious Claiming Activity	21/06/2023	18/10/2023	Visit conducted no fraud identified
INV/23/01228	CV Issues	27/06/2023	27/06/2023	Duplicate of INV/23/00991
INV/23/01310	Working elsewhere in contracted time	05/07/2023	05/07/2023	Enquiries completed, no fraud issues identified, matters reported have already been dealt with historically at managerial level. DOI to be submitted regarding voluntary work.
INV/23/01403	Overpayment of Salary - Late Termination	18/07/2023	21/11/2023	Overpayment repayment commenced
INV/23/01578	Mis use of Research Budget	01/08/2023	06/10/2023	no offences identified
INV/23/01619	Sending prescription overseas	03/08/2023	06/09/2023	No fraud identified
INV/23/01633	Agency Worker False Timesheets	03/08/2023	04/10/2023	Internal Disciplinary sanction - Removed from Bank staff list and restricted from any future agency work with the organisation. No financial loss to the organisation.
INV/23/01634	Salary Sacrifice Vehicle not transferred when subject left organisation, no further deductions/payments made	03/08/2023		

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INV/23/01636	Suspect has been carrying out UBER work whilst off sick from HB with chronic Back issues	07/08/2023	21/11/2023	Interview under caution, full and frank admission, restorative justice, disciplinary outcome (employment terminated), monies recovered
INV/23/01681	Optical Claim Fraud	10/08/2023	16/08/2023	No offences identified
INV/23/01680	Optical Claim Fraud	10/08/2023	25/09/2023	No fraud identified, measures put in place to reduce risk of future occurrence
INV/23/01679	Optical Claim Fraud	10/08/2023	04/12/2023	No Fraud Identified. Advice letter only.
INV/23/01696	No Termination	14/08/2023		
INV/23/01703	Intel report re staff at St Davids acting nepotistically	14/08/2023	30/08/2023	No offences identified
INV/23/01644	Intel from CFA	14/08/2023	30/08/2023	Suspected malicious report, no issues identified
INV/23/01732	Salary Overpayment	16/08/2023	21/11/2023	Overpayment repaid in full
INV/23/01736	Salary Overpayment	16/08/2023	16/08/2023	Transferred to CFS WALES
INV/23/01806	Working elsewhere in contracted time	24/08/2023	14/09/2023	No offences identified
INV/23/01968	Referral form from directorate - staff member working abroad whilst of sick	13/09/2023	21/11/2023	Employment terminated following disciplinary investigation.
INV/23/02002	Staff member stealing CD's from Omnicell	15/09/2023		
INV/23/02137	Administrator at GP created false prescriptions	28/09/2023	04/10/2023	Disciplinary sanction - subjects work within the GP practice terminated.
INV/23/02182	Dual claims for optom services	03/10/2023	06/11/2023	Unable to prove offence - Letter of advice sent
INV/23/02097	Altered prescriptions	26/09/2023	16/11/2023	Insufficient evidence to prove who is responsible. Letter of advice sent out.
INV/23/02207	Working Elsewhere whilst sick	12/10/2023		
INV/23/02286	Working elsewhere whilst sick	12/10/2023	23/10/2023	No further action. Managerial informal discussion held.
INV/23/02420	NURSE at HMP Cardiff believed to have carried out work for an agency	26/10/2023	01/11/2023	No overlaps in shifts identified. No offences.
INV/23/02421	Money missing suspected stolen	26/10/2023		
INV/23/02436	Dual claims for optom services	30/10/2023	21/11/2023	Letter of advice sent - unable to prove offence
INV/23/02479	Working for ABUHB whilst sick at CAVUHB	03/11/2023	16/11/2023	No offences identified. Shifts worked at ABUHB but legitimately.
INV/23/02496	CIT report - false sickness	10/11/2023	16/11/2023	Subject is involved in a domestic abuse situation with ex partner. Believed malicious.
INV/23/02613	NHS Uniform for sale on Facebook	21/11/2023	21/11/2023	Link no longer active, no information available to investigate
INV / CFS WALES	Overpayment	28/12/2023	28/12/2023	Transferred to CFS Wales

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INV/23/02950	Working elsewhere during contracted hours	03/01/2024	05/01/2023	Disciplinary Outcome - Informal Discussion
INV/24/00074	Intelligence Report - Patient Data	10/01/2024	16/01/2023	NFA
INV/24/00102	Working Elsewhere whilst sick	16/01/2024		
INV/24/00145	Dual OPTOM claim	19/01/2024	20/02/2024	Advice given - No fraud identified
INV/24/00259	Possible Falsified Prescription	01/02/2024	09/02/2024	No fraud identified, prescription identified to be genuine
INV/24/00336	Overpayment	09/02/2024		
INV/24/00462	Working elsewhere whilst sick	21/02/2024		
INV/24/00451	False sickness	21/02/2024	23/02/2024	Intelligence did not relate to member of CAVUHB Staff
INV/24/00458	Theft and Working Elsewhere in Contracted Time	22/02/2024	27/03/2024	Written warning given regarding professional issues, no fraud issue.
INV/24/00471	Working elsewhere whilst sick	26/02/2024	06/03/2024	No evidence of fraud identified
INV/23/02714	Alleged to be selling prescription medication	28/02/2024	28/02/2024	Post on facebook on "joke" page, not as reported
INV/24/00505	False Sickness Car Crash	29/02/2024		
INV/24/00548	Overpayment	05/03/2024		
INV/24/00579	Working elsewhere whilst sick	07/03/2024	12/03/2024	Subject dismissed by organisation
INV/24/00660	Optician making false CPD claim to HB	14/03/2024		

Fraud Risk

A total of 3 Fraud Risk Assessments are being conducted at this time. These are incomplete and will be reported upon further when complete.

The areas that the risk assessments that are ongoing are:

1. Impersonating a medical professional
2. Petty Cash processes
3. Optometry services – free tests and vouchers

National Fraud Initiative

Work has continued into the latest NFI data dump. The below table provides the total matches that are addressed by the Counter Fraud Team.

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Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	311	201
Payroll to Payroll - Tel. No.	54	54
Payroll to Payroll - Email	1	1
Payroll to Pension	132	132
Payroll to Company Director/Trade Creditor	116	45
Payroll to Creditor	190	146

3. Other

NA

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