

Public Audit & Assurance Committee Meeting

Tue 03 September 2024, 09:00 - 10:15

Microsoft Teams

Agenda

09:00 - 09:10 **1. Preliminaries (09:00 – 09:10)** 10 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: 02.07.2024 & 11.07.2024

Rhian Thomas

- 📄 1.4a Public Audit Committee Minutes 02.07.2024.pdf (11 pages)
- 📄 1.4b - Special Public Audit Minutes 11.07.2024.pdf (3 pages)

1.5. Actions following meeting held: 02.07.2024

Rhian Thomas

- 📄 1.5 Action Log - Public Audit & Assurance (3).pdf (1 pages)

1.6. Any Other Urgent Business

Rhian Thomas

09:10 - 10:05 **2. Items for Review & Assurance (09:10 – 10:05)** 55 min

2.1. Internal Audit Progress Report including: (20 MINUTES)

Ian Virgil

- *Implementation of the People & Culture Plan (Substantial Assurance)*
- *Medical Staff Additional Sessions (CD&T CB) (Reasonable Assurance)*
- *Performance Reporting (Reasonable Assurance)*
- *Health & Safety (Reasonable Assurance)*

The completed reports can be found in the supporting documents folder.

- 📄 2.1a - CV AC A&A Progress Report September 24 cover (2).pdf (2 pages)
- 📄 2.1b - CV AC A&A Progress Report September 24.pdf (16 pages)

2.2. Audit Wales Update (15 MINUTES)

Wales Audit

Saunders-Narayan
02/09/2024 08:52:06

- *Audit Addendum report*

- 📄 2.2a - 4206A2024 CVUHB Audit Committee Update (September 2024).pdf (12 pages)
- 📄 2.2b - 2023-24 CVUHB Audit of Accounts Addendum (FINAL).pdf (14 pages)

2.3. Post Payment Verification End of Year report 2023/2024 (10 MINUTES)

Catherine Phillips

- 📄 2.3 - PPV End of Year Report 2023-2024.pdf (3 pages)
- 📄 2.3a C&VUHB End of Year 2023-2024.pdf (1 pages)

2.4. Procurement Update

Catherine Phillips / Claire Salisbury

2.4.1. Procurement Compliance Report / Single Tender Actions (10 MINUTES)

Catherine Phillips / Claire Salisbury

- 📄 2.4.1 - Procurement Audit Committee Board Report - Sept 2024 v1.pdf (7 pages)

2.4.2. Procurement Compliance Report – Chair’s Action Review

Catherine Phillips / Claire Salisbury

- 📄 2.4.2 - Procurement Chair’s Action Appendix to Audit Committee Board Report - Sep 24 v1.pdf (3 pages)

10:05 - 10:15 3. Items for Approval/Ratification (10:05 – 10:15)

10 min

3.1. Written Controlled Documents Policy & Procedure (10 MINUTES)

Matt Phillips

- 📄 3.1 Written Controlled Documents Policy & Procedure (1).pdf (2 pages)
- 📄 3.1a - UHB 001 Sept 2024 - DRAFT.pdf (3 pages)
- 📄 3.1b - UHB 242 Procedure - DRAFT.pdf (24 pages)

10:15 - 10:15 4. Items for Noting & Information

0 min

4.1. Counter Fraud Progress Update

Catherine Phillips / Henry Bales

- 📄 4.1a - COUNTER FRAUD PROGRESS _ PUBLIC _ COVER SHEET Q2 (1).pdf (2 pages)
- 📄 4.1b - COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC Q2.pdf (8 pages)

10:15 - 10:15 5. Agenda for Private Audit and Assurance Committee

0 min

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

10:15 - 10:15 6. Any Other Business

0 min

Rhian Thomas

10:15 - 10:15 7. Review & Final Closure

Saunders Nathan
02/09/2024 08:52:36

0 min

Rhian Thomas

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

5 November 2024 via MS Teams

7.3. 10-minute break prior to the Private Meeting

Rhian Thomas

7.4. Declaration:

Rhian Thomas

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].

Saunders, Nathan
02/09/2024 08:52:36

**Minutes of the Public Audit & Assurance Committee Meeting
Held On 02 July 2024 at 9:00am
Via MS Teams**

View the meeting here: <https://youtu.be/rXZpJ6DoEGQ>

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| 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 |
| Ceri Phillips | CP | Vice Chair of the Health Board |
| John Union | JU | Independent Member for Finance |
| In Attendance: | | |
| Edward Hunt | EH | Programme Director – Strategic Planning |
| 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) |
| Helen Lawrence | HL | Assistant Director of Finance |
| Robert Mahoney | RM | Deputy Director of Finance |
| Lianne Morse | LM | Deputy Director of People & Culture |
| Urvisha Perez | UP | Audit Lead - Audit Wales |
| Matt Phillips | MP | Director of Corporate Governance (DCG) |
| Frankie Thomas | FT | Head of Corporate Governance |
| Ian Virgil | IV | Head of Internal Audit (HIA) |
| Observers: | | |
| Glynis Mulford | GM | Risk & Regulation Officer |
| Secretariat: | | |
| Nathan Saunders | NS | Senior Corporate Governance Officer |
| Apologies: | | |
| Marie Davies | MD | Interim Executive Director of Strategic Planning |
| Rachel Gidman | RG | Executive Director of People and Culture |
| Catherine Phillips | CP | Executive Director of Finance (EDF) |

| Item No | Agenda Item | Action |
|--------------------------|---|--------|
| AAC 24/07/001 | Welcome & Introduction The Committee Chair (CC) welcomed everyone to the meeting. | |
| AAC 24/07/002 | Apologies for Absence Apologies for absence were received. The Committee resolved that: a) Apologies were noted. | |

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| <p>AAC 24/07/003</p> | <p>Declarations of Interest</p> <p>The Committee resolved that:</p> <p>a) No Declarations of Interest were noted.</p> | |
| <p>AAC 24/07/004</p> | <p><u>Minutes of the Meeting Held on 20 May 2024 – click to view</u></p> <p>The Minutes of the Meeting Held on the 20 May 2024 were received.</p> <p>The Committee resolved that:</p> <p>a) The draft minutes of the meetings held on 20 May 2024, were held to be a true and accurate record of the meeting.</p> | |
| <p>AAC 24/07/005</p> | <p><u>Actions – Following Meeting held on 20 May 2024 – click to view</u></p> <p>The Actions were received.</p> <p>The Committee resolved that:</p> <p>a) The Actions were discussed and noted.</p> | |
| <p>AAC 24/07/006</p> | <p><u>Internal Audit Progress Report – click to view</u></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"> • The report received was the first audit progress report to update the Committee on delivery of the 2024/25 Internal Audit Plan whilst also picking up on the remaining audits from the 2023/24 plan. • Section 2 noted that 4 audits had been scheduled to come to the Committee in July 2024 but deadlines were not met and the reasons for the delays were outlined within the report. • Section 3 noted that 7 audits had been finalised since the previous meeting of the committee with scores which included: <ul style="list-style-type: none"> - Follow-up: Management of Health Board Policies - Follow-up: Medical Records Tracking (CD&T CB) - Eyecare Digitisation Programme - PCIC CB Governance Arrangements - IMTP Development Process - Temporary Staffing Costs - Decarbonisation • Section 4 – the progress of delivery of the 2024/24 Internal Audit Plan which outlined 37 reviews of which 5 were work in progress and 10 at planning stage. | |

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- Section 5 outlined changes made to the 2024/25 Internal Audit Plan since approval at the Committee meeting in May 2024.

It was noted that the planned timing of the audit of Business Continuity Planning had moved from Q1 to Q3 at the request of the service.

- It was noted that section 6 of the report outlined the assurance on recommendation tracking and confirmed that Internal Audit had looked at a number of recommendations that were recorded to the Committee as complete during 2023/24, with testing undertaken to confirm the accuracy of those.
- Section 7 outlined each of the finalised audits mentioned in section 3 and a summary of each finalised audit was provided to the Committee:

- **Decarbonisation (Limited Assurance)**

The HIA advised the Committee that Internal Audit had issued limited assurance on that area but had acknowledged that a lot of positive work had been done to promote decarbonisation within the Health Board and the team had highlighted a number of initiatives to potentially reduce the carbon emissions within the Health Board.

The Programme Director – Strategic Planning (PDSP) was asked to provide an update on what actions would be undertaken to improve the assurance rating of the audit.

The PDSP advised the Committee that there was a lack of a costed plan to meet the NHS Wales 16% carbon reduction target by 2025. He outlined the challenges and the need for organisational transformation, mentioning the "Shaping Our Future Well-being" plan as a potential vehicle for achieving carbon reduction goals.

It was noted that the Board Assurance Framework (BAF) had been re-engineered and was being presented to the Board at its Board Development session in August.

He added that there was an ongoing review of the Welsh Government's (WG) carbon reduction target and the importance of financial sustainability, productive capacity, and prevention in addressing decarbonisation and noted that there was a need for a comprehensive approach involving the entire organisation to achieve the decarbonisation targets.

The Director of Corporate Governance (DCG) added that the limited assurance provided by Internal Audit was timely because there were wider discussions happening with the Board around decarbonisation and sustainability.

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The CC noted that the 2024/25 plan would be updated to add a 12 month follow up on the limited assurance audit on decarbonisation and asked that regarding actions, where would the Health Board expect to be in those 12 months.

The DCG responded that the BAF work would be closed off by September 2024 and the PDSP noted that there was no reason a costed plan could not be drawn up by then but that it would need assistance from the whole organisation.

- Management of Health Board policies (Reasonable Assurance)

The Interim Deputy Head of Internal Audit (IDHIA) advised the Committee that since completion of the original audit there had been a number of changes to the staff within the Corporate Governance Department, including appointment of a new Director of Corporate Governance which had led to changes in the arrangements and processes for the management of policies.

She added that management had made good progress in introducing the new arrangements and therefore addressing the recommendations detailed in the initial Final Internal Audit Report. Of the nine recommendations made, six of them were closed and the one high recommendation had been moved down to medium.

- Follow-up: Medical Records Tracking CD&T (Reasonable Assurance)

The IDHIA advised the Committee that Management had made reasonable progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report. Of the seven recommendations made, three of them had been closed, including two of the high priority recommendations.

It was noted that the Health Board's Records Management Policy and Procedure had both been updated and a Health Records Security & Storage action Plan had been developed.

The CC asked that the report be received by the Quality, Safety & Experience Committee in the future.

- Eyecare Digitisation Programme (Reasonable Assurance)

The HIA advised the committee that whilst Internal Audit had provided reasonable assurance over the review, in coming to that position Internal Audit considered the Variation Agreement that was completed during 2023, which clarified and updated several requirements from the original contract.

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- PCIC CB Governance Arrangements (Reasonable Assurance)

The HIA advised the Committee that matters that required management attention included:

- Terms of References (TOR) were out of date for some of the groups/ committees within the Clinical Board.
- Non-compliance with the frequency of meeting requirements set out in the TOR.
- Meetings were not always attended in line with the terms of reference.

- IMTP Development Process (Reasonable Assurance)

The HIA advised the Committee that Internal Audit has issued reasonable assurance and significant matters which required management attention included:

- 2 high priority matters
- 2 medium priority matters

The CC noted that one of the recommendations was around errors in labelling financial data and asked what would be done to rectify that.

The Deputy Director of Finance (DDF) responded that a huge amount of data flowed through the team and noted that it would be looked at on a continuous improvement basis.

The HIA added that the report had been cleared with the Deputy Director of Finance who had provided assurance that areas would be tightened.

- Temporary Staffing Costs (Limited Assurance)

The IDHIA advised the Committee that the Health Board had and continued to make significant progress with its ambition to curb reliance on agency staffing noting that since spring 2023, the Health Board had implemented additional controls and mechanisms to scrutinise the use of temporary staff and ensure that those were only engaged where necessary after alternative and more cost-effective options have been explored.

The Deputy Director of People & Culture (DDPC) was asked to provide an update on what actions would be undertaken to improve the assurance rating of the audit.

The DDPC acknowledged the limited assurance outcome as disappointing but not surprising.

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| | <p>She highlighted the significant progress made in curbing reliance on agency staffing, the implementation of additional controls, and the development of an escalation process for high-band staff allocation.</p> <p>The DDPC added that there was now a focus on effective rostering and adherence to procedures, with a team approach involving the corporate nursing team and finance team for rostering reviews and emphasised the ongoing efforts to improve efficiency and reduce agency, overtime, and bank usage.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered b) The proposed adjustments to the 2024/25 plan were approved. | |
| <p>AAC 24/07/007</p> | <p>Head of Internal Audit Opinion – click to view</p> <p>The Head of Internal Audit Opinion was received.</p> <p>The HIA reminded the Committee that the draft version had been received by the Committee at the workshop held in May 2024 and that the final version had been updated to be received by the Committee at the meeting.</p> <p>He added that the overall opinion for 2023/24 was that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively’.</p> <p>It was noted that the report also included details of the 5 audits that had been removed or deferred from the plan during 2023/24, as reported to previous meetings of the Committee and that those audits and the reason for their removal / deferment had been considered when compiling the HIA Opinion.</p> <p>The HIA concluded that the opinion would be reflected in the Health Boards Annual Report.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) It was Recommended to the Board that it agrees and endorses the Head of Internal Audit Opinion and Annual Report for 2023/24. | |
| <p>AAC 24/07/008</p> | <p>Audit Wales Update – click to view</p> <p>The Audit Wales Update was received.</p> <p>The Audit Manager – Audit Wales (AMAW) advised the Committee that items of the financial audit and the audit of the annual Accounts</p> | |

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| | <p>Performance Report Accountability Report, it was all on track for the Special meeting being held by the Committee on 11 July 2024 and then Special Board on the same day.</p> <p>He added that final checks were being performed on the financial accounts and that it was worth noting that the 2023/24 Pay award was voted back into last week as an acceptance by the unions, mainly affecting junior doctors.</p> <p>It was noted that WG was currently preparing a note for inclusion in the health bodies' annual accounts regarding that pay award.</p> <p>The Audit Lead - Audit Wales (ALAW) advised the Committee that in terms of the performance audit work, exhibit 2 received by the Committee showed Audit Wales' current and planned work which included:</p> <ul style="list-style-type: none"> • Structured assessment work for 2024/25 had started and so Committees of the Board would see Audit Wales attending those meetings. • Review of Unscheduled Care which could examine different aspects of the unscheduled care system and included analysis of national data sets to present a high-level picture of how the unscheduled care system was currently working <p>The ALAW advised the Committee that exhibit 3 provided information on other relevant examinations and studies published by the Auditor General in the last six months and highlighted the Community Pharmacy Data Matching Pilot specifically.</p> <p>The Committee resolved that:</p> <p>a) The Audit Wales Update was noted.</p> | |
| <p>AAC 24/07/009</p> | <p><u>Declarations of Interest, Gifts & Hospitality Report – click to view</u></p> <p>The Declarations of Interest, Gifts & Hospitality Report was received.</p> <p>The DCG advised the Committee that the report was received by the Committee periodically and last time, it noted that everything was being transferred over to the Electronic Staffing Record (ESR) which had now be completed.</p> <p>He added that Employees were required to make a single declaration and then update when things changed and all Board members needed to make an annual declaration.</p> <p>It was noted that bands 7 and above would continue to be the focus of data capture which would be achieved by targeted emails to account holders and a piece of work would be developed with Executive Director</p> | |

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| | <p>of People & Culture and Executive Medical Director to target those medics not currently recording interests on ESR.</p> <p>The Committee resolved that:</p> <p>a) The ongoing work being undertaken within Standards of Behaviour was noted.</p> | |
| <p>AAC 24/07/010</p> | <p>Recommendation Tracker Update – click to view</p> <p>The Recommendation Tracker Update was received.</p> <p>The DCG advised the Committee that the report had also been received at the previous meeting and so the actual trackers had not been included this time.</p> <p>He added that he had committed to 2 key areas to report back to the Committee on which included:</p> <ul style="list-style-type: none"> • Aged Internal Audit recommendations from pre-2022 of which there were 7. • The system of recording recommendations – It was noted that the Corporate Governance team had been transferring the regulatory trackers on to AMAT with 2 of the 3 areas (Internal Audit & Audit Wales) having been transferred across and it was just the regulatory trackers to conclude. <p>It was noted that another update would be received in November 2024 and that the AMAT platform would be used to present the data.</p> <p>The Committee resolved that:</p> <p>a) Assurance was noted from the progress which had been made in completing the recommendations that continued to be monitored and updated made by Internal / External Audit and Regulatory Reviews.</p> <p>b) Assurance was noted by the progress which had been made since the previous Audit and Assurance Committee Meeting in May 2024.</p> | |
| <p>AAC 24/07/011</p> | <p>Structured Assessment Response – click to view</p> <p>The Structured Assessment Response was received.</p> <p>The Head of Corporate Governance (HCG) reminded the Committee that Audit Wales undertook a structured assessment on the Health Board on an annual basis and that they had highlighted 7 formal recommendations for the Health Board and within those recommendations, the Corporate Governance Team identified 14 actions to be undertaken which were outlined for the Committee with updates/responses to each provided.</p> | |

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| | <p>The ALAW thanked the HCG for the summary provided and noted that good progress had been made.</p> <p>The Committee resolved that:</p> <p>a) Assurance was noted from the actions and recommendations outlined at Appendix 2 received and the ongoing work to complete the actions and recommendation</p> | |
| <p>AAC 24/07/012</p> | <p>Policy Update – click to view</p> <p>The Policy Update was received.</p> <p>The DCG advised the Committee that the Policy Update received was due to the Health Boards control status moving from Limited Assurance to Reasonable Assurance, a positive improvement due to ongoing actions being resolved.</p> <p>He added that there were 2 key areas to note which included:</p> <ul style="list-style-type: none"> • The Written Control Documents – Development and Approval Procedure (UHB 242) required a review which was ongoing and would be brought back to the Committee for final Approval in September 2024. • The Management of Policies, Procedure and other Written Control Documents Policy (UHB 001) had been reviewed and no substantial alteration was required <p>The Committee was advised that the use of the Audit Management and Tracking (AMaT) system had been used to transfer all of the Health Board policies which outlined that 138 policies were in progress or completed (i.e. in date) and 261 were overdue.</p> <p>The DCG noted that the use of AMaT meant that people were automatically reminded when their policy was out of date and that work was ongoing to address those.</p> <p>He added that there had been positive work undertaken between the Corporate Governance Team, The Executive Assistant’s and the Executives to address the policy issues.</p> <p>The DCG concluded that a synchronisation exercise was underway to review of all of the Health Board systems that stored policies ensuring that they were appropriately aligned with the AMaT repository with an intended aim to ensure that AMAT, the CAVUHB website, and CAVUHB SharePoint all held the same Policies and in the same format with alignment of referencing and numbering to ensure ease of searching.</p> <p>The Committee resolved that:</p> | |

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| | <p>a) The update and continued course of action was noted.</p> | |
| <p>AAC 24/07/013</p> | <p>Procurement Compliance Report / Single Tender Actions – click to view</p> <p>The Procurement Compliance Report / Single Tender Actions report was received.</p> <p>The DDF advised the Committee that the Procurement Compliance Report / Single Tender Actions was received at each meeting and that it worked through the areas of activity outside of the Health Boards procurement which were in breach of its Standing Financial Instructions (SFIs) or Single Tender Actions (STA) or Single Quotation Actions (SQA).</p> <p>He added that the paper set out all of the non-compliant activity and the actions undertaken to reduce those.</p> <p>The Committee resolved that:</p> <p>a) The content of the report was noted b) The content of the report was agreed.</p> | |
| <p>AAC 24/07/014</p> | <p>Losses and Special Payments Panel Report 2023-2024 – click to view</p> <p>The Losses and Special Payments Panel Report 2023-2024 was received.</p> <p>The DDF advised the Committee that the report was an anomaly due to the timing of the paper received and noted that the Committee usually would have received an update from the Losses and Special Payments Panel held on 20th November 2023 November earlier in the year.</p> <p>He added that the report received outlined and summarised the outcomes from the Losses and Special Payments Panel held on 20 November 2023 and also 22 May 2024.</p> <p>The Committee resolved that:</p> <p>a) The write offs for the period outlined in the Opinion and Key issues Section of that report as recommended by the Losses and Special Payments Panel held on 20th November 2023 and 22nd May 2024 were approved.</p> | |
| <p>AAC 24/07/015</p> | <p>Counter Fraud Progress Update – click to view</p> <p>The Counter Fraud Progress Update was received.</p> | |

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| | <p>The Lead Local Counter Fraud Specialist (LLCFS) advised the Committee that he would take the report as read.</p> <p>He added that the report received was the usual report received at each meeting and noted that it included a benchmarking table around e-learning across Wales.</p> <p>The Committee resolved that:</p> <p>a) The report was noted.</p> | |
| AAC 24/07/016 | <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 24/07/017 | <p>Any Other Business</p> <p>No Other Business was discussed.</p> | |
| AAC 24/07/018 | <p>Items to be deferred to Board / Committee</p> <p>The CC reminded the Committee that it had been noted that the _____ would be received by the Quality, Safety & Experience Committee at its meeting held in August.</p> | |
| | <p>Date and time of next committee meeting</p> <p>Special meeting held Tuesday 11th July 2024 at 9am via MS Teams</p> | |

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**Minutes of the Special Audit and Assurance Committee Public Meeting
Held on Thursday 11 July 2024 at 9am
Via MS Teams**

To view the meeting, please click here:

https://www.youtube.com/watch?v=6hlcV_U0Bws

(please note, you may need to copy & paste the link into your browser)

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| Chair: | | |
| Rhian Thomas | RT | Independent Member – Capital and Estates |
| Present: | | |
| David Edwards | DE | Independent Member - ICT and Committee Vice Chair |
| Mike Jones | MJ | Independent Member - Trade Union |
| Ceri Phillips | CP | UHB Vice Chair |
| John Union | JU | Independent Member for Finance |
| In Attendance: | | |
| Rhodri Davies | RD | Audit Wales |
| Rachel Gidman | RG | Executive Director of People & Culture |
| Mark Jones | MJ | Audit Manager - Audit Wales |
| Helen Lawrence | HL | Assistant Director of Finance |
| Robert Mahoney | RM | Operational Deputy Director of Finance |
| Matt Phillips | MP | Director of Corporate Governance |
| Francesca Thomas | FT | Head of Corporate Governance |
| Ian Virgil | IV | Head of Internal Audit |
| Secretariat | | |
| Nathan Saunders | NS | Senior Corporate Governance Officer |
| Apologies: | | |
| Charles Janczewski | CJ | UHB Chair |
| Urvisha Perez | UP | Audit Wales |
| Catherine Phillips | CP | Executive Director of Finance |

| Item No | Agenda Item | Action |
|--------------------------|--|--------|
| AAC 24/07/001 | Welcome & Introduction The Committee Chair (CC) welcomed everyone to the meeting. | |
| AAC 24/07/002 | Apologies for Absence Apologies for absence were noted. The Committee resolved that: a) Apologies were noted. | |
| AAC 24/07/003 | Declarations of Interest The Committee resolved that: | |

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| | a) No Declarations of Interest were noted. | |
| AAC 24/07/004 | Any other urgent business There was no other urgent business noted. | |
| | Items for Approval / Ratification | |
| AAC 24/07/005 | <p>Introduction to Annual Report and Accounts 2022-23 (click to view)</p> <p>The Operational Deputy Director of Finance (ODDF) introduced Helen Lawrence, the Assistant Director of Finance (ADF) who briefed the Committee on the accounts overview and the amendments made since the meeting held 20 May 2024.</p> <p>The Audit Manager - Audit Wales (AMAW)</p> <p>The ODDF thanked the ADF and their team for the comprehensive work undertaken around the annual accounts.</p> <p>The Audit Manager - Audit Wales (AMAW) briefed the Committee on the findings from Audit Wales on the annual report and accounts and noted that the Committee required the briefing before it could make the recommendation to the Board for approval.</p> <p>The AMAW thanked the Finance and Corporate Governance teams and all those involved for their help in completing the work.</p> <p>The CC echoed the thanks of the AMAW.</p> <p>She added that the recommendations would be taken at the end of the meeting which are outlined below.</p> <p><u>The Committee resolved that:</u></p> <p>a) The reported financial performance contained within the Annual Report and Accounts and that the UHB had not met its statutory financial duties in respect of revenue expenditure but had met its statutory financial duties in respect of capital expenditure was noted</p> <p>b) The changes made to the Draft Annual Report and Accounts were noted.</p> <p>c) The ISA 260 Report, the Letter of Representation, the response to the Audit enquiries to those</p> | |

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| | <p>charged with governance and management and the Annual Report and Accounts were reviewed.</p> <p>d) The Committee recommended to the Board that it agree and endorse the ISA 260 Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management.</p> | |
| <p>AAC 24/07/006</p> | <p>The CVUHB Annual Report 2023-2024 including the Annual Accountability Report, Performance report and the Financial Statements (click to view)</p> <p>The Head of Corporate Governance (HCG) reminded the Committee that a draft version of the annual report was received by the Committee at its workshop held on 20 May 2024.</p> <p>It was noted that since that period, a window of amendments had been undertaken with Audit Wales and those had been worked through with the Audit Wales Team, the Finance Team and the Corporate Governance Team.</p> <p>The HCG advised the Committee that the annual accounts had now been merged into the annual report document and could viewed.</p> <p><u>The Committee resolved that:</u></p> <p>a) The Annual Report & Accounts for 2023-2024 - Appendix 1 for was recommended for onward approval by the Board.</p> | |
| <p>AAC 24/07/007</p> | <p>Any Other Business</p> <p>No other business was discussed.</p> | |
| | <p>Date & time of next Meeting</p> <p>Tuesday 3 September 2024 – 9am via MS Teams</p> | |

Saunders, Nathan
02/09/2024 08:52:36

Public Action Log
Following Audit & Assurance Committee Meeting
02 July 2024
(Updated for the meeting being held 02 July 2024)

| REF | SUBJECT | AGREED ACTIONS | LEAD | DATE | STATUS/COMMENTS |
|---|---|--|----------------------------|-------------------|--|
| Actions | | | | | |
| AAC 24/07/006 | Internal Audit Progress Report – Decarbonisation | Decarbonisation to be added to the Board Assurance Framework (BAF). Work to be completed by September 2024 | Ian Virgil / Matt Phillips | 03.09.2024 | COMPLETED Update to be provide by Matt Phillips |
| AAC 24/07/010 | Recommendation Tracker Update | Next update to be received in November 2024. AMaT will be used to present data | Matt Phillips | 05.11.2024 | COMPLETED On Forward Plan for November meeting |
| AAC 24/07/011 | Policy Update | Written Controlled Document Procedure (UHB 242) to be received by Committee for approval | Matt Phillips | 03.09.2024 | COMPLETED On Forward Plan for September Meeting |
| Actions referred to Board / Committees | | | | | |
| AAC 24/07/006 | Internal Audit Progress Report – Medical Records Tracking (CD&T CB) | QSE Committee to consider report to ensure recommendations were being implemented | Ian Virgil / Matt Phillips | 27.08.2024 | COMPLETED On Forward Plan for QSE August Meeting |

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|--|---------------------------------------|---------|----------|-----------------|-------------|---|
| Report Title: | Internal Audit Progress Report | | | Agenda Item no. | 2.1 | |
| Meeting: | Audit & Assurance Committee | Public | X | Meeting Date: | 03/09/24 | |
| | | Private | | | | |
| Status <i>(please tick one only):</i> | Assurance | X | Approval | X | 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 2024/25 plan was formally approved by the Audit Committee at its May 24 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 that informed the 23/24 Opinion have been finalised since the May 24 meeting:

- Implementation of the People & Culture Plan (Substantial Assurance)
- Medical Staff Additional Sessions (Reasonable Assurance)

The following reports informing the 24/25 Opinion have also been finalised since the May 24 meeting:

- Performance Reporting (Reasonable Assurance)
- Health & Safety (Reasonable Assurance)

The Executive summaries from the final reports are included within the progress report, with the full versions of the reports within the committee supporting papers.

The progress report also includes details of proposed adjustments to the 2024/25 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 adjustments to the 2024/25 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 | 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 | 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 | |
|------------|--|-----------|---|-------------|---|---------------|---|-------------|--|

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 includes the outcome from an audits that provide assurance around controls and processes relating to patient safety.

Financial: Yes/No

Workforce: Yes/No

The progress report includes the outcome from audits that provide assurance around controls and processes relating to workforce.

Legal: Yes/No

The progress report includes the outcome from audits that provide assurance around controls relating to legal requirements.

Reputational: Yes/No

The progress report includes the outcome from audits that provide assurance around reputational issues.

Socio Economic: Yes/No

Equality and Health: Yes/No

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec Date:

| | |
|--|--|
| | |
|--|--|

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Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee September
2024

NWSSP Audit and Assurance Services



GIG
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WALES

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



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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 2024/25 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 2024/25 was agreed by the Audit & Assurance Committee in May 2024 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Assignments with Delayed Delivery

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

| Audit | Current Position | Draft Rating | Reason |
|--|------------------|--------------|---|
| Maternity Care – Ockenden Review | Draft | Reasonable | Delay in completing fieldwork due to waiting for information from management. |
| Safeguarding | Draft | Reasonable | Delay in completion of fieldwork due to availability of Internal Audit resource. |
| Interventions Not Normally Undertaken | Work in Progress | | Further fieldwork to be undertaken at request of management. |
| Specialist Services CB - Governance Arrangements | Work In Progress | | Delay in completion of fieldwork due to the number of areas to cover and availability of Internal Audit resource. |
| Consent Process | Work in Progress | | Delay in initial meeting with lead contacts and agreeing draft brief. |

3. Outcomes from Completed Audit Reviews




Nine audit reports from the 2023/24 plan were not finalised in time for submission to the Audit Committee in May 24, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2023/24.

Seven of the reports were submitted to the July meeting of the Committee and the remaining two have now been finalised as detailed in the table below.

Two assignments that will inform the 2024/25 opinion have been finalised since the previous meeting of the committee and are also highlighted in the table below along with the allocated assurance ratings.

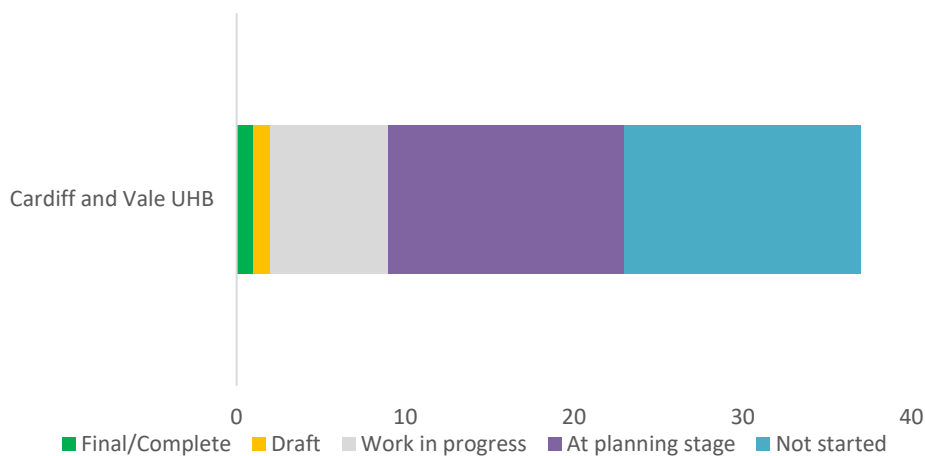
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The Executive Summaries from the final reports are provided in Section five. The full reports are included separately within the Audit Committee supporting papers for information.

| FINALISED AUDIT REPORTS | | ASSURANCE RATING |
|---|-------------|---|
| 2023/24 Opinion | | |
| Implementation of the People & Culture Plan | Substantial |  |
| Medical Staff Additional Sessions | Reasonable |  |
| 2024/25 Opinion | | |
| Performance Reporting | Reasonable |  |
| Health & Safety | | |

4. Delivery of the 2024/25 Internal Audit Plan

There are a total of 37 reviews within the 2024/25 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that one audit from the 2023/24 plan has been finalised so far this year and one other have reached the draft report stage.

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

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

Appendix A also includes details of the two audits from the 2023/24 plan that were not sufficiently progressed to be included within the Head of Internal Audit Opinion for 2023/24. One of the audits has been finalised and the second is currently at the draft

report stage and the outcomes will feed into the 2024/25 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 24/25 Internal Audit Plan

The planned audit of 'Concerns / Complaints / Putting Things Right' is proposed for removal from the plan, as an audit has recently been completed by the Welsh Risk Pool and the Health Board is awaiting the reported results. The removal of the audit is supported by the Executive Director of Nursing.

The Executive Director of Finance and Chief Operating Officer have requested an additional advisory audit of the revenue investment made by the Health Board into the Endoscopy Unit. It is proposed that the days allocated for the 'Concerns / Complaints / Putting Things Right' audit will be utilised to carry out the additional audit.

Management have requested that the planned audit of 'Estates Assurance – Energy Management' be deferred from Q2 until Q4 due to ongoing metering issues with the current energy supplier. An alternative estates assurance scope may be considered if the issues are not resolved by Q4.

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6. Final Report Summaries

7.1 Implementation of the People & Culture Plan

Purpose


To provide assurance that there are effective processes in place for ensuring appropriate implementation of the People and Culture Plan, with a specific focus on how the plan is being embedded within the Clinical Boards.

Overview

We have issued substantial assurance on this area. We only identified one low finding that requires management attention:

- Reporting is not currently taking place against all the 2024 key performance indicators.

Report Opinion

| | | Trend |
|--|---|---------------------------------|
|  Substantial | Few matters require attention and are compliance or advisory in nature. | N/A |
| Low impact on residual risk exposure. | | No previous audits in this area |

Assurance summary¹

| Objectives | Assurance |
|------------------------------------|-------------|
| 1 Plan Milestones and Objectives | Substantial |
| 2 Governance Arrangements | Substantial |
| 3 Delivery of Themes | Substantial |
| 4 Embedding within Clinical Boards | 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 | Performance Monitoring | 1 Operation | Low |

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7.2 Medical Staff Additional Sessions

Purpose

The audit reviewed the application of the priorities that have been developed in relation to additional sessions worked by medical staff.

Overview

We have issued reasonable assurance on this area.

The Clinical Boards are effectively utilising the new Additional Duty Hours rate card and the system of identifying and managing escalated shifts is also being used effectively.

The matters requiring management attention relate to the processes for managing WLI payments and staff breaks, including:

- The WLI forms are not always being completed to confirm that a WLI session has been worked. There is no reconciliation undertaken between the Patchwork system and the tracker.
- A number of sessions were paid at the WLI rate but the reasons recorded were unrelated to WLIs.
- Junior Doctors were undertaking WLI sessions and were being paid different rates.
- WLI sessions were being entered retrospectively onto the Patchwork system.
- We identified breaks being removed at the time of creation within the system, and insufficient reasons for not taking a break being accepted.

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 ADH Rate Card is being utilised within the Clinical Boards. | Substantial |
| 2 Authorisation of rates outside of rate card. | Substantial |
| 3 WLI Payments are being used for activity which forms part of a planned WLI programme. | Limited |
| 4 Staff are taking breaks during their shifts. | Reasonable |
| 5 Monitoring, reporting and scrutiny of proposals takes place at appropriate levels within 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 | Completion of WLI request forms | 3 | Operation | High |
| 2 | WLI requests with unrelated reasons | 3 | Design | High |
| 3 | Junior doctors agreed rate for WLI sessions | 3 | Design | Medium |
| 4 | Approval process and retrospective sessions | 3 | Design | Medium |
| 6 | Removing mandatory breaks from the system | 4 | Design | High |
| 7 | Inadequate reasons provided | 4 | Operation | Medium |

7.3 Performance Reporting

Purpose

To undertake an assurance review of the operation / effectiveness of the Integrated Performance Report (IPR).

Overview



We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Adequate checks should be undertaken to ensure the accuracy of performance measures within the IPR.
- Update of the IPR guidance document required.
- Need for consistency in the sequence of periodic reporting presented monthly for each performance measure.
- Improve the monitoring of underperforming measures highlighting actions to be undertaken.

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

Report Opinion

| | |
|--|---------|
| | Trend |
| <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;"> <p style="color: #1a3d54;">Reasonable</p>  </div> <div> <p>Some matters require management attention in control design or compliance.</p> <p>Low to moderate impact on residual risk exposure until resolved</p> </div> <div style="margin-left: 20px; align-self: center;">  </div> </div> | 2021/22 |

Assurance summary¹

| | Objectives | Assurance |
|---|--|-------------|
| 1 | Appropriate governance arrangements to ensure effective reporting and oversight of the Health Board's IPR | Substantial |
| 2 | Robust systems and processes are in place to capture and validate the data required to produce the I PR | Reasonable |
| 3 | Timetable is in place for the compilation of the IPR | Reasonable |
| 4 | Arrangements are in place to ensure senior management are held to account for performance. Actions to address highlighted areas of low performance are monitored | 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 | IPR data is checked for accuracy | 2 | Operation | Medium |
| 2 | Update of IPR Guidance Document | 2 | Design | Medium |
| 3 | Reporting periods are complied with | 3 | Operation | Medium |
| 4 | Monitoring of underperforming measures | 4 | Operation | Medium |

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7.4 Health & Safety

Purpose

The overall objective of this audit was to review the current progress in delivery against the action plan that was developed following an external review of the Health & Safety arrangements in 2021.

Overview

We have issued reasonable assurance on this area.

Our report makes one medium and one low priority recommendation with the medium recommendation being detailed below:

- Recalculation of elapsed target dates should be made in the live action tracker document containing reasons for the overrun and the redefined target date.

Since the previous audit of Health and Safety, we are able to evidence that work has progressed on implementing the recommendations from the external health and safety report.

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend



2022

Assurance summary¹

| Objectives | Assurance |
|---|-------------|
| 1 Appropriate governance arrangements to provide oversight of the implementation of the external review of the health and safety arrangements | Reasonable |
| 2 External review recommendations have been satisfactorily actioned | Reasonable |
| 3 Cases whereby actions remain outstanding, reasons have been documented, revises timescales for implementation have been agreed | 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 | Action Plan Updates | 1, 2, 3 | 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 |
|---|--------|-------------------------------|----------|---------|-------------------------------|------------------|----------------------------|
| 2023/24 Plan | | | | | | | |
| Performance Reporting | 11 | Digital & Health Intelligence | | | Final Report | Reasonable | September |
| Maternity Care – Ockenden Review | 31 | Nursing | | | Draft Report | Reasonable | September |
| 2023/24 Plan | | | | | | | |
| Health & Safety | 4 | People & Culture | Q1 | | Final Report | Reasonable | September |
| Safeguarding | 15 | Nursing | Q1 | | Draft Report | Reasonable | September |
| Interventions Not Normally Undertaken (INNU) | 17 | Public Health | Q1 | | Work in Progress | | November |
| Specialist Services CB - Governance Arrangements | 26 | COO | Q1 | | Work in Progress | | November |
| Legal Services | 3 | Corporate Governance | Q2 | | Work in Progress | | November |
| Core Financial Systems | 10 | Finance | Q2 | | Planning – Draft brief issued | | November |
| Smoking Cessation | 18 | Public Health | Q2 | | Work in Progress | | November |
| Local Data Repository | 21 | Digital & Health Intelligence | Q2 | | Work in Progress | | November |
| Follow-up: Surgery CB - Consultant Job Plans | 28 | COO | Q2 | | Planning – Draft brief issued | | November |
| Follow-up: Implementation of Health Roster System | 6 | People & Culture / Nursing | Q3 | | Planning – Draft brief issued | | November |

| Planned output. | Ref No | Exec Director Lead | Plnd Qtr | Adj Qtr | Current Status | Assurance Rating | Planned / Actual Committee |
|--|-----------|-------------------------------|---------------|---------|--------------------------------------|------------------|----------------------------|
| Charitable Funds | 11 | Finance | Q3 | | Planning – Draft brief issued | | November |
| Consent Process | 29 | Medical | Q1 | | Work in progress | | February |
| <i>Capital Systems</i> | <i>12</i> | <i>Finance</i> | <i>Q2</i> | | <i>Planning – Final brief issued</i> | | <i>February</i> |
| Surgery CB - Governance Arrangements | 27 | COO | Q2 | | Planning – Draft brief issued | | February |
| Therapies and Health Sciences Agency and Locum Staff | 31 | Therapies and Health Sciences | Q2 | | Planning | | February |
| Endoscopy Unit Investment | 38 | Finance / COO | Q2/3 | | Planning – Final brief issued | | February |
| Data Quality Strategy | 20 | Digital & Health Intelligence | Q2/3 | | Planning | | February |
| Scheme of Delegation | 2 | Corporate Governance | Q3 | | Planning – Draft brief issued | | February |
| Business Continuity Planning (Deferred from 23/24 plan) | 7 | Strategic Planning | Q1 | Q3 | Planning – Final brief issued | | February |
| Procurement & Contract Management | 9 | Finance | Q3 | | | | February |
| Waiting List Management | 24 | COO | Q3 | | | | February |
| Records Management | 30 | Digital & Health Intelligence | Q3 | | | | February |
| Medicine CB - Acute Position Model / Same Day Emergency Care | 25 | COO | Q3 | | | | April / May |
| Occupational Health Service | 5 | People & Culture | Q4 | | | | April / May |
| Follow-up Alcohol Standards | 19 | Public Health | 4 | | | | April / May |
| Office 365 benefits realisation | 22 | Digital & Health Intelligence | 4 | | | | April / May |

| Planned output. | Ref No | Exec Director Lead | Plnd Qtr | Adj Qtr | Current Status | Assurance Rating | Planned / Actual Committee |
|--|-----------|-----------------------------------|---------------|-----------|---|------------------|----------------------------|
| Planned Care Programme | 23 | COO | Q3/4 | | | | April / May |
| Risk Management / Board Assurance Framework | 1 | Corporate Governance | Q4 | | | | April / May |
| Hosting of the Substance Misuse Area Planning Team and Board | 8 | Strategic Planning | 4 | | | | April / May |
| Follow-up: Temporary Staffing Costs | 33 | People & Culture / Finance | 4 | | | | April / May |
| Follow-up: Decarbonisation | 37 | Strategic Planning | 4 | | | | April / May |
| <i>Estates Assurance - Energy Management</i> | <i>13</i> | <i>Finance</i> | Q2 | <i>Q4</i> | <i>Planning</i> | | <i>TBC</i> |
| <i>Follow-up: Estates Condition</i> | <i>14</i> | <i>Finance</i> | <i>TBC</i> | | | | <i>TBC</i> |
| <i>Development of Integrated Audit Plans</i> | <i>32</i> | <i>Strategic Planning/Finance</i> | <i>N/A</i> | | | | <i>Ongoing</i> |
| <i>Approved Integrated Audit Plan Assignments:</i> | | | | | | | |
| • UHW Tertiary Tower | 34 | Strategic Planning | Q3/4 | | Planning – Final brief issued | | April / May |
| • UHW Lifts | 35 | Strategic Planning | Q3/4 | | Planning – Final brief issued | | April / May |
| • UHW / UHL Mortuary Refurbishment | 36 | Strategic Planning | Q2 | | Work in Progress | | February |
| Reviews removed from the plan | | | | | | | |
| Concerns/ Complaints/ Putting Things Right (Duty of Candour) | 16 | Nursing | | | Proposed for removal from the plan as an audit has recently been completed by the Welsh Risk Pool and the Health Board is awaiting the reported results. To be agreed by September AC. | | |

REPORT RESPONSE TIMES

| Audit | Rating | Status | Draft issued date | Responses & exec sign off required | Responses & Exec sign off received | Final issued | R/A/G |
|-----------------------|------------|--------|-------------------|------------------------------------|------------------------------------|--------------|-------|
| Performance Reporting | Reasonable | Final | 06/08/24 | 28/08/24 | 21/08/24 | 21/08/24 | G |
| Health & Safety | Reasonable | Final | 13/08/24 | 04/09/24 | 20/08/24 | 20/08/24 | G |

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KEY PERFORMANCE INDICATORS

| Indicator Reported to Audit Committee | Status | Actual | Target | Red | Amber | Green |
|---|----------|------------------|------------|------------|------------|------------|
| Operational Audit Plan agreed for 2024/25 | G | May 2024 | By 30 June | Not agreed | Draft plan | Final plan |
| Audit reports to agreed Audit Committee | R | 29% 2 from 7 | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from fieldwork completion to draft reporting [10 working days] | G | 100% 4 from 4 | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time taken for management response to draft report [15 working days] | G | 100% 1 from 1 | 80% | v>20% | 10%<v<20% | v<10% |
| Report turnaround: time from management response to issue of final report [10 working days] | G | 100% 1 from 1 | 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>Unsatisfactory 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: September 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.

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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 presented 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 | The Auditor General certified the 2023-24 Performance Report, Accountability Report, and Financial Statements on 12 July. He issued an unqualified true and fair audit opinion, except for a qualified regularity opinion because the Health Board did not meet its revenue resource allocation over the three-year period ending 2023-24. | Complete | Considered by the Audit and Assurance Committee and Board in July 2024 |

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| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|---|-------------------------------|--|-----------------------------------|---|
| | | Members of the Audit and Assurance Committee considered our Audit of Accounts Report on 11 July and are therefore aware of the audit findings. | | |
| Audit of Accounts Report Addendum – recommendations 2023-24 | Executive Director of Finance | To set out recommendations arising from our 2023-24 audit of accounts work. | Complete | To be considered by the Audit and Assurance Committee in September 2024 |
| Audit of the 2023-24 Charitable Funds Accounts | Executive Director of Finance | To provide an audit opinion on the Health Board's Charitable Funds Accounts. | Planned to start in November 2024 | To be confirmed |

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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 |
|-----------------------------------|----------------------------------|---|--|--------------------------------|
| Structured Assessment 2024 – core | Director of Corporate Governance | <p>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:</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. | Fieldwork underway | November 2024 |
| Review of Unscheduled Care | Chief Operating Officer | This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a | Blog and data tool published in April 2022 | |

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| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|--|-------------------------------|--|---|---|
| | | <p>high-level picture of how the unscheduled care system is currently working.</p> <p>The work includes 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 are also reviewing progress being made in managing unscheduled care demand by helping patients access services which are most appropriate for their unscheduled care needs (Part 2).</p> | <p>Part 1 – Regional report being drafted.</p> <p>Part 2 – Fieldwork underway</p> | <p>November 2024</p> <p>November 2024</p> |
| 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 | November 2024 |

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| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|--|---|---|--------------------|--------------------------------|
| Planned Care Review | Chief Operating Officer | <p>This work follows on from the national report on <u>tackling the planned care backlog</u>, and will 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 • Use of the additional Welsh Government financial allocations to improve waiting lists. | Fieldwork underway | To be confirmed |
| 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 |
| Review of eye care services | Chief Operating Officer | Following on from our report on orthopaedic services last year, we will review the Health | Planning | To be confirmed |

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| Area of work | Executive Lead | Focus of the work | Current status | Planned date for consideration |
|-------------------|----------------|---|----------------|--------------------------------|
| (2024 local work) | | <p>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> | | |

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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.

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

| Title | Publication Date |
|--|------------------|
| <u>Community Pharmacy Data Matching Pilot</u> <ul style="list-style-type: none">• Article related to this report• Blog related to this report | May 2024 |
| <u>Supporting Ukrainians in Wales</u> | March 2024 |

Additional information

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

| Title | Publication Date |
|---|------------------|
| <u>Annual Report and Accounts 2023-24</u> | August 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.

Audit of Accounts Report Addendum – Cardiff and Vale University Health Board

Audit year: 2023-24

Date issued: August 2024

Document reference: 4398A2024

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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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Audit of Accounts Report Addendum

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Audit of accounts report addendum

Introduction

- 1 This report is an addendum to the Audit of Accounts Report that we presented to the Audit and Risk Committee on 11 July 2024. It sets out the recommendations arising from our audit of the 2023-24 annual report and accounts; and provides an update on the progress you have made against the previous year's recommendations.

Recommendations from this year's audit

- 2 **Exhibits 1 to 6** set out this year's audit findings and recommendations, together with the management responses to each of them.

Exhibit 1

| Matter arising 1 – there is a weakness in the new process for the related party declarations of interest | |
|---|---|
| Findings | <p>For 2023-24 the Health Board introduced a new process to administer its annual declarations of interest from senior officers and Board Members. Under the new process they submit their returns via the Electronic Staff Records (ESR) system.</p> <p>Governance officers then process a report from ESR that lists DOIs made by <u>all</u> employees and Board Members.</p> <p>Governance officers then manually extract the relevant interests (i.e. for the relevant senior officers and Board Members) and manually copy them into a PDF document.</p> <p>Each PDF document is then signed and dated via Docusign by the relevant senior officer / Board Member.</p> <p>We consider that the manual copy-and-paste part of the process carries the risk of transposition errors arising.</p> |
| Recommendation | <p>The Health Board should strengthen the new process by creating a customised report from ESR, which can be run for the relevant senior officers and Board Members, for their review and signing as being up to date and accurate at the financial year-end (or during the financial year for anyone who leaves the Health Board).</p> |
| Accepted in full by management | Accepted |

Matter arising 1 – there is a weakness in the new process for the related party declarations of interest

| | |
|----------------------------|--|
| Management response | Recommendation to all Board members that a DOI will be completed on ESR on a regular basis as good practice. In March, Corporate Governance will make a specific request of all Board members that a ESR DOI is completed so that the UHB has a comprehensive and automated record as close to the Balance Sheet Date as possible. |
| Implementation date | March 2025 |

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Exhibit 2

| Matter arising 2 – lack of derecognition of assets being replaced | |
|--|---|
| Findings | <p>Chapter 7 (paragraph 7.1) of the Welsh Government’s 2023-24 Manual for Accounts (MFA) states that: <i>‘An entity recognises in the carrying amount of an item of PPE the cost of replacing part of such an item when that cost is incurred if recognition criteria are met. Carrying amount of replaced parts are derecognised (p.13 IAS16)’.</i></p> <p>Our testing and conversations with finance officers established that the Health Board does not apply this MFA requirement. Therefore, replaced property, plant and equipment (PPE), being those that are typically part of a larger asset, are not derecognised as required.</p> <p>During the audit we considered the impact for 2023-24 and we are satisfied that there was a low risk of material misstatement for that year. However, the risk will increase for 2024-25 as another year would have passed since last year’s quinquennial valuation. It is therefore important that from 2024-25 the Health Board complies with the MFA requirement.</p> |
| Recommendation | <p>The Health Board should comply with the Manual for Accounts (Chapter 7) regarding the derecognition of property, plant and equipment.</p> |
| Accepted in full by management | <p>Management accept that is an issue.</p> |
| Management response | <p>In addition to the above extract, the MFA goes on to state the current approach and the practical difficulties applying them</p> <p>7.1 <i>The District Valuer reports on three elements of land and property. These are:</i></p> <ul style="list-style-type: none"> • <i>External works;</i> • <i>Structure;</i> • <i>Internal Engineering</i> <p><i>There are clear practical difficulties in derecognising previously capitalised parts of an asset (para 70 IAS 16).</i></p> <p>7.2 <i>In seeking to comply with IAS 16 consideration should be given in the first instance to endeavour to identify the value of replaced asset parts and de-recognise them as losses. If this is not possible, the approach set out below should be adopted.</i></p> |

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Matter arising 2 – lack of derecognition of assets being replaced

- 7.3 *A pragmatic approach to the adoption of this part of the Standard, which should facilitate compliance but avoid significant and costly work being undertaken, is:*
- 7.4 *Schemes funded via the All-Wales Capital Programme will continue to be treated as Assets Under Construction until they are brought into use and a revaluation carried out at this point. This will allow parts of assets to be derecognised via an AME impairment at the point of revaluation.*
- 7.5 *All discretionary schemes containing an element of replacement will be revalued where they are completed in year and the value of the works and fees is greater than £0.5 million. Other schemes (i.e., those under £0.5 million) will be considered as part of the normal revaluation cycle.*
- 7.6 *In relation to major schemes which contain an element of replacement and span more than one financial year, organisations will need to consider whether Assets Under Construction contain elements which need to be derecognised as they have been replaced in year. In this instance, organisations should use suitable estimates to consider any impairment of the Asset Under Construction incorporating derecognition, or to apportion overall impairment when bringing the asset into service incorporating derecognition.*
- 7.7 *It has been agreed that the policy in these circumstances, where separable derecognition is not possible, the impairment when the asset is brought into service - or estimated impairment for schemes spanning more than one financial year, including the element of derecognition is chargeable to AME.*

Management accepts the potential issues that may arise year on year and for the need to review how derecognition of assets are accounted for, however as per the MFA there has to be '*A pragmatic approach to the adoption of this part of the Standard, which should facilitate compliance but avoid significant and costly work being undertaken*'. This has been added to the September All Wales Capital Technical Accounting Group Agenda for discussion and to look at options for a practical consistent All Wales approach to derecognising assets across multiple locations.

Proposed action will be brought to Audit Wales for agreement before implementation of new process.

Implementation date

Review September 2024 for implementation prior to 24/25 accounts

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Exhibit 3

| Matter arising 3 – the relocation expenses policy was not properly applied | |
|---|--|
| Findings | <p>The 2023-24 remuneration report discloses a relocation expense of £1,396 that was paid to a senior officer. We established that the expenses related to hotel costs that were incurred during the three months January to March 2023. They were claimed on 5 April 2023, being some 14 months after the officer had commenced their new post.</p> <p>We found that the payment does not comply with the Health Board's Relocation Expenses Policy because:</p> <ul style="list-style-type: none"> • hotel costs are not listed as being allowable; and • the policy requires claims to be submitted no later than one year after commencement in post. <p>The Policy does state that exceptions can be approved by the Remuneration and Terms and Service Committee. However, we found that the payment had been approved by the Chair of the Committee and was not considered and minuted by the Committee itself.</p> |
| Recommendation | <p>The Health Board should ensure that its Relocation Expenses Policy is always properly applied, with decisions made and recorded at the stipulated level of delegation.</p> <p>Also, the Health Board should consider whether hotel costs should be listed in the Relocation Expenses Policy as being allowable.</p> |
| Accepted in full by management | Accepted |
| Management response | <p>Hotel costs are not specifically listed in the Relocation Expenses Policy. The Committee viewed these costs as a reasonable claim category under the policy. When the policy is reviewed under normal review timescales we will consider being more explicit on this point.</p> <p>Relocation expenses can be an intermittent claim occurrence. The controls around timescale are dependant on good awareness amongst support staff. The need to seek renewal of approval after 12 months have elapsed from the original approval has been re-emphasised to relevant support staff.</p> <p>The payment referred to was retrospectively approved at Remuneration & Terms of Service Committee on the 26 June 2024 and a paper is available to support this.</p> |
| Implementation date | March 2025 |

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Exhibit 4

| Matter arising 4 – Regular user access reviews of ProLease do not take place | |
|--|---|
| Findings | We found that some MRI (the Prolease supplier) users had been set up with Prolease access, without the knowledge of the local NHS system administrators. While it is understandable that MRI staff have access to maintain the system, as per the contracts in place, the Health Board need to have assurance that the supplier is using system access appropriately. |
| Recommendation | The Health Board should perform regular (e.g. monthly or quarterly) formal checks of the Prolease users who have access; and remove any users who no longer need access. The Health Board should also review the audit log to determine whether any inappropriate actions have been taken by unknown MRI users, and to promptly investigate any such actions. |
| Accepted in full by management | Accepted |
| Management response | The All Wales Capital TAG Prolease subgroup have agreed that system administrators will run user audit reports on a monthly basis and will be circulated to the group for review on a quarterly basis. |
| Implementation date | June 2024 |

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Exhibit 5

| Matter arising 5 – there are no regular user-access reviews of the ESR ‘recruitment and applicant enrolment administration’ user responsibility profile | |
|--|--|
| Findings | <p>We established that 22 Health Board officers use the local ESR recruitment and applicant enrolment administration’ user responsibility profile (URP), within the Health Board’s payroll and workforce HR team. This access is a privileged (or high-level) that permits the set up and addition of new positions and the appointment of new employees to the payroll.</p> <p>We found that the Health Board does not undertake regular reviews of its users and their access levels, to ensure access is restricted to the appropriate number of users.</p> |
| Recommendation | <p>The Health Board should:</p> <ul style="list-style-type: none"> • restrict the number of officers who have privileged (high level) access to the ESR system, to ensure that it is granted only to those who need it; and • regularly review, for example, every quarter, access to the ‘recruitment and applicant enrolment administration’ user responsibility profile (URP) to monitor user activity. |
| Accepted in full by management | <p>Yes</p> |
| Management response | <ul style="list-style-type: none"> • The People Analytics Team will facilitate the quarterly review using BI reporting. The report will identify the holders of the URP and the supervisor will be contacted to see whether the allocation is appropriate. • This check will be extended to HR Admin for the same reason. |
| Implementation date | <p>30 September 2024</p> |

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Recommendations from previous years audits

- 3 **Exhibit 6** sets out previous audit recommendations that the Health Board is yet to fully implement as intended, with commentary on the progress.

Exhibit 6: progress against last year's recommendations

| Audit Year | Recommendation | Progress |
|------------|---|---|
| 2022-23 | The Health Board should strengthen its process for the identification and disclosure of related party transactions and balances. | Last year three Board Members had submitted incomplete related party declarations of interest (DOIs). This year there were five Board Members who had submitted incomplete DOIs; and three of the five Members were the same people who had omitted DOIs the previous year. |
| 2022-23 | The Health Board should strengthen its review of payable balances (more than one year old) to ensure they are still valid and payable. | Limited progress has been made by the Health Board, as per our review of accounts payable there was £1.13 million of payable balances greater than one year old (2022-23 there was £1.9 million). |
| 2022-23 | The Health Board should ensure that the ESR payroll system leaver report is sent every month to the IT department, being a key control to the removing of former staff. | The co-dependency with NWSSP processes does cause some uncertainty over timescale. Implementation is anticipated during 2024. |
| 2020-21 | The Health Board should replace its unsupported Windows 2008 servers and W7 devices. | The Health Board has an ongoing programme in place to replace or upgrade all affected devices. Over 11,000 Windows 7 machines have been removed and replaced with Windows 10. CAV Digital continue to work with the departments and clinical boards to remove Windows 2008 Servers and have reduced this number by over 50% in the past 18 months. Work continues in this area. |

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| | | |
|---------|--|--|
| 2020-21 | The Health Board should update and test its IT Disaster Recovery Plan (DRP) to gain assurance that IT systems can be restored if needed. | <p>The Health Board is reviewing and updating its IT DRP as part of a programme to refresh its IT security documentation.</p> <p>CAV Digital have procured the services of a BC/DR specialist partner to update the existing DRP. The initial draft is currently being reviewed and is expected to be completed late 2024.</p> |
| 2020-21 | The Health Board should update its IT change-control policy and procedure. | <p>The Health Board is updating its change control policy as part of its new helpdesk system.</p> <p>Change Management is now implemented for Digital Operations and a formal Change Advisory Board has been created. The CAB meet once a month with remote and informal meetings via the Service Desk weekly. Change Management is planned to be deployed to the wider Digital Teams in early 2025.</p> |
| 2020-21 | The Health Board should evaluate and consider upgrading its IT1 and IT2 data centre controls. | <p>The Health Board is currently reviewing its data centre rooms and is considering whether to decommission some of them.</p> <p>IT1 and IT2 have been cleared of Server and Compute for CAV Digital. There are still networking and some legacy hosted 3rd party hardware in IT1. The majority of systems have been consolidated in the SAC Building, UHW Pod and Pod2. Electrical work is nearly complete in UHL for improved power distribution and UPS protection. Woodland House improvements are complete. These two new locations will allow the installation of DR and non essential production servers and equipment in early 2025.</p> |
| 2020-21 | The Health Board should strengthen its formal monitoring of user | The Health Board has made some progress against this recommendation, but it has not been fully implemented. |

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| | | |
|---------|---|--|
| | <p>access rights to the WellSky system. Also, the Health Board should ensure that its monitoring is based on regular reviews, and a clear and up-to-date record (retaining historic details) of all users, and confirmation that each user's access is appropriate.</p> | <p>This request relates to a specific Citrix accessed application which is hosted and managed by DHCW and used by Pharmacy.</p> |
| 2020-21 | <p>The Health Board should strengthen its assessment of network security vulnerability by:</p> <ul style="list-style-type: none"> • 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. | <p>The Health Board has made some progress on this recommendation and at the time of the audit fieldwork (May 23), the internal penetration testing is more regular, and outputs are monitored, but external penetration testing is still not been completed.</p> <p>In late 2023 two external Pen Tests were completed for several DMZ and Externally accessed systems. One for UHW and another for GPW (CICG Site).</p> <p>Working with DHCW a new SIEM and Vulnerability scanning has been implemented and is monitored by both CAV Digital and DHCW Cyber.</p> |
| 2019-20 | <p>The quality of some of the Health Board's underlying working papers requires further improvement.</p> | <p>The Health Board has further improved its processes and records for 2023-24. However, there were still some working papers (e.g. those that supported notes 9.1 to 9.6) that had typed numbers, balancing figures, which resulted in numerous audit adjustments.</p> |

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| | | | | | |
|--|--|---------|-----------------|---------------|--------------------------------|
| Report Title: | Post Payment Verification End of Year report 2023/2024 | | Agenda Item no. | 2.3 | |
| Meeting: | Audit Committee | Public | X | Meeting Date: | 3 rd September 2024 |
| | | Private | | | |
| Status <i>(please tick one only):</i> | Assurance | X | Approval | Information | |
| Lead Executive Title: | Catherine Phillips Executive Director of Finance | | | | |
| Report Author (Title): | NHS Wales Shared Services Partnership: Amanda Legge, All Wales, Post Payment Verification Manager | | | | |

Main Report

Background and current situation:

1. Situation /Background

1.1 This paper highlights the narrative on how practices have been performing over the current Post Payment Verification (PPV) cycle.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

In mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. It also compares the overall performance of the Health Board against the national PPV visits.

The paper is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately. PPV provides assurance in all contractor disciplines, except for General Dental Services.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.

2. Specific Matters for Consideration

2.1 The past year in 2023-2024, PPV began recovering from the backlog of work that we had, due to a new payment system within PCS and the inability for practices to submit NHS numbers to evidence their claims. This system was developed and enhanced which allowed us to return to Business as usual in April 2023, and has maintained an excellent level of PPV, which continues to provide Health Boards with reasonable assurance that public monies are being appropriately claimed.

The following key points should be noted:

General Medical Services (GMS): Due to the backlog of PPV work across Wales, we created the visit plan for 2023-2024 to try to complete as many visits as possible that we could in the year with the aim of condensing our normal 3-year rolling plan into 2 years. We managed to complete all 172 routine visits across Wales with 27 for Cardiff & Vale University Health Board. Regarding the revisits that were due in 2023-2024, and because we wanted to complete all routine visits along with Ad-hoc requests, we only managed to carry out a small number across Wales including 4 for yourselves.

Firstly, in this financial year, we will be concentrating on all outstanding revisits, and if a revisit is due at the same time as the routine, we will do an 'extended visit' which means 10% of the claims for the routine and 100% check on the services that were triggered in the initial routine.

General Ophthalmic Services (GOS): The visit plan for GOS 2023-2024 was not finalised after explaining to our HB's that these visits were subject to change due to a new way of verifying claims. PPV began remote access options having full support from Optometry Wales and carried out a small percentage of virtual visits via Microsoft TEAMS, which proved successful. Unfortunately, this was more gradual than anticipated due to the lack of electronic patient records, but we did manage to complete 16 for Cardiff & Vale University Health Board.

Future visits will now be included in the 2024-2025 visit plan and is still changeable, and although we are hoping to increase the number of remote visits, we will also incorporate physical visits to carry us through this transition period of electronic patient records, which is being encouraged by Welsh Government.

General Pharmacy Services (GPS): In 2023/2024 NWSSP/PPV introduced a new service check after a successful pilot, which was the Quality and Safety Scheme and completed all visits planned. We have also begun

the Collaborative Working Scheme verification this upcoming financial year 2024-2025. We can verify both these services remotely.

We are also investigating other avenues for PPV in GPS and beginning another pilot early this year.

Additional Services: After technical issues with our dispensing Data checks, and a lot of developing, we can now progress with our quarterly provision of these reports Nationally across Wales.

From the pilot we carried out and informing practices of the regulations surrounding dispensing eligibility, we have the data which shows the future success of this service.

Clinical Waste Self Assessments were piloted for GMS and have been Live this last year to ensure compliance with legislation. We are planning to conduct a pilot with the Self Assessments for Pharmacies in the next few months in 2024-2025.

Quarterly meetings are scheduled with the Head of Primary Care, Primary Care Managers, Finance Lead, PPV Team and local Counter Fraud team to regularly review the progress report and to discuss themes, recommendations, and any risks. We are also investigating other avenues of savings from the provision of Clinical Waste services and now produce a 'non-collection' 6 monthly report to all our HB's.

There are bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV to discuss and agree any issues regarding the National application of the programme. PPV are planning to commence a National GPS Working Group to align with the above, which has proved successful.

PPV training events and roadshows to Practice Managers have been delivered locally and we now record these in advance, based on our trend data analysis. In addition to facilitating one-on-one training requirements, particularly for new practice managers, we created a video recorded guide for both GOS and GMS.

Recommendation:

The Committee is requested to:

It is recommended that the Audit & Risk Assurance Committee Members **note** the contents of this report. There are no options included in this report. The report is for Assurance.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please place an "X" in the below boxes as relevant.

| | |
|---|--|
| <p>1.  Putting People First</p> <p>Click the objective above to view more detail.</p> | <p>2.  Providing Outstanding Quality</p> <p>Click the objective above to view more detail.</p> |
| <p>3.  Delivering in the Right Places</p> <p>Click the objective above to view more detail.</p> | <p>4.  Acting for the Future</p> <p>Click the objective above to view more detail.</p> |

Five Ways of Working (Sustainable Development Principles) considered

Please place an "X" in the below boxes as relevant

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

Quality Impact Assessment Completed?:

Please place an "X" in the below boxes as relevant.

| | | |
|---|--|--------------|
| Yes – (please provide completed QIA document) | No – (Please provide reasoning, e.g. not required) | Comment here |
|---|--|--------------|

Impact Assessment:

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

Risk: Yes

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider the be the best approach to support practices in improving throughout the claiming process.

Safety: No

| | |
|---|-------|
| Financial: No | |
| Workforce: No | |
| Legal: No | |
| Reputational: No | |
| Socio Economic: No | |
| Equality and Health: No | |
| Decarbonisation: No | |
| Welsh Language: No | |
| Approval/Scrutiny Route <i>(please note anywhere else this paper has been before):</i> | |
| Committee/Group/Exec | Date: |
| | |
| | |

Saunders, Nathan
02/09/2024 08:52:36

Audit Report - 1st April 2023 to 31st March 2024 = Cardiff & Vale University Health Board

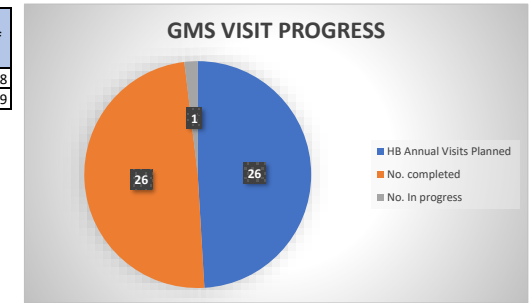
To Notes

| |
|--|
| All Planned visit totals were sent to HB for 23/24 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers |
| Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations |
| PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise |
| Training/support is provided to practices after visit where necessary |

| GMS | Visit Type | HB Annual Visits Planned | No. completed | No. In progress | Queries with Practice /HB | No. Recoveries | Value of recoveries | All Wales Completed | All Wales No. in progress | All Wales Planned | All Wales Value of Recoveries |
|--------------|------------|--------------------------|---------------|-----------------|---------------------------|----------------|---------------------|---------------------|---------------------------|-------------------|-------------------------------|
| | | Routine | 26 | 26 | 1 | 1 | 417 | £15,998.14 | 172 | 2 | 172 |
| Revisit | 18 | 2 | 1 | 1 | 55 | £3,712.50 | 28 | 3 | 136 | £69,831.69 | |
| Total | | 44 | | | | | | | | | |

Summary of themes/findings/issues

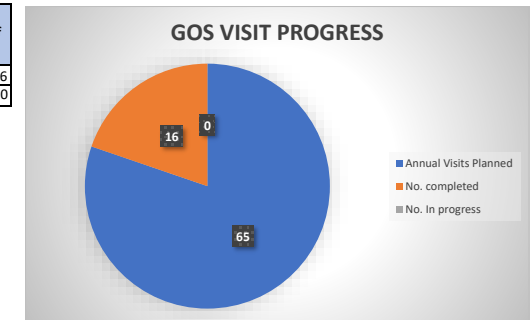
Due to the new payment system, all Revisits across Wales were on hold until Dec 2023



| GOS | Visit Type | Annual Visits Planned | No. completed | No. In progress | Queries with Practice /HB | No. Recoveries | Value of recoveries | All Wales Completed | All Wales No. in progress | All Wales Planned | All Wales Value of Recoveries |
|--------------|------------|-----------------------|---------------|-----------------|---------------------------|----------------|---------------------|---------------------|---------------------------|-------------------|-------------------------------|
| | | Routine | 65 | 16 | 0 | 0 | 55 | £2,098.09 | 44 | 0 | 301 Rolling Plan |
| Revisit | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | £0.00 | |
| Total | | 65 | | | | | | | | | |

Summary of themes/findings/issues

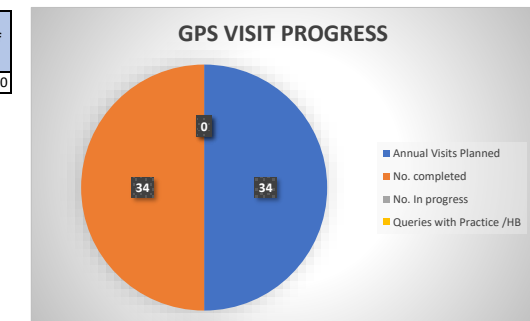
As contractors are transitioning to electronic records, remote access visits are slow in progressing so we have re-introduced physical visits too.



| GPS | Visit Type | Annual Visits Planned | No. completed | No. In progress | Queries with Practice /HB | No. Recoveries | Value of recoveries | All Wales Completed | All Wales No. in progress | All Wales Planned | All Wales Value of Recoveries |
|--------------|------------|-----------------------|---------------|-----------------|---------------------------|----------------|---------------------|---------------------|---------------------------|-------------------|-------------------------------|
| | | Q&S Scheme | Routine | 34 | 34 | 0 | 0 | 0 | £0.00 | 229 | 0 |
| Total | | 34 | | | | | | | | | |

Summary of themes/findings/issues

Nothing to report at this stage



Created by: Nathan
 09/09/2024 08:52:36

| | | | | | |
|--|---|---------|----------|-----------------|--------------------------------|
| Report Title: | Procurement Compliance Report / Single Tender Actions | | | Agenda Item no. | 2.4.1 |
| Meeting: | Audit Committee | Public | X | Meeting Date: | 3 rd September 2024 |
| | | Private | | | |
| 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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Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

ASSESSMENT AND ASSURANCE

Non-Compliant Activity (14)

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 | Length at Risk/ Breach | Clinical Board | Reason | Action/Status |
|--|------------------------|------------------------|---|---|---|
| Cardiff University Commercial Trial costs | £37,293.21 | One off requirement | Executives | Service did not engage with Procurement | Closed – no further requirement for this trial. Procurement advised SFI's as reminder to governance adherence and looking at process for any future requirements. |
| Purchase of Invivoscribe reagents | £15,640.00 | One off requirement | AWMG | Service did not engage with Procurement | In Progress – Procurement and Services establishing compliant contract. |
| Purchase of Oasis PRiME HLB uElution Plate 1/pkg | £7,082.40 | One off requirement | C,D&T | Under £5,000.00 threshold order was placed with the supplier and therefore, within governance at the time of order, however, the supplier later disputed the price. | Closed – no further requirement. Procurement advised SFI's as reminder to governance adherence. |
| Secondment fees to Charity Organisation. | £53,869.12 | 18 months | Executives | Service did not engage with Procurement | In Progress – compliant contract being put in place. |
| Security Services at CAVHIS CRI | £25,628.59 | 3 months | Capital Planning Estates and Facilities | Service did not engage with Procurement | Closed – one off requirement. |
| Compostable Food Waste | £7,521.00 | One off requirement | Capital Planning Estates and Facilities | Service did not engage with Procurement | Closed – no further requirement. |
| Best Practice Day Event 2024 | £6,495.00 | One off event | C,D&T | Service did not engage with Procurement | In Progress – Discussion with Service on possible future requirements. |
| Home Dialysis Installation, Decommissioning and Electrical Works | £5,426.00 | One off works | Specialist | Service did not engage with Procurement | In Progress – Tender in progress. |
| Greenhouse Gas Emissions Trading Scheme Civil Penalty Notice for 2018, 2019, 2020 and 2021 | £29,620.89 | 4 years | Capital Planning Estates and Facilities | Service did not engage with Procurement | Closed – Penalty Notices. |
| AB4U Partner In-Care Service | £5,940.00 | One off requirement | Surgery | Service did not engage with Procurement | Closed – no further requirement. |

| | | | | | |
|-------------------------------------|------------|---------------------|---------|---|---|
| Myriad Genetics | £49,500.00 | 2 months | AWMG | Service did not engage with Procurement | In Progress – compliant contract being put in place. |
| Eye Care Consultancy | £23,900.00 | 2 months | Surgery | Service did not engage with Procurement | Closed – compliant route completed |
| Cardiff and Vale College - Coaching | £10,000.00 | One off requirement | C,D&T | Service did not engage with Procurement | Closed – no further requirement. |
| Transcription Services | £5,934.25 | One off requirement | Surgery | Service did not engage with Procurement | In Progress – Investigating if this requirement can be included in current contract |

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 |
|---------------------------------|------------------------|-----------------|-----------------------|----------------|---|---|
| Independent Prescribing courses | £25,300.00 | June 2024 | 12 months | Surgery | Service did not engage with Procurement | In Progress – Ongoing review of requirement |

Other Non-Compliant Activity (5 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 | Length at Risk/Breach | Clinical Board | Reason | Action /Status |
|---|---------------|-----------------------|----------------|---|---|
| Professional Legal Fees | £12,505.00 | 2 months | Executives | NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment | Closed – Legal requirement |
| Professional Legal Fees (Blake Morgan) | £8,606.60 | One off service | Executives | NWSSP Legal and Risk select barristers with no Procurement or Health Board involvement in appointment | Closed – Legal requirement |
| Audit Wales | £23,784.00 | 2023/24 Audit Fees | Executives | Closed – Financial requirement | Closed – 2023/24 requirement |
| Courier charges for cancer prep to patients | £5,500.00 | One off requirements | C,D&T | Emergency delivery charge | Closed – One off requirement |
| Cardiac Life Vests | £10,800.00 | One off purchase | Specialist | Zoll has removed the distribution rights from Dot Medical who have a contract with the Health Board. Zoll are now providing these direct. | In Progress – Contract being put in place with new supplier |

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 |
|----------------|---------------|-----------------|-----------------------|----------------|--------|---------------|
| | | | | | | |

It should be noted that Procurement have booked training refresher sessions with areas of high non compliance on Standing Financial Instructions (SFI's) and Public Contracts Regulations (PCR) to proactively reduce the number of breaches by Clinical Boards.

Report of Single Tender/Quotations Actions

Retrospective – (Nil Return)

The report outlines all SQA/STA (Nil Return) requests during the period the 1st June 2024 to 31st July 2024.

| Clinical Board | Supplier | Name of Project | Retrospective Value of Contract Excl VAT | STA Type |
|----------------|----------|-----------------|--|----------|
| | | | | |

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 (11) requests during the period the 1st June 2024 to 31st July 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 |
|----------------|---------------------------------|---|----------------------------------|---|
| C,D&T | CBS Butler | Agency Clinical Coders | £72,000.00 | Capability with existing equipment or service |
| C,D&T | Salt Recruitment | Agency Clinical Coders | £30,000.00 | Capability with existing equipment or service |
| C,D&T | DQD Engineering | PWS Distribution System Annual Maintenance Contract | £28,328.75 | Sole Supplier of Goods or Services |
| AWMGS | Synlab Diagnostics Global S.A.U | Haem-onc karyotyping | £111,000.00 | Urgent Operational Requirement |
| Executives | GMAC Computer Systems Ltd | Charitable CRM System | £25,756.00 | Sole Supplier of Goods or Services |

| | | | | |
|------------|---|--|------------|------------------------------------|
| C,D&T | AGFA HealthCare UK Ltd | AGFA DX-D 40 detector drop insurance for 15 AGFA detectors | £43,344.00 | Sole Supplier of Goods or Services |
| C,D&T | Medray UK Ltd | DRX-1 detector drop insurance for 4 Carestream detectors | £11,782.80 | Sole Supplier of Goods or Services |
| Specialist | RD Biomed Limited | Sample Analysis for cardiac arrest patients | £18,000.00 | Sole Supplier of Goods or Services |
| Executives | University of South Wales | Network 75 Scheme - Finance Trainees | £63,500.00 | Sole Supplier of Goods or Services |
| Specialist | Medical Data Solutions and Services Ltd | Clinical Information System Service Support - Haemophilia | £8,307.27 | Sole Supplier of Goods or Services |
| AWMGS | Ideagen | Additional Licenses for Q Pulse | £25,845.25 | 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) | |
|--|------------------------|-----------|----------|------------------------|-----------|----------|------------------------|-----------|
| Clinical Board | Non-Compliant Breaches | Exemption | Covid-19 | Non-Compliant Breaches | Exemption | Covid-19 | Non-Compliant Breaches | Exemption |
| AWMGS | 1 | 0 | 0 | 1 | 0 | 0 | 3 | 0 |
| Children and Women | 2 | 0 | 0 | 3 | 0 | 0 | 0 | 0 |
| Capital Planning, Estates and Facilities | 3 | 2 | 1 | 2 | 3 | 0 | 5 | 6 |
| Clinical, Diagnostics and Therapies | 2 | 0 | 0 | 11 | 4 | 0 | 9 | 2 |
| Executives | 8 | 5 | 0 | 21 | 9 | 0 | 11 | 10 |
| Medicine | 2 | 1 | 0 | 1 | 0 | 0 | 1 | 0 |
| Mental Health | 0 | 0 | 0 | 2 | 1 | 0 | 8 | 0 |
| PCIC | 0 | 0 | 0 | 2 | 0 | 0 | 3 | 0 |
| Specialist | 3 | 1 | 0 | 10 | 1 | 0 | 2 | 2 |
| Surgery and Dental | 9 | 1 | 0 | 10 | 0 | 0 | 5 | 1 |
| TOTALS | 31 | 10 | 1 | 63 | 18 | 0 | 47 | 21 |

STA/SQA's by Department

| | 2022/23 | | 2023/24 | | 2024/25 (YTD) | |
|--|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|
| Clinical Board | No. of SQA's/STA's | SQA/STA's Breached | No. of SQA's/STA's | SQA/STA's Breached | No. of SQA's/STA's | SQA/STA's Breached |
| AWMGS | 3 | 3 | 0 | 0 | 2 | 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 | 16 | 0 |
| Executives | 23 | 1 | 13 | 2 | 8 | 0 |
| Medicine | 4 | 0 | 0 | 0 | 2 | 0 |
| Mental Health | 3 | 0 | 1 | 0 | 1 | 0 |
| PCIC | 11 | 3 | 3 | 0 | 1 | 0 |
| Specialist Services | 11 | 1 | 3 | 0 | 3 | 1 |
| Surgery Services and Dental | 11 | 0 | 5 | 1 | 2 | 0 |
| Grand Total | 117 | 13 | 54 | 3 | 39 | 1 |

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report
- **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: |
| | |
| | |
| | |

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|--|---|---------|-----------------|---------------|
| Report Title: | Procurement Compliance Report – Chair’s Action Review | | Agenda Item no. | 2.4.2 |
| 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 Board approval is obtained for the purchase of all goods and services for contracts over the value of £500k.

There are some situations where approval must be sought outside Board approval and therefore, a Chair’s Action request is submitted. The reasons can be as follows;-

- Urgent Operational Requirement
- Unforeseen/unplanned circumstances
- Emergencies
- Exemptions

A review of the number of Board and Chair’s Actions reports was requested by the Director of Finance and following the initial report in March 2022, an annual report is now provided by Procurement Services.

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

In March 2022, a review of Board approvals was undertaken for financial year 2021/22 and up to December 2022 for 2022/23 financial year. In 2021/22 the majority of approvals (72) were issued via the Chair’s Action route with 2 through the formal Board meeting. During the financial year 2022/23 up to December 2022 (at the time of the first report), Procurement Services issued 36 requests. This was highlighted to Procurement Services and therefore, planning for approval was advised to be in line with Board meeting dates.

In order to confirm the number of genuine Chair’s Action requests, Procurement commenced tracking the Board/Chair’s Action requests from September 2022 with the below categories. In addition to these categories, two further types (categories 6 and 7) were included in January 2023;

1. Board Agenda does not have capacity for request
2. Emergency/Unforeseen circumstances
3. Exemption - contract value above estimated contract value
4. Procurement have not provided sufficient time within Board dates for approval.
5. Urgent Operational Requirement
6. Delays to process causing Procurement Services to miss the project planned Board date
7. AW Contracts Ratification which are being challenged and/or not in line with Board dates

It should be noted that in January 2024, the Board approved a request from Executives to amend the delegated financial limits in line with other Health Boards in Wales, details as follows;

Table 1 – Delegated Financial Thresholds and Approvers

| Delegation | Delegated Financial limit Prior to January 2024 £’000 | Delegated Financial limit From to January 2024 £’000 |
|---------------------|---|--|
| Reserved for Board | >500 | >1,000 |
| Chief Executive | 500 | 1,000 |
| Director of Finance | 125 | 500 |

Please note that WG reporting /approving requirements remain.

Table 2 below provides the numbers and categories for the Chair’s Actions from the initial report through to the 31st July 2024 in financial years.

Table 2 – Category and Numbers of Board and Chair Actions Requests

| Cat No. | Category | 2022/23 | 2023/24 | 2024/25 (YTD) |
|--------------|--|-----------|-----------|---------------|
| 1 | Board Agenda does not have capacity for request | 7 | 4 | 0 |
| 2 | Emergency/Unforeseen circumstances | 3 | 1 | 0 |
| 3 | Exemption - contract value above estimated contract value | 0 | 0 | 0 |
| 4 | Procurement have not provided sufficient time within Board dates for approval | 2 | 1 | 0 |
| 5 | Urgent Operational Requirement | 26 | 4 | 2 |
| 6 | Delays to process causing Procurement to miss the project planned Board date | 6 | 5 | 0 |
| 7 | AW Contracts Ratification which are being challenged and/or not in line with Board dates | 1 | 4 | 0 |
| Total | | 45 | 19 | 2 |

It is noted that there has been a significant improvement, attributed to enhanced planning and the changes in the delegated financial limits.

Recommendation:

The Board / Committee are requested to:

- **NOTE** the contents of the Report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

| | | | |
|---|--|---|--|
| 1. Reduce health inequalities | | 6. Have a planned care system where demand and capacity are in balance | |
| 2. Deliver outcomes that matter to people | | 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: |
| | |
| | |
| | |

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| | | | | | |
|--|--|----------|---|------------------|------------------|
| Report Title: | Written Controlled Documents Policy & Procedure | | | Agenda Item No.: | 3.1 |
| Meeting: | Audit and Assurance | Public | x | Meeting Date: | 3 September 2024 |
| | | Private | | | |
| Status <i>(please tick one only):</i> | Assurance | Approval | X | Information | |
| Lead Executive: | Director of Corporate Governance | | | | |
| Report Author: | Senior Corporate Governance Officer | | | | |

Main Report

Background and current situation:

The Corporate Governance Directorate have responsibility to coordinate the production, publication and archiving of Cardiff and Vale University Health Board Policies and other Controlled Documents. The responsibilities and processes necessary to enable these activities are described in UHB 001 (Management of Policies, Procedure and other Written Control Documents Policy) and in UHB 242 (Written Control Documents – Development)

UHB 001 required review in accordance with its published review date. This review has occurred and has not resulted in any substantial alteration.

UHB 242 also required review in accordance with its published review date. Following review, the document was amended to achieve the following:

- To provide a clearer definition of the various types of controlled documents to be used within the Health Board.
- To provide a clearer articulation of the process to be adopted when drafting new controlled documents.
- To update the document and reflect the change in process of storing and tracking each policy via the AMaT (Audit Management and Tracking) System
- Updates to policy are still ongoing as the new system and process is implemented.

The updated policy and procedure are attached as appendices.

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

Key actions taken to improve Policy Management:

- Amendments to UHB 001 and UHB 242 documents were a necessary step in the improvement of controlled document management and were consistent with recommendations made in the original audit against Policy Management.

Recommendation:

The Committee are requested to:

- **Approved** the updated Written Controlled Documents Policy (UHB 001) & Procedure (UHB 242) attached as appendix 1 & 2

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

| | | | | | | | | | |
|------------|---|-----------|--|-------------|--|---------------|--|-------------|--|
| Prevention | x | Long term | | Integration | | Collaboration | | Involvement | |
|------------|---|-----------|--|-------------|--|---------------|--|-------------|--|

Impact Assessment:

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

Risk: Yes

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Safety: Yes

Improved management of controlled documents provides greater access to potential risk control processes and procedures.

Financial: No

Workforce: No

Legal: Yes

Improved management of controlled documents provides greater evidence of Cardiff and Vale University Health Board's statutory compliance.

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec | Date:

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02/09/2024 08:52:36

| | |
|---|---|
| Reference Number: UHB 001 Version Number: 6 | Date of Next Review: 5 July 2026 Previous Trust/LHB Reference Number: N/A |
| MANAGEMENT OF POLICIES, PROCEDURES AND OTHER WRITTEN CONTROL DOCUMENTS POLICY | |
| <p>Policy Statement</p> <p>Cardiff and Vale University Health Board (C&V UHB) has a responsibility to ensure compliance with legislative, statutory and regulatory requirements. Policies, procedures and other written control documents develop and describe our ‘ways of working’ and outline how staff should perform their roles to meet these requirements. A robust and clear governance framework for the management of documents is essential to minimise risk to patients, employees, contractors, the public and the organisation itself; therefore, the Health Board has developed a system to support the development or review, approval, dissemination and management of these documents.</p> <p>This policy outlines the process for development, consultation, approval, dissemination, and review of key organisational documents such as policies, strategies, procedures, guidelines and protocols.</p> | |
| <p>Policy Commitment</p> <p>Our documents will be written in plain language so that all staff, stakeholders and where appropriate our patients and the people we serve, are clear about what is expected. It will be possible to find them easily on our internet and/or intranet sites. Where appropriate our documents will be available in the Welsh Language and they will also be supported by other media or format, for example podcasts.</p> <p>Each document will have an “owner” who has responsibility for making sure that it is regularly reviewed and kept up to date.</p> <p>A combined Equality and Health Impact Assessment will be completed for all policies (and where appropriate procedures and other written control documents).</p> <p>Our staff and stakeholders will be actively consulted during the development of all policies (and where appropriate procedures and other written control documents).</p> <p>There will be clear and appropriate methods for the approval of policies and other written control documents and a comprehensive register will be maintained for all such documents.</p> | |
| <p>Supporting Procedures and Written Control Documents</p> | |

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| Document: Management of Policies, Procedures and Other Written Control Documents | 2 of 3 | Approval Date: X Sept 2024 |
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This policy and UHB 242: Written Control Documents – Development and Approval Procedure describe the following with regard to written control documents:

- The process for developing/updating documents
- The requirements regarding equality and health impact assessment
- Style and formatting
- Consultation and approval arrangements
- Recording, storage and archiving
- Communication and publication
- Any learning, education or development needs

Other supporting documents are:

UHB 142: Records Management Policy.
 UHB 183: Records Retention and Destruction Protocol.
 UHB 202: Safety Notices and Important Documents Management Policy.
 UHB 228: Producing Written Information for Patients Guidance.
 UHB 242: Written Control Documents - Development and Approval Procedure
 UHB 246: Information Governance Policy.

Scope

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

This policy relates to organisation wide key documents. However, its principles also apply to any local key documents to ensure that they are appropriately authenticated and regularly reviewed to ensure a reliable, accessible and valid source of best practice for staff.

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| Equality and Health Impact Assessment (EHIA) | The policy relies on the generic EHIA for Administrative Type Policies |
| Policy Approved by | Audit and Assurance Committee |
| Group with authority to approve procedures written to explain how this policy will be implemented | Health System Management Board |
| Accountable Executive | Director of Corporate Governance |

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Disclaimer

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

| Summary of reviews/amendments | | | |
|--------------------------------------|-----------------------------|-----------------------|---|
| Version Number | Date Review Approved | Date Published | Summary of Amendments |
| 1 | N/A | 17/09/09 | New policy |
| 2 | 12/09 | N/K | Minor amendments |
| 3 | 06/11 | 07/11 | Amendments throughout document to reflect changes in approval processes and recognise mechanism required to develop Directorate documentation. |
| 4 | 01/07/14 | 08/07/14 | Amendments to reflect new policy format |
| 5 | 30/11/17 | 05/12/17 | Change in titles Reference to new Equality and Health Impact Assessment launched in September 2016 Changes in supporting Procedure to reflect Committee changes |
| 6 | 05/07/22 | 12/07/22 | Changes in supporting Procedure to reflect changes in approval process. |
| 7 | Aug 24 | Sept 24 | Review conducted, submitted with updated procedure 242 to audit committee |

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| Reference Number: UHB 242 Version Number: 4 | Date Published: TBC Date of Next Review: TBC.2027 |
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Written Control Documents - Development and Approval Procedure

Introduction and Aim

To ensure that Cardiff and Vale University Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will develop and describe our “ways of working” in policies, procedures and other written control documents. In this regard, the Management of Policies, Procedures and Other Written Control Documents Policy (UHB 001) has been produced.

This procedure translates the principles from that policy into more detailed guidance, including individual responsibilities for developing and reviewing written control documents. This is summarised at Table 1: Steps Involved in Document Creation/Amendment (page 8).

Unless otherwise stated, the phrase ‘*key documents*’ will be used in this procedure when a point is equally relevant to a range of control documents whether they be strategies, policies, procedures, guidelines etc.

Objectives

This procedure ensures consistency in the format, compilation, approval and dissemination of all control documents, so that they are:

- Developed and reviewed when required;
- “Owned” – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date.
- Written in plain language so that they can be understood and people are clear of what is expected.
- Subject to Equality and Health Impact Assessments (EHIA) where required;
- Recorded, stored and archived in accordance with the UHB Records Management Retention and Destruction Protocol;
- Appropriately co-produced and consulted on;
- Considered and approved by the appropriate forum/senior officer (with delegated powers);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and our Publication Scheme.

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| Scope This procedure applies to all of our staff in all locations including those with honorary contracts. In addition to the responsibilities detailed within the procedure, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them. | |
| Equality and Health Impact Assessment | The procedure relies on the generic EHIA for Administrative-type policies. |
| Documents to read alongside this Procedure | UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy. |
| | UHB 142: Records Management Policy. |
| | UHB 183: Records Retention and Destruction Protocol. |
| | UHB 202: Safety Notices and Important Documents Management Policy. |
| | UHB 228: Producing Written Information for Patients Guidance. |
| | UHB 246: Information Governance Policy. |
| Approved by | Audit and Assurance Committee |

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| Accountable Executive or Clinical Board Director | Director of Corporate Governance |
| Author(s) | Corporate Archivist and Records Management Manger |
| <u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate | |

| Summary of reviews/amendments | | | |
|--------------------------------------|--------------------------------|-----------------------|---|
| Version Number | Date of Review Approved | Date Published | Summary of Amendments |
| 1 | 18/09/2014 | 24/09/2014 | Content previously included within Management of Policies, Procedures and Other Written Control Documents Policy. The revised policy is in the new shorter format and this procedure has been written in support of the new policy. |

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|-----|------------|------------|---|
| 1.1 | 10/12/2015 | 16/12/2015 | Title of Appendix 2 corrected |
| 2 | 30/11/2017 | 05/12/2017 | Revised Procedure. Titles amended Reference to new EHIA that replaced EQIA Changes in Committee structure and inclusion of R&D |
| 3 | 05/07/2022 | 09/08/2022 | Revised to reflect change to UHB 001: Management of Policies, Procedures and Other Written Control Documents Policy. Definitions moved from appendix to main body. Document Approval process revised. Committee titles updated. |
| 4 | TBC | TBC | Full review of policy, amendments throughout, review of approval committees in line with current Health Board structure. Including additional appendices for clarity |

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1. Definition of Terms

1.1 **Note.** These definitions are adapted from a range of sources. There are no single legal definitions and the terms can mean different things to different organisations.

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1.2 Strategy. A long-term plan designed to achieve particular goals or objectives. A strategy is often a broad statement of an approach to accomplishing these desired goals or objectives. A strategy may be supported by policies and procedures. Strategies always require an Equality & Health Impact Assessment (EHIA).

1.3 Policy. A formal written statement of intent, describing the broad approach or course of action that the Health Board is taking with a particular issue. The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff. An Operational Policy is a statement outlining the objectives, principal functions and modes of operation of an entire hospital or a department, particular service or activity.

Policies are usually underpinned by evidenced based procedures and guidelines. Policies are mandatory and usually require an EHIA.

1.4 Procedure. A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy. They must include reference to any evidence used. Procedures are considered mandatory. The equality impact of a procedure that supports a policy may be covered by that policy's EHIA but consideration should always be given to the need for a specific EHIA.

1.5 Protocols. Protocols are an agreed framework that provides step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is necessary to record the alternative action that is to be taken and the rationale for this. Protocols may have potential to impact on people with protected characteristics and therefore consideration should be given to conducting an EHIA.

1.6 Guidelines. Guidelines give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them.

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Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

1.7 Standard. A standard is a statement, reached through consensus, which clearly identifies the desired outcome. A standard is usually used within audit as a measure of success. Standards may be published as a standalone document or may be incorporated into a strategy or policy.

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; however, it could prove difficult to defend a case if a standard is not adhered to.

2. Responsibilities

2.1 Executive and Clinical Board Directors

2.1.1 The delegated responsibilities of Executive and Clinical Board Directors are set out in the Scheme of Delegation. They have responsibility for:

- a. Verifying that there is a need for a new written control document and ensuring that there is no duplication or conflict with other written control documents within their sphere of influence.
- b. Ensuring that appropriate written control documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role).
- c. Personally checking for accuracy of content prior to submission to a committee/group for approval.
- d. Maintaining a list of up to date policies and written control documents, supported by the Head of Corporate Governance.
- e. Ensuring that there are arrangements in place to capture, respond to and review documents when external organisations (e.g. Health and Safety Executive, Royal Colleges) publish new and updated information which require action by the Health Board.
- f. Ensuring that consultation has taken place and impact assessments, including the equality and health impact assessment, have been completed where necessary. Where these have not been undertaken a reason for this will be provided.

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g. Ensuring that any training requirements specific to the document have been referenced.

h. Establishing an appropriate date for review of the key document.

i. Ensuring that, where a process of audit and/or review has been agreed, this is maintained and reported on.

2.2 Document Authors

2.2.1 Authors are employees who have been given the task of writing or reviewing a key document. Employment documents should always have at least two authors i.e. a management representative and a staff representative.

2.2.2 Authors are responsible for the review of their documents. If an author leaves the Health Board or takes up a non-related post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive Director and Clinical Board Director will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

2.2.3 Authors must:

a. Liaise with Executive or Clinical Board Directors to make sure policies and written control documents are implemented appropriately and, where necessary, compliance with these documents is formally audited.

b. Make sure that documents are reviewed in line with the review date or amended as a result of changes to practice, organisational structure or legislation.

c. Work with the Executive/Clinical Board Director and the Head of Corporate Governance to ensure appropriate engagement and consultation with relevant individuals and groups.

d. Inform the Executive or Clinical Board Director of any learning, education, development or resource issues needing to be addressed prior to the granting of approval.

e. Undertake the necessary impact assessments, including EHIA.

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f. Consider the findings and make sure that appropriate action has been taken in response to EHIAs.

g. Send the approved document to the Head of Corporate Governance for publication within **five working days** of approval by Board or Committee.

h. Following review ensure Audit tracking dates and actions on Audit Tracking software (AMaT) have been updated.

2.4 Corporate Governance

2.4.1 The Director of Corporate Governance is responsible for ensuring that the Health Board has arrangements in place to ensure effective development and management of key documents.

2.4.2 The Head of Corporate Governance is part of the Director of Corporate Governance's team. They undertake the function of organisation wide "Policy Process Manager" and can provide advice and assistance on any aspect of document development and review. The Corporate Governance Team can be contacted via governanceteam.cav@wales.nhs.uk.

2.4.3 The Corporate Governance Team maintains a register of all documents which are centrally recorded and will be able to advise if a document already exists. All of these documents are both published on the UHB Website and SharePoint site.

2.4.4 The Head of Corporate Governance will arrange for draft documents to be shared with the Community Health Council during the Engagement and Consultation phase. They will also arrange for approved documents and the accompanying EHIA (if applicable) to be published on the intranet/internet as appropriate within **ten working days** of receipt from the author or Committee Secretary.

The policy will then be posted online and shared for a 28-day consultation period, during this time comments are to be sent to the document author.

Following consultation period Corporate Governance will remove the documented from the consultation pages and await the latest version, updated with feedback from the consultation process to be submitted for approval at the required committee.

Once approved, final version is to be submitted to Corporate Governance to share across platforms and retain in the corporate repository.

3. Process for Drafting or Revising Key Documents

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3.1 Each pan-Health Board policy and written control document will be sponsored by a lead Executive Director. At Clinical Board/Directorate level written control documents will be sponsored by the appropriate Director or Clinical Board Director (see Appendix 2).

3.2 In accordance with the Equality Act 2010 (as may be amended), all strategies and policies will be subject to an EHIA (see Paragraph 6).

3.3 In the case of **employment policies**, (excluding those enforced from Welsh Government following national negotiations and other “All Wales policies”), staff representatives and management will jointly negotiate a draft policy for submission to the Resources and Delivery Committee (or another appropriate Committee if this is superseded) for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Board for final consideration and approval.

3.4 All Wales Policies are to be accompanied by a CAV UHB Policy Cover sheet which must include the appropriate Exec lead and Responsible individual to conduct future reviews to ensure the policy remains adequate to the Health Board. This will allow All Wales Policies to be controlled locally and not rely on National reviews to be conducted, demonstrating assurance to our employees that the policy is still relevant to our Health Board.

3.4 The development of policies and written control documents will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance.

3.5 Sources of information used should be appropriately referenced or acknowledged.

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Table 1: Steps Involved in Document Creation/Amendment

| Stages | Lead | Action | Additional Information |
|---------------|---------------|---|--|
| Step 1 | Policy Author | Identify the need for a new (or revised version of an existing) Policy or Key Document) by completing the Key Document Approval Form at Appendix 1. | Approval obtained from the Corporate Governance Team following submission of the Approval Form |
| Step 2 | Policy Author | <p>Carry out an Equality & Health Impact Assessment (EHIA)</p> <p>The purpose of an EHIA is to identify and eliminate any negative effect that the key document may have upon groups, individuals or communities as a consequence of their race, gender, disability, religion or belief, sexual orientation, age, Welsh language, gender reassignment, pregnancy or maternity, marital or civil partnership status or human rights.</p> <p>EHIA should start at the beginning of key document making or review. This enables equality considerations to be considered throughout the design or review. Responsible officers must therefore carry out the EIA process and start by screening the document for relevance to equality. The EHIA Process should be used to carry out the screening (see Appendix 2).</p> <p>Responsibility for completing the EHIA lies with the officer(s) responsible for the key document, however the Equality & Welsh Language Teams are able to support as required.</p> | <p>Support available from the Equality and Welsh Language Teams.</p> <p>See 'Definition of Terms' for guidance on the EHIA requirements for each Key Document type</p> |
| Step 3 | Policy Author | <p>Understand Key Document Format and Template Requirements</p> <p>The drafted Key Document needs to comply with:</p> <ul style="list-style-type: none"> • The Document Format at Paragraph 5. • The Template requirements at Paragraph 5. • As required the EHIA Format at Paragraph 6. | Advice available from the Corporate Governance Team |
| Step 4 | Policy Author | Draft the Key Document | Advice available from |

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| | | | the Corporate Governance Team |
| Step 5 | Policy Author | Engagement and Consultation Engagement and consultation on all policies and written control documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience. | See Paragraph 7. Allow at least 28 working days |
| Step 6 | Executive Lead/Author | Obtain Approval Lead Executive to discuss with Head of Corporate Governance the process to be adopted for draft document approval by Board, committee or other appropriate group. | See Appendix 2. |
| Step 7 | Executive Lead/Author | Approval Following approval, the author of the document is responsible for submitting the final document to the Corporate Governance Team for publication via the Internet and adding to Audit tracking database. In accordance with the Welsh Language Standards, some policies need to be made available in Welsh. This should take place once the final version is approved. | See Paragraph 4 for specific requirement |
| Step 8 | Corporate Governance Team | Publication When the policy has been received from the Policy Author the Corporate Governance Team will update the repository and upload to the internet as required. | |
| Step 9 | Executive Lead/Author | Review Executive Leads/Authors are responsible for reviewing the key document in accordance with the review date set when published and/or changed circumstances requiring more immediate review. The Corporate Governance Team operate Audit tracking software which will automate due date reminder notifications 3 months prior to required date. Major updates will require resubmitting to committee/board, minor updates can be approved by Exec lead for submission to sub committee | See Paragraph 8 for specific requirement. |

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4. Approval for Key Documents

4.1 Some “All Wales” policies are developed by the Welsh Government or by Health Boards and Trusts working together. The Health Board is often mandated to adopt these documents. Where this is the case they will be reported to the Board or a Board Committee so that there is a record of their adoption.

4.2 Where policies relate to equitable access to safe and sustainable, high quality specialised and tertiary services (Relevant Services), the Board will delegate approval to the Joint Welsh Health Specialised Services Committee (WHSSC).

4.3 All other strategies and policies will be approved in accordance with the guidance provided at Appendix 2. In accordance with Standing Orders the Health Board's top-level organisation structure and corporate policies require Board approval; Lead Executives/Authors who feel that their draft policy requires deviation from the guidance in Appendix 2 should discuss with the Head of Corporate Governance.

4.4 Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc., an interim review may be undertaken. This will be agreed in advance with the Corporate Governance Directorate to ensure that the completion of an interim review does not expose the Health Board to an increased level of risk. The Board will periodically receive an update on all controlled documents approved by committee or other appropriate group.

4.5 Once approved, documents will be published on the UHB Internet and SharePoint sites. Under limited circumstances it may be necessary to redact information from a document prior to publication on the Internet e.g. direct dial telephone numbers within the Major Incident Plan. The Committee/Group approving the document will determine if redaction is required. Where this has been agreed the reason and extent of redaction will be explained in the published document.

5. Document Format

5.1 Document templates have been developed which contain the mandatory sections for inclusion in policies and written control documents (See Appendix 3).

5.2 This Template must be used for all Health Board wide, Clinical Board or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative

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format is acceptable and a “basic template” is also shown in Appendix 3. As a minimum the following principles must be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date for next review shown.
- Date of last review shown.
- Job title of Lead Exec supporting, demonstrating department ownership
- Author’s details.
- Pages numbered.

5.3 The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

5.4 Policies, procedures and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients or their families they will ensure that the content is explained to them by an interpreter, translated if necessary or available in accessible formats (e.g. e-readers for the visually impaired).

5.5 In accordance with the requirements of the Data Protection Act 2018 (as may be amended), the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

5.6 Certain key documents may require the collection and processing of personal data as defined and regulated by personal data legislation as applies in Wales and /or the UK (including, without limitation, the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR)). Authors and sponsoring Executive Directors must ensure that the proposed key documents complies with these requirements, liaising with The Digital and Information Technology Directorate as required.

5.7 If the Health Board is adopting an externally approved document (such an All-Wales Policy) it will not need reformatting providing it meets the standards set above. These documents will be provided a CAV policy cover sheet, given a reference number, dated, recorded and uploaded as if they were a Health Board authored document.

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6. Equality and Health Impact Assessments

6.1 The Equality Act 2010 requires the undertaking of Equality and Health Impact Assessments and all Health Board policies will require the completion of such **before** the policy is consulted upon.

6.2 These assessments determine whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that Cardiff and Vale University Health Board take into consideration the needs of all individuals who work for us and/or access our services.

6.3 Health Impact Assessment (HIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. HIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework.

6.4 Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further EHIA. If an EHIA has not been completed the reason for this will be explained at the beginning of the document. Where an EHIA has been completed the impact will be included in the document.

6.5 EHIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document. A generic EHIA for Administrative-Type Policies has also been produced and formally agreed and can be used in support of the review and development of such policy types. This is available on the Policies page of the Intranet.

7. Engagement and Consultation

7.1 Written control documents must not be written in isolation. Engagement and consultation on all key documents occur with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and

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staff representation. Where appropriate, documents should be co-produced with that target audience.

7.2 The Health Board is developing a range of mechanisms to involve patients, carers and members of the public in its work. This will strengthen the stakeholder involvement with the Health Board, demonstrate our commitment to working with the local community, and develop our services and policies jointly. If required, authors should contact the Assistant Director of Patient Experience and the Assistant Director of Planning for advice and assistance in identifying the appropriate groups/individuals for co-production and consultation.

7.3 When a final draft has been developed the formal consultation can start. The consultation period should be a minimum of **28 working days**.

7.4 The policy author should send the document and equality and health impact assessment (if applicable) to the Head of Corporate Governance who will arrange for the documents to be uploaded onto the Health Board's Written Control Documents Consultation Page on the Intranet. They will also make sure that they are brought to the attention of appropriate consultees on a weekly basis. This will include the Community Health Council in accordance with mutually agreed principles.

8. Key Document Review

8.1 When drafting or reviewing a document the author should consult with the sponsoring executive to determine the most appropriate date for the key document to be reviewed.

8.2 Such consideration should be cognisant of any specific requirements imposed by statutory, regulatory or professional bodies, and the likelihood of a rapidly changing context or background to the key document.

8.3 The maximum 'life' of a key document before review will be three years from the date of publication.

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Appendix 1

Key Document Approval Form

This form should be completed by the document author and sent to the Corporate Governance Department for approval before production of the document.

| | | | | |
|--|-----------------|---------------------------|---------------------------|--------------------------|
| 1. Key Document Category: | New | <input type="checkbox"/> | Existing | <input type="checkbox"/> |
| 2. Key Document Type: | Choose an item. | | | |
| 3. What is the reason for developing a new key document? | | | | |
| • Improve or standardise organisational procedures | | | | <input type="checkbox"/> |
| • In response to learning from a complaint, incident or claim | | | | <input type="checkbox"/> |
| • In response to alerts, safety notifications, Welsh Health Circulars etc | | | | <input type="checkbox"/> |
| • Re-organisation of a service/department | | | | <input type="checkbox"/> |
| • New or amended legislation | | | | <input type="checkbox"/> |
| • Other (please specify) | | Click here to enter text. | | |
| 4. What is the reason for amending an existing key document? | | | | |
| • Routine review | | | | <input type="checkbox"/> |
| • Improve or standardise organisational procedures | | | | <input type="checkbox"/> |
| • In response to learning from a complaint, incident or claim | | | | <input type="checkbox"/> |
| • In response to alerts, safety notifications, Welsh Health Circulars etc | | | | <input type="checkbox"/> |
| • Re-organisation of a service/department | | | | <input type="checkbox"/> |
| • New or amended legislation | | | | <input type="checkbox"/> |
| • Other (please specify) | | Click here to enter text. | | |
| What Key Document need replacement/update? | | Click here to enter text. | | |
| Review type required: | Full Review | <input type="checkbox"/> | Interim Review | <input type="checkbox"/> |
| 5. What will be/is the title of the key document? | | | Click here to enter text. | |
| 6. What will be/is the aim of the document? | | | Click here to enter text. | |
| 7. Which other key documents will be/are relevant to the document? | | | Click here to enter text. | |
| 8. Please indicate which of the following will need to be considered/consulted when developing/reviewing this document: | | | | |
| • Consent | | | | <input type="checkbox"/> |
| • Deprivation of Liberty Safeguards (DOLS) | | | | <input type="checkbox"/> |
| • Mental Capacity Act | | | | <input type="checkbox"/> |
| • Mental Health Act | | | | <input type="checkbox"/> |
| • Data Protection/GDPR | | | | <input type="checkbox"/> |
| • Safeguarding | | | | <input type="checkbox"/> |

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| | |
|---|---------------------------|
| • Equality and Diversity | <input type="checkbox"/> |
| • Welsh Language | <input type="checkbox"/> |
| • Patient Safety and Concerns | <input type="checkbox"/> |
| • Health and Safety | <input type="checkbox"/> |
| • Risk and Regulation | <input type="checkbox"/> |
| • Workforce and Development | <input type="checkbox"/> |
| • Information Governance | <input type="checkbox"/> |
| • Financial | <input type="checkbox"/> |
| • Business Continuity/Emergency Planning/Major Incident | <input type="checkbox"/> |
| • Other: | Click here to enter text. |
| 9. Who will be/is the sponsoring Executive Lead for this key document? | Click here to enter text. |
| 10. Lead Author Details: | |
| Name: | Click here to enter text. |
| Job Title: | Click here to enter text. |
| Email Address | Click here to enter text. |

| | | | |
|--|-----------------------------|--------------------------|-----------------------------|
| For Use by Corporate Governance: | | | |
| a. Date Received by Corporate Governance | Click here to enter a date. | | |
| b. Permission to develop key document given? | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Full or Interim Review approved: | Choose an item. | | |
| d. If NOT permitted why? What actions must author take to gain permission? | Click here to enter text. | | |
| e. Approved title and reference number for NEW Key Document | Click here to enter text. | | |
| f. Identify any other external or UHB Key Documents to be signposted/referenced in the new/reviewed key document | Click here to enter text. | | |
| g. General Advice and follow up actions: | Click here to enter text. | | |
| Name of Approver: | Click here to enter text. | | |
| Job Role: | Click here to enter text. | Date Approved: | Click here to enter a date. |
| Date that Approval Form Returned to Author: | Click here to enter a date. | | |

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Appendix 2: Example of approving Committee/ Group

| Example Subject Areas | Approving Body | Sub groups / committees |
|--|------------------------------|--|
| Corporate Governance Counter Fraud Financial Governance Capital | Audit & Assurance | Finance & Performance Digital Health & Intelligence IMT Capital groups |
| Employee Wellbeing and Stress Environmental Management Food Safety and Hygiene Smoking | People & Culture | Health & Safety Sub-Committee Policy sub group |
| Clinical Governance / Patient Experience / Quality and Safety Consent to Examination or Treatment Nutrition and Catering Patient and Public Information Mental Capacity related policies Mental Health Act related policies | Quality, Safety & Experience | Mental Health Future Hospitals Clinical Boards (QSE Groups) |
| Equality, Diversity and Human Rights Fire Policy Fundraising and Investment Policies Major Incident Plan | The Board | Board of Development Board of Trustees Charitable Funds Senior Leadership Board (SLB) Sustainability Programme Board (SPB) |

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Appendix 3

TEMPLATES FOR DOCUMENTS

The template is designed for use when developing policies, procedures and other written control documents. It may not be suitable for all documents but any deviation will be agreed with the Head of Corporate Risk and Governance. Documents should be formatted in line with Corporate Style as follows:

| | |
|--|--|
| Electronic format | Development - Microsoft Word Publishing - PDF Read only (this will be arranged by the Head of Corporate Risk and Governance after the Policy reference number has been added. |
| Document Style | Corporate Policy Template Corporate Procedure Template Employment Policy Template Employment Procedure Template |
| Audit trail | Record information regarding consultation during development. |
| Body text | Arial 12 |
| Headings | Arial 12 (Lower Case) |
| Tables and charts | Arial (size as appropriate) |
| Flow charts | Use Standard Flow Chart Symbols where possible |
| Use of bold | Headings only or to emphasise text |
| Alignment | Left Justified |
| Line spacing | Paragraphs – Single |
| Paragraph spacing | One line between paragraphs and section headings |
| Underlining | None |
| Contents page Contents page if >3 pages | As template Use judgement - help reader to find relevant information more easily |
| Staff Names | Use titles only. No names |
| Logo | Use UHB logo as incorporated in corporate template |

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| | |
|---------------------|---|
| Headers and footers | Arial 9 |
| Margins | Top and bottom of page 2.54 cm, sides 3.17cm |
| Document Title | To be included in the header on every page after first page |
| Page numbering | To be included in the header on every page after first page. It will include the page number and total number of pages (page x of x) |
| Bullets | <ul style="list-style-type: none"> • Use standard bullets only, as they do not always format across different systems |
| Abbreviations | State in full in first usage with abbreviation in brackets |
| Printing | A4 / double sided |
| Hyperlinks | <p>Hyperlinks should be considered for use in key documents when this will reduce the volume of a document or in any other way improve the reader's experience and understanding.</p> <p>However, consideration should be given to the anticipated longevity of a link to a site external to C&V UHB. If it is assessed that a link has reasonable potential to change it should not be used. All hyperlinks should be preceded or superseded with a full reference to the external information source to enable access if the hyperlink fails.</p> <p>Hyperlinks in Approved Documents: Authors are responsible for ensuring the accuracy of hyperlinks to external sites when submitting approved documents to Corporate Governance for publishing. If hyperlinks to existing C&V UHB published key documents are required these will be inserted by the Corporate Governance Team prior to publishing; authors should clearly indicate which key documents require this action.</p> |
| Referencing | All reference material should be listed in full at the end of every document in Harvard style. |

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| | |
|-------------------|--|
| Glossary of terms | <p>All documents need to be user friendly. They will be read by staff and members of the public. Therefore all necessary abbreviations, technical terms, jargon and specific wording must be clearly explained to the reader.</p> <p>Where possible always use plain English. Information to help with this is available on the Plain English Campaign web site.</p> |
| Version Control | <p>Reference Number will be provided by the Corporate Governance Department. Documents to state 'Draft' as watermark whilst in development together with version number of draft e.g. Draft 1.</p> |

DRAFT

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APPENDIX 4

Audit and Tracking of Policies

About AMaT

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Auditing is a vital part of healthcare, helping to improve patient care, manage risk, and comply with reporting requirements. But it is also time-consuming, labour-intensive, and often slow to deliver results and actions.

AMaT was created with NHS clinical audit teams to give you more control over your audit activity and to provide real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts.

AMaT is easy to implement, and simple to use. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.


AMaT is intuitive and perfectly aligned with our processes whilst being designed around a dashboard system, which means the results of your audit and improvement data can be seen at a glance in easy-to-read graphical presentations.

Whether you need to share audit results trust-wide, or tailor them for specific specialities and divisions, AMaT will help you increase awareness and education throughout your organisation.

The dashboards provide clear visuals for your audit data, giving you real-time insight into how well you're performing, and providing the ability to react swiftly to implement change and improvements where necessary.

AMaT is intuitive and simple to use, it works seamlessly with all elements of your audit process: upload files from other sources; create pro formas and questionnaires; send instant email notifications to co-workers for their input; submit reports to managers, and generate completion certificates - from your desktop or mobile device.

The AMaT Module that policies are stored under is Inspections Recommendations and Actions



Inspections

X

AMaT enables organisations to manage all recommendations, information requests, actions and evidence before, during and following an inspection.

AMaT intrinsically provides the following benefits for inspections:

- ✓ Instant overview of the progress of all recommendations and actions
- ✓ Approval process for actions and evidence of completion
- ✓ Linking themes and regulations to recommendations
- ✓ Timely notifications and overdue alerts to ensure evidence and actions are completed



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On signing in to AMaT you will always be greeted by your own 'To Do List'

Hello, you have overdue items in your TO DO LIST.

X

Please click on the red alert triangle in the top right corner of each page to view and access your overdue items.

VIEW MY TO DO LIST

GO TO HOMEPAGE

From here you can either view listing or close to access the AMaT System

Centrally held Policies are located under Inspections Recommendations and Actions, with a sub filter on Origin by Corporate Governance

University Health Board

HOME
Dashboards
Your inspections
Inspection actions

Inspections dashboard

GENERATE PDF

Filter inspections

To filter the inspections, please use the filters provided.

Inspection origin:

Inspection type:

Action status:

Recommendation status:

Completed inspections?:

ADD NEW INSPECTION

SEARCH

CLEAR

Once Origin has been selected, click search to view all Policies, these are stored in order of policy reference i.e. UHB001

Inspections

We have found 185 inspections that match your search criteria.

| Code | Title | MD | SD | WN | PIR | Actions | | | | | | | | View |
|-------------------------------|----------------------------------|----------|----|----|-----|-------------|--------------------|------------------------------|---------|--------------------|-------------------------------|----------|-----------|------|
| | | | | | | In progress | Partially complete | Partially complete (Overdue) | Overdue | Unable to complete | Completed (awaiting approval) | Rejected | Completed | |
| Corporate Governance/2022/313 | UHB 001 - Management of Policies | 0/1 (0%) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | VIEW |
| Corporate Governance/2016/314 | UHB 002 - Data Protection Policy | 0/1 (0%) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | VIEW |
| Corporate Governance/2020/316 | UHB 003 - Child Abduction Policy | 0/1 (0%) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | VIEW |
| Corporate Governance/2021/317 | UHB 004 - MRSA | 0/1 (0%) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | VIEW |
| Corporate Governance/2014/318 | UHB 005 - Interpreter Services | 0/1 (0%) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | VIEW |

Each policy will have 1 Recommendation and 1 Action assigned to it

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Recommendation

Policy must be reviewed 3 months before expiry date

Action

- 1) Download the policy version and share with the Exec lead and Authors for review
- 2) Provide an update to the relevant Committee / Board
- 3) Once the policy is approved, upload the new policy onto AMaT and amend the action dates to carry any recommendations/actions forward

The policies on AMaT are saved as Word documents for ease of review and update

There is a Notes section within AMaT that can track all actions conducted for each Policy. All Policy correspondence is to be conducted within AMaT this will save the history of movement and reviews whilst notifying the Inspection Team members that Actions are being conducted/completed

Benefits

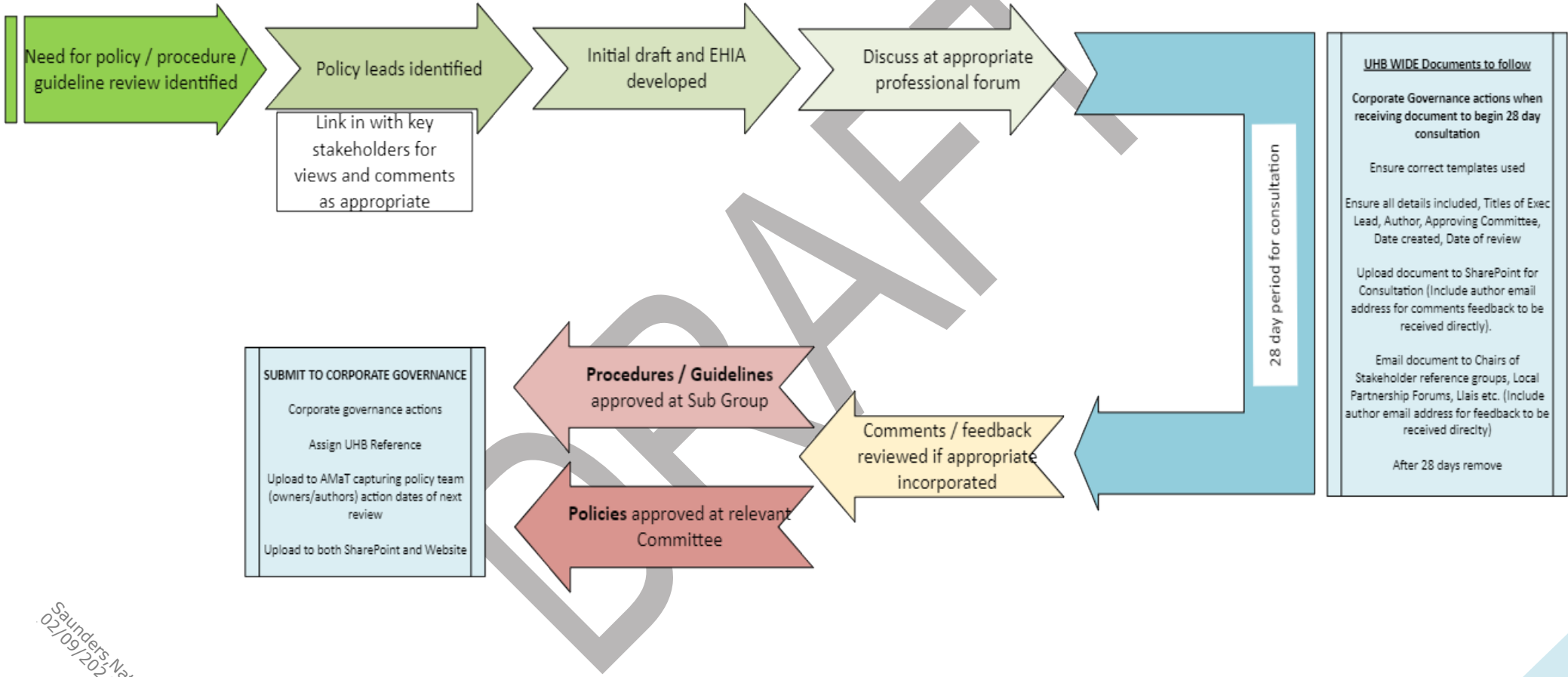
1. Increased transparency
2. Ownership retained by Author and/or Executive Lead
3. Each policy will have an Inspection Team consisting of Author/s Executive Assistant Corporate Governance officers and where appropriate Clinical Directors, Executives etc. there is no restriction to volume of users who can be assigned to manage the life of a policy
4. The Inspection Team will receive Automated Notifications when a policy is due for renew, these are set 3 months prior to review date
5. Should the 'Author' have left the Health Board when a review is required the remaining Inspection Team members will add additional members to assist the inspection team and ensure the review is conducted in a timely manner
6. A wider team action removes the onus from an individual and shared responsibility to ensure no policies are forgotten

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Appendix 5

Example flowchart of document creation (See table 1, page 9 for detailed guidance on creation and reviews)



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| | | | | | |
|--|--|---|----------|-----------------|------------|
| Report Title: | Counter Fraud Progress Report | | | Agenda Item no. | 4.1 |
| Meeting: | Audit Committee | Public | x | Meeting Date: | 03/09/2024 |
| | | Private | | | |
| Status <i>(please tick one only):</i> | Assurance | x | Approval | Information | x |
| Lead Executive: | Executive Director of Finance - Catherine Phillips | | | | |
| Report Author (Title): | Local Counter Fraud Specialist - Henry Bales | | | | |
| 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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GIG
CYMRU
NHS
WALES

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

NHS WALES

Counter Fraud Progress Report

18/06/2024 – 16/08/2024

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Saunders
02/09/2024/AM/136

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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 18/06/2024-16/08/2024

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 2024-2025, 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– (1) Market Place event has taken place and 50 new members of staff presented to.

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E- Learning – Verbal Update

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

Prevention

Local Bulletins/Alerts – (2)

- Primary care ‘phishing’ attempts to initiate payment diversion fraud. Alert issued to relevant parties.
- Alert issued in relation to patient using false details in order to obtain prescription only medication at Hospital sites.

IBURN (intelligence bulletin) – (1)

Cyber scam relating to a third-party supplier to a NHS Scotland organisation. Third-party supplier had been compromised and this led to a number of NHS email addresses also being compromised. As a result, there was a risk to NHS organisations that have had dealings with this company. Alert issued to relevant teams (Cyber Security and Finance for awareness).

FPN (Fraud Prevention Notice issued by CFA) – (0)

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. This exercise is now complete.

| Report Type | Total No. of Matches | No. Cleared |
|-------------------------------|----------------------|-------------|
| Payroll to Payroll - NI | 311 | 311 |
| Payroll to Payroll - Tel. No. | 54 | 54 |

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| | | |
|---|------------|------------|
| Payroll to Payroll - Email | 1 | 1 |
| Payroll to Pension | 132 | 132 |
| Payroll to Company Director/Trade Creditor | 116 | 116 |
| Payroll to Creditor | 190 | 190 |

Referrals

During this reporting period there have been a total of 21 referrals made to the team. 15 of these referrals have been investigated and informally resolved with 6 promoted to formal investigation as below.

Investigations

A summary of the investigations for 24-25 is provided below. At the time of reporting 12 investigations remain open and are being investigated by the team. Investigations of note will be subject to update in private session.

| Investigation Number | Investigation Subject | Date Opened | Date Closed | Outcome |
|-----------------------------|--|---------------------------|--------------------|---|
| INV/23/00079 | Staff Over Payment | CARRIED OVER - 10/01/2023 | 18/04/2024 | CCJ awarded for full amount. |
| INV/23/00096 | Overpayment of Salary - Non Starter | CARRIED OVER - 12/01/2023 | 18/04/2024 | CCJ awarded for full amount. |
| INV/23/00113 | Suspected Overtime Fraud (EW) | CARRIED OVER - 13/01/2023 | 18/04/2024 | Subject dismissed following disciplinary hearing, subject repaid £53.03, extrapolated fraud prevention figure £636.36 |
| INV/23/00825 | Salary Overpayment for Sick Pay | CARRIED OVER - 02/05/2023 | | |
| INV/23/01634 | Salary Sacrifice Vehicle not transferred when subject left organisation, no further deductions/payments made | CARRIED OVER - 03/08/2023 | | |
| INV/23/01696 | No Termination | CARRIED OVER - 14/08/2023 | 08/07/2024 | Payment plan commenced to repay overpayment. |

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| INV/23/02002 | Staff member stealing CD's from Omnicell | CARRIED OVER - 15/09/2023 | | |
| INV/23/02207 | Working Elsewhere whilst sick | CARRIED OVER - 12/10/2023 | 31/05/2024 | Subject interviewed under caution, no fraud found, internal disciplinary outcome of Verbal Warning due to breaches in policy/procedure. |
| INV/23/02421 | Money missing suspected stolen | CARRIED OVER - 26/10/2023 | | |
| INV/24/00102 | Working Elsewhere whilst sick | CARRIED OVER - 16/01/2024 | | |
| INV/24/00336 | Overpayment | CARRIED OVER - 09/02/2024 | | Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified. |
| INV/24/00462 | Working elsewhere whilst sick | CARRIED OVER - 21/02/2024 | | |
| INV/24/00505 | False Sickness Car Crash | CARRIED OVER - 29/02/2024 | 11/06/2024 | Investigation carried out with WAST and SWP and HGP that showed subject had been dishonest in relation to car crash. Due to the small value involved the internal enquiry continued alongside the criminal. Subject was dismissed from employment at a disciplinary panel. This considered proportionate and not in public interest to to proceed to prosecution. Case closed. |
| INV/24/00548 | Overpayment | CARRIED OVER - 05/03/2024 | 08/07/2024 | Repayment made in full |
| INV/24/00660 | Specsavers making false CPD claim to HB | CARRIED OVER - 14/03/2024 | 07/06/2024 | NFA |
| INV/24/00876 | Allegation of selling prescription medication | 09/04/2024 | 10/04/2024 | No offences identified - inaccurate intelligence |
| INV/24/00909 | dishonesty to obtain special paid leave | 09/04/2024 | 07/06/2024 | Two days leave returned via final payroll |
| INV/24/01037 | Working for agency whilst off sick with UHB | 22/04/2024 | | |
| INV/24/01016 | Obtaining free prescriptions when not entitled | 23/04/2024 | 07/05/2024 | Measures taken to prevent any future issues, no fraud identified. |
| INV/24/01024 | COVID SCAM CALL TO M of Public | 23/04/2024 | 23/04/2024 | No counter fraud issues |
| INV/24/01064 | Senior nurse allocating lucrative/inflated banded shifts to herself | 25/04/2024 | 30/04/2024 | No fraud identified, internal process issues identified recommendations made. |

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| INV/24/01117 | Altered prescription presented at pharmacy - not dispensed | 30/04/2024 | 07/05/2024 | Altered prescription presented, not dispensed, unable to prove who presented/altered prescription. |
| INV/24/01240 | Duplicate claim for Optom Services | 15/05/2024 | 07/06/2024 | Insufficient evidence to progress |
| INV/24/01254 | Fraudulent email asking for payment to be made | 16/05/2024 | 20/05/2024 | No financial loss, prevention measures put in place. Referrer suitably advised |
| INV/24/01314 | Secondary care whilst possibly not ordinarily resident in UK | 23/05/2024 | 07/06/2024 | Enquiries completed, no offences identified. |
| INV/24/01389 | Working elsewhere whilst sick | 30/05/2024 | 30/05/2024 | Enquiries completed no agency shifts completed whilst on sick leave. No fraud identified. |
| INV/24/01426 | Fraudulent email asking for payment to be made | 03/06/2024 | 05/06/2024 | No financial loss, prevention measures put in place. Referrer suitably advised |
| INV/24/01454 | Fraudulent email asking for payment to be made | 06/06/2024 | 07/06/2024 | No financial loss, prevention measures put in place. Referrer suitably advised |
| INV/24/01461 | Fraudulent email asking for payment to be made | 07/06/2024 | 17/06/2024 | No financial loss, prevention measures put in place. Referrer suitably advised |
| INV/24/01513 | Two domiciliary providers have made claims for GOS services for same patient | 13/06/2024 | 04/07/2024 | No fraud identified. Advice Given. |
| INV/24/01514 | Two claims for GOS in short space of time | 13/06/2024 | 04/07/2024 | Advice letter sent. Lack of controls in place, no offence provable. Risk work completed, steps underway to improve system. |
| INV/24/01515 | Two claims for GOS in short space of time | 13/06/2024 | 04/07/2024 | Advice letter sent. Lack of controls in place, no offence provable. Risk work completed, steps underway to improve system. |
| INV/24/01516 | Two claims for GOS in short space of time | 13/06/2024 | 04/07/2024 | No issues identified. |
| INV/24/01509 | Pharmacist dispensing cheaper drugs claiming for expensive | 14/06/2024 | 18/06/2024 | Transferred to CFS Wales |
| INV/24/01637 | Duplicate claim for Optom Services | 26/06/2024 | 04/07/2024 | No Issues Identified. |
| INV/24/1661 | Fraudulent email asking for payment to be made | 28/06/2024 | 01/07/2024 | No financial loss, prevention measures put in place. Referrer suitably advised |
| INV/24/01743 | Procurement / Theft Issues Capital and Estates | 08/07/2024 | | Enquiries completed no offence identified. |
| INV/24/01970 | Two claims within one month at two opticians | 02/08/2024 | | |
| INV/24/01971 | Two claims in one day for acute eye issues | 02/08/2024 | | |

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| INV/24/01972 | Inflated travel expense claims | 02/08/2024 | | |
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3. Significant Salary Overpayments

The new All Wales Salary Overpayments Policy requires that the Counter Fraud team review all significant salary overpayments prior the employee being informed of the issue. The Counter Fraud team have a five-day window to carry out an initial assessment of the surrounding circumstances and decide whether the matter will be formally investigated as a financial crime.

During this period 5 significant salary overpayments have been referred to the Counter Fraud team. These have all been investigated and reviewed and returned to the finance team for financial recovery. Due to the circumstances involved none have been progressed to formal investigation.

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