

Public Audit & Assurance Committee Meeting

Tue 04 February 2025, 09:00 - 11:00

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: 05.11.2024

Rhian Thomas

 1.4 Public Audit Committee Minutes 05.11.2024.pdf (8 pages)

1.5. Actions following meeting held: 05.11.2025

Rhian Thomas

 1.5 Action Log - Public Audit & Assurance (7).pdf (1 pages)

1.6. Any Other Urgent Business

Rhian Thomas

09:10 - 10:45 **2. Items for Review & Assurance (09:10 – 10:25)**
95 min

2.1. Internal Audit Progress Report including (30 MINUTES):

Ian Virgil

- Capital Systems – Substantial Assurance
- Maternity Care – Ockenden Review (Reasonable Assurance)
- Smoking Cessation (Reasonable Assurance)
- Consent Process (Reasonable Assurance)
- Mortuary Refurbishment at UHW (Reasonable Assurance)
- Interventions Not Normally Undertaken (Limited Assurance)
- Follow-up: Implementation of Health Roster System (Limited Assurance)
- Legal Services (Advisory)
- Decision Making (Advisory)

 2.1 IA Progress Report February 25 cover.pdf (2 pages)

 2.1 IA Progress Report February 25.pdf (25 pages)

 2.1a Capital Systems Final Audit Report.pdf (8 pages)

Saunders Nathan
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- 📄 2.1b Maternity Care Final Internal Audit Report.pdf (19 pages)
- 📄 2.1c Smoking Cessation Final Internal Audit Report.pdf (11 pages)
- 📄 2.1d Consent Process Final Internal Audit Report.pdf (10 pages)
- 📄 2.1e Mortuary Refurbishment Final Report.pdf (28 pages)
- 📄 2.1f Interventions Not Normally Undertaken (INNU) Final Internal Audit Report.pdf (22 pages)
- 📄 2.1g Follow-up Implementation of Health Roster System Final Internal Audit Report.pdf (17 pages)
- 📄 2.1h Legal Services Final Internal Audit Report (Advisory) response.pdf (19 pages)
- 📄 2.1i Decision Making Final Internal Audit Report (Advisory).pdf (15 pages)

2.2. Audit Wales Update (30 MINUTES):

Wales Audit

1. *Annual Audit Report 2024*
2. *Outline Audit Plan 2025*
3. *2024 Structured Assessment*

- 📄 2.2 CVUHB Audit Committee Update (February 2025).pdf (14 pages)
- 📄 2.2.1 CVUHB Annual Audit Report 2024 (Final) (1).pdf (24 pages)
- 📄 2.2.2 CVUHB 2025 Outline Audit Plan (Final).pdf (11 pages)
- 📄 2.2.3 CVUHB Structured Assessment 2024 Report (Final).pdf (42 pages)

2.3. Audit Wales Audits (15 MINUTES):

Wales Audit

1. *Urgent and Emergency Care: Flow out of Hospital – Cardiff & Vale Region*
2. *Discharge Planning Progress Update*
3. *Review of cost savings arrangements*

- 📄 2.3.1 Cardiff and Vale Regional Flow out of Hospital Report.pdf (50 pages)
- 📄 2.3.2 C&VUHB Discharge Planning Local Report Final.pdf (18 pages)
- 📄 2.3.3 C&VUHB Cost Savings Report - Final.pdf (26 pages)
- 📄 2.3.3a C&VUHB Review of Cost Savings Arrangements - Management Response.pdf (10 pages)

2.4. Procurement Compliance Report / Single Tender Actions / No PO No Pay (10 MINUTES)

Catherine Phillips

- 📄 2.4 Procurement Audit Committee Board Report - Feb 2025 v1 (1).pdf (10 pages)
- 📄 2.4a STA's reported Feb 25 (1).pdf (1 pages)

2.5. Internal Audit Tracker Update (10 MINUTES)

Matt Phillips

- 📄 2.5 Internal Audit Tracker Update Report - January 2025 Final.pdf (4 pages)
- 📄 2.5a Appendix 1 - Internal Audit Report 2022 actions 29.01.2025.pdf (9 pages)
- 📄 2.5b Appendix 2 - Internal Audit Report outstanding actions 29.01.2025.pdf (47 pages)
- 📄 2.5c Appendix 3 - AMAT Guide.pdf (8 pages)

10:45 - 10:50 3. Items for Approval/Ratification (10:45 – 10:50) 5 min

3.1. Report of the Losses and Special Payments Panel (5 MINUTES)

Robert Mahoney

- 📄 3.1 Report of the November 2024 Losses and Special Payments Panel.pdf (2 pages)
- 📄 3.1a Appendix 1 - Minutes of the November 2024 Losses & Special Payments Panel.pdf (8 pages)

10:50 - 10:50 4. Items for Noting & Information 0 min

Saunders Nathan
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4.1. Counter Fraud Progress Update

Catherine Phillips / Henry Bales

 4.1 COUNTER FRAUD PROGRESS _ PUBLIC _ COVER SHEET P4.pdf (2 pages)

 4.1a COUNTER FRAUD PROGRESS REPORT - CAVUHB PUBLIC P4.pdf (9 pages)

10:50 - 10:50 5. Agenda for Private Audit and Assurance Committee

0 min

Approval of Private Committee Minutes

Counter Fraud Progress Update (Confidential – ongoing investigations)

Health Board Salaries Overpayment Update

Health Board Salaries Underpayment Update

10:50 - 10:50 6. Any Other Business

0 min

10:50 - 10:50 7. Review & Final Closure

0 min

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

Rhian Thomas

7.2. Date and Time of the next Committee meeting:

Tuesday 20 May 2025 via MS Teams

7.3. 5 minute break prior to the Private Meeting

10:50 - 10:50 8. Declaration:

0 min

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

Saunders,Nathan
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Minutes of the Public Meeting



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

Audit & Assurance Committee

Held On 05 November September 2024 at 9:00am
Via MS Teams

[View the full meeting here:](#)

Please note that each item has been linked below so that it will start playing from that point. If you are unable to view sections, please copy and paste the link into your preferred internet browser.

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:		
Steve Betty	SB	Deputy Counter Fraud Manager
Rachel Chilcott	RC	Corporate Governance Officer
Rachel Gidman	RG	Executive Director of People and Culture
Lucy Jugessur	LJ	Deputy Head of Internal Audit (DHIA)
Sarah Lloyd	SL	Director of Operations – CD&T
Robert Mahoney	RM	Deputy Director of Finance
Urvisha Perez	UP	Audit Lead - Audit Wales
Matt Phillips	MP	Director of Corporate Governance (DCG)
Andrew Partridge	AP	Corporate Archivist & Records Management Manager
Frankie Thomas	FT	Head of Corporate Governance
Ian Virgil	IV	Head of Internal Audit (HIA)
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Henry Bales	HB	Lead Local Counter Fraud Specialist (LLCFS)
Marie Davies	MD	Interim Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance (EDF)

Item No	Agenda Item	Action
AAC 24/11/001	Welcome & Introduction (click to view) The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 24/11/002	Apologies for Absence (click to view) Apologies for absence were received. The Committee resolved that: a) Apologies were noted.	
AAC 24/11/003	Declarations of Interest The Committee resolved that: a) No Declarations of Interest were noted.	

AAC 24/11/004	Minutes of the Committee meeting held 03.09.2024 (click to view) The Minutes of the Meeting Held on the 03.09.2024 were received. The Committee resolved that: a) The draft minutes of the meetings held on 03.09.2024 were deemed to be a true and accurate record of the meeting.	
AAC 24/11/005	Actions following meeting held: 03.09.2024 (click to view) The Actions were received. The CC advised the Committee that she had not received a response to action AAC 24/08/009 which asked how successful the Health Board were at retrospectively implementing contract terms. It was noted that a response would be provided offline via email. The Committee resolved that: a) The Actions were discussed and noted.	
AAC 24/11/006	Internal Audit Progress Report: (click to view) The Internal Audit Progress Report was received. The Head of Internal Audit (HIA) advised the Committee that he would take the report as read and highlight key areas which included: - Audit Plan Delivery: it was noted that out of the 35 audits in the 2024-2025 plan, three audits had been finalised, three were in draft, ten were in progress, and twelve were at the planning stages. The HIA acknowledged the delays but assured that resources were in place to deliver the full plan. - Delays and Challenges: the HIA advised the Committee that seven audits planned for the November 2024 meeting were delayed due to a combination of internal audit resourcing issues and delays in receiving information from the Health Board. He emphasised ongoing communication with management to address those delays - Changes to the Plan: The HIA proposed removing two audits from the 2024-2025 plan: The Charitable Funds audit, due to an ongoing external review and organisational changes, and the Planned Care audit, to avoid duplication with Audit Wales' work. - New Standards: The Committee was informed about new global internal audit standards coming in January 2025, which would be adopted for public sector organisations from April 2025. It was noted that the standards would not fundamentally change Internal Audit's work but would require some adjustments, particularly in evidencing progress on audit actions. - Executive Summaries: The HIA advised the Committee that three reports had been finalised, with two receiving reasonable assurance and would be outlined by the Deputy Head of Internal Audit (DHIA) in more detail. He noted	

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that the Maternity Care Ockenden Review audit was brought as a draft due to delays in finalising the report.

The IDHIA provided further detail on the three reports which included:

- [Safeguarding Audit](#): It was noted that Internal Audit had reviewed the adequacy of systems and controls related to safeguarding across the health board and progress against the Joint Inspectorate review of child protection arrangements (JICPA).

Assurance Level provided: Reasonable assurance.

Findings: Two medium and two low findings. Issues included uncertainty about the quorum of a safeguarding steering group meeting and poor attendance from some members. Another issue was ensuring the implementation of the JICPA improvement plan actions.

The CC asked what the management response had been to the findings.

The DHIA responded that the findings and action points had been acknowledged by management and work had moved forward.

- [Specialist Clinical Board Governance Arrangements](#): it was noted that Internal Audit had reviewed governance and financial arrangements within the Specialist Service Clinical Board, including escalation processes and updates to the Health Board's Committees.

Assurance Level provided: Reasonable assurance

Findings: One high and one medium recommendation. The high recommendation was related to outdated or missing terms of reference for several groups and governance forums. The medium recommendation was about the lack of minutes, agendas, and action logs for some meetings

The CC asked if guidance could be given on the findings by the Director of Corporate Governance (DCG).

The DCG advised the Committee that an advisory piece of work was being conducted by internal audit, which focused on decision-making across the organisation.

He added that the advisory work aimed to understand how decision-making operated within clinical boards and ensured consistent frameworks and structures including reviewing terms of reference and governance arrangements to identify areas for improvement.

The Executive Director of People & Culture (EDPC) suggested that the advisory piece of work on decision-making should include a focus on learning and sharing outcomes across all clinical boards and she emphasised the importance of ensuring that all clinical boards heard the outcomes of audits and learn from them, potentially through forums like the Senior Leadership Board or the operating delivery group.

- [Maternity Care](#): The DHIA advised the Committee that the Maternity Care audit assessed the progress made by the Health Board in implementing the

	actions from the Ockenden review and ensuring compliance with its recommendations. She added that the audit was still and draft with a reasonable assurance provided. It was noted that key findings included ongoing monitoring activities related to the progress of Ockenden recommendations were limited, and responsible individuals and target dates were not always defined and the Maternity and Neonatal Oversight Group's minutes were only available for December 2023 and January 2024, making it difficult to verify whether progress was discussed in subsequent meetings. The Committee resolved that: - The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered. - The proposed adjustments to the 2024/25 plan were approved.	
AAC 24/11/007	Audit Wales Update (click to view) The Audit Wales Update was received. The Audit Lead - Audit Wales (ALAW) provided the Committee with an update on Audit Wales' activities which included: - Financial Audit Work: The audit of the 2023-24 charitable funds account was scheduled to start later in November 2024, with the Board of Trustees meeting being held on January 23rd to consider the audited accounts. The Auditor General was due to certify them on January 24th 2025. - Performance Audit Work: Several reports were in the clearance process which included: - Structured Assessment Report: Issued in October 2024 with a meeting scheduled with the Health Board Chair and DCG to discuss it. - Cost Savings Arrangement Review: Issued in draft, with a meeting scheduled to discuss findings. - Local and Regional Discharge Planning Reports: Issued in draft, awaiting management response from regional partners. - Other Reviews included: - Managing Urgent and Emergency Care Demand: At the reporting stage. - Planned Care Review: At the latter stages of fieldwork - Eye Care Services Review: Project brief issued, but the setup meeting was yet to be held - Investment into Digital Systems Review: Scoping work was ongoing. - NHS Wales Finance Data Tool: it was noted that Audit Wales had updated the tool to include data up to March 31 2024. - National Fraud Initiative in Wales 2022-23 Report: It was noted that the report summarised the period between April 1, 2022, and March 31, 2024 and that	

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	the next round was underway, with data submissions due in November 2024 and matches expected by the end of December 2024. The Independent Member – Finance (IMF) asked the ALAW if Audit Wales looked across Wales on the cost saving report, which was due to come out in January 2025. The ALAW responded that the same reviews had been done across all health bodies in Wales and so there was an option to do a summary report as well however it was noted that Audit Wales were just issuing the local reports at that moment in time. The Committee resolved that: a) The Audit Wales Update was noted.	
AAC 24/11/008	Medical Records Tracking Verbal Update (click to view) The Medical Records Tracking Verbal Update was received. The Director of Operations for CD&T (DOCDT) presented to the Committee and provided relevant information which included: • The original Medical Records Tracking Audit report was issued on January 24, 2023, with limited assurance for the tracking of acute medical records. A follow-up report in June 2023 showed progress, moving to reasonable assurance, but four actions remained open which included: - Establishing Clinical Information Management Group: This group was to be chaired by the Medical Director but had not yet been established. The DOCDT emphasised that it was a straightforward action that should be completed by November 2024. - System for Tracking Medical Records: The DOCDT chaired a Clinical Information Programme Board focused on transforming the current system and incorporating issues highlighted by the Ombudsman. It was noted that the action was partially complete, pending the establishment of the Clinical Information Management Group. - Communication Strategy: A strategy was being developed to ensure appropriate handling and transfer of clinical records. Progress included training by the PMS team, periodic reminder emails to staff, and a training package for all existing staff on their responsibilities. This action was also partially complete. - Location-Based Tracking and Monitoring: Five out of seven libraries had moved to location-based tracking. The largest library, with approximately a quarter of a million records, was still in progress. The action was ongoing and was expected to take about a year to complete. The UHB Vice Chair (UHBVC) asked about the progress towards digitalisation and the abolishment of paper records within the health board and inquired whether there was any pushback from clinicians or if the delay was due to financial constraints. The DOCDT responded that the transition to a true digital health record was still several years away and was constrained by the current systems and available technology.	

	She added that whilst there were efforts to make marginal gains with existing systems, significant investment and development were needed for a comprehensive digital transformation. The HIA added that Internal Audit would be looking at medical records in the future and would pick up on the plans for the digitalisation of records and assurance could be given that plans would move forward. The CC asked that the slides presented be shared with the Quality, Safety & Experience Committee for noting at their next meeting. The Committee resolved that: a) The Medical Records Tracking Update was noted.	
AAC 24/11/009	Procurement Compliance Report / Single Tender Actions (click to view) The Procurement Compliance Report / Single Tender Actions report was received. The Deputy Director of Finance (DDF) provided an overview of the Procurement Compliance Report. It was noted that the report detailed the monitoring of non-compliance with standard procurement processes up to the end of September 2024 and included instances of non-compliant activity and the actions taken by procurement to address those issues which included: Reminding staff of the need to follow due process and attempting to make non-compliant activities compliant retrospectively. The DDF advised that Committee that there were some areas with significant increases in non-compliance, particularly in CD&T, AWMGS, Mental Health, and PCIC and mentioned that he would remind his finance team to support those clinical boards in addressing the issues. The Committee resolved that: a) The contents of the Report were noted b) The contents of the Report were approved.	
AAC 24/11/010	Policies Verbal Update (click to view) The Policies Update was received. The DCG advised the Committee of four key priority areas of work undertaken by the Corporate Governance Team which included: - Declarations of interest, - Policies, - Trackers - Risk He elaborated on the progress and current status of policies within the organisation which included:	

	• System Transition: Policies had been transitioned to the Audit Management and Tracking (AMAT) system, which had streamlined the process and improved efficiency. • Reduction in Policies: The number of policies reduced from 529 to 427 through data cleansing and verification with policy owners. • Overdue Policies: The number of overdue policies had decreased from over 400 to 290, indicating progress but still highlighting the need for further improvement. • Automated Reminders: Policy owners now received automated reminders from the AMAT system, helping to ensure timely updates and reviews. • Efficiency and Transparency: The new system allowed for better oversight and management of policies, making it easier to track and update them as needed. It was also noted that the Corporate Governance Team were working on ensuring that the system was fully utilised and that policy owners were comfortable with using it by providing updates and training. The Committee resolved that: a) The Policies Update was noted.	
AAC 24/11/011	<u>Internal Audit Tracker Update Report</u> The Internal Audit Tracker Update Report was received. The Internal Audit Tracker Update was presented by the DCG and the Corporate Governance Officer (CGO). Key points included: • The Internal Audit tracker had been moved to the AMAT system, which is also used for policies and other regulatory inspections. • The Corporate Governance team were in the process of uploading all internal audit recommendations into the AMAT system, including recommendations from Internal Audit, Audit Wales reports, and regulatory inspections. • The AMAT system provided a dashboard that allowed users to view and update the status of recommendations. It offered transparency and ease of access for all relevant stakeholders. • The system allowed for dynamic data updates, meaning that any changes or updates to recommendations could be made in real-time and viewed by all users. • The new system was expected to improve efficiency by reducing the time and effort required to track and update recommendations. It also aimed to eliminate duplication of efforts across different departments. • The team planned to ensure that all data was fully uploaded and that the system would be used effectively across the organisation. They also aimed to provide training and support to ensure that all users were comfortable with the new system. The CGO provided a demonstration of the AMAT system, showing how recommendations were tracked and updated within the system. The CC asked about the potential for using a thematic approach to review open actions from audit reports and more specifically, recommendations that were over three years old and asked what timescale was in place to transfer all of the data over to the AMAT system.	

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	The DCG responded that it was important to focus on older open actions to ensure relevancy and emphasised the efficiency and dynamic nature of AMAT, which allowed for real-time updates and the ability to draw out data as required. He added that there were 3 trackers to transfer onto AMAT. Internal Audit, Audit Wales and Regulatory and noted that by the next Committee meeting, all of the data would be transferred. The HIA advised the Committee that the Internal Audit Team were in the process of introducing a new, slightly updated template for their reporting to the Health Board which aimed to streamline the process and focus on key areas that the Committee and the Health Board needed to be aware of. The CC concluded the discussion and asked the Committee to provide suggestions as to how it could align overdue actions and thematic reviews. The Committee resolved that: a) The progress which had been made in completing management actions that continued to be monitored and updated by Internal Audit was noted. b) The progress which had been made on transferring to the AMAT system was noted.	
AAC 24/11/012	Counter Fraud Progress Update The Counter Fraud Progress Update was received. The Committee resolved that: a) The Counter Fraud Progress Update was noted.	
AAC 24/11/013	Agenda for Private Audit and Assurance Committee i. <i>Counter Fraud Progress Update (Confidential – ongoing investigations</i> ii. <i>Health Board Salaries Overpayment Update</i>	
AAC 24/11/014	Any Other Business No Other Business was discussed.	
AAC 24/11/015	Items to be deferred to Board / Committee Medical Tracking Report to go to the Quality, Safety and Experience Committee for noting.	
	Date and time of next committee meeting 4 February 2025 via MS Teams	

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Public Action Log
Following Audit & Assurance Committee Meeting
05 November 2024
(Updated for the meeting being held 04 February 2025)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Actions					
AAC 24/11/011	Internal Audit Tracker Update	All trackers to be added onto AMAT in preparation for the next Committee meeting and data columns language to be addressed.	Matt Phillips	04.02.2025	UNDERWAY Report on 04.02.25 to update
AAC 24/11/011	Internal Audit Tracker Update	Oldest actions on the Internal Audit tracker to be addressed and reported to the Committee	Matt Phillips	04.02.2025	COMPLETED On Forward Plan for 04.02.2025 meeting
Actions referred to Board / Committees					
AAC 24/11/008	Medical Records Tracking	Quality Committee to receive the presented slides at its next meeting for noting & information	Paul Bostock	18.02.2025	COMPLETED On Forward Plan for Quality Committee

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Report Title:	Internal Audit Progress Report			Agenda Item no.	2.1	
Meeting:	Audit & Assurance Committee	Public	X	Meeting Date:	04/02/25	
		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 informing the 24/25 Opinion have been finalised since the September 24 meeting: • Capital Systems (Substantial Assurance) • Maternity Care – Ockenden Review (Reasonable Assurance) • Smoking Cessation (Reasonable Assurance) • Consent Process (Reasonable Assurance) • Mortuary Refurbishment at UHW (Reasonable Assurance) • Interventions Not Normally Undertaken (Limited Assurance) • Follow-up: Implementation of Health Roster System (Limited Assurance) • Legal Services (Advisory) • Decision Making (Advisory) The Executive summaries from the final / draft 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		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration	X	Collaboration	X	Involvement	X

Impact Assessment:

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

Risk: Yes/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 audits that provide assurance around controls and processes relating to patient safety.

Financial: Yes/No

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

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:

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee February
2025

NWSSP Audit and Assurance Services



GIG
CYMRU
NHS
WALES

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



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

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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 February Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Surgery Clinical Board - Consultant Job Plans Follow-up	Draft	Limited	Delay in receiving management actions and sign-off of draft report.
Endoscopy Unit Investment	Draft	Advisory	Delay in completing fieldwork due to complexity of subject area and number of meetings required.
Modernisation of Passenger Lifts UHW	Draft	Reasonable	Delay in completion of fieldwork due to Audit team sickness absence.
Local Data Repository	Work in Progress		Initial delay in receiving information from management. Fieldwork was on hold pending discussion with Executive lead but now re-started.
Data Quality Strategy	Work in Progress		Delay in completion of fieldwork due to availability of Internal Audit resources.

3. Outcomes from Completed Audit Reviews

Nine audit reports have been finalised since the last meeting of the Committee in November 24.

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

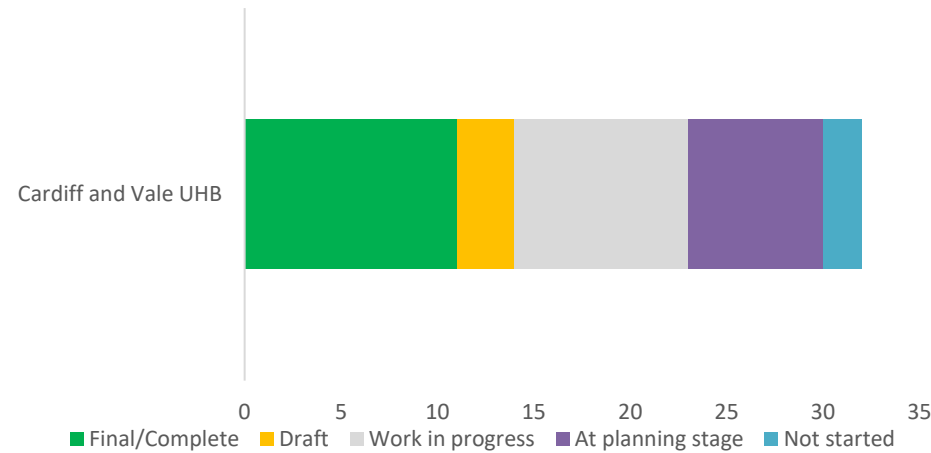
The Maternity Care - Ockenden Review audit was part of the 2023/24 plan but was not completed in time to feed into the 2023/24 annual opinion. The report was

submitted to the November meeting in draft but has now been finalised with the management actions included. The outcome will inform the 2024/25 opinion.

FINALISED AUDIT REPORTS		ASSURANCE RATING	
Capital Systems	Substantial		
Maternity Care – Ockenden Review	Reasonable		
Smoking Cessation			
Consent Process			
Mortuary Refurbishment at UHW			
Interventions Not Normally Undertaken	Limited		
Follow-up: Implementation of Health Roster System			
Legal Services	Advisory		
Decision Making			

4. Delivery of the 2024/25 Internal Audit Plan

There are a total of 32 reviews within the 2024/25 Internal Audit Plan, (including the changes highlighted below), and overall progress is summarised below.



The illustration above shows that eleven audits from the 2024/25 plan have been finalised so far this year and three others have reached the draft report stage.

In addition, there are nine audits that are currently work in progress with a further seven 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. Both audits have now been finalised 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 audit of the Hosting of the Substance Misuse is proposed for removal from the plan due to imminent changes to the Planning Executive portfolio and departure of the lead manager. The removal was supported by the Executive Director of Strategic Planning.

The follow-up audit of Decarbonisation has been proposed for deferral to the 2025/26 plan due to the recent change in Executive lead and time required for actions to be developed and implemented. The deferral is supported by the Executive Director of Finance.

The audit of the Occupational Health Service is proposed for deferral to the 2025/26 plan due to current pressures on the team around a move from UHW to Woodland House and staff shortages. The deferral is supported by the Executive Director of People & Culture.

6. Development of the 2025/26 Internal Audit Plan

Meetings are being held with the Health Board's Executive Directors, Chief Executive, Chairman and Audit Committee Chair during February to discuss potential areas for inclusion within the 2025/26 Internal Audit Plan.

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

7. Updated Report Template

As part of the Audit & Assurance Services' IMTP objectives for 2024/25, one objective focused on our reporting process/template as we recognised changes in reporting formats across the public sector, which included reviewing Welsh Government Internal Audit's new template. Following a period of review and consideration in the Service, a new template has been agreed, which ensures compliance with both the current Public Sector Internal Audit Standards (PSIAS) and Global Internal Audit Standards being implemented from January 2025 (replacing the PSIAS from 1 April 2025).

This template will be operational across all NHS Wales organisations from 1st October 2024. However, reports that were in the process of being developed for on-going reviews will be in the old format. There may also be instances where this template may not be appropriate e.g. advisory / follow-up reviews, and we will adapt our report accordingly.

The key changes in the new template are summarised below:

- Report layout is now landscape;
- Reasonable assurance is now a lighter green assurance rating instead of yellow;
- Low risk recommendation has been removed and any opportunities for enhancement, that do not impact internal control, will now be noted to management as part of debrief meetings/correspondence;
- Executive Summary has expanded to capture key narrative for first glance of the key matters from the review;
- New Findings and Agreed Action Plan section – Includes an overview of the findings by each agreed objective with a key finding but no recommendation section; our approach to agreeing management action has changed where we will meet and agree the management response with the auditee. There is a new section to record what evidence we expect to see to support implementation. We have also added a Theme section which will classify what the key finding relates to and correlates to the Executive Summary page – Summary of Management Actions section.

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8. Final Report Summaries

8.1 Capital Systems

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Audit Plan. Capital systems coverage during 2024/25 focused on the development of the Health Board's new construction framework. The framework has been designed to adopt NEC4 contracts and includes contractors by lots for building work, based on scheme value; whilst Mechanical, Electrical and Asbestos are shown independently.

The review covered appropriate determination of lots, the selection of contractors including review of due diligence and the appropriateness of specific arrangements for monitoring of framework contractors including KPI's.

It was agreed that the initial operation of the framework was outside of the scope of this review.

Overview

The framework demonstrated a scoring methodology that reflected not only value, but also acknowledged milestones, time risk allowance and critical path considerations among other metrics. The framework also described processes that should be followed for awarding of emergency works, rotational works, and mini competition.

We have concluded reasonable assurance on this area due to the strong due diligence processes used to select contractors, and the significant improvements over the previous framework that have increased the protection provided to the Health Board by the framework, such as inclusion of quantitative and qualitative scoring, KPI monitoring of contractors and termination clauses.

The framework is sensibly designed to allow smaller works to be undertaken using the framework contract (which has the necessary NEC clauses in it) without the need for a separate NEC contract which minimises the risk to the Health Board, whilst expediting the time taken to get underway on smaller urgent works.

It was noted in developing the framework that the Health Board sought advice from NWSSP Procurement Services and NWSSP Legal Services and sought direction from the Welsh Government in developing the framework.



An assurance rating of substantial was determined in relation to this review.

The matters requiring management attention include:

- A framework policy document was not yet in place; however, it was noted that the Capital Manual was in the process of being updated to reference the new framework.
- The review length of the framework necessitates "future proofing", including review of whether the framework has been suitable for the Health Board and contractors.
- Four of thirty framework contracts sampled were not sealed after the commencement, however confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Financial Credit Scoring should be undertaken on framework contractors and Group parents or owners on an annual basis,
- Signposting to relevant policies and owners should be added to the PowerPoint guide to the framework,

- Anto-collusion clauses should be used in future contracts which do not have separate NEC contracts.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Governance - A review of the development process to review assessment, approval and appropriate notification of the adoption of the framework.	1	Reasonable
2 Selection and Appointment – To ensure the appropriate application of Standing Order, Standing Financial Instructions, and national and local procurement policies in the selection and appointment of contractors to the framework.	2, 3	Substantial
3 Value for Money and Award – To ensure that there is an appropriate assessment of value for money and the application of appropriate competitive tender/quotation arrangements within the framework.	4	Substantial
4 Approvals - That roles and responsibilities and approval requirements are adequately defined, and that procurement and contract strategies are clearly communicated and approved.	5	Reasonable

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8.2 Maternity Care – Ockenden Review

Purpose

The overall objective of this audit was to assess the progress made by the Health Board in implementing the actions from the Ockenden review and ensuring compliance with recommendations.

Overview

We have issued reasonable assurance on this area.

We were able to evidence that a number of recommendations from the Ockenden report had been implemented. However, status updates were not being made on the progress of implementing the remaining recommendations. The matters requiring management attention include:

- Reviews of action plans and associated ongoing updates.
- Reporting of details in relation to the progress on the implementation of recommendations to the Maternity and Neonatal Oversight Group.

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

Report Opinion

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

Assurance summary¹

Objectives		Assurance
1	The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions	Reasonable
2	Appropriate governance arrangements in place which provide effective oversight of the implementation of the Ockenden report recommendations	Reasonable
3	Regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees	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	Action plan reviews and updates	1,2	Design	Medium
2	Progress Reporting on the recommendations	2,3	Operation	Medium

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8.3 Smoking Cessation

Purpose

To undertake a review of hospital based Smoking Cessation services, and the processes and actions being taken to achieve public health targets in relation to smoking cessation within Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Health Board provides a hospital Smoking Cessation Service that can be accessed by staff, patients and family members who want support in giving up smoking. It offers a number of strategies and approaches which are undertaken in partnership with the NHS Wales' 'Help Me Quit' programme and services.

The Welsh Government produced 'A smoke-free Wales: Our long-term tobacco control strategy' in July 2022 with its long-term plan towards a smoke-free Wales by 2030, and NHS Wales has a Performance Measure of "percentage of adult smokers who make a quit attempt via smoking cessation services – Target = 5% annually". This is reported as part of the Health Board's Integrated Performance Report (IPR), and the hospital Smoking Cessation Service plays a key role in helping to achieve this strategy.

There is also a NICE guidance in place, which was last updated in 2023: 'Tobacco: preventing uptake, promoting quitting and treating dependence (NG209)' and this covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are ready to stop in one go.



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

- A review of the Hospital Smoking Cessation Service needs to be undertaken to establish if it is appropriately resourced to fully deliver its mandate.
- There is currently an absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives

Related Findings

Assurance

1	Structures and processes are in place to facilitate and deliver smoking cessation services within the Health Board and to the Cardiff and Vale population.	1	Limited
2	Documentation informing patients about smoking cessation education, advice and access to support services is available within hospital wards and other relevant clinical areas.	2	Limited
3	Patients current smoking status is recorded/updated within their clinical records upon accessing clinical services, and relevant support/referral offered.	-	Reasonable
4	Plans are in place, and are being progressed, to ensure that public health targets in relation to smoking cessation can be met.	-	Substantial
5	The Health Board is able to show that it complies with NICE guidance on smoking cessation and supports the Welsh Government's 'A smoke-free Wales: Our long-term tobacco control strategy'.	-	Substantial
6	Smoking cessation progress activity can be evidenced and is subject to regular reporting to the Health Board and other stakeholders.	-	Substantial

8.4 Consent Process

Purpose

The review of the Consent Process operating was completed in line with the 2024/25 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Welsh Government issued a revised Welsh Health Circular (WHC) '2023/021: Guide to Consent for Examination or Treatment' in August 2023 which replaced the previous WHC 2017/036. The new Circular sets out consent in the context of the framework of the Duty of Quality. It also brings together in one place links to materials, guidance and training information developed and promoted by the NHS Wales Welsh Risk Pool, to support NHS organisations in Wales to approach the taking of consent consistently and robustly. The Circular has an action that 'Health Boards need to have quality assurance mechanisms in place to ensure the continuous monitoring, review and improvement of the consent policy into practice.'

The Quality, Safety and Experience Committee approved an updated Consent to Examination or Treatment Policy on the 30 August 2023 with it being published on the Health Board's website on the 6 October 2023. The Health Board's Policy reflects the model All-Wales policy and states that Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given his or her consent. Consent will only be valid if:

- The patient has capacity to give consent;
- It is given freely and not under duress; and
- The patient has been properly informed.

Consent can be given in writing, verbally or even indicated non-verbally and it is essential in all cases that an adequate record of the consent is maintained.



We have concluded **reasonable** assurance on this area. The significant matters requiring management attention include:

- There is out-of-date and/ or non-validated consent related information detailed within the Health Board's Consent to Examination or Treatment Policy and on the Internet.
- There is a lack of agreed risk-based methodology to monitor consent compliance.
- The Health Board need to consider the efficiency and effectiveness of consent communication channels that are currently being utilised.
- Consent training required to be undertaken for all appropriate staff.
- The Consent group's governance arrangements require improvement.

Full details of matters arising are detailed within the Findings & Agreed Action Plan

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 The Health Board's Consent to Examination or Treatment Policy aligns with the Welsh Health Circular (WHC/2023/021) and has been effectively communicated to staff.	1	Reasonable
2 Staff are complying with the Consent to Examination or Treatment Policy for all patient's that are required to give consent.	2	Limited
3 Appropriate staff have undertaken the required consent training.	3	Reasonable
4 Effective quality assurance mechanisms are in place, in line with the stated action within the WHC	4	Reasonable

8.5 Mortuary Refurbishment at UHW

Purpose

The audit reviewed the delivery and management arrangements in place to progress the mortuary refurbishment project at University Hospital Wales (UHW). This was the first audit of the project.

Overall Audit Opinion and Overview

Significant unforeseen issues have been encountered at this project, which had not been factored into the original project plans. These were only identified during the survey and demolition phase, noting intrusive surveys could not be undertaken until the Mortuary service decanted, and the as-built information held by the UHB was limited for this area of the site. Unexpected issues have included floor slab thickness, extent of services within the ceilings, presence of asbestos and structural walls.

As a result, the original design has required significant re-working, delaying completion from October 2024 to February 2025, extending the construction period from an initial 34 weeks to 50 (47% increase). The impact of winter pressures on the mortuary service has necessitated the procurement of additional temporary capacity to cover this period.

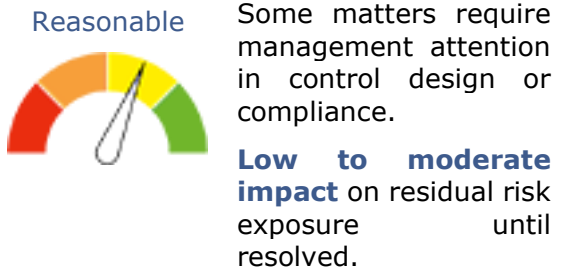
Costs have similarly increased, from the original approved budget of £3,385m, to a current forecast £4,308m (27%). An initial addition of £330k was added to the project budget from discretionary capital funds in May 2024, based on forecasts at that time. At the time of reporting, a further £593k requirement had been confirmed, and the UHB was liaising with Welsh Government to discuss the potential funding of the total £924k forecast overspend. Management advised that support from discretionary capital has been agreed, should WG funding not be approved, to enable continuation of the works.

Whilst noting the significant time and cost pressures at the project, the application of robust management controls in key areas such as risk management, contractual changes and cost control have been evidenced.

The significant matter arising at the project is:

- The documenting and sharing of lessons learned to ensure future projects benefit from the experience and learning from this project. This should encompass consideration of why the issues encountered at this project were unforeseen, and how this risk will be mitigated at future projects.

Report Classification



Assurance summary ¹

Assurance objectives	Assurance
1 Project Performance	Limited
2 Governance	Reasonable
3 Financial Assurance	Reasonable
4 Technical Assurance	Reasonable
5 Advisers	Reasonable
6 Change Control	Reasonable
7 Quality Assurance	Substantial

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

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

Acknowledging that the issues occurring at the project could not have been reasonably foreseen by the project team during the planning stage, with robust management controls evidenced in responding to the escalating costs, an overall **Reasonable Assurance** has determined at this time.

Recognising that the Draft Report was issued for management attention in October 2024, management indicated in their responses that the majority of issues raised within this report had been addressed at the time of issue of the Final Report.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Finalisation and approval of the updated Capital Projects Manual.	2	Design	Medium
2	Increased scrutiny of project delivery at the Acute Infrastructure & Sustainability Capital Programme Board.	2	Operation	Medium
4	Improved accuracy of financial reporting to Welsh Government.	3	Operation	Medium
5	Appropriate signing of contracts in line with Standing Orders.	4	Operation	Medium
6	Assurance that appointed advisers hold appropriate insurances.	5	Operation	Medium
7	The documentation and sharing of lessons learned from the delivery of this project.	6	Operation	Medium

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8.6 Interventions Not Normally Undertaken

Purpose

The overall objective of this review was to determine if there are effective arrangements and processes in place to support consistent application of Interventions Not Normally Undertaken (INNU) across the Health Board.

Overview

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

- The Health Board does not currently have a complete set of Hospital Health Pathways in place to aid consistent application of the INNU policy.
- INNU policy only covers some of the interventions which Welsh Government considers should be covered.
- Lack of concise evidence on patient files to support the need for an INNU to take place meant we were unable to undertake testing to ensure compliance with the policy.
- Issues have been identified in relation to the completeness of the INNU monitoring report in place.
- Regular and effective review of the underlying data does not take place.
- Regular and appropriate INNU monitoring updates are not provided to the Quality, Safety and Experience Committee.

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

Report Opinion

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives	Assurance
1 Policy and procedures are in place	Limited
2 The correct process has been followed to support INNU decisions	Not assessed
3 'Do-Not-Do' interventions are not undertaken	Substantial
4 Compliance against the policy is adequately monitored and reported	Limited

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	Clinical Pathways require updating	1 Operation	High
2	The updated IPFR policy is not available on the Health Board's SharePoint and public website	1 Operation	Medium
3	INNU report issues	2 Operation	Medium
4	Lack of clear evidence to support interventions taking place	2 Design	High
6	There is no effective INNU monitoring mechanism in place	4 Operation	High

8.7 Follow-up: Implementation of Health Roster System

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Implementation of Health Roster System (CVU 2324-09) review that was reported as part of our 2023/24 work programme.

Overview of findings

Management have made some progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the nine recommendations made, five of them have been closed, including one of the high priority recommendations. There is a Safecare dashboard in place which records the Safecare compliance for day and night.

One recommendation is partially complete with the high recommendation having moved down to low.

The remaining three recommendations, with two highs and a medium priority, have not moved. Whilst we can see some actions have been implemented, the underlying issues have not been addressed as there are still a considerable number of rosters not being produced on a timely basis. In addition, rosters are not being consistently verified and finalised. The auto-rostering functionality uptake has improved but is still below the Health Board's target.

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Follow-up Report Classification

		Trend
Limited 	Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.	

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Rostering procedure requires updating	Low		Closed
2	Roster process is not timely	High		High
3	HealthRoster system segregation of duties	Medium		Closed
4	Auto-rostering functionality uptake	Medium		Medium
5	Annual leave requests	Low		Closed
6	Annual leave interface	Low		Closed
7	Incorrect working hour balances	High		Low
8	Roster verification and finalisation	High		High
9	Safecare census missing patient data	High		Closed

8.8 Legal Services

Purpose

To assess the current processes operating within the Health Board around the use of legal services with specific focus on current levels of expenditure, funding arrangements and approval/oversight of legal advice requests.

Overview

As this is an advisory review no assurance rating is provided. We identified a number of internal control deficiencies relating to the following:

- The Health Board’s model for requesting and approving legal service expenditure makes it difficult to provide assurance that quality and value for money is being achieved.
- Whilst the legal spend budget sits within the Corporate Governance Team our findings indicate that Clinical Boards and Corporate Services have developed localised arrangements for requesting and approving legal services within their budgets.
- The arrangements in place for requesting and approving legal spend need to be clearly defined within a Standard Operating Procedure and communicated to all staff as our findings indicate that some Clinical Boards and Corporate Services have developed localised procedures and are often operating in silos.
- The legal spend budget for the Health Board, as at September 2024 consisted of a £117k overspend with 5 months of the year remaining suggesting a larger overspend is likely.
- Financial and operational data concerning legal service use is available however it is not being compiled and shared for reporting purposes. There is a lack of sharing of lessons learnt and legal advice across the Health Board and this could result in duplication of efforts and saving inefficiencies.
- The external solicitor hourly rates published on the Health Board’s intranet (within the Corporate Governance page) relate to the older National Procurement Framework contract “NPS-PS-0001-14” which ended in 2019 and have been superseded by the new Legal Services by Solicitors Framework (NPS-PS-000-000102).

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Report Classification

Assurance
not applicable



Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate:

- 1 Legal service expenditure
- 2 Legal service funding
- 3 Authorisation and approval of legal service expenditure
- 4 Monitoring and reporting of legal service expenditure

Opportunities:

Audit
Objective

1	Development of Standard Operating Procedures and raising awareness of Legal Advice Page	1
2	Legal and Risk (NWSSP) Service Level Agreement and National Procurement Framework update	1
3	Review the suitability of the legal service arrangements model	2
4	External solicitors pricing	3
5	Financial and operational legal service data reporting and sharing across the Health Board	4
6	Financial reporting and oversight	4

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8.9 Decision Making

Purpose

To assess the effectiveness and operation of the Health Boards decision making and including a review of the Clinical Board’s terms of reference (TOR).

Overview

As this is an advisory review no assurance rating is provided. We identified a number of internal control deficiencies relating to the following:

- The Health Board’s ‘Scheme of Delegation and Earned Autonomy Framework’ is complicated and not easy to follow.
- The terms of reference (ToR) for the Senior Leadership Board (SLB) and the Clinical Boards should provide more clarity on the items that should be taken to these forums for decisions to be made, in accordance with the Scheme of Delegation and Earned Autonomy Framework.
- Clinical Board ToR should be reviewed more regularly and a standardised template put in place for them.

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Report Classification

Assurance
not applicable



Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:

1	The Health Board’s Scheme is clear and up to date.
2	Staff awareness of the Scheme
3	Decisions made within the Health Board align to the requirements of the Scheme
4	Clinical board ToR support and empower Clinical Board Directors in making decisions
5	Decisions made by Clinical Board Directors are taken in line with the requirements of the Scheme

Opportunities:

		Audit Objective
1	Review of the ‘Scheme of Delegation and Earned Autonomy Framework’	1 & 2
2	Senior Leadership Board delegation	3
3	Review of Clinical Board’s ToR and delegation	4

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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			Final Report	Reasonable	November & February
2023/24 Plan							
Health & Safety	4	People & Culture	Q1		Final Report	Reasonable	September
Safeguarding	15	Nursing	Q1		Final Report	Reasonable	November
Specialist Services CB Governance and Financial Arrangements	26	COO	Q1		Final Report	Reasonable	November
Interventions Not Normally Undertaken	17	Public Health	Q1		Final Report	Limited	February
Consent Process	29	Medical	Q1		Final Report	Reasonable	February
Legal Services	3	Corporate Governance	Q2		Final Report	Advisory	February
Capital Systems	12	Finance	Q2		Final Report	Substantial	February
Smoking Cessation	18	Public Health	Q2		Final Report	Reasonable	February
Decision Making	2	Corporate Governance	Q3		Final Report	Advisory	February
Follow-up: Implementation of Health Roster System	6	People & Culture / Nursing	Q3		Final Report	Limited	February
Surgery Clinical Board - Consultant Job Plans Follow-up	28	COO	Q2		Draft Report	Limited	May

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
Endoscopy Unit Investment	38	Finance / COO	Q2/3		Draft Report	Advisory	May
Core Financial Systems	10	Finance	Q2		Work in Progress		May
Local Data Repository	21	Digital & Health Intelligence	Q2		Work in Progress		May
Surgery CB - Governance Arrangements	27	COO	Q2		Work in Progress		May
Therapies and Health Sciences Agency and Locum Staff	31	Therapies and Health Sciences	Q2		Work in Progress		May
Data Quality Strategy	20	Digital & Health Intelligence	Q2/3		Work in Progress		May
Business Continuity Planning (Deferred from 23/24 plan)	7	Strategic Planning	~~Q1~~	Q3	Work in Progress		May
Contract Management	9	Finance	Q3		Work in Progress		May
Waiting List Management	24	COO	Q3		Planning – Final brief issued		May
Medicine CB - Acute Position Model / Same Day Emergency Care	25	COO	Q3		Planning – Draft brief issued		May
Records Management	30	Digital & Health Intelligence	Q3		Work in Progress		May
Risk Management / Board Assurance Framework	1	Corporate Governance	Q4		Work in Progress		May
Follow-up: Alcohol Standards	19	Public Health	Q4		Planning – Draft brief issued		May
Office 365 benefits realisation	22	Digital & Health Intelligence	Q4		Planning – Final brief issued		May
Follow-up: Temporary Staffing Costs	33	People & Culture / Finance	Q4		Planning – Draft brief issued		May
<i>Estates Assurance - Energy Management</i>	<i>13</i>	<i>Finance</i>	~~Q2~~	<i>Q4</i>	<i>Planning – Final brief issued</i>		<i>May</i>

Planned output.	Ref No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current Status	Assurance Rating	Planned / Actual Committee
<i>Follow-up: Estates Condition</i>	14	Finance	TBC				TBC
<i>Development of Integrated Audit Plans</i>	32	Strategic Planning/Finance	N/A				Ongoing
<i>Approved Integrated Audit Plan Assignments:</i>							
• Mortuary Refurbishment at UHW	36	Finance	Q2		Final Report	Reasonable	February
• Modernisation of Passenger Lifts UHW	35	Finance	Q3/4		Draft Report	Reasonable	May
• UHW Tertiary Tower	34	Finance	Q3/4		Planning – Final brief issued		May
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. Agreed by September AC.				
Charitable Funds	11	Finance	Proposed for deferral to the 2025/26 plan, as the service is currently going through an external review and Organisational Change Process (OCP). Agreed by November AC.				
Planned Care Programme	23	COO	Proposed for removal from the plan due to current changes in processes and personnel in this area. It is also noted that Audit Wales are doing a review of Planned Care this year. Agreed by November AC.				
Hosting of the Substance Misuse Area Planning Team and Board	8	Strategic Planning	Proposed for removal from the plan due to imminent changes to the Planning Executive portfolio and departure of the lead manager. To be agreed by the February AC.				
Follow-up: Decarbonisation	37	Finance	Proposed for deferral to the 2025/26 plan due to recent change in Executive lead and time required for actions to be developed and implemented. To be agreed by the February AC.				
Occupational Health Service	5	People & Culture	Proposed for deferral to the 2025/26 plan due to current pressures on the team around a move from UHW to Woodland House and staff shortages. To be agreed by the February 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
Safeguarding	Reasonable	Final	04/09/24	25/09/24	07/10/24	07/10/24	R
Specialist Services CB Governance and Financial Arrangements	Reasonable	Final	07/10/24	28/10/24	24/10/24	24/10/24	G
Interventions Not Normally Undertaken	Limited	Final	14/11/24	05/12/24	02/12/24	03/12/24	G
Legal Services	Advisory	Final	25/11/24	18/12/24	18/12/24	18/12/24	G
Smoking Cessation	Reasonable	Final	14/11/24	06/12/24	06/12/24	19/12/24	G
Follow-up: Implementation of Health Roster System	Limited	Final	24/10/24	14/11/24	06/01/25	07/01/25	R
Maternity Care – Ockenden Review	Reasonable	Final	19/08/24	10/09/24	20/01/25	20/01/25	R
Decision Making	Advisory	Final	06/01/25	27/01/25	16/01/25	20/01/25	G
Consent Process	Reasonable	Final	21/11/24	12/12/24	22/01/25	22/01/25	R
Mortuary Refurbishment at UHW	Reasonable	Final	03/10/24	24/10/24	23/01/25	23/01/25	R
Capital Systems	Substantial	Final	09/01/25	30/01/25	23/01/25	23/01/25	G

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	54% 7 from 13	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 14 from 14	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	62% 8 from 13	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 13 from 13	80%	v>20%	10%<v<20%	v<10%

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Assurance Ratings

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

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Capital Systems Management (Framework)

Final Internal Audit Report

2024/25

Cardiff and Vale University Health Board



Substantial Assurance

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Review Reference

SSU-CVU-2425-12

Fieldwork

October 2024 - November 2024

Executive Sign Off

23 January 2025

Audit Committee

February 2025

Executive Lead

Catherine Phillips, Executive Director of Finance

Audit Team

Huw Richards, Head of Internal Audit
Eifion Jones, Deputy Head of Internal Audit

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Executive Summary

Purpose

This audit was commissioned in accordance with the agreed 2024/25 Audit Plan. Capital systems coverage during 2024/25 focused on the development of the Health Board's new construction framework. The framework has been designed to adopt NEC4 contracts and includes contractors by lots for building work, based on scheme value; whilst Mechanical, Electrical and Asbestos are shown independently.

The review covered appropriate determination of lots, the selection of contractors including review of due diligence and the appropriateness of specific arrangements for monitoring of framework contractors including KPI's.

It was agreed that the initial operation of the framework was outside of the scope of this review.

Overview

The framework demonstrated a scoring methodology that reflected not only value, but also acknowledged milestones, time risk allowance and critical path considerations among other metrics. The framework also described processes that should be followed for awarding of emergency works, rotational works, and mini competition.

We have concluded reasonable assurance on this area due to the strong due diligence processes used to select contractors, and the significant improvements over the previous framework that have increased the protection provided to the Health Board by the framework, such as inclusion of quantitative and qualitative scoring, KPI monitoring of contractors and termination clauses.

The framework is sensibly designed to allow smaller works to be undertake using the framework contract (which has the necessary NEC clauses in it) without the need for a separate NEC contract which minimises the risk to the Health Board, whilst expediting the time taken to get underway on smaller urgent works.

It was noted in developing the framework that the Health Board sought advice from NWSSP Procurement Services and NWSSP Legal Services and sought direction from the Welsh Government in developing the framework.

An assurance rating of **substantial** was determined in relation to this review.

The matters requiring management attention include:

- A framework policy document was not yet in place; however, it was noted that the Capital Manual was in the process of being updated to reference the new framework.
- The review length of the framework necessitates "future proofing", including review of whether the framework has been suitable for the Health Board and contractors.
- Four of thirty framework contracts sampled were not sealed after the commencement of the framework, however confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.

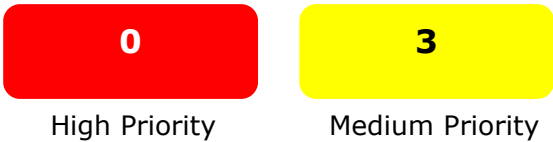
Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Financial Credit Scoring should be undertaken on framework contractors and Group parents or owners on an annual basis,
- Signposting to relevant policies and owners should be added to the PowerPoint guide to the framework,
- Anti-collusion clauses should be used in future framework contracts which do not have separate NEC contracts.

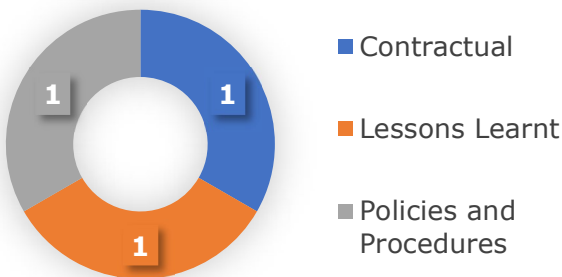
Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Governance - A review of the development process to review assessment, approval and appropriate notification of the adoption of the framework	1	Reasonable
2	Selection and Appointment – To ensure the appropriate application of Standing Order, Standing Financial Instructions, and national and local procurement policies in the selection and appointment of contractors to the framework.		Substantial
3	Value for Money and Award – To ensure that there is an appropriate assessment of value for money and the application of appropriate competitive tender/quotation arrangements within the framework.	2	Substantial
4	Approvals - That roles and responsibilities and approval requirements are adequately defined, and that procurement and contract strategies are clearly communicated and approved.	3	Reasonable

Management Actions



Themes



Risk Types

Financial Loss

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Findings & Agreed Action Plan

Objective 1: Governance

Reasonable

Overview / Summary of Observations

The new framework was developed by the University Health Board (UHB) and NWSSP Procurement Services with input from the Welsh Government.

The new framework adequately remedies the following issues with the previous framework:

- Cancellations were previously included in calculating the remaining OJEU Approval limit;
- Performance and qualitative metrics did not contribute to the ongoing retention of a contractor on the framework;
- Rotational selection of contractors was not limited to emergency works; and
- Specialist frameworks (Asbestos, Mechanical and Electrical) did not exist.

The sizes of the lots on the new framework were appropriate, reflecting the size of the most frequent capital projects. Mechanisms were also in place to enable the development of smaller urgent projects through the framework arrangements (without the requirement for standalone NEC contracts).

KPI's were designed to reflect those applied at the Building for Wales framework, which were comprehensive with a mix of qualitative and performance metrics.

The framework mechanics were clearly captured on a user-friendly PowerPoint presentation; however, it has no signposting to owners or policies for the framework. There was no framework policy currently in place. The Health Board were currently relying on the wording of the contract and KPI forms to assert governance arrangements. It was noted that at the time of the audit, the Capital Manual was being reviewed to ensure it appropriately reflected the new framework requirements.

Key Findings		Risk & Impact	Agreed Management Action
1	Framework Policy There was no framework policy in place to explain, for example: • What to do in case of contractor failure/ withdrawal. • Extenuating circumstances, such as merging of two individual framework contractors. • Responsibility and accountability for the framework • To ensure ongoing governance is outlined e.g. regular credit checking of contractor and parent companies etc. Saunders Nathan 08/05/2025 15:28:30	Risk to the Health board is increased without policies that outline current contractual requirements, risk mitigation actions and accountability.	Agreed Action: Partially Completed: The draft Capital Management Plan appropriately references use of the framework. The plan is currently being peer reviewed and will be finalised when approval can be tabled. Policy will be drawn up to outline framework usage protocol, including changes to the framework, and ownership.
			Expected Evidence of Implementation: The draft Capital Management Plan which references the policy for use of the framework will be finalised by the date below. A framework policy will be embedded in the above Capital Management Plan or independently published and circulated.
			Medium Priority
Theme: Policies & Procedures		Control Design	

Overview / Summary of Observations

72 companies identified from having previously completed work for the Health Board or operating locally and within the appropriate sectors, were originally contacted to determine their interest in the new framework. The companies that responded were initially screened to determine presence in UK and length of time in operation.

Once tenders were received, successful companies were scored using an evaluator form covering fixed metrics. Companies were subsequently financially screened/vetted utilising Dun and Bradstreet reports. Prospective companies were also required to complete Conflict of Interest forms.

Despite the requirement within Schedule 1 of All Wales Standing Financial Instruments, the framework contracts did not provide for anti-collusion clauses; in larger contracts the separate NEC contract would mitigate this issue, but an enhancement which should be considered at the next framework review would be to add clauses to the framework contracts <£25,000 who do not have a separate NEC contract but rely on NEC based clauses within the framework contract alone.

It was noted that since the launch of the framework (and the financial screening), one of the contractors on the major building framework (lot 3), had failed (September 2024). A review of the screening undertaken prior to the launch of the framework in March 2023 did not highlight any concerns with due diligence undertaken on the contractor by the Health Board.

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Overview / Summary of Observations

72 companies were approached to determine interest in the new framework – a mix of existing and new contractors for the Health Board, with a range of specialities.

Of the final 23 contractors added to the framework, 11 were not initially part of the 72 contractors invited to hear about the framework and were approached due to having recently undertaken work for the Health Board or as a result of having been on a previous framework.

There is evidence that the Health Board have struggled in the past to get responses to invitations to tender and the creation of the new framework reflected this. Day rates and profit margin varied widely between contractors placed onto the framework in the same lots as each other.

Whilst there are KPI’s in place that deter contractors on the framework from failing to submit tenders, with failure to bid on 3 consecutive tenders rendering the contractor unable to bid on the next two mini competitions, this is only enforceable if there is not a “reasonable justification” which is not specifically determined, and assumes that the contractor who has not bid on 3 tenders will be incentivised to bid on the next 2.

The Health Board have advised that they are undertaking a ‘post implementation review’ to ensure that the framework is successful from both a Health Board and contractor perspective.

Key Findings		Risk & Impact	Agreed Management Action
2	Contract rates should recognise inflation as appropriate. Due to inflation and recognition of the time value of money in relation to the length of the framework (4 years + potential 2-year extension). A lesson learnt exercise should be undertaken now that the framework is operating to determine how attractive the framework is to contractors, reviewing uptake rates, whilst also confirming that the framework is operating as intended and continues to offer Value for Money (VfM). The Health Board have advised that they are undertaking a ‘post implementation review’ to ensure that the framework is successful from both a Health Board and contractor perspective.		Agreed Action: A lesson learnt exercise will be undertaken to establish whether the framework is operating as expected and fulfils the needs of the Health Board and contractors.
			Expected Evidence of Implementation: A post implementation review document will be available for review.
		Medium Priority	Officer: Director of Capital, Estates and Facilities Date: 30 May 2025
Theme: Lessons Learnt		Control Design	

Overview / Summary of Observations

Each of the four types of sub-framework (building, mechanical, electrical and asbestos) were subject to their own framework report, which was approved by the Executive Director of Finance, the Chief Executive Officer, 2 Independent Board Members and the Chair and aligned with the Health Board Scheme of Delegation.

The framework as a whole was approved via an 'LHB Application Form to Gain Consent from the Welsh Ministers to Enter into Contracts over £1 million (v2 18.06.2013)' and an email from the Welsh Government was observed during the audit confirming approval by the Director General of Health and Social Services.

30 individual framework contracts between the Health Board and framework contractors were reviewed and all were approved by the Director of Finance and the Chief Executive Officer and aligned with the Health Board Scheme of Delegation.

Of the 30 framework contracts sampled, 4 in the largest size lot were undated (though each stated a framework end date). The contract seals were applied in April 2024, shortly after the Framework was launched. Confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.

Key Findings		Risk & Impact	Agreed Management Action
3	Framework contracts should be dated before commencement of the framework Of the 30 framework contracts sampled, 4 in the largest size lot were undated (though each stated a framework end date). The contract seals were applied in April 2024, shortly after the Framework was launched. Confirmation was received that no works contracts were let with these contractors before the framework contracts were finalised.	That work is carried out under the framework which was not covered by a contract to protect the Health Board’s liability.	Agreed Action: Completed: The Health Board have re-iterated policy in their new draft Capital Management Plan guidance to ensure that contracts are not undertaken off-framework without following appropriate Health Board procurement policies. Framework contracts will be signed, sealed and dated ahead of framework commencement and works undertaken under that framework for all future frameworks.
			Expected Evidence of Implementation: Framework contracts will be signed and sealed ahead of future framework commencement.
		Medium Priority	Officer: Director of Capital, Estates and Facilities Date: 20 January 2025
Theme: Contractual		Control Operation	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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

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

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Cardiff and Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Maternity Care – Ockenden Review Final Internal Audit Report

January 2025

Cardiff & Vale University Health Board



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Cardiff and Vale
University Health Board



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Review reference:	CVU 2324-31 Maternity Care
Report status:	Draft Report
Fieldwork commencement:	11 March 2024
Fieldwork completion:	16 August 2024
Debrief meeting:	16 August 2024
Draft report issued:	19 August 2024
Management response received:	20 January 2025
Final report issued:	20 January 2025
Auditors:	Warren Alexander – Principal Auditor Lucy Jugessur – Deputy Head of Internal Audit
Executive sign-off:	Jason Roberts – Executive Director of Nursing
Distribution:	Abigail Holmes – Director of Midwifery and Neonatal Services
Committee:	Audit & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

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Executive Summary

Purpose

The overall objective of this audit was to assess the progress made by the Health Board in implementing the actions from the Ockenden review and ensuring compliance with recommendations.

Overview

We have issued reasonable assurance on this area.

We were able to evidence that a number of recommendations from the Ockenden report had been implemented. However, status updates were not being made on the progress of implementing the remaining recommendations. The matters requiring management attention include:

- Reviews of action plans and associated ongoing updates.
- Reporting of details in relation to the progress on the implementation of recommendations to the Maternity and Neonatal Oversight Group.

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

Report Opinion

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

Assurance summary¹

Objectives	Assurance
1 The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions	Reasonable
2 Appropriate governance arrangements in place which provide effective oversight of the implementation of the Ockenden report recommendations	Reasonable
3 Regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees	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	Action plan reviews and updates	1,2	Design	Medium
2	Progress Reporting on the recommendations	2,3	Operation	Medium

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1. Introduction

- 1.1 Our audit review of Maternity Care – Ockenden Review was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 In March 2022 the second and final Ockenden report into Maternity Services at Shrewsbury and Telford Hospital NHS Trust was published. The report detailed failings within Maternity and Neonatal services that resulted in avoidable harm to mothers and babies within their care. The report outlined 89 recommendations that all Trusts/Health Boards in the UK should adhere to, to improve the quality of maternity and neonatal services. Following its publication, the Health Board carried out an immediate self-assessment of the service and of the 89 report recommendations, 45 of the requirements were already met, 27 were partially met and 17 were not met at all. The Health Board have produced an Ockenden improvement plan to address the outstanding recommendations.
- 1.3 As well as the Ockenden review, Healthcare Inspectorate Wales (HIW) undertook an unannounced inspection in November 2022. Following the review, eight immediate assurance recommendations were made, and a secondary, unannounced follow-up inspection was performed in March 2023 finding that improvements had been made in many areas, whilst also indicating that significant challenges remained and that overall, improvements were not progressing at the pace required. The most recent HIW Inspection took place in March 2024, where improvements were once again noted; favourable comments were made with respect to many areas, including improvements with staffing levels, albeit with some challenges remaining around PROMPT (Practical Obstetric Multi-Professional Training) and other mandatory training compliance rates, and multidisciplinary team working.
- 1.4 A business case was presented to the Health Board Investment Group in January 2023 setting out proposed investments and in response, the midwifery establishment was increased.
- 1.5 A Maternity Oversight Group was established and chaired by the Executive Director of Nursing and attended by the Executive Medical Director as well as Clinical Board representatives to oversee progress with the Ockenden improvement plan, HIW improvement plan and wider quality and patient safety themes.
- 1.6 The Executive Director of Nursing is the lead for this review.
- 1.7 The principal risks under consideration in the performance of this audit have related to the Health Board's ability to demonstrate compliance with recommendations made in various external reviews and reports, including the Ockenden review, Healthcare Inspectorate Wales' unannounced inspections, and the Maternity and Neonatal Safety Support Programme (MatNeoSSP) review.

2. Detailed Audit Findings

Objective 1: The Health Board has produced an action plan from the Ockenden report and effective progress is being made against the actions to ensure that all the partially met and unmet recommendations are implemented.

- 2.1 An action plan was produced in March 2022, as a response to the 89 recommendations arising from the Ockenden report. Responses to 80 recommendations had been assigned red (26), amber (22) and green ratings (32). Six of the responses did not appear to have been rated, and three recommendations were determined to be not applicable to Cardiff and Vale Maternity Services. We also found that target dates were not recorded against actions. **(Matter Arising 1 – Medium Priority)**
- 2.2 Progress has been made against the actions listed in the response to the Ockenden report. In the early stages following the report, it can be observed that additional funding had been secured for Maternity Services and several new posts were created within the department, in accordance with the recommendations of the report. Status updates do not appear to have been recorded against action plans since the initial combined assurance document was produced. Progress against actions has been confirmed during this audit by examination of reports made to the Quality, Safety and Experience Committee (QS&E), initial management responses detailed in action plans and enquiries with staff. **(Matter Arising 1 – Medium Priority)**
- 2.3 Some examples of actions which have been taken in response to the recommendations of the Ockenden report include the appointment of four new Delivery Suite Coordinators, the implementation of new training programmes and the recruitment of six band 5 neonatal nurses to support the transitional care unit.
- 2.4 Since the publication of the Ockenden report, Maternity Services across England and Wales have been subject to heightened scrutiny. In the case of Cardiff and Vale UHB, for the purposes of this audit, the reviews or reports which have been taken into consideration include;
 - Ockenden Final Report (Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust). Publication date: 30 March 2022.
 - Maternity Neonatal Safety Support Programme Cymru Discovery Phase Report (MatNeoSSP) (July 2023).
 - Healthcare Inspectorate Wales Hospital Inspection Report (Unannounced) Maternity Unit, University Hospital of Wales. Inspection date: 8-10 November 2022. Follow up Inspection date: 27 – 29 March 2023. Publication date: 21 June 2023.
 - Healthcare Inspectorate Wales Hospital Inspection Report (Unannounced) Maternity Unit, University Hospital of Wales. Inspection date: 19 – 21 March 2024. Publication date: 21 June 2024.

- 2.5 The Maternity and Neonatal Services in Wales Assessment, Assurance and Exception Reporting Tool was also examined as part of this audit, which in addition to incorporating recommendations from the HIW reports and the Ockenden report, also included actions derived from a review of maternity services at Cwm Taf Morgannwg Health Board, and reports by MBRRACE-UK.
- 2.6 The MatNeoSSP Discovery Phase Report was published in July 2023, recommending 124 improvement actions, including 59 priority areas. A spreadsheet has been produced for the purposes of tracking responses to these recommendations; compliance was indicated in the case of 40 of the identified actions, non-compliance in the case of 49, whilst 24 were designated as being non-applicable, and no response was indicated in the case of 11 recommended actions.
- 2.7 Whilst it was evident that some of the recommended actions in the MatNeoSSP Discovery Phase Report had been acknowledged and evaluated insofar as comments were listed in relation to 69 of them, target dates were not defined, responsible Officers were not designated, and no further reviews or status updates appear to have taken place. **(Matter Arising 1 – Medium Priority)**
- 2.8 The Assurance and Exception Reporting Tool was produced in May 2022 in order to collate recommendations and associated actions from the various reviews and reports that had taken place at that point. This document also utilised a red, amber, green rating system and contained 80 recommendations, including 48 designated as originating from the Ockenden report; of these 48, six were rated as red, 10 as amber, with the remaining 32 being given a green rating. Again, target dates were not recorded against actions. **(Matter Arising 1 – Medium Priority)**
- 2.9 It can be determined from sources such as responses to HIW inspection reports, that progress has been made with respect to the implementation of management actions, and following the production of the initial action plans, some degree of ongoing monitoring of this progress appears to have taken place, although the documentation available to evidence this is limited. **(Matter Arising 1 – Medium Priority)**
- 2.10 Whilst additional funding has been allocated to Maternity Services in order to support the improvements recommended by the Ockenden report, the Director for Maternity and Neonatal Services indicated that there have nevertheless been restrictions to progress in some areas due to budgetary constraints.
- 2.11 Actions arising from all inspections and reviews are now recorded in the AMaT Audit Management system. This system was implemented after the responses to the Ockenden report were collated, and as such, the actions arising from it have not been input into it.
- Conclusion:**
- 2.12 Action plans were found to have been produced in response to the Ockenden report and in response to a number of other third-party inspections and reviews. There is evidence from HIW inspection reports that effective progress has been made in

implementing the actions arising from HIW inspections, whilst other management responses to action plans and reports to the QSE Committee demonstrate that general progress is being made against recommended actions. We have provided **Reasonable Assurance** for this objective.

Objective 2: There are appropriate governance arrangements in place, which provide effective oversight of the implementation of the Ockenden report recommendations.

- 2.13 All of the management actions listed in the action plans relating to the HIW reports reviewed during the course of this exercise were found to have been assigned to individual officers who are responsible for implementing the actions at an operational level. Management actions in relation to other action plans were not assigned to individual responsible Officers. **(Matter Arising 1 – Medium Priority)**
- 2.14 Governance arrangements have been strengthened by the appointment of the Director for Maternity and Neonatal Services, who maintains responsibility for ensuring that the actions reviewed as part of this audit are implemented and that progress in these areas are monitored.
- 2.15 Regular reports have been made to the Quality, Safety and Experience Committee and the Board, although these have not always contained sufficient detail to facilitate effective oversight in respect of the Maternity Services reviews because action plans and tracker documents have not been regularly updated. **(Matter Arising 2 – Medium Priority)**

Conclusion:

- 2.16 Governance arrangements were generally found to be satisfactory, and a clear reporting structure is in place. Responsibility for the implementation of management actions arising from the various reviews has not always been clearly assigned. We have provided **Reasonable Assurance** for this objective.

Objective 3: There is regular reporting and scrutinisation on the progress of implementing the recommendations to appropriate Groups and Committees within the Health Board.

- 2.17 The Executive Nurse Director reports on matters which relate to Maternity Services to the Quality, Safety & Experience Committee and directly to the Board. We examined the QSE Committee minutes since the initial response to the publication of the Ockenden report, and it is evident that the status of Maternity Services has attracted significant attention from the Committee. Initially, a high level of detail was included in the updates, which specified the Health Board's level of compliance with the recommendations from the Ockenden report and from other reviews, but similarly detailed ongoing progress reports do not appear to have taken place. **(Matter Arising 2 – Medium Priority)**

- 2.18 A maternity thematic review report was made to the QSE Committee in October 2023. This report made direct reference to the Ockenden report and included details of progress relating to some areas encompassed by the report's recommendations. However, the position statement of compliance against all recommendations does not appear to have been updated since a self-assessment exercise was carried out immediately in response to the Ockenden report.
- 2.19 A Maternity and Neonatal Oversight Group was formed, initially in order to co-ordinate responses to the Ockenden report. The group convenes monthly, and its attendees include the Director for Maternity and Neonatal Services and the Executive Director of Nursing. It has not been possible to determine the level of information reported to and discussed within this group. Minutes from December 2023 and January 2024 were examined, and no direct reference to the Ockenden report or the overall position with respect to the associated actions had been documented. **(Matter Arising 2 – Medium Priority)**

Conclusion:

- 2.20 There was little evidence to confirm that progress is being monitored via the Maternity and Neonatal Oversight Group. However, there was evidence of some progress updates being provided to the QSE Committee. We have provided **Reasonable Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Action Plan Reviews and Updates (Design)		Impact
Whilst there is evidence to support that progress has been made with respect to implementing actions specified by the various external reviews. It appears that ongoing monitoring activities have been limited. The Red, Amber, Green analysis of the Ockenden Report’s recommendations demonstrated that the Health Board was aware of the recommendations and the overall level of compliance in relation to them. The analysis did include prospective actions where shortcomings in compliance were identified, but responsible individuals were not specified, and target dates were not defined. These actions, amongst those arising from several other reviews and reports, were carried forward into a Assurance and Exception Reporting Tool, but this was not documented in the original action plans, and therefore the audit trail from the original action plans is incomplete. An analysis of the improvement actions recommended by the MatNeo SSP Discovery Phase Report was produced, but some actions were not directly addressed and status updates have not taken place. Additionally, responsible individuals were not designated and target dates were not defined.		Potential risk of: Maternity Services are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports.
Recommendations		Priority
1.1	Action plans relating to the reviews and reports which were incorporated into the combined assurance document should be reviewed. Status updates should be recorded against all actions and actions should be closed where appropriate. In cases where actions are carried forward to another action plan, this should be recorded in the original action plan, including reference details of the superseding action.	Medium
1.2	It should be assured that target dates are defined and that responsible individuals are designated in respect of each agreed action of the Assurance and Exception Reporting Tool. In cases where recommended actions are not agreed, information to show that the recommendation has been considered should be recorded.	Medium

1.3	Action plans should be regularly reviewed in accordance with a prescribed schedule, and in response to progress milestones being achieved. Status updates should be entered against each action and timescales should be recalculated where appropriate.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	Review the Audit Management and Tracking (AMaT) system to ensure all action plans relating to the reviews and reports which were incorporated into the combined assurance document are present, enabling appropriate monitoring of required actions and increased oversight.	10/02/2025	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)
	In the event that outstanding action plans as detailed above are not already inputted into the AMaT system for the purpose of tracking/ oversight, this should be rectified with immediate effect.	10/02/2024	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)
	Review the Inspections/ Inspection Actions* as detailed above via the AMaT system during the <i>Midwifery and Nursing Senior Leadership Board</i> meeting ensuring that the following details are confirmed with the attending Senior Management Team;	10/02/2025	Senior Management Team (Children and Women's Clinical Board)
	<i>Appropriate allocation of person responsible for action, Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions, Appropriate proposed timeframe for action completion, Evidence required for action completion, Progress Status.</i>		
	If it is identified that reallocation of an action to an increasingly suitable responsible person is required, this should be done with immediate effect to further support action completion. This may be required as a result of role changes.	10/02/2025	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)
	Where possible/ applicable, status updates can be advised during the Midwifery and Nursing Senior Leadership Board meeting with further superseding actions	10/03/2025	Senior Management Team (Children and Women's Clinical Board)

	confirmed to support Inspection recommendation completion if required. These superseding actions should be detailed for monitoring purposes within the Nursing and Senior Leadership Board meeting minutes, as well as noted on the relevant Inspection Action via the AMaT system. In the event of achieved action completion, evidence to support this should be provided to the Risk and Governance Team for upload to the AMaT system if the individual does not feel confident to do this. AMaT user training has already been implemented by the Cardiff and Vale University Hospital Clinical Audit Team during the Directorate Clinical Governance Day on the 7th February 2024. Bespoke AMaT training is arranged on request by the Risk and Governance Team. Outstanding Inspection Actions should form a part of a formalised Midwifery and Nursing Senior Leadership Board meeting agenda, and this should be revisited on a monthly basis as a minimum. This is proposed as an ongoing rolling action. In the event of further action plans resulting from subsequent external reviews, these should be inputted into the AMaT system to support contemporary monitoring and oversight. In view of this being a prospective action, a Target Date for this cannot be stipulated. <i>*Please note that the terms action plan and Inspections/ Improvement Action are used interchangeably due to the terminology used by the AMaT system.</i>	10/03/2025 N/A N/A	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife) Hannah McLoughlin (Clinical Governance and Risk Lead Midwife) Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)
1.2	It should be noted that when inputting Inspections/ Inspection Actions into the AMaT system, it is a system requirement to allocate a <i>Responsible Person</i>, to assign a <i>Due Date</i> and confirm an <i>Action rating</i>. This is, therefore, a forced function in the context of AMaT Inspection publications. The below actions are posed to further support outstanding Inspection Action completion.		

Review the Inspections/ Inspection Actions via the AMaT system during the Midwifery and Nursing Senior Leadership Board ensuring that the following details are confirmed with the attending Senior Management Team; - <i>Appropriate allocation of person responsible for action,</i> - <i>Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions,</i> - <i>Appropriate proposed timeframe for action completion,</i> - <i>Evidence required for action completion,</i> - <i>Progress Status.</i> Once Inspection Actions are assigned to a responsible person, the individual will be notified of this automatically by the AMaT system via email. In the event of Inspection Action reallocation, the Risk and Governance Team contact the relevant individual to advise them of this and the reason for the allocation out of courtesy. Once reassigned via the AMaT system,	10/02/2025	Senior Management Team (Children and Women's Clinical Board)
In the event of pre-existing Inspection Actions which are locally considered to be unachievable, not based in evidence or non-applicable in the context of contemporary practice, a narrative detailing the justification for not proceeding with this should be inputted into the AMaT system Inspection Action Comments/Updates. The Progress status should then be progressed to Unable to complete/ Rejected dependent upon the individual action.	N/A	Senior Management Team (Children and Women's Clinical Board)
The decision not to be proceed with an Inspection Action should be a collective decision made by the Senior Management Team in conjunction with the Quality and Safety Team. Where able, alternative Inspection Actions should be identified/ implemented to support the Inspection recommendation.	N/A	Senior Management Team (Children and Women's Clinical Board)
In the event that Inspection Actions cannot be achieved, consideration should be given as to whether this poses a risk of harm. If a risk of harm is identified attributable to the unachievable Inspection Action, the inclusion of this on the Directorate Risk Register would be advisable.	N/A	Senior Management Team (Children and Women's Clinical Board)

	In the event of a further external review necessitating subsequent action planning, the proposed actions should be decided as a collective with input from Clinical Governance Team the Quality and Safety Team, ensuring that the actions are specific, measurable, achievable, realistic and time-bound. <i>In view of these being prospective actions, a Target Date for this cannot be stipulated.</i>	N/A	Senior Management Team (Children and Women's Clinical Board)
1.3	Review the Inspections/ Inspection Actions via the AMaT system during the Midwifery and Nursing Senior Leadership Board meeting ensuring that the following details are confirmed with the attending Senior Management Team; - <i>Appropriate allocation of person responsible for action,</i> - <i>Confirmation of Specific, Measurable, Achievable, Relevant and Time-Bound actions,</i> - <i>Appropriate proposed timeframe for action completion,</i> - <i>Evidence required for action completion,</i> - <i>Progress Status.</i> Where possible/ applicable, status updates can be advised during the Midwifery and Nursing Senior Leadership Board meeting with further superseding actions confirmed to support recommendation completion if required. These superseding actions should be detailed for monitoring purposes within the Nursing and Senior Leadership Board meeting minutes, as well as noted on the relevant Inspection Action in the Updates/ Comments section via the AMaT system. Monthly 1:1 meetings are currently held between the Head of Midwifery and Risk and Governance Lead Midwife, which provides further opportunity to discuss any outstanding Inspection Actions and update these accordingly via the AMaT system. Supporting actions are agreed during these meetings and revisited at subsequent meetings. This is noted as an ongoing action. The AMaT system utilizes automated push notifications to alert individuals of outstanding Improvement Actions. These are sent on a weekly basis via secure NHS email.	10/02/2025 10/03/2025 N/A N/A	Senior Management Team (Children and Women's Clinical Board) Hannah McLoughlin (Clinical Governance and Risk Lead Midwife) Lois Mortimer (Head of Midwifery)

	If required, direct updates are requested of the responsible person by the Risk and Governance Team via variable means (email, In-person, telephone etc). Bespoke support for the responsible person will be implemented for the responsible person by the Risk and Governance Team if required to facilitate Inspection Action completion. This is noted as an ongoing action.	N/A	Risk and Governance Team
	The progress of outstanding Inspection Actions can be shared hence forth on a monthly basis via the Directorate Quality, Safety and Experience (QSE) report, as well as Directorate and Clinical Board Quality and Safety Meetings.	28/01/2025	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)

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Matter Arising 2: Progress Reporting on the recommendations (Operation)		Impact
We were only provided with the Maternity and Neonatal Oversight Group minutes for December 2023 and January 2024 and subsequently work undertaken in the Oversight Group could not be determined during the audit. Nonetheless, it was observed that the group is well positioned to provide oversight in terms of ensuring that action plans are monitored, and that relevant information is reported to the QSE Committee where appropriate. Whilst it is evident that maternity care has been given substantial attention by the Quality, Safety and Experience (QSE) Committee, the content of updates provided to the Committee has not always included sufficient information. Reports to the QSE Committee have featured detailed progress reports against specific actions arising from the Ockenden Report and various other reviews, but it does not appear that an analysis of the overall level of compliance has been undertaken since the action plans were initially compiled. The provision of up to date assurances to the QSE Committee in relation to the Health Board's compliance with the recommendations arising from the Ockenden report and various other reviews has been precluded by the absence of management information in the form of updated action plans and related analyses.		Potential risk of: Assurances with respect to the progress of Maternity Services in implementing recommended actions may not be measured effectively or communicated appropriately to the Health Board or nominated Committee(s).
Recommendations		Priority
2.1	The scope of the Maternity and Neonatal Oversight Group should be reviewed, and it should be ensured that the monitoring of progress against action plans is highlighted as a core function of the group.	Medium
2.2	Regular status updates should be reported to the Quality, Safety and Experience Committee with respect to overall progress against implementing actions recommended by external reviews.	Low

Agreed Management Action		Target Date	Responsible Officer
2.1	The Terms of Reference for the Matneo oversight group should be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, ensuring the monitoring of progress against action plans is highlighted as a core function.	31/03/2025	Maternal and Neonatal Safety Support Program
	The fixed agenda for the MatNeo oversight group should be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, ensuring the monitoring of progress against action plans is highlighted as a core function.	31/03/2025	Maternal and Neonatal Safety Support Program
	The updated fixed agenda should include a summary of outstanding Inspection Actions, ensuring regular discussion/ revisiting to enable action progression and overall accountability.	31/03/2025	Maternal and Neonatal Safety Support Program
	Risk and Governance Lead Midwife to provide relevant information regarding outstanding Inspection Actions to inform MatNeo oversight group. This action is dependent upon the previous actions for Recommendation 2.1.	N/A	Clinical Governance and Risk Lead Midwife
	Outstanding Inspection Actions should be presented during the MatNeo oversight group to further support Inspection Action completion. This action is dependent upon the previous actions for Recommendation 2.1.	N/A	Abigail Holmes (Director of Midwifery)
2.2	The agenda for the Quality, Safety and Experience Committee meeting to be reviewed, agreed and updated accordingly by key stakeholders/ meeting attendees, to include the overall progress against implementing actions recommended by external reviews.	31/03/2025	Quality, Safety and Experience Committee
	Risk and Governance Lead Midwife to provide relevant information regarding outstanding Inspection Actions to inform the Quality, Safety and Experience Committee meeting discussion. This action is dependent upon the previous actions for Recommendation 2.2.	N/A	Hannah McLoughlin (Clinical Governance and Risk Lead Midwife)
	Outstanding Inspection Actions should be presented during the Quality, Safety and Experience Committee meeting to further support Inspection Action	N/A	Abigail Holmes (Director of Midwifery)

	completion and ensure further oversight. This action is dependent upon the previous actions for Recommendation 2.2.		

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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Smoking Cessation

Final Internal Audit Report

2024/25

Cardiff and Vale University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Head of Internal Audit

Deputy Head of Internal Audit

CVU-2425-18

28th August to 7th November 2024

6th December 2024

4th February 2025

Claire Beynon, Executive Director of Public Health

Ian Virgill

Lucy Jugessur

Executive Summary

Purpose

To undertake a review of hospital based Smoking Cessation services, and the processes and actions being taken to achieve public health targets in relation to smoking cessation within Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Health Board provides a hospital Smoking Cessation Service that can be accessed by staff, patients and family members who want support in giving up smoking. It offers a number of strategies and approaches which are undertaken in partnership with the NHS Wales' 'Help Me Quit' programme and services. The Welsh Government produced 'A smoke-free Wales: Our long-term tobacco control strategy' in July 2022 with its long-term plan towards a smoke-free Wales by 2030, and NHS Wales has a Performance Measure of "percentage of adult smokers who make a quit attempt via smoking cessation services – Target = 5% annually". This is reported as part of the Health Board's Integrated Performance Report (IPR), and the hospital Smoking Cessation Service plays a key role in helping to achieve this strategy. There is also a NICE guidance in place, which was last updated in 2023: 'Tobacco: preventing uptake, promoting quitting and treating dependence (NG209)' and this covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are ready to stop in one go.

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

- A review of the Hospital Smoking Cessation Service needs to be undertaken to establish if it is appropriately resourced to fully deliver its mandate.
- There is currently an absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Structures and processes are in place to facilitate and deliver smoking cessation services within the Health Board and to the Cardiff and Vale population.	1	Limited
2 Documentation informing patients about smoking cessation education, advice and access to support services is available within hospital wards and other relevant clinical areas.	2	Limited
3 Patients current smoking status is recorded/updated within their clinical records upon accessing clinical services, and relevant support/referral offered.	-	Reasonable
4 Plans are in place, and are being progressed, to ensure that public health targets in relation to smoking cessation can be met.	-	Substantial
5 The Health Board is able to show that it complies with NICE guidance on smoking cessation and supports the Welsh Government's 'A smoke-free Wales: Our long-term tobacco control strategy'.	-	Substantial
6 Smoking cessation progress activity can be evidenced and is subject to regular reporting to the Health Board and other stakeholders.	-	Substantial

Summary of Management Actions

The table below summarises the findings made, their priority rating, theme and details on whether the finding relates to a control design issue or control operation issue. We group our findings into themes, which allows us to identify common themes and trends across NHS Wales organisations.

2

High Priority

Quality, Safety & Patient Experience	[Control Operation]	Control Design Issues: Inadequate or poorly designed controls that do not address risks	1
Communication & Engagement	[Control Design]	Control Operation Issues: Controls that are not executed correctly or consistently	1

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Findings & Agreed Action Plan

Objective 1: Structures and processes are in place to facilitate and deliver smoking cessation services within the Health Board and to the Cardiff and Vale population.

Limited

The delivery of smoking cessation services forms part of the Health Board's 2023 10 year 'Shaping our Future Well-being Strategy'. A suite of strategic priority change programmes were established relating to local public health provision titled 'Shaping our Future - Population Health Plan 2022-2025'. One of the programmes was the "development of our hospital patient Smoking Cessation Service to increase the number of smokers routinely engaging with smoking cessation services."

The Health Board also has a 'No Smoking and Smoke Free Environment' procedure in place for staff and patients which states the provision of both a public health team led, and hospital based smoking cessation service to support and facilitate those wishing to stop smoking.

Our review of the content and delivery objectives of both the 'Shaping our Future - Population Health Plan 2022-2025', and the UHB 'No Smoking and Smoke Free Environment' Procedure confirms that both are in alignment with, and also make reference to, the requirements of the Welsh Government Smoke Free Wales 2030 Strategy.

The Hospital Smoking Cessation Service is supported by a formal structure, standing operating procedure and a delivery mandate that outlines its aims and objectives. However, the service's ability to fully deliver it's aims and objectives is potentially limited due to the current establishment and funding arrangements.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Appropriate Resourcing of Hospital Smoking Cessation Service</u> The Hospital Smoking Cessation Service sits and reports managerially within the Medicine Clinical Board, and its staffing establishment sits within the Integrated Medicine Directorate budget. The Hospital Smoking Cessation Service is currently budgeted to provide a 7am-3pm Monday to Friday service at UHW, a five hour a week service at UHL, and a fifteen-hour a week service at Barry Hospital for patients from across the Vale of Glamorgan. As such, there is a limited service provided at UHL in comparison to that of UHW, and also to that of the 15 hours service provision at Barry Hospital. Currently the focus of the Hospital Smoking Cessation Service is only that of counselling work, and there is no resource to undertake proactive promotional awareness exercises across the	Health Board patients are not aware of smoking cessation advice and services.	<u>Final Agreed Action:</u> Ahead of the decision on future funding via the business case, the Hospital Smoking Cessation Service and Public Health Team will review collaborative working arrangements to ensure referral and treatment pathways are efficient, appropriate, meet the needs of patients/clients and ensure smooth transition from inpatients to outpatient/community services. Once future funding is established, the two teams will work collaboratively to assess what action is required to optimise resourcing to the Hospital Smoking Cessation Service to enable it to effectively deliver its formally documented mandate and role in full.

UHB hospital sites, nor Ward liaison work in respect of nursing NRT (Nicotine Replacement Therapy) advice provision.

This Service currently holds no budget of its own and there is no evidence of it having been subject to any review of its ability to effectively and efficiently undertake its full role and prescribed mandate.

The key issue is that of historical establishment funding for these posts, which were in place prior to the launch of the Welsh Government Smoke Free Strategy. Also, there is no additional funding available from the Medicine Clinical Board, given its own budgetary pressures and constraints relating to other clinical needs.

As such there is a clear risk that the stated organisational strategic and patient focussed operational objectives pertaining to smoking cessation cannot be delivered effectively and in accordance with the Welsh Government Smoke Free Wales 2030 Strategy.

Expected Evidence of Implementation:
Review of pathways complete by end February 2025

Future service plan developed – by June 2025

High Priority

Officer: Siân Griffiths, Consultant in Public Health Medicine

Emma Keen, Deputy General Manager, Integrated Medicine

Date: June 2025

Theme: Quality, Safety & Patient Experience

Control Operation

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Objective 2: Documentation informing patients about smoking cessation education, advice and access to support services is available within hospital wards and other relevant clinical areas.

Limited

There is a Hospital Smoking Cessation Service site on the Health Board's Sharepoint site. However, from our review of the site, there is only a home page which provides a brief overview of the Health Board's smoke-free status and relevant legislation, smoking cessation support information, and contact numbers for the Hospital Smoking Cessation Service team members.

The Health Board Local Public Health Team internet site has a 'Stopping Smoking' webpage which includes information and contact information relating to the NHS Wales smoking cessation service 'Help Me Quit', as well as that of the Health Board Smoking Cessation Service.

However, there is a lack of specific smoking cessation promotional information on the Sharepoint site and also within the Health Board's hospital sites and ward areas.

Key Findings	Risk & Impact	Agreed Management Action
2 <u>Absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board</u> It was evident from our review that no smoking cessation promotional information, or advice documentation has been posted to the Hospital Smoking Cessation Sharepoint site. Although the site has pages set up in readiness for the provision of 'Get help', Clinical Factsheets, Help Me Quit, Top tips to quit and Reasons to quit, none of this information was held within these tabs. We note that the Smoking Cessation Manager and Local Public Health Team Tobacco Lead, have requested the upload of this documentation by the IT Webmasters, but it remains on a 'waiting list' to be undertaken. We visited the UHW and UHL sites to verify whether there were any smoking cessation promotional information in the form of posters/leaflets on display within publicly accessible areas e.g. Concourse Receptions, and patient/staff Lift areas, and there were none available. Furthermore, there were none available within the clinical areas that we sampled for our testing; namely, the	Health Board patients are not aware of smoking cessation advice and services.	Final Agreed Action: Work will be undertaken collaboratively between the Hospital Smoking Cessation Service and Public Health Team to increase and improve the level of awareness of smoking cessation support available via electronic media across the UHB for patients, staff and visitors. In addition, more Smoking Cessation promotional resources will be placed on display within public, clinical and Ward based settings. Expected Evidence of Implementation: Communications plan developed by February 2025 Evidence of increased communications across all media within the hospital setting by Summer 2025

CAVOC, UHL Outpatients waiting area and Inpatient nursing stations, and the waiting areas and nursing stations at Wards B2 Link and B7, UHW.

Additionally, no awareness or outreach exercises have been undertaken at Wards or clinical departments by the three Hospital Smoking Cessation team members at UHW, UHL and Barry Hospital respectively, this is due to the staffing establishment constraints as discussed previously in this report.

There is a risk of lessened awareness relating to the Service due to the lack of promotional information and guidance documentation posted to the Health Board Smoking Cessation Service Sharepoint site and absence of of information for patients and staff, and specifically those staff working in hospital Wards and Outpatient areas.

This is further exacerbated by the lack of time available for Smoking Cessation Advisors to undertake in-person awareness exercises within Ward and clinical areas across the Health Board.

Our testing identified there are no metrics in respect of feedback provided by service users of the Hospital Smoking Cessation Service, or of the uptake of promotional information provided by the Service.

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High Priority

Increase in number of appropriate referrals to Hospital Smoking Cessation service by Autumn 2025

Increasing trend in number of staff completing e-learning module – monitor quarterly

Officer: Helen Poole, Smoking Cessation Counsellor
Catherine Perry, Principal Public Health Practitioner
Date: Autumn 2025

Objective 3: Patients current smoking status is recorded/updated within their clinical records upon accessing clinical services, and relevant support/referral offered.	Reasonable

We planned to visit four Wards (Inpatients CAVOC, UHL; Ward C7, Ward B2 Link and Ward B7, UHW) in order to ascertain whether a patient’s smoking status was recorded upon admission via a standard clerking pro-forma, and also whether this information is recorded anywhere else within the Ward. However, due to ongoing staffing shortages and sickness on Ward C7, Ward B2 Link, and Ward B7, UHW, we were unable to undertake testing in these areas, but did so within the Inpatients Ward at CAVOC, UHL.

Additionally, we sought to identify if Ward staff were aware of the Hospital Smoking Cessation Team, and how to contact them if required to provide support, and/ or undertake a formal referral into their service.

As such, we identified that there is an awareness of the Hospital Smoking Cessation Team within CAVOC, and Ward Management were satisfied that nursing staff knew how to contact them when required.

Our testing also confirmed that recording of patient smoking status on Clinical Workstation nursing portal has recently been implemented on the Ward, and smoking status is also incorporated into Ward admission pre-surgery assessment documentation and surgical anaesthetic charts. We note at the time of our testing none of the patients were smokers, and this status was recorded accordingly within the aforementioned documentation.

We also sought to ascertain whether any patients that were smokers had been offered Nicotine Replacement Therapy (NRT) during their stay, and also the existence of a Ward stock in the event that the Pharmacy Department could not efficiently provide e.g. outside of Pharmacy working hours.

Whilst testing was not able to validate whether any smokers had been prescribed NRT due to there being no smokers present at the time of our audit; we could confirm that an adequate supply was held in the CAVOC Inpatient Ward drug storage cabinet.

Whilst we have not identified any findings under this objective, we are only able to provide reasonable assurance due to the restriction on the level of testing we were able to undertake.

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Objective 4: Plans are in place, and are being progressed, to ensure that public health targets in relation to smoking cessation can be met.

Substantial

Smoking Cessation delivery progress action plans are in place within both the Local Public Health Team and the Hospital Smoking Cessation Service, and both show evidence of progress during 2023/24 and year to date 2024/25 to ensure that potentially preventable smoking related harm is reduced/removed across Cardiff and the Vale of Glamorgan.

The achievement of these are supported by a draft Business Case which is currently scheduled for review by the Business Case Panel in November 2024. The Business Case seeks to obtain additional funding to support the UHB's achievement of the Welsh Government target for the country to be smoke free by 2030. However, if the additional funding fails to be secured there is a risk that the current plans in place may not be fully actualised and the strain on the current Hospital Smoking Cessation Service will continue and targets may not be achieved.

Objective 5: The Health Board is able to show that it complies with NICE guidance on smoking cessation and supports the Welsh Government's 'A smoke-free Wales: Our long-term tobacco control strategy'.

Substantial

Our review of the content and delivery objectives of both the 'Shaping our Future - Population Health Plan 2022-2025', and the UHB No Smoking and Smoke Free Environment Procedure confirms that they are in alignment with, and refers to, the requirements of the Welsh Government Smoke Free Wales 2030 Strategy and NICE Guidance on smoking cessation.

Operationally, this is further confirmed via the public facing information stated on the Cardiff and Vale Local Public Health Team internet page relating to tobacco control and cessation, as well as its work and action plans which underpin the smoking cessation strategy and procedure.

Furthermore, the work undertaken by, and the work and action plan of the Hospital Smoking Cessation Service also confirms the incorporation of NICE Guidance on an operational basis.

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Smoking cessation is reported as part of Aim 1 "People in Wales have improved health and well-being with better prevention and self-management" within the Integrated Performance Report (IPR) which is reported to the Board and also the Finance and Performance Committee.

The NHS Wales Performance Measures are:

- Percentage of adult smokers who make a quit attempt via smoking cessation services - 5% per year – The IPR which was taken to the September Board meeting had the in month performance at 0.6%; and
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks - The IPR which was taken to the September Board meeting had the in month performance as 70%.

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Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Consent Process

Draft Internal Audit Report

2024/25

Cardiff and Vale University Health Board



Reasonable Assurance

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Saunders-Nathan
08/05/2025 15:28:30

Review Reference

CVU-2425-29

Fieldwork

17th September – 11th November
2024

Executive Sign Off

22nd December 2024

Audit Committee

4th February 2025

Executive Lead

David Fluck, Executive Medical
Director

Head of Internal Audit

Ian Virgill

Deputy Head of Internal Audit

Lucy Jugessur

Executive Summary

Purpose

The review of the Consent Process operating was completed in line with the 2024/25 Internal Audit Plan for the Cardiff and Vale University Health Board (the 'Health Board').

Overview

The Welsh Government issued a revised Welsh Health Circular (WHC) '2023/021: Guide to Consent for Examination or Treatment' in August 2023 which replaced the previous WHC 2017/036. The new Circular sets out consent in the context of the framework of the Duty of Quality. It also brings together in one place links to materials, guidance and training information developed and promoted by the NHS Wales Welsh Risk Pool, to support NHS organisations in Wales to approach the taking of consent consistently and robustly. The Circular has an action that 'Health Boards need to have quality assurance mechanisms in place to ensure the continuous monitoring, review and improvement of the consent policy into practice.'

The Quality, Safety and Experience Committee approved an updated Consent to Examination or Treatment Policy on the 30 August 2023 with it being published on the Health Board's website on the 6 October 2023. The Health Board's Policy reflects the model All-Wales policy and states that Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given his or her consent. Consent will only be valid if:

- The patient has capacity to give consent;
- It is given freely and not under duress; and
- The patient has been properly informed.

Consent can be given in writing, verbally or even indicated non-verbally and it is essential in all cases that an adequate record of the consent is maintained.

We have concluded **reasonable** assurance on this area. The significant matters requiring management attention include:

- There is out-of-date and/ or non-validated consent related information detailed within the Health Board's Consent to Examination or Treatment Policy and on the Internet.
- There is a lack of agreed risk-based methodology to monitor consent compliance.
- The Health Board need to consider the efficiency and effectiveness of consent communication channels that are currently being utilised.
- Consent training required to be undertaken for all appropriate staff.
- The Consent group's governance arrangements require improvement.

Full details of matters arising are detailed within the Findings & Agreed Action Plan

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The Health Board's Consent to Examination or Treatment Policy aligns with the Welsh Health Circular (WHC/2023/021) and has been effectively communicated to staff.	1	Reasonable
2	Staff are complying with the Consent to Examination or Treatment Policy for all patient's that are required to give consent.	2	Limited
3	Appropriate staff have undertaken the required consent training.	3	Reasonable
4	Effective quality assurance mechanisms are in place, in line with the stated action within the WHC	4	Reasonable

Summary of Management Actions

Management Actions

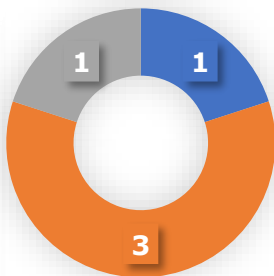


High Priority



Medium Priority

Themes



- Communication & Engagement
- Governance
- Performance Monitoring

Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: The Health Board’s Consent to Examination or Treatment Policy aligns with the Welsh Health Circular (WHC/2023/021) and has been effectively communicated to staff.

Reasonable

The Health Board Consent to Examination or Treatment Policy was approved by the Quality Safety and Experience Committee on the 30 August 2023 and is available on the Health Board’s Sharepoint site. There is an embedded link within the Policy to the Welsh Government’s Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) which is dated December 2019 but has since been superseded by the current version WHC/2023/21. This error is replicated on the Health Board intranet site.

Our operational testing noted that over time ad hoc uncontrolled versions of the documents have been uploaded to the Health Board’s public internet site including procedures dating back to 2016, that may not comply with current policy and clinical procedures. There is therefore a risk that patients may be mis-informed, delaying treatment, adding to costs and increased complaints.

As well as the Consent to Treatment Policy being available on Sharepoint, there are also the All-Wales consent forms which were revised in October 2024 and a link to EIDO Healthcare patient information leaflets (which have been certified by the Welsh Risk Pool (WRP)) about medical procedures.

In July 2024 an independent Peer Review of the Consent to Examination and Treatment Process was undertaken within the Health Board to assess if the Health Board was compliant with the All-Wales Consent Policy. Following the agreed action plan based upon the report’s recommendations, the Board have undertaken a review of the governance arrangements for controlling consent related patient information. This includes the development and approval of the Health Boards Locally Procedure Specific Patient Information Leaflet (LPSPIL) and the Procedure Specific Consent Forms standard operating procedures (PSCFs).

These do not include electronic based data, for example our review noted that Clinicians have and are producing tablet-based solutions explaining procedures to patients as part of the consent process. There is a risk that without appropriate oversight they may not meet an agreed standard.

Key Findings		Risk & Impact	Agreed Management Action
1	<u>Public access to out-of-date Consent information.</u> The Health Board’s Consent to Examination and Treatment Policy and internet site provides access to out-of-date consent information which does not reflect current best practice. This information includes: • The Welsh Government’s revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent 31 December 2019. This has since been superseded by WHC/2023/21.	Financial and reputational risks to the Health Board if the consent process is not complied with.	Clinical Boards to review information available to patients via public platforms and ensure that documentation is up to date and local patient information is used only where there is no EIDO or nationally recognised alternative. LPSPIL Guidance to be amended to reflect that guidance also applies to digital resources. Expected Evidence of Implementation: Feedback from CBs and evidence of regular review. Amendment made to LPSPIL

In addition to the above specific clinical procedural information linked to consent, there is also other out of date documentation which includes: • Endoscopy patient information leaflets/colon-consent form December 2016. • Neuro routine EEG Consent Information Sheet which is not dated. • Gastro Consent Form 2016 Our review also noted that Clinicians are producing tablet based solutions to explain procedures. The new SOP LPSPIL does not include electronic media-based communications.		
Theme: Governance	Medium Priority Control Design	Officer: Documentation review – Clinical Board triumvirate LPSPIL - MCA Project Lead (whilst Consent Lead post vacant) Date: 01/04/2025

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The Consent to Examination or Treatment Policy states that “consent can be given in writing, verbally or even indicated non-verbally. In all cases it is essential that an adequate record of the consent is maintained for future reference.”

As detailed in objective 1, there was an independent Peer Review of the Consent to Examination and Treatment Process undertaken within the Health Board. It was agreed with Assistant Director of Quality and Patient Safety and the Assistant Medical Director Patient Safety and Clinical Effectiveness that we would place reliance on the Peer review to inform our audit. The Peer review identified that a consent form was being used in 98% of all cases reviewed. However, it was identified that in only 68% of all cases reviewed there was evidence of the consent dialogue being recorded within the patient’s notes/ written communication with the patient. Furthermore, it was also identified within the Peer review that there were low scores of 7% and 6% respectively for ‘A patient information leaflet offered to the patient’ and ‘what type of patient information leaflet was offered to the patient.’

In compliance with the recommendations from the Peer review the Board have established (January 2024) a Consent Group and one of their responsibilities is to ‘identify what arrangements should be in place for obtaining valid consent within Cardiff and Vale UHB and to ensure compliance with the relevant law and national guidance’. Although there has been a Consent Group developed to assist in identifying arrangements in place for obtaining valid consent, it is the responsibility of the Clinical Boards and the Clinicians to ensure that they are supporting this and obtaining the required consent.

The WG Guide to Consent for Examination or Treatment 2017 (section 71/72) defines the circumstances where written and verbal consent are appropriate, with the caveat that consent should be noted on all patients’ medical records. Currently there are no defined KPI parameters set to reflect the method of recording, and its associated inherent level of risk, which may vary in different scenarios. Additionally, there is also no agreed method of compliance monitoring.

It was identified from meetings with staff in Interventional Radiology and Cardiovascular that departments use different methods to deliver their consent message, for example leaflets, e-mail, texting, tablets, traditional post or a combination of these. These processes have been adopted over time on an ad hoc basis and have not been periodically assessed for their efficiency and effectiveness, for example due to tight deadlines patients may receive posted consent related information after their visit. There is a risk that the most efficient and effective method of delivery is not being utilised for example e-mail instead of postal services.

Key Findings		Risk & Impact	Agreed Management Action
2.1	<u>No defined KPI parameters in place</u> It was recognised that a Consent Group has been set up and the terms of reference state one of the responsibilities as “identifying what arrangements should be in place for obtaining valid consent within Cardiff and Vale UHB.” However, the Clinical Boards and Clinicians need to support this and ensure that consent is being obtained. Furthermore, there needs to be risk based	Financial and reputational risks to the Health Board if the consent process is not complied with.	The Consent Group will work in partnership with the Clinical Boards and Clinicians, who are ultimately responsible for their team’s compliance with consent policies, to ensure that consent is obtained and the extent of it being acquired is monitored. KPIs to be agreed by the CAV Consent Group. The Welsh Risk Pool have developed a Consent Peer Review Tool for bi-annual review of identified clinical areas however, this can also be used more widely across the

	consent monitoring governance improvements in place as we identified that: • There is no agreed KPIs for consent compliance, for example where verbal or written consent is appropriate. • There is no current agreed methodology for monitoring compliance, for example regular sample tests to ensure written consent has been appropriately recorded.		UHB to review whether proper consent processes are being followed in any given area.
		High Priority	Expected Evidence of Implementation: Evidence of local audits of consent processes to be fed back at Clinical Board Q&S meetings and the Consent Group and minuted.
	Theme: Governance	Control Design	Officer: MCA Project Lead (whilst Consent Lead post vacant), Clinical Board triumvirate Date: 30/04/2025
2.2	<u>Consent communication channels</u> The terms of reference for the Consent Group states one of the responsibilities of the Group as "identifying what arrangements should be in place for obtaining valid consent within Cardiff and Vale UHB." The methods applied to deliver consent messaging has not been assessed for its efficiency and effectiveness. There is therefore a risk that consent messaging could be compromised by not offering the most effective method of delivery.	Financial and reputational risks to the Health Board if the consent process is not complied with.	<i>We will undertake a review of the current channels used to communicate consent messaging. Our objective will be to understand the most efficient and effective methods staff can utilise when communicating with patients.</i>
		Medium Priority	Expected Evidence of Implementation: Liaise with the UHB's Communications Team to look at proven most effective means of communicating with staff.
	Theme: Governance	Control Design	Officer: MCA Project Lead (whilst Consent Lead post vacant) Date: 01/04/2025

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A presentation on Consent was taken to the Quality, Safety and Experience Committee in March 2024 and it was confirmed that the Wales Risk Pool had recognised that all Health Boards should mandate consent training.

Following the recommendations of the Welsh Risk Pool and the independent Peer Review of the Consent to Examination and Treatment Process, the Board mandated consent training for all registered professionals.

Compliance is monitored within ESR following the update of staff profiles on 26 August 2024. On the 31 October 2024 2,698 Allied Health Professionals, Medical and Dental and Registered Nursing and Midwifery staff had undertaken the Consent training from a population of 7,926 (34.04%). Managers have access to ESR data and additional oversight is provided by the newly formed Health Board Consent Group who meet periodically to review and report on overall compliance.

Key Findings		Risk & Impact	Agreed Management Action
3	<u>Undertaking Consent training.</u> As at the 31 October 2024 only 34.04% of relevant staff had undertaken the consent training.	Welsh Risk Pool could withdraw financial support if staff do not undertake consent training.	The Consent Group report on compliance with Consent to Treatment training at each meeting. In addition, compliance figures are circulated to all Clinical Boards on a monthly basis for reporting at Quality and Safety meetings; with a breakdown by professional group.
			Expected Evidence of Implementation: Clinical Board Quality & Safety minutes to reflect discussion around compliance with training.
		Medium Priority	
	Theme: Performance Monitoring	Control Operation	Officer: MCA Project Lead (whilst Consent Lead post vacant) and Clinical Board triumvirate Date: Monthly – Ongoing

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Section 12 of the WHC/2023/21 states that 'Health Boards need to have quality assurance mechanisms in place to ensure the continuous monitoring, review and improvement of the consent policy into practice.' The Health Board have established a Consent Group to oversee quality assurance, training and compliance. They are currently undertaking a review of inhouse consent documentation. Additionally, we noted several areas where the Health Board's Consent Group terms of reference and meeting governance could be improved.

As stated previously, the Health Board undertook a Peer Review of the Consent to Examination and Treatment Policy and the aim was to understand if 'the Health Board is compliant against the All-Wales consent policy. To establish if there are areas of good practice and areas of poor compliance and to establish an action plan to ensure compliancy against the standards.' Each of the criteria was assessed and where there were areas for improvement identified an action plan was produced to address these weaknesses.

Key Findings		Risk & Impact	Agreed Management Action
4	<u>Consent Group's Term of reference (ToR) and meeting governance</u> Our review of the Consent Groups' terms of reference and meeting governance processes highlighted areas that require improvement. These are as follows: - The ToR does not have a review panel and owner. - The key participating functions are not named within the ToR. - We recommend that the ToR should include a minimum annual attendance requirement for key participants. - An attendance record should be maintained and results reported at each meeting. - All the groups agreed actions should be indexed and linked to mitigating evidence. - Projected action delivery dates should be included.	Financial and reputational risks to the Health Board if the consent process is not complied with.	We have during the audit process taken onboard the findings and moved quickly to implement the suggested improvements. We are in the process of fully complying.
			Expected Evidence of Implementation: Updated ToR and meeting minutes
		Medium Priority	Officer: MCA Project Lead (whilst Consent Lead post vacant) Date: 01/04/2025
Theme: Governance		Control Design	

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Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence presents a material loss, error, or misstatement. Poor system design or widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design or limited non-compliance.

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Mortuary Refurbishment at University Hospital Wales Final Internal Audit Report

January 2025

Cardiff & Vale University Health Board



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University Health Board



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Review reference:	CVU-SSU-2425-36
Report status:	Final
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Debrief meeting:	19 th September 2024
Fieldwork completion:	23 rd September 2024
Draft report issued:	3 rd October 2024
Management response received:	20 th January 2025
Final report issued:	23 rd January 2025
Auditors:	NWSSP: Audit & Assurance - Specialist Services Unit (SSu)
Executive sign-off:	Catherine Phillips, Executive Director of Finance
Distribution:	Sarah Lloyd, Director of Operations / Senior Responsible Officer Geoff Walsh, Director of Capital, Estates & Facilities / Project Director Stephen Gardiner, Head of Capital Planning Alex Hawkins, Project Manager Matt Phillips, Director of Corporate Governance
Committee:	Audit Committee



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Acknowledgement

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

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Executive Summary

Purpose

The audit reviewed the delivery and management arrangements in place to progress the mortuary refurbishment project at University Hospital Wales (UHW). This was the first audit of the project.

Overall Audit Opinion and Overview

Significant unforeseen issues have been encountered at this project, which had not been factored into the original project plans. These were only identified during the survey and demolition phase, noting intrusive surveys could not be undertaken until the Mortuary service decanted, and the as-built information held by the UHB was limited for this area of the site. Unexpected issues have included floor slab thickness, extent of services within the ceilings, presence of asbestos and structural walls.

As a result, the original design has required significant re-working, delaying completion from October 2024 to February 2025, extending the construction period from an initial 34 weeks to 50 (47% increase). The impact of winter pressures on the mortuary service has necessitated the procurement of additional temporary capacity to cover this period.

Costs have similarly increased, from the original approved budget of £3,385m, to a current forecast £4,308m (27%). An initial addition of £330k was added to the project budget from discretionary capital funds in May 2024, based on forecasts at that time. At the time of reporting, a further £593k requirement had been confirmed, and the UHB was liaising with Welsh Government to discuss the potential funding of the total £924k forecast overspend. Management advised that support from discretionary capital has been agreed, should WG funding not be approved, to enable continuation of the works.

Whilst noting the significant time and cost pressures at the project, the application of robust management controls in key areas such as risk management, contractual changes and cost control have been evidenced.

The significant matter arising at the project is:

- The documenting and sharing of lessons learned to ensure future projects benefit from the experience and learning from this project. This should encompass consideration of why the issues

Report Classification

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary ¹

Assurance objectives	Assurance
1 Project Performance	Limited
2 Governance	Reasonable
3 Financial Assurance	Reasonable
4 Technical Assurance	Reasonable
5 Advisers	Reasonable
6 Change Control	Reasonable
7 Quality Assurance	Substantial

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

encountered at this project were unforeseen, and how this risk will be mitigated at future projects.

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

Acknowledging that the issues occurring at the project could not have been reasonably foreseen by the project team during the planning stage, with robust management controls evidenced in responding to the escalating costs, an overall **Reasonable Assurance** has determined at this time.

Recognising that the Draft Report was issued for management attention in October 2024, management indicated in their responses that the majority of issues raised within this report had been addressed at the time of issue of the Final Report.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Finalisation and approval of the updated Capital Projects Manual.	2	Design	Medium
2	Increased scrutiny of project delivery at the Acute Infrastructure & Sustainability Capital Programme Board.	2	Operation	Medium
4	Improved accuracy of financial reporting to Welsh Government.	3	Operation	Medium
5	Appropriate signing of contracts in line with Standing Orders.	4	Operation	Medium
6	Assurance that appointed advisers hold appropriate insurances.	5	Operation	Medium
7	The documentation and sharing of lessons learned from the delivery of this project.	6	Operation	Medium

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1. Introduction

- 1.1 This audit reviewed the delivery and management arrangements in place to progress the mortuary refurbishment project at the University Hospital Wales (UHW). The audit was commissioned in accordance with the agreed Integrated Audit Plan provided within the approved Business Justification Case (BJC) for this project.
- 1.2 The UHW mortuary and post-mortem facility was the subject of a regulatory inspection by the Human Tissue Authority (HTA) in August 2017, with the outcome that the facility was found to be non-compliant with the regulatory standards required to maintain a licence under the Human Tissue Act. Failure against the regulatory standards can result in the suspension of licensed activities i.e. storage of the deceased and the undertaking of post-mortem examinations, with the potential revocation of the UHB licence and ultimately prosecution with an unlimited fine.
- 1.3 The refurbishment scheme includes reconfiguration of the facility to allow for increased storage including obese patients, a layout that will support better flow and body handling, improved viewing and identification etc. The scheme also includes costs to undertake works to the mortuary at the University Hospital Llandough (UHL), to improve its condition to allow it to be used as a temporary facility whilst the building works at UHW are undertaken.
- 1.4 The BJC was approved by Welsh Government in November 2023, providing £3.385m capital funding for the project. Works commenced on site in January 2024.
- 1.5 The risks considered in this review included:
 - Potential failure to achieve key project objectives (e.g., delivery to time, cost, and quality).
 - The UHB may not be adequately protected through its contractual mechanisms.
 - Agreed contractual conditions may not be appropriately applied.
 - Insufficient quality in performance or works.

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2. Detailed Audit Findings

2.1 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in **Appendix A**.

Project Performance: Consideration of performance against project objectives (e.g. time, cost, benefits, critical success factors etc.).

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

2.3 The Mortuary project has experienced a number of unforeseen issues discovered during the UHW demolition stage, which have significantly impacted project performance to date. These include unexpected floor slab thickness, extent of services within the ceilings, presence of asbestos, structural walls and drainage issues. The absence of as-built drawings for this area of the hospital, coupled with the inability to undertake invasive surveys until the Mortuary service decanted, has meant time and cost provisions have proved insufficient.

Time

2.4 The UHL phase achieved sectional completion on 12th March 2024, slightly behind the contract completion date of 6th March 2024.

2.5 UHW works commenced on 7th March 2024, with an original 34 week construction period. The latest accepted programme for the UHW works detailed the following:

Milestone	Original Contract Completion Date	Revised Contract Completion Date	Accepted Programme (Rev 8) Planned Completion
UHW Completion	30 th October 2024	4 th March 2025	18 th February 2025

2.6 The contract completion date had been extended to 4th March 2025, but the latest accepted programme indicated the Contractor was forecasting planned completion slightly ahead of this, by 18th February 2025 (2 weeks in advance of the revised contract completion).

2.7 Programme revision 9, not yet accepted, included planned completion as 28th February 2025.

2.8 The project has been delayed by 16 weeks (46%) to date, and noting completion now extends past winter 2024, forecast winter pressures have necessitated the funding of additional temporary body storage at the UHL site.

Cost

2.9 The project budget set out in the BJC, and approved by Welsh Government, was £3,385,000, with a works cost of £2,171,000.

- 2.10 In May 2024 the Capital Management Group approved additional funding of £330k, from discretionary capital funds, to cover the known cost impact at that time of the issues outlined in para. 2.3 (comprising £220k of the total forecast overspend at that time), and temporary additional storage capacity (costing £110k) at UHL over the winter period, noting the programme extension.
- 2.11 At the time of reporting, the cost position was reported as:

	Original Budget	Forecast	Variance
Works costs	£2,171,000	£2,500,746	-£329,746
UHB Fees	£414,000	£387,484	£26,516
Non-works	£100,000	£216,745	-£116,745
Equipment	£25,000	£25,000	£0
Balance of Contingency	£252,000	£608,741	-£356,741
VAT	£423,000	£570,216	-£147,216
Total	£3,385,000	£4,308,932	-£923,932

- 2.12 Management has confirmed that a further £593k of funding would be required to deliver the project, and discussions were ongoing with Welsh Government to confirm whether this could be centrally funded (in addition to the £330k previously internally funded). The £923k total forecast overspend represents a 27% increase from the original project budget. The Director of Finance had been made aware of the latest increase, with management advising that agreement has been given that the additional monies would be supported from Discretionary Capital should Welsh Government support not be provided.
- 2.13 It is acknowledged that the additional costs primarily result from works not originally anticipated within the project plans (and not from client changes/additional requirements etc.) but that would have been incurred even if the area had been available for surveying before works commenced. Surveying in advance, whilst providing greater awareness of risks and improved adequacy of contingency from the outset, would not necessarily have reduced the eventual expenditure. It is also recognised that the full decant of the Mortuary service at an earlier point to enable surveying, would have increased costs beyond those currently incurred.

Quality

- 2.14 Noting the above delays to project completion, the realisation of the anticipated benefits outlined within the business case will also be delayed. Management have confirmed, however, that despite the extent of re-design required to the original plans, all efforts have been made to maintain the original intended benefits (e.g. increased body store capacity). Whilst opportunities for cost savings have been considered, it has been concluded that this would be detrimental to the aims of the project.

- 2.15 The quality of retained information in relation to the UHW site (e.g. as-built drawings/technical information etc.) has impacted the project team's ability to accurately design and cost this project and poses a risk to the future planning of further works on the site.
- 2.16 The UHB received monthly reports from the external Supervisor, monitoring the progression and quality of works. Whilst noting the works remained at demolition stage at the time of review, no significant issues had been reported to date.
- 2.17 The UHB maintained Key Performance Indicators for contractor and adviser performance. Performance had been generally assessed positively, with the exception of the Design Team. Whilst recognising the unforeseen extent of re-design required, response to design requests had been slow, impacting on wider project progress. The UHB had appropriately escalated this, with additional resources subsequently provided by the Design Team to mitigate the issues.
- 2.18 We also recognise that improved project management controls were evident at this project compared with those seen at previously audited projects: with the UHB's Capital and Estates team having implemented a number of previously agreed audit recommendations arising from other project audits.

Project Performance Conclusion

- 2.19 Noting the current significant time and cost pressures, **limited assurance** is determined in respect of the project's performance against its original agreed parameters. Whilst recognising the project team have applied robust controls in managing this, the forecast outturn position has impacted the UHB's availability of discretionary capital funds for other priority projects, and placed pressure on the Mortuary service in operating from temporary accommodation for a prolonged period.
- 2.20 The following sections of the report outline the matters which require management attention, with low to moderate impact on residual risk exposure until resolved.

Governance: *Assurance that adequate governance arrangements were in place, including appropriately defined roles and responsibilities, project governance structure, stakeholder engagement, information retention systems, and clearly defined accountability & delegation arrangements. Appropriate approvals have been obtained at key stages.*

- 2.21 At project audits, project controls are typically assessed against the requirements of the respective health boards' capital procedural documents e.g. capital manuals, financial control procedures etc. We noted that the UHB's existing Capital Projects Manual was last updated in 2015, and was now considered out of date and no longer fit for purpose. The absence of a current, approved Manual risks the inconsistent and inappropriate application of project management controls. The UHB committed to updating the Manual in 2021, but whilst recent progress has

been made, the updated Manual had not yet been reviewed and approved for use (**MA1**).

- 2.22 The key project roles of Senior Responsible Officer (SRO) and Project Director had been appropriately assigned, with clear engagement through the governance structure.
- 2.23 The Project Board role for the mortuary project was provided by the Acute Infrastructure & Sustainability Capital Programme Board, which oversees major capital projects progressed by the UHB. The project was appropriately represented through attendance of the SRO and Project Director, and members received the internal Project Progress Report at each meeting. However, minuted discussions were minimal and indicated the project did not receive much in the way of individual focus. Whilst this may be appropriate for a well-performing project, the Mortuary project is experiencing significant time and cost pressures, and we would expect the extent of these, and associated impact on service delivery, to receive due scrutiny in line with the Programme Board's terms of reference (**MA2**).
- 2.24 Whilst recognising the above, the Project Team was also attended by the SRO and Project Director, and detailed discussions were evident at this forum in respect of project performance, risks and mitigating actions.
- 2.25 A Commercial Team was also in place, to manage contract delivery, attended by UHB representatives, its advisers (including external Project Manager and Cost Adviser), and the Contractor.
- 2.26 Appropriate approval processes have been evidenced to date, with escalating cost pressures reported to the Capital Management Group in a timely manner (May 2024) with a view to securing additional funding. As discussed within the *Project Performance* section, a further update was being prepared in light of escalating costs and additional funding requirements. The Health Board has subsequently confirmed that approval of the capital overspend and reallocation of the capital programme in-year was granted by the Board.
- 2.27 An improved project filing system was evidenced (from that seen at prior audits), with a systematic and comprehensive set of documents retained. We were advised this structure has been rolled out to all projects delivered by the UHB's Capital team to ensure a consistent approach, with spot checks undertaken by management to assess compliance. We have recommended the Project Team minutes be added to this repository, for completeness (**MA3**).
- 2.28 We have also recommended enhancements to project control documentation, including the Project Execution Plan (PEP) and the Project Team's Terms of Reference, to ensure clarity in intended arrangements (**MA3**).
- 2.29 Recognising the above, **reasonable assurance** has been determined in respect of the project governance arrangements applied to date.

Financial Assurance: *Adequate cost control and reporting systems were operated. Adequate processes and procedures were in place to validate the costs incurred to date, in accordance with the requirements of the contract. Assessment of the ongoing arrangements for the review of risk and associated management of contingency funds.*

- 2.30 The UHB received comprehensive monthly reports from its external cost adviser and produced its own internal progress reports incorporating cost performance, which were shared with the Project Team and Programme Board. Noting the ongoing cost pressures at the project, the reports clearly presented the forecast budget position, including reference to costed risks and remaining project contingency.
- 2.31 Whilst the reported financial position was discussed in detail at Project Team meetings, as noted in the *Governance* section, there was minimal discussion noted at the Programme Board (see **MA2**).
- 2.32 Cost information is reported to Welsh Government bi-monthly via the Project Progress Reports. Whilst the most recent report (July 2024) included narrative information in relation to the allocation of £330,000 discretionary capital, the cost sections did not incorporate this revised budget position (**MA4**).
- 2.33 The July 2024 valuation, in the sum of £881,755 (with an in-month payment of £181,169) was reviewed. Audit testing confirmed that the valuation had been appropriately assessed by the Cost Adviser in accordance with the NEC Option A contract conditions, and that the assessment of work done to date accorded with the project progress reports.
- 2.34 Noting the ongoing cost pressures at the project, we evidenced a robust process of risk management operating between the Project Manager, Cost Adviser and the UHB, including an up-to-date costed Risk Register incorporating Early Warning Notices. However, it was emphasised by management that the risk position was evolving and was being closely monitored, as risks continued to be re-assessed as new information emerged alongside surveys, re-design activity, and associated Contractor quotations.
- 2.35 Recognising the robust financial control processes in place, but with scope for improved scrutiny of the financial position at Programme Board in line with the responsibilities set out in the terms of reference (and in the context of the significant ongoing performance issues), **reasonable assurance** has been determined.

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Technical Assurance: *Assurance that appropriate contractual documents were in place for the Contractor. Effective management of the programme. Appropriate application of a Project Bank Account.*

- 2.36 The project has utilised the NEC Option A contract (*'priced contract with activity schedule'*), which is appropriate for the size and nature of the project, and in accordance with the approved contract strategy defined within the Business Justification Case (BJC).
- 2.37 The contract had been appropriately completed, including provisions for delay damages, and was stored securely on UHB premises. However, one UHB signature applied at the contract was not in accordance with the requirements detailed within Standing Orders (**MA5**).
- 2.38 Contractor insurances were in place in accordance with the requirements specified within the contract, with the UHB holding evidence of the current policies. Insurances were also reported in the Cost Adviser's monthly report.
- 2.39 The Contractor had submitted regular programmes for review by the Project Manager, with the latest accepted programme being Rev. 6 (see *Project Performance* section). Rev. 7 had been rejected on contractual grounds, with Rev. 8 being scrutinised at the time of the audit.
- 2.40 Recognising the programme slippage, with the works still at demolition stage, an internal programme for operational commissioning had not yet been prepared. An Operational Group was to be implemented from October 2024 onwards to manage this process. We have recommended internal governance arrangements such as these be included within the Project Execution Plan (see **MA4**).
- 2.41 A Project Bank Account was not required at this project, as the works cost was below the threshold set by Welsh Government.
- 2.42 Noting the above, **reasonable assurance** is determined in this area.

Advisers: *Appropriate appointment and contractual arrangements were in place. Assurance that delivery was adequately monitored, including fee management and monitoring and reporting arrangements.*

- 2.43 External advisers had been appointed for the following disciplines:
 - Project Management;
 - Cost Advice;
 - Design Team;
 - NEC Supervisor.

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- 2.44 It was confirmed that all appointments had been appropriately procured from existing national frameworks, with advice and sign-off from NWSSP Procurement Services, and UHB approval in accordance with the delegated limits for the procurement process.
- 2.45 We noted that Service Level Agreements / Call-Off Contracts have been utilised for the adviser appointments, as opposed to NEC Professional Services Contracts. As agreed by management within the 2023/24 UHL Endoscopy audit report, NEC contracts would be considered at projects where appropriate to the size and complexity of the instructions. Recognising the specific difficulties in project delivery and adviser performance at this project, management should assess whether the application of NEC contracts would have improved project control, as part of the recommended lessons learned exercise (see *Change Control* section, **MA7**).
- 2.46 Only the Supervisor call-off contract (via the SEWTAPS Framework) specified the required level of insurances to be held by the adviser. The UHB did not hold any evidence of the insurances held (e.g. Professional Indemnity), and advised they placed reliance on the frameworks to make these checks. It would be prudent for the UHB to understand the levels of insurance required by the respective frameworks and obtain assurance that these are appropriate to the UHB's / project's needs, and in date for the period of the associated project (**MA6**).
- 2.47 Adviser payments were appropriately monitored against detailed activity schedules.
- 2.48 Noting the above, **reasonable assurance** is determined in this area.

Change Control: *Appropriate internal and contractual change control mechanisms have been applied at the project.*

- 2.49 As referenced within the *Governance* section, a recommendation has been made that the Project Execution Plan be updated. The Project Execution Plan was lacking in UHB-specific information regarding internal change controls, such as the Project Information Form (PIF) process and delegated approval limits (see **MA3**).
- 2.50 Management advised that following previous project audit observations and a review of the internal change management process, the Capital & Estates team have amended their approach, to incorporate dynamic pricing of PIFs based on estimates, and then firming up the costs for final approval once confirmed. This provides more up to date cost information with which to assess sufficiency of risk provisions and contingency, and also enables the PIFs (initially based on estimates) to receive formal delegated approval at an earlier stage. This was seen to be operating effectively at the Mortuary project in light of the significant ongoing cost pressures.

- 2.51 The project has experienced significant change from the original design, programme and cost plan. Whilst recognising the changes result from unforeseen issues only identified once surveys and demolition works could commence, management advise that learning has taken place as the project has progressed, which will inform the delivery of future projects. The UHB should ensure this learning is documented and shared (**MA7**).
- 2.52 Noting the majority of changes had not yet been agreed, with costs continuing to be reviewed and firmed up, a sample of five agreed changes, totalling £68k, was reviewed. All had been appropriately documented and authorised (in line with UHB delegated limits). In an improvement from previous audit findings at other projects, all but one of the contractual instructions/responses reviewed had also been managed in line with the contractual timeframes, which has been facilitated by the updated PIF approval process.
- 2.53 Whilst noting the need to document and share lessons learned from this project, the controls applied in managing the volume of changes encountered were robust. **Reasonable assurance** has been determined.

Quality Assurance: *Arrangements were in place to monitor achievement of investment objectives and benefits. Appropriate controls were applied in the management of contractor and adviser performance, in line with Local Framework and contractual requirements. Assurance that appropriate quality control arrangements were in place for the works. Adequate arrangements were in place for commissioning and handover.*

- 2.54 The BJC clearly set out the intended benefits anticipated from the project, which included compliance with HTA requirements, increased capacity, rapidity of post-mortem examinations, improved productivity and improved maintenance of dignity. As discussed in para. 2.9, management have taken decisions to maintain these targeted benefits, despite the project requiring significant structural re-design. Achievement of the targeted benefits is to be measured on completion of the facilities.
- 2.55 Key Performance Indicators (KPIs) were maintained for both the Contractor and advisers, based on the Designed for Life Framework approach. Performance was assessed as good at the majority of appointments, with the exception of the design team, where timeliness in responding to the significant volume of re-design requests has been poor. This had been appropriately escalated by the UHB, with additional resource allocated to the project by the design team to mitigate the issues.
- 2.56 As discussed in the *Advisers* section, we have recommended the lessons learned exercise incorporates consideration of whether the application of NEC Professional Services contracts for advisers would have improved performance management controls (see **MA7**).

- 2.57 Monthly reports are received from the Supervisor, with weekly reports also issued to the UHB and Contractor. The majority of issues (defects) previously reported had been closed, with a small number of new issues raised at the latest report. No significant issues had been reported to date.
- 2.58 As discussed at para. 2.39, internal commissioning plans had not yet been developed, noting the delayed project timeline (see **MA4**).
- 2.59 Noting the above, **substantial assurance** has been determined in this area.

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Appendix A: Management Action Plan

Matter Arising 1: Governance - Capital Projects Manual (Design)		Impact
The UHB’s existing Capital Projects Manual was last updated and approved in 2015. There has been a planned action within Capital, Estates & Facilities (CEF) to review and update this key document for a number of years, as first agreed in 2021 as part of the department’s response to remedy compliance issues identified by the Director of Corporate Governance. The agreed recommendation made in that review was as follows: <i>"Review the capital procedures manual that was produced to provide guidance to the major capital and discretionary capital teams on key stages of project development including procurement and standing financial instructions to ensure it aligns to the current requirements" (ref CEF5)."</i> At the time of the current review, we evidenced that this activity was well underway but had not yet concluded. The UHB considered the existing manual was no longer fit for purpose and was not therefore being applied at current projects. Noting the absence of documented and agreed project controls, the ongoing review should be concluded as soon as possible.		Potential risk of: • Delivery of projects in the absence of agreed, standardised controls.
Recommendations		Priority
1.1	The review of the Capital Projects Manual should be concluded and approved as soon as possible, and brought into use for all projects delivered by Capital, Estates & Facilities as previously agreed. Saunders Nathan 08/05/2025 15:28:30	Medium

Agreed Management Action		Target Date	Responsible Officer
1.1	Agreed. A revised Capital Planning Manual in draft has been developed and is being reviewed internally. Upon completion of internal review, it will be shared with colleagues in NWSSP A&A SSu to comment and advise on any suggested amendments etc. The document will then be updated as necessary prior to it being considered within the UHB governance framework for approval, with the intention to implement from 1 st June 2025.	31.05.2025	Head of Capital Planning

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Matter Arising 2: Governance – Programme Board (Operation)	Impact
The mortuary project reports into the Acute Infrastructure & Sustainability Capital Programme Board, which provides the Project Board role for the UHB’s major capital projects. Specific responsibilities documented within the Terms of Reference, in relation to the Project Board role, include: • <i>"To oversee the delivery of projects within the timetable and cost and required quality;</i> • <i>To provide formal authority for committing resources, and obtaining appropriate approvals within the UHB, to deliver the capital projects;</i> • <i>To ensure capital and revenue risk assessment and risk management strategies are in place for each scheme and monitored regularly;</i> • <i>To ensure the schemes deliver value for money;</i> • <i>To ensure and monitor adherence to the project programme and to report variance;</i> • <i>To ensure there are mechanisms in place to minimise the disruptive effects of the projects on the running of the UHB, its staff, patients and visitors".</i> The Programme Board meetings reviewed were attended by both the mortuary project’s Senior Responsible Officer and Project Director, with the internal Project Progress Report shared with members. Whilst the Progress Report contained comprehensive detail on the project’s progress, risks etc., the minuted discussions were minimal and not reflective of the current time and cost risks facing the project (or associated implications of the same). It is recognised that the most recent minutes (August 2024) were not available during the audit, and it could not therefore be confirmed whether the recent escalation of risks received greater focus. Whilst noting the above, it is recognised that the escalating costs had been reported to Capital Management Group for executive scrutiny and approval of additional funding.	Potential risk of: • The project is not subject to sufficient oversight and scrutiny, which may compromise informed decision making.

Recommendations		Priority	
2.1	The Acute Infrastructure & Sustainability Capital Programme Board should demonstrate that sufficient scrutiny and oversight is afforded to the mortuary project, noting the significant time and cost risks currently faced.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	As an ongoing live project, the Director of Capital, Estates and Facilities reports progress and highlights risk on a monthly basis to the Capital Management Group. This group is responsible for the financial delivery of a scheme and recommends increases or otherwise to the funding of projects. Due to the uplift required for this scheme, the report requesting additional funding was discussed in the UHB Capital Management Group, the Senior Leadership Board and Board, where the additional funding was finally endorsed. In addition, the Project Team status reports and minutes are included in the papers for the Acute Infrastructure Board and the progress, programme and costs reported accordingly along with any decisions/issues for escalation.	Completed	Director of Capital, Estates and Facilities

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Matter Arising 3: Governance - Project Control Documentation (Operation)		Impact
The Project Execution Plan (PEP) was prepared by the external Project Manager and had last been updated in May 2024 to reflect changes to the completion date; it was therefore up to date and being managed as a "live" document. Whilst comprehensive in areas such as the advisers' roles, NEC procedures (risk, change, programme etc.), this in places appeared generic, and excluded key matters of UHB control such as the PIF process, internal delegated authority limits, internal risk management etc. It also did not document the project structure in terms of Project Board/Project Team and associated terms of reference (only focusing on the progress / commercial meetings which involve the external advisers), detail the Senior Responsible Officer, or the plans to initiate an Operational Group to manage operational commissioning. It was also noted the Project Team terms of reference could be improved, in that it appeared out of date (compared with Project Team discussions regarding memberships), did not specify a quorum, and referenced monitoring against a Management Control Plan, which was not in place. Whilst we evidenced an improved and comprehensive project filing structure (compared with that seen at prior project reviews), Project Team minutes were not filed within the structure and were not readily available to the Project Team.		Potential risk of: • Inadequate documentation of intended project controls (particularly recognising the absence of a current Capital Projects Manual); • Key documents are not easily accessible.
Recommendations		Priority
3.1	The Project Execution Plan should be appropriately tailored to the UHB's internal control requirements, including for example: • Project Governance structure, including role and function of the Project Board and Project Team, detail of the SRO and plans for the implementation of an Operational Group to manage operational commissioning; • Change Management process, including PIF process and delegated limits; and	Low

	Internal Risk Management process.		
3.2	The Project Team terms of reference and Project Team function should be reviewed, including: - Whether ToR v2 needs updating to reflect additional members as agreed by the Project Team; and - Whether there would be a benefit to specifying a quorum.	Low	
3.3	Project Team minutes should be filed within the project filing structure.	Low	
Agreed Management Action		Target Date	Responsible Officer
3.1	Agreed.	Complete	Head of Capital Planning
3.2	ToR v2 will be updated to reflect the additional members agreed by the project team, and a specified quorum will be considered going forward on further schemes.	Complete	Director of Capital, Estates and Facilities
3.3	Agreed.	Complete	Head of Capital Planning

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Matter Arising 4: Financial Assurance - Welsh Government Reporting (Operation)			Impact
The July 2024 Project Progress Report (PPR) submitted to Welsh Government, noted the approval of £330k from discretionary capital within Section 7 of the report. However, the revised budget position was not included within Section 11 of the report. The forecast outturn, both in total and under each budget area had also not been updated. It is noted a similar recommendation was made at the 2023/24 UHL Endoscopy audit report (recommendation 1.2).			Potential risk of: Inaccurate financial position presented to Welsh Government.
Recommendations			Priority
4.1	WG PPRs should be updated at Section 11 to reflect the allocation of discretionary capital funds to the project budget, and the forecast outturn cost in total and under each budget area.		Medium
Agreed Management Action		Target Date	Responsible Officer
4.1	Information was provided in the narrative; however, the comment is noted and will be addressed going forward.	Complete	Head of Capital Planning

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Matter Arising 5: Technical Assurance – Contract Authorisation (Operation)		Impact	
Standing Orders ref. 9.0.2, in respect of signing and sealing documents, states: "Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal." The main contract was executed under seal, signed by the Chief Executive and a member of the Corporate Governance team. The Corporate Governance department have advised that the contract signing was urgent, and the required second representative was not available. We have been advised by management that this issue has not occurred again at other contracts signed within the UHB.		Non-compliance with Standing Orders.	
Recommendations		Priority	
5.1	Contracts should be signed in accordance with the UHB’s Standing Orders.	Medium	
Agreed Management Action		Target Date	Responsible Officer
5.1	All contracts including signing/sealing etc are completed in line with the relevant Governance procedures and orders are not progressed until contracts are completed appropriately and approved in line with SFI’s	Complete	Director of Corporate Governance

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Matter Arising 6: Advisers - Insurances (Operation)		Impact	
Whilst recognising (as per MA1) the Capital Projects Manual is out of date and currently being updated, the extant version states: <i>"The Project Manager is responsible for establishing that all appointed consultants hold the current, relevant insurances."</i> At the Mortuary project, advisers were appointed from both the SBS framework (Design Team, Cost Adviser and Project Manager) and SEWTAPS framework (Supervisor). Only the Supervisor Service Level Agreement (SLA) specified the required Professional Indemnity Insurance limit, with the SBS SLAs not making reference to insurances. The UHB had not evidenced whether the insurances held by the advisers met their requirements, and advised they placed reliance on the frameworks to have checked the insurances and ensured these remained in date for the duration of the framework agreement (and project duration).		The UHB may not be adequately protected if adviser insurances are insufficient or out of date.	
Recommendations		Priority	
6.1	The UHB should liaise with the relevant frameworks and obtain assurance that appointed advisers hold (and maintain) appropriate Professional Indemnity Insurance for the period of the contract and thereafter.	Medium	
Agreed Management Action		Target Date	Responsible Officer
6.1	The UHB will ensure a process is in place with procurement, so on further schemes insurances documents are included from the outset.	31.03.25	Head of Capital Planning

Matter Arising 7: Change Control – Lessons Learned (Operation)		Impact
As discussed in the <i>Project Performance</i> section, the UHB was unable to undertake invasive surveys ahead of commencement of works, as the mortuary was a live environment. There was also an absence of as-built information available to inform the planning process. The extent of issues revealed as demolition commenced and invasive surveys were undertaken far exceeded the provisions included within the BJC and the contract. The impact has been a significant forecast overspend of circa £923k at the time of reporting, and associated delays of four months. Management has confirmed that lessons learned have been identified during project delivery, which will inform the approach to future projects planned for the UHW site (whilst recognising that there may be limited opportunity for applying a different approach). It should be ensured this learning is appropriately documented, to act as a central reference point within Capital and Estates, and also reported to an appropriate governance forum.		Staff turnover may risk the loss of learning that could benefit future projects.
Recommendations		Priority
7.1	Lessons learned from the delivery of the Mortuary project should be documented, shared with relevant teams within the UHB, and reported to an appropriate forum (e.g. CMG/Programme Board). The issues considered may include for example: - The positive management controls applied at this project that would benefit application at future projects; - assurance that arrangements are now in place to centrally hold the new build/survey information obtained from this project; - the potential benefits of undertaking a wider review to identify any gaps in build/survey information across the site, to inform risk assessment of future projects;	Medium

	• that at future projects that may be similarly impacted, time will be taken for appropriate intrusive surveys ahead of commencement of works; • assurance that at future projects that may be similarly impacted, the UHB will ensure sufficient contingency is built into the business case, for consideration by WG; • that at future projects, where WG do not approve the full requested contingency, or where there are significant uncertainties regarding risk, the Board be appropriately informed of the associated risks to the UHB; • whether the application of NEC Professional Services Contracts for the advisers would have enabled better performance management / control aligned with the NEC Option A contract, and that adviser contract strategy at future projects will be detailed in the business case.		
Agreed Management Action		Target Date	Responsible Officer
7.1	Lessons learned from this scheme will be shared with other projects. It is difficult to ensure you have sufficient contingency built in to a project if you are not aware or are unable to reasonably assess the “unknowns”. In this project was it reasonable to assume the depth of the slab, no, it had not been encountered within the UHW site previously or had been referenced on existing drawings. Therefore, without an intrusive destructive survey the slab depth was not known, a fair assumption was made and costs and design applied. The reason for the additional cost of this project has been well documented in reports issued to the Capital Management Group and the Senior Leadership Board of the Health Board, therefore the issues of the slab thickness have been well documented and recorded for future reference.	Completed	Director of Capital, Estates and Facilities

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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Interventions Not Normally Undertaken

Final Internal Audit Report

December 2024

Cardiff & Vale University Health Board



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Committee:	Audit & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The overall objective of this review was to determine if there are effective arrangements and processes in place to support consistent application of Interventions Not Normally Undertaken (INNU) across the Health Board.

Overview

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

- The Health Board does not currently have a complete set of Hospital Health Pathways in place to aid consistent application of the INNU policy.
- INNU policy only covers some of the interventions which Welsh Government considers should be covered.
- Lack of concise evidence on patient files to support the need for an INNU to take place meant we were unable to undertake testing to ensure compliance with the policy.
- Issues have been identified in relation to the completeness of the INNU monitoring report in place.
- Regular and effective review of the underlying data does not take place.
- Regular and appropriate INNU monitoring updates are not provided to the Quality, Safety and Experience Committee.

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

Report Opinion

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary¹

Objectives		Assurance
1	Policy and procedures are in place	Limited
2	The correct process has been followed to support INNU decisions	Not assessed
3	'Do-Not-Do' interventions are not undertaken	Substantial
4	Compliance against the policy is adequately monitored and reported	Limited

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	Clinical Pathways require updating	1	Operation	High
2	The updated IPFR policy is not available on the Health Board's SharePoint and public website	1	Operation	Medium
3	INNU report issues	2	Operation	Medium
4	Lack of clear evidence to support interventions taking place	2	Design	High
6	There is no effective INNU monitoring mechanism in place	4	Operation	High

1. Introduction

- 1.1 Our audit review of Interventions Not Normally Undertaken (INNU) was undertaken in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 To ensure the Health Board delivers its aims, objectives, responsibilities, and legal requirements consistently, consideration has been given to ensure that only effective treatments are undertaken, and resources are only used for procedures where there is a benefit to the patient. As such, a number of interventions that are not normally undertaken, have been identified where there is:
 - currently insufficient evidence of clinical and /or cost effectiveness; or
 - the intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG); and/or
 - the intervention is considered to be of relatively low priority for NHS resources.
- 1.3 In clinically exceptional circumstances, where a clinician believes a patient should receive an INNU listed treatment an Individual Patient Funding Request (IPFR) application can be made for consideration by the IPFR panel.
- 1.4 In addition, a number of 'Do-Not-Do' interventions also exist, for which there are no exceptions as they are not supported for use under NICE Guidance.
- 1.5 The relevant lead for this review is the Executive Director of Public Health.
- 1.6 The potential risks considered in the review were:
 - Patients undergo procedures that only have marginal effectiveness, are ineffective or have limited clinical value;
 - NHS resources are not used in the most effective way; and/or
 - Patients are not treated equitably.

2. Detailed Audit Findings

Objective 1: An up-to-date INNU policy and supporting procedures are in place and accessible to all relevant stakeholders.

- 2.1 The Health Board has an Interventions Not Normally Undertaken (INNU) policy in place which includes detailed clinical guidance regarding each of the listed procedures which was approved in August 2022 and is due for review in October 2025.
- 2.2 In August 2023, Welsh Government (WG) issued 'INNU New National Approach' guidance to all Health Boards to try to achieve a consistent national approach regarding identification of INNUs and application of the INNU list:

- The WG guidance lists 139 interventions which they consider have limited or no clinical benefit. The WG have requested all Health Boards to review their list and ensure that the procedures only find their way onto treatment pathways where there is likely to be a clear clinical benefit.
 - Of the 139 interventions listed, 45 (32%) are listed by WG, within an annex A of the guidance, as being covered by the Health Board's policy and 94 (68%) are listed as not covered by the Health Board's policy.
- 2.3 We have since been advised by the Value in Health Programme Manager that the Health Board follows WHSCC policy where they exist for INNU procedures listed. 37/94 (39%) have live policies to refer to and are linked in the local policy. It has been agreed that each procedure will be explicitly listed in a revised local policy and WHSCC link provided in this format. Subsequently, 57/94 (60%) require consultation with clinical leads to be added to the local INNU as not previously listed. Work is being undertaken to update 19/94 where other Health Boards have policies, and this aims to be completed by quarter 3 2024/25. The remainder require an evidence review and further discussion at a national level prior to updating the list (38/94).
- 2.4 While the Health Board has undertaken some work in reviewing the list of INNUs specified by WG, including reviewing the policies and procedures that are in place and identifying where there are gaps, work on implementing this WG guidance is yet to be fully completed as they are awaiting work to be completed by Health Technology Wales (HTW). **(Matter Arising 1 – Medium Priority)**
- 2.5 As per paragraph 2.3, the Health Board has undertaken some work on the new Hospital Health Pathways portal. However, they do not have a complete set of Hospital Health Pathways in place to aid consistent application of the INNU policy. We have since been advised by the Value in Health Programme Manager that the Health Board have received an All Wales guidance list and a review of documentation held on Community HealthPathways for the respective INNU procedures was completed. A summary paper was circulated to the INNU working group in December 2024 and actions are to be completed by quarter 3 2024/25. **(Matter Arising 1 – High Priority)**
- 2.6 The Health Board's INNU policy includes eight (18%) interventions that do not have clinical codes attributed to them to aid identification, categorisation and monitoring. It is uncertain if these codes exist. **(Matter Arising 1 – Medium Priority)**
- 2.7 The Health Board has dedicated pages on INNU on its SharePoint and public website which provide a comprehensive source of relevant information.
- 2.8 The Health Board adopted the latest All Wales IPFR policy in February 2024. However, its SharePoint and public websites show the preceding version. We were informed by the IPFR Administrator that the All Wales Lead for IPFR believes there are discrepancies in the updated version and that discussions are being held on how it should be amended. **(Matter Arising 2 - Medium Priority)**

Conclusion:

2.9 While the Health Board has an INNU policy in place and SharePoint pages which provide a comprehensive source of relevant information, the policy only covers 32% of the interventions which WG considers should be covered and only limited work has been undertaken to address the remainder as the Health Board are awaiting evidence appraisals from HTW. Furthermore, the Health Board does not have a complete set of Hospital Health Pathways in place to aid consistent application of the INNU policy. We have provided **Limited Assurance** for this objective.

Objective 2: Where INNUs are undertaken, the correct process has been followed to support the decision to carry out the intervention.

2.10 To undertake testing of a sample of INNU, we were initially provided with a detailed transaction report covering the period July 2023 – June 2024. Reviewing this, we noted that:

- There were differences in the number of INNU cases shown compared with the routine monitoring report for the same period considered under objective 4. This was due to the underlying data having been changed since the routine report was run. **(Matter Arising 3 – Medium Priority)**
- The transaction report lists 39 types of INNU whereas Welsh Government's review in August 2023 lists 45 types for the Health Board and the Health Board's own policy lists 48. **(Matter Arising 3 – Medium Priority)**
- 163 clinicians undertook INNU procedures of which:
 - The largest admission methods were waiting list (60%) and Maternity Antepartum (23%). **(Matter Arising 3 – Medium Priority)**
 - There were four 'dummy' clinicians listed. **(Matter Arising 3 – Low Priority)**

2.11 We tested a sample of 30 INNU cases and established that IPFR applications had not been received or processed for them. Furthermore, no IPFR applications had been received or processed for any other interventions listed in the report for the period July 2023 to July 2024. However, we do not know whether IPFR applications were required for these cases, or if they met the criteria for access.

2.12 We planned to test these INNU cases to underlying patient records. However, there was no guidance in place setting out how evidence should be retained within patient files to confirm the patient met the criteria for an INNU to take place. As such, without significant clinical support to review the documentation contained in each of the files in our sample, we were unable to complete this test. **(Matter Arising 4 – High Priority)**

2.13 The lack of a summary document or checklist on patient files could hinder staff within the Health Board undertaking any monitoring of INNU activity. Similarly, there is a lack of evidence of cross checking or approval being carried out to confirm

the INNU policy criteria has been met ahead of adding a patient to a relevant waiting list. **(Matter Arising 4 – High Priority)**

Conclusion:

2.14 Due to the lack of a standardised approach for capturing information on patient files if it is believed the criteria for an INNU has been met, we have been unable to fully perform our planned testing. As such, we have not been able to provide an assurance opinion for this objective.

Objective 3: Interventions listed as 'Do-Not-Do' are not undertaken.

2.15 Where an intervention is 'Do-Not-Do', this is stated within the INNU policy.

2.16 There are eight interventions categorised as 'Do Not Do'. Of these, the Health Board's INNU monitoring report indicates that seven of them had no cases during July 2023 – June 2024.

2.17 However, for the eighth intervention, there was no row in the INNU monitoring report and so there is a lack of positive confirmation that there were no cases during the period. **(Matter Arising 5 – Low Priority)**

Conclusion:

2.18 Interventions listed as 'Do-Not-Do' are generally not undertaken. However, one intervention was not covered by the Health Board's INNU monitoring report. We have provided **Substantial Assurance** for this objective.

Objective 4: Mechanisms are in place to monitor compliance against the policy, with compliance / non-compliance appropriately reported.

2.19 An INNU report is generated showing the numbers of cases for each type of INNU for each month and the cumulative totals for the 12 months to date and distributed to a standard group of staff on a monthly basis. Recipients can access and drill down into the data by accessing the underlying Business Intelligence System (BIS).

2.20 From our review, it was identified that:

- The number of types of INNU procedures in the report (39) differs to the number in the list in the Health Board's policy (48). **(Matter Arising 3 – Medium Priority)**
- A regular and effective review of the underlying data does not take place. **(Matter Arising 6 – High Priority)**

2.21 Furthermore, no escalation process is in place, and regular and appropriate INNU monitoring updates are not provided to the appropriate Committee. **(Matter Arising 6 – High Priority)**

Conclusion:

2.22 While an appropriately structured INNU report is generated and distributed monthly, a regular and effective review of the underlying data does not take place.

Furthermore, no escalation process is in place and regular and appropriate INNU monitoring updates are not provided to the Quality, Safety and Experience Committee. We have provided **Limited Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: The INNU policy & Clinical Pathways require updating (Operation)	Impact
The Health Board has an INNU policy in place which includes detailed clinical guidance regarding each of the listed procedures. It was approved by the Quality, Safety and Experience (QSE) Committee on the 30 August 2022, and published on the 2 September 2022 and is due for review in October 2025. On 25 August 2023, Welsh Government (WG) issued guidance to all Health Boards regarding INNUs to try to achieve a consistent national approach across Wales regarding identification of INNU and application of the INNU list. This lists 139 interventions which they consider have limited or no clinical benefit. WG requested all Health Boards to review their list and ensure that only the procedures listed should be undertaken unless alternatives have been tried and failed. It has been agreed that Health Technology Wales (HTW) will undertake a review. In such cases, an exemption should be requested using the Individual Patient Funding Request (IPFR) process. While the Health Board has undertaken some work reviewing the list of INNUs provided by WG, including reviewing policies and procedures that are in place and identifying where there are gaps, work on implementing this WG guidance is yet to be completed as the Health Board are awaiting the review by HTW. The Health Board does not have a complete set of Hospital Health Pathways in place to guide clinicians regarding the actions which should be taken and so aid consistent application of the INNU policy. The Health Board’s INNU policy includes eight (18%) interventions that do not have clinical codes attributed to them to aid identification, categorisation and monitoring. These are: 1. Clinical Diagnostic and Therapeutics Radiology - Open MRI scans; 2. Surgery Orthopaedics - Electrical & electromagnetic field treatments bone non-union; 3. Surgery Orthopaedics - Abrasion arthroplasty; 4. Surgery ENT - Nasal surgery for snoring; 5. Surgery Neurosurgery - Subthalamic nucleotomy for Parkinson’s disease; 6. Medicine Gastroenterology - pH/Manometry Impedance Studies; 7. Medicine Respiratory Children & Women CAMHS - Melatonin for delayed sleep phase disorder; and 8. Medicine Stroke services Clinical Diagnostic and Therapeutics General rehabilitation - Slings and Pulleys.	Potential risk that the Health Board’s INNU policy is not consistently applied which may result in patients undergoing interventions that have marginal effectiveness, NHS resources not being used in the most effective way, and patients not being treated equitably.

Recommendations		Priority	
1.1	A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy.	High	
1.2	Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns.	Medium	
1.3	Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.	Medium	
Agreed Management Action		Target Date	Responsible Officer
1.1	Community HealthPathways is in place and actions from the review following the notification from WG is due for completion Q4 24/25. There is an ambition to upload guidance onto the Hospital HealthPathways platform to support secondary care clinicians with patient management in line with the INNU policy. This is due for completion ~Q3 25/26 depending on other project priorities. As Community HealthPathways is the most impactful platform to support patient management we feel these timelines are appropriate to respond to the matter arising.	Community HealthPathways- March 2025 Hospital HealthPathways- October 2025	Sophia Jones Value in Health Programme Manager
1.2	The INNU Policy is due for revision Q2-2025 however activities commenced early (2023) to respond to the WG Guidance letter as referenced above. Clinical leads of each speciality area have been notified of the procedures within their respective areas listed in the Welsh Government (WG) issued 'INNU New National Approach' guidance. They have been requested to provide approval for the procedures to be included in the CAVUHB policy and to confirm the narrative attached to each procedure is appropriate. This activity is scheduled to be	March 2025	Sophia Jones Value in Health Programme Manager

	completed by end of Q4 24/25, however there is still a requirement for an evidence review to be completed from HTW prior to publishing.		
1.3	Revision of the INNU policy will include revision of the OPCS codes for each procedure. Where there are no codes available, our digital and informatics team will determine if there are appropriate codes to utilise. If not, we will raise this with the National Clinical Effectiveness team.	March 2025	Sophia Jones Value in Health Programme Manager Kerry Ashmore Head of Business Intelligence

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Matter Arising 2: The updated IPFR policy is not on the Health Board's intranet and public website (Operation)		Impact	
The latest All Wales IPFR policy was adopted by the Health Board's Quality, Safety and Experience Committee on the 13 February 2024. However, the Health Board's SharePoint and public website show the previous version. We were informed by the IPFR Administrator that the All Wales Lead for IPFR believes that there are discrepancies in the updated version that are not in line with the advice provided by the King's Council in their original draft of the updated policy and so discussions are being held on how the new policy should be amended. In addition, the link to the NHS Wales IPFR Application Form on the public website did not work.		Potential risk that the Health Board's IPFR policy is not consistently applied which may result in patients undergoing interventions that have marginal effectiveness, NHS resources not being used in the most effective way, and patients not being treated equitably.	
Recommendations		Priority	
2.1	Progress regarding the All Wales IPFR policy should be monitored so that resolution of the discrepancies is promptly identified. When this occurs, the amended policy should be presented to the Quality, Safety and Experience Committee for adoption, and then made available on the Health Board's intranet and public website.	Medium	
2.2	The link to the NHS Wales IPFR Application Form on the public website should be updated so that it works correctly.	Low	
Agreed Management Action		Target Date	Responsible Officer
2.1	The JCC (formerly WHSSC) met with panel chairs on the 18th of September to discuss the discrepancies with the updated IPFR policy. A number of wording discrepancies in the IPFR policy were identified. The IPFR Policy is currently being reviewed, and the final version of the IPFR Policy will be shared and sent to the Health Boards for approval. The Lead for Clinical Commissioning/IPFR has not confirmed a completion date or when we are likely to receive a final version of the IPFR Policy. Saunders Nathan 08/05/2025 15:48:33	March 2025	Gemma Farley-Hoyland IPFR Administrator

2.2	We will review links on our external website and relink as necessary.	November 2024	Gemma Farley-Hoyland IPFR Administrator

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Matter Arising 3: INNU report issues (Operation)				Impact
To undertake testing of a sample of INNU, we were initially provided with a detailed transaction report covering the period July 2023 – June 2024. Reviewing this, we noted that there were differences in the number of INNU cases shown compared with the routine monitoring report for the same period. Specifically:				Potential risk that the Health Board’s INNU policy is not consistently applied which may result in patients undergoing interventions that have marginal effectiveness, NHS resources not being used in the most effective way, and patients not being treated equitably.
Month	Total number of INNU cases per the transaction report run for the audit	Total number of INNU cases per the routine monitoring report	Difference in the total number of INNU cases	
July 2023	243	242	1	
September 2023	213	212	1	
March 2024	214	212	2	
April 2024	296	272	24	
May 2024	247	192	55	
June 2024	121	66	55	
Difference in the total number of INNU cases			138	
The Information Analyst who provided the report stated that the differences were due to the underlying data having been changed i.e. additional records had been coded since the report was previously run. We have since been advised that the Health Board code in arrears so there will be discrepancies. The report lists 39 types of INNU procedures whereas Welsh Government's review in August 2023 lists 45 types for the Health Board and the Health Board’s own policy lists 48. From review of the transaction report, we identified that 163 clinicians undertook INNU procedures of which: • The largest admission methods for INNU procedures were waiting list (60%), Maternity Ante-partum (23%). • There were four ‘dummy’ clinicians listed as undertaking INNU cases. ‘Midwifery, Ob’ had undertaken 20% of all the total number of INNU cases within the Health Board. The other ‘dummy’ clinicians were ‘Ent Paeds, Dr Consultant’, ‘Paediatrics, Dr Consultant’ and ‘Urology, Dr Consultant’.				

Recommendations		Priority	
3.1	The reason for data being changed should be identified and corrective action taken as this should not occur.	Medium	
3.2	The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved.	Medium	
3.3	Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards.	Medium	
3.4	Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	Low	
Agreed Management Action		Target Date	Responsible Officer
3.1	CAVUHB, as with all other health boards across Wales, are experiencing challenges within clinical coding workforce capacity. There is a National and local programme of work underway to address this. Whilst the programme of work progresses, review of procedure numbers will be reviewed against 4 months prior for any additions and process will be followed as per 4.3.	March 2025	Sophia Jones Value in Health Programme Manager
3.2	Action being taken is described in 1.1. Included within this is a revision and update of the Health Board's report once codes have been identified.	March 2025	Kerry Ashmore Head of Business Intelligence
3.3	The INNU procedure monitoring list will be reviewed by the Value in Health Programme monthly. Quarterly, each clinical board will be required to review the top 5 interventions with the highest procedure count over the period. They will be requested to review the	March 2025	Sophia Jones Value in Health Programme Manager

	appropriateness of these procedures against the INNU policy and provide feedback and an action plan if needed to the INNU working group.		
3.4	The INNU working group will investigate the reason for using 'dummy' clinician listings and confirm a process to review these.	March 2025	Sophia Jones Value in Health Programme Manager

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Matter Arising 4: Lack of clear evidence to support interventions taking place (Design)			Impact
As part of our fieldwork, we considered reviewing patient files to determine if there was sufficient evidence to support the decision for the patient to be added to an INNU list. However, this approach would have required clinical input to help analyse the contents of the files. Given the clinical time and resource this would have required, a decision was made to not progress with our testing.			Potential risk that interventions are inconsistently carried out, without supporting evidence, with marginal benefit to the patient and at a cost to the Health Board.
Recommendations			Priority
4.1	For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy has been met.	High	
4.2	Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	High	
Agreed Management Action		Target Date	Responsible Officer
4.1	We will work with clinical leads to ensure that a clear record is retained within the patient record to demonstrate compliance with the INNU policy if there is a clinical exception.	March 2025	Sophia Jones Value in Health Programme Manager
4.2	We will work with the clinical leads to develop an appropriate process to do this. We will consider good practice existing within the health board, such as the tonsillectomy pathway to inform the process we will take across the piece.	March 2025	Sophia Jones Value in Health Programme Manager

Matter Arising 5: 'Do-Not-Do' interventions (Operation)		Impact	
The INNU policy states interventions that are 'Do-Not-Do'. From review of the policy, we identified eight interventions categorised as 'Do Not Do' and checked whether any cases were reported in the Health Board's INNU monitoring report for July 2023 – June 2024. For seven of the eight interventions, a row was included in the Health Board's INNU monitoring report which indicated that there were no cases during the period. However, for the eighth intervention 'Nasal surgery for snoring', there was no row in the Health Board's INNU monitoring report and so there was no positive confirmation that no cases occurred during the period. However, we can confirm that the report did not record any instances of this intervention having been undertaken.		'Nasal surgery for snoring' interventions may be undertaken in contravention to the INNU 'Do-Not-Do' policy.	
Recommendations		Priority	
5.1	'Do-Not-Do' intervention 'Nasal surgery for snoring' should be included in the Health Board's INNU monitoring report so that occurrence of cases can be monitored.	Low	
Agreed Management Action		Target Date	Responsible Officer
5.1	An OCPS code for this procedure is not provided on the All Wales Guidance List. As mentioned above, our digital and information team will endeavour to source an alternative code to track this procedure. If not possible, this will be escalated to the National Clinical Effectiveness Group.	March 2025	Kerry Ashmore Head of Business Intelligence

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Matter Arising 6: There is no effective INNU monitoring mechanism in place (Operation)		Impact
An INNU report is auto generated which shows the numbers of cases for each of the 39 types of INNU each month and the cumulative totals for the 12 months to date. The report is auto distributed by email on the 21st of each month. Recipients of the report can access and drill down into the underlying data by clicking the link at the bottom of the email and entering their Business Intelligence System (BIS) login details when prompted. The monthly report is distributed to ten people who work in Operations (3), Surgery Clinical Board (3), Medicine Clinical Board (1) and the Commissioning Team (3). We emailed each of the recipients questioning if any action was taken on receipt of the monthly emails to monitor compliance against the INNU policy to which we received replies from all of them. In summary, it appears that minimal action is generally taken by staff on receipt of the auto generated emails and the distribution list needs to be reviewed and updated so that the emails are sent to all appropriate staff. There is no escalation process in place for those INNU cases recorded on the report. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. Furthermore, it was evidenced that no INNU monitoring updates have been provided to an appropriate Committee.		Potential risk that the Health Board's INNU policy is not consistently applied which may result in patients undergoing interventions that have marginal effectiveness, NHS resources not being used in the most effective way, and patients not being treated equitably.
Recommendations		Priority
6.1	The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete.	High
6.2	All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur.	High
6.3	An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director.	High

6.4	Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	Medium	
Agreed Management Action		Target Date	Responsible Officer
6.1	This will be taken forward and immediately actioned.	December 2024	Sophia Jones Value in Health Programme Manager
6.2	As per response in 3.3	March 2025	Sophia Jones Value in Health Programme Manager
6.3	As per response in 3.3	March 2025	Sophia Jones Value in Health Programme Manager
6.4	Any updates/amendments to the INNU Policy will be processed through the QSE Committee. A process for monitoring of INNU policy compliance and quarterly reporting of this will be developed to ensure the most appropriate forum receives the update and supports management of INNU's. Management of INNUs sits within the clinical service remit. Assurance is within the role of the QSE committee.	March 2025	Sophia Jones Value in Health Programme Manager

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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Follow-up: Implementation of Health Roster System

Final Internal Audit Report

January 2025

Cardiff & Vale University Health Board



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University Health Board



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Auditors:	Lucy Jugessur, Deputy Head of Internal Audit
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Committee:	Audit and Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system

Executive Summary

Purpose

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of the agreed management actions from the Implementation of Health Roster System (CVU 2324-09) review that was reported as part of our 2023/24 work programme.

Overview of findings

Management have made some progress in addressing the recommendations, and the management actions detailed in the initial Final Internal Audit Report.

Of the nine recommendations made, five of them have been closed, including one of the high priority recommendations. There is a Safecare dashboard in place which records the Safecare compliance for day and night.

One recommendation is partially complete with the high recommendation having moved down to low.

The remaining three recommendations, with two highs and a medium priority, have not moved. Whilst we can see some actions have been implemented, the underlying issues have not been addressed as there are still a considerable number of rosters not being produced on a timely basis. In addition, rosters are not being consistently verified and finalised. The auto-rostering functionality uptake has improved but is still below the Health Board’s target.

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Follow-up Report Classification

		Trend
Limited	Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.	↔

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Rostering procedure requires updating	Low	↑	Closed
2	Roster process is not timely	High	↔	High
3	HealthRoster system segregation of duties	Medium	↑	Closed
4	Auto-rostering functionality uptake	Medium	↔	Medium
5	Annual leave requests	Low	↑	Closed
6	Annual leave interface	Low	↑	Closed
7	Incorrect working hour balances	High	↑	Low
8	Roster verification and finalisation	High	↔	High
9	Safecare census missing patient data	High	↑	Closed

1. Introduction

- 1.1 The follow-up review of ‘Implementation of Health Roster System’ was completed in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the ‘Health Board’). The opinion provided through this review is a key component, which will inform the Head of Internal Audit’s Annual Opinion.
- 1.2 This was a follow-up review of the original report that was issued in November 2023. This identified nine issues and resulted in an overall assurance rating of ‘Limited Assurance’.
- 1.3 The Lead Executive Directors for this review are the Executive Director of People & Culture and the Executive Nurse Director.

Audit Risks

- 1.4 The potential risks considered in the original review were as follows:
 - Late preparation and agreement of rosters may impact the work life balance of staff;
 - Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and
 - Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

2. Findings

- 2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	4	1	1	2
Medium	2	1	-	1
Low	3	3	-	-
Total	9	5	1	3

- 2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

Appendix A: Management Action Plan

Previous Matter Arising 2: Roster process is not timely (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that rosters are created, approved and published in line with the roster timetable.		High
Management Response	Target Date	Responsible Officer
The Corporate Nursing Team (working with the e-rostering team) are producing monthly reports for Roster Managers, Senior and Lead Nurses. The reports contain information on rosters that have not been approved or not approved in accordance with the rostering timetable. Recently these reports have been sent to Clinical Board DoN requesting that more focus is placed on the importance of publishing the roster 6 weeks in advance. Compliance will be monitored monthly via the Rostering KPI dashboard.	31/03/2024	Emma Davies, Senior Nurse, Nurse Staffing Levels Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards
Current findings		Residual Risk
Weekly notifications are sent to remind staff that the rostering timetable needs to be complied with. Reports are sent to Roster Managers, Lead and Senior Nurses and Clinical Board Director of Nurses. Roster reviews have been undertaken with a number of the wards and one of the areas that is considered within the reviews is 'whether the rosters are partially and fully approved on time'. We were provided with a report, and it highlighted the number of rosters on time, late and unapproved for the seven Clinical Boards and the Corporate Division for the roster periods 31 st March to 18 th August 2024. During that period there were 2780 rosters and of these 1370 (49%) were late and 154 (6%) were still unapproved at the time of our audit. Below is a table of the numbers of on time, late and unapproved rosters for that period:		- Late preparation and agreement of rosters may impact the work life balance of staff; - Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks.

Clinical Board	On time	Late	Unapproved	Grand Total
Specialist Services	260	239	31	530
Surgical	249	242	14	595
Medicine	207	238	44	489
Mental Health	146	241	15	402
Children & Women	188	166	23	377
CD&T	102	147	13	262
PCIC	92	83	13	188
Corporate	12	14	1	27

Conclusion: This recommendation is not completed.

New Recommendations		Priority
2.1	Rosters need to be published on time in line with the roster timetable and also approved.	High
Management Response		Responsible Officer
2.1	In response to many rosters not being published 6 weeks before they commence, a new monthly report has been developed to identify both the number and percentage of wards/departments who are not issuing their rosters on time for each Clinical Board. This is presented at the Nursing and Productivity Group each month to ensure	Carys Fox / CB Directors of Nursing

this is being performance managed by the Clinical Board Directors of Nursing. However, due to the current way that theatre lists are configured, this means that the same target for peri-operative staff cannot be included at this time but will however aim to achieve this same objective but over a longer period.		

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Previous Matter Arising 4: Auto-rostering functionality uptake (Operation)		
Original Recommendation		Original Priority
The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.		Medium
Management Response	Target Date	Responsible Officer
- The e-rostering team have just undertaken roster reviews with approx. 45 ward areas, this was an in-depth review which took 50 days in total. The team are working with Roster Managers daily to ensure the rules and parameters they need are built into the HealthRoster system. The aim is to build confidence in the function, change behaviours and increase the number of rosters that are created using the auto-roster functionality. The improvement will be monitored monthly through the KPI dashboard. - The e-rostering Leads (3x band 6) are aligned to CBs to ensure that Roster Managers have the appropriate level of support to use the system to its full potential, including auto rostering.	31/03/2024	Paul Jones, E-Rostering Manager Roster Managers, Clinical Boards
Current findings		Residual Risk
Roster reviews have been undertaken with the wards and it was evidenced that the usage of the auto-roster functionality was discussed within these reviews. The e-rostering Leads have been aligned to the Clinical Boards to provide support as required. We were advised by the E-Rostering Manager that to produce a roster it has been agreed that: 25% of roster completion should be undertaken via requests from the staff; 50% of roster completion should be through auto-rostering; and - The remaining 25% of roster completion should be then completed by the Rostering Manager.		- Ineffective rostering arrangements may impact high quality standards of care and create an exposure to greater clinical risks; and - Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the

We were provided with a report of all rosters for the roster dates 31st March to the 18th August 2024 and it showed the % of rosters that had been auto-rostered. There were 2780 rosters and the average % of rosters that had been auto-rostered were 38% for all these rosters. We note that this is an improvement on the percentage of auto-rostering at the time of our original audit, but still falls short of the agreed 50% target. Conclusion: This recommendation is not completed.		financial burden on the Health Board.	
New Recommendation(s)		Priority	
4.1	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	Medium	
Management Response		Target Date	Responsible Officer
4.1	Although the auto rostering feature has been made available for all areas, take up has been limited due to individual work life balance agreements not being up to date in the Health Roster system. CB Directors of Nursing will request all areas who are not using the auto roster feature to contact the E-Rostering team to ensure all WLB agreements are current and can therefore improve the capability of publishing usable rosters.	1 April 2025	Carys Fox / CB Directors of Nursing

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Previous Matter Arising 7: Incorrect working hour balances (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that staff balances are being managed adequately to ensure that staff are working their contracted hours and are not owing or being owed excessive hours.		High
Management Response	Target Date	Responsible Officer
Embedding an effective rostering culture is one of the UHB's top priority and the system will support drive the efficiency. Corporate Nursing, People & Culture and Clinical Boards have worked together to reach an agreement on how we will support managers to embed effective rostering principles and achieve this priority. - Monthly e-rostering reports were piloted in October, every DoN has received a report for their Clinical Board, detailing every member of staff who has an owing time balance between 24 and 100 hours. Lead Nurses are validating this data and rostering the outstanding hours as appropriate. Progress will be monitored on a quarterly basis. - For time balances owed over 100 hours the E-Rostering Team are undertaking regular reviews of rosters. Any staff member that owes over 100 hours will be discussed and validated with the Roster Manager. Changes will be made in the system to correct the balance and any genuine time balances will be rostered by the Roster Manager. - A Rostering Dashboard has been created that provides high level data in relation to rostering KPIs. This will be developed into a more intuitive tool once the DataHub has been implemented. The dashboard will help monitor the agreed KPIs and will provide assurance that effective rostering is being embedded into the UHB and efficiencies are being achieved through the HealthRoster system.	31/03/2024	Emma Davies, Senior Nurse, Nurse Staffing Levels
	31/03/24	Paul Jones, E-Rostering Manager
	31/03/24	Paul Jones, E-Rostering Manager
Current findings		Residual Risk
The Corporate Nursing Team have produced a Nurse Staffing Dashboard and there is a report of 'Staff with a time imbalance of >18 hours (Current Roster)'.		Ineffective rostering arrangements may impact high quality standards of care

Corporate Nursing have reviewed all Nurses that had more than 18 hours and produced reports showing this data. They worked with Senior and Lead Nurses to address it. Reports have continued to be produced showing the excess hours and are shared with the wards. The E-Rostering team cleansed all the rosters to ensure that there were no staff with over 100 hours balance. In cases where there are staff with over 100 hours balance the E-Rostering team will investigate the reasons for it and address accordingly. Although the management actions have been actioned and we can see improvements have been made, there are still cases whereby staff have excessive hours. Conclusion: This recommendation is partially completed.		and create an exposure to greater clinical risks; and • Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.	
New Recommendation(s)		Priority	
7.1	E-Rostering team need to continue to work with Corporate Nursing to ensure that staff balances are being managed adequately.	Low	
Management Response		Target Date	Responsible Officer
7.1	There have been some significant improvements in managing the hours owed but it is accepted that this needs to be performance managed on an ongoing basis within the Clinical Boards. However, it needs to be noted that there will be a number of situations such as staff on sick leave and maternity leave who will be unable to work the hours back within specific timeframes.	Ongoing	Carys Fox/CB Directors of Nursing

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Previous Matter Arising 8: Roster verification and finalisation (Operation)		
Original Recommendation		Original Priority
Arrangements should be put in place to ensure that Roster Managers are finalising shifts in a timely manner. staff balances are being managed adequately		High
Management Response	Target Date	Responsible Officer
A monthly report is sent to Roster Managers to inform them how many unverified shifts they have outstanding, any outstanding shifts are escalated to the DoN 3 days and 1 day before the payroll is run. It has been agreed with the Executive Director of Nursing that any shifts that have not been verified in time will not be processed for Payroll, this has been communicated to all Roster Managers. Unverified shifts are no longer a KPI that the Health Board intends to use. The number of unverified shifts will be closely monitored by the e-rostering team and if it becomes problematic it will be escalated to DoNs, Corporate Nursing team and the EDoN.	31/03/2024	Paul Jones, E-Rostering Manager Directors of Nursing, Clinical Boards
Current findings		Residual Risk
There is a weekly report produced of unverified shifts which are sent to Roster Managers to advise them of the need to verify the shifts. In addition, an email is sent along with a report of all unfinalised shifts to the Clinical Board Director of Nurses confirming the dates that the shifts need to be finalised by for them to be paid on the next payrun. Rosters being finalised at least weekly is included within the roster reviews. We were provided with a report of all unverified shifts for the period April to October 2024 for the seven Clinical Boards and the Corporate Division. It was highlighted that there are 6716 shifts that had not been verified for that period. Below is a table of the unverified shifts by Clinical Board and the Corporate Division:		Inadequate management oversight of the rostering process may result in inefficient rostering arrangements, which may impact patient safety, staff wellbeing and increase the financial burden on the Health Board.

Clinical Board	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	Grand Total
Medicine	17	344	200	153	202	224	187	1327
Specialist Services	27	155	41	90	89	210	161	773
Children & Women	22	373	71	163	54	134	149	966
Surgery	6	74	27	99	12	34	127	379
Mental Health	33	188	738	211	130	51	67	1418
PCIC	0	16	82	26	9	27	37	197
CD&T	0	59	65	51	958	1	11	1145
Corporate	1	78	136	133	146	0	17	511

Conclusion: This recommendation is not completed.

New Recommendation(s)			Priority
8.1	Roster Managers should ensure that they are finalising shifts in a timely manner. Clinical Board Director of Nurses need to emphasise the importance to the Roster Managers of finalising the shifts.		High
Management Response		Target Date	Responsible Officer
8.1	Although the verification of bank and agency shifts is no longer an issue, the verification of substantive shifts within the Clinical Boards requires improvement. A report is now presented monthly at NPG to identify the number of shifts that are not approved by the payroll deadline and then have to be cancelled. The report will	1 April 2025	CB Directors of Nursing

enable the Executive Director of Nursing to performance manage this issue on an ongoing basis. A further communication will be developed and sent to all Ward Sisters and Charge Nurses explaining that the deadlines need to be complied with as it delays the payments to their staff and also results in them having to do additional work by re-entering the shift on health Roster and then verifying.		

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. Follow up: All recommendations implemented and operating as expected
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. Follow up: All high priority recommendations implemented and progress on the medium and low priority recommendations.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved. Follow up: No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved. Follow up: No action taken to implement recommendations

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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Legal Services

Final Internal Audit Report (Advisory)

December 2024

Cardiff & Vale University Health Board



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University Health Board



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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

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Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To assess the current processes operating within the Health Board around the use of legal services with specific focus on current levels of expenditure, funding arrangements and approval/oversight of legal advice requests.

Overview

As this is an advisory review no assurance rating is provided. We identified a number of internal control deficiencies relating to the following:

- The Health Board’s model for requesting and approving legal service expenditure makes it difficult to provide assurance that quality and value for money is being achieved.
- Whilst the legal spend budget sits within the Corporate Governance Team our findings indicate that Clinical Boards and Corporate Services have developed localised arrangements for requesting and approving legal services within their budgets.
- The arrangements in place for requesting and approving legal spend need to be clearly defined within a Standard Operating Procedure and communicated to all staff as our findings indicate that some Clinical Boards and Corporate Services have developed localised procedures and are often operating in silos.
- The legal spend budget for the Health Board, as at September 2024 consisted of a £117k overspend with 5 months of the year remaining suggesting a larger overspend is likely.
- Financial and operational data concerning legal service use is available however it is not being compiled and shared for reporting purposes. There is a lack of sharing of lessons learnt and legal advice across the Health Board and this could result in duplication of efforts and saving inefficiencies.
- The external solicitor hourly rates published on the Health Board’s intranet (within the Corporate Governance page) relate to the older National Procurement Framework contract “NPS-PS-0001-14” which ended in 2019 and have been superseded by the new Legal Services by Solicitors Framework (NPS-PS-000-000102).

Report Classification

Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.
	These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate:	
1	Legal service expenditure
2	Legal service funding
3	Authorisation and approval of legal service expenditure
4	Monitoring and reporting of legal service expenditure

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Opportunities:		Audit Objective
1	Development of Standard Operating Procedures and raising awareness of Legal Advice Page	1
2	Legal and Risk (NWSSP) Service Level Agreement and National Procurement Framework update	1
3	Review the suitability of the legal service arrangements model	2
4	External solicitors pricing	3
5	Financial and operational legal service data reporting and sharing across the Health Board	4
6	Financial reporting and oversight	4

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1. Introduction

- 1.1 Our advisory audit of Legal Services was undertaken and completed in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 The Health Board generally receives legal advice from the Lawyers within the NHS Wales Shared Services Partnership Legal and Risk Team. They provide specialist experience, knowledge and understanding of the legal, administrative and policy issues affecting the operation on the NHS in Wales. In addition, legal services can be provided by external firms in accordance with the National Procurement Service list.
- 1.3 Requests for legal advice within the Health Board should be made via the Corporate Governance Team by completion of a 'Request for Legal Advice' form. The Corporate Governance team are also responsible for approving invoices for legal services used within the Health Board.
- 1.4 The review will include a deep dive of the arrangements in place for requesting, authorising and approving of legal service spend within the following areas:
 - Mental Health Clinical Board,
 - Children and Womens Clinical Board,
 - Specialist Services Clinical Board,
 - Capital, Estates and Facilities Clinical Board.

The above sampled areas were agreed with the Head of Corporate Governance.

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

Advisory Audit Risks

- 1.6 The potential risks considered in this review are as follows:
 - The Health Board is unaware of the total level of spend on legal services within the Health Board; and
 - The processes in place within the Health Board for engaging legal services are inadequate.

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2. Detailed Audit Findings

Objective 1: Establish the total level of spend on legal services across all departments within the Health Board.

2.1 Over the last 6 months, the Corporate Governance Team has made efforts to strengthen and improve the oversight and visibility of legal service expenditure across the Health Board. As part of the new arrangements:

- All staff wishing to access legal advice are required to document their request, obtain necessary authorisation and share this with the Corporate Governance Team who can then approve the expenditure (invoice approval).
- Documentation templates (Complex Patient and Commercial Legal Advice request forms) have been created by the Corporate Governance Team and are readily available via the Legal Advice SharePoint page. The forms intend to capture key information relating to the legal advice request such as the reason for urgency, RAG rating of request, information concerning the case, person requesting, person authorising and patient related information.
- The Corporate Governance Team refrain from paying legal service invoices until a legal service request form has been completed.
- The Corporate Governance Team maintain a spreadsheet of all legal service invoices that have been paid through the legal service budget.

Discussions with our sampled areas confirmed that not all staff are aware of the Legal Advice page or the requirement to formally document requests and share these with the Corporate Governance Team. As such, some areas have developed localised procedures for requesting and approving legal service spend outside of the legal spend budget. The Health Board should consider raising awareness of the Legal Advice page and developing Standard Operating Procedures. **(Opportunity One)**

2.2 Whilst most of the legal service provision for the Health Board is provided by Legal and Risk Services (NWSSP), from time to time the Health Board will need to seek specialised legal advice from external Solicitors (commercial/property legal advice). We note that the Health Board has access to competitive pricing for external Solicitors through the National Procurement Service (NPS) Framework. The Legal Advice page contains information on how to access the framework and the agreed/contracted hourly rates for external Solicitors. Upon review, we note that the framework rates referenced on the Legal Advice page relate to an older version of the framework contract which expired in 2019. We are aware that the new framework contract was awarded in 2021 (NPS reference 2021/S 000-000102). **(Opportunity Two)**

2.3 We note that a Service Level Agreement (SLA) is in place between the Health Board and Legal and Risk Services (NWSSP). A review of the information within

the Legal Advice page (Health Board intranet) revealed that the pricing/costing information for using Legal and Risk Services (NWSSP) was incorrect. The hourly rates detailed on the intranet page did not reflect the price increase that was agreed as part of the new SLA signed in May 2024. Whilst the 2024 rates represent a small increase per hour (4% uplift), we recommend that the information be updated on the Legal Advice page but also taken into consideration for the current budget profiling and future years budgets. **(See Opportunity Two)**

- 2.4 Discussions with Finance identified that all legal advice expenditure should be coded to a specific general ledger subjective code (34400 – Legal Fees) and individuals approving these costs must ensure that these codes are used appropriately. Further sub-category codes are utilised to apportion the costs further to projects/divisions/directorates and Clinical Boards/Corporate Services.
- 2.5 A review of the financial system identified that not all legal spend is being channeled through the legal advice budget. We obtained a general ledger transaction report of all costs coded to 34400 – Legal Fees for the period April 2024 to September 2024. Analysis of the data confirmed that the Health Board’s total level of spend on legal services across all departments is as follows:

Table 1

Clinical Board/Corporate Service	Legal service spend April to September 2024
Corporate Executives (Corporate Governance Team)	£243,620
Capital, Estates and Facilities	£43,981
Central & Reserves	£17,548
Primary, Community and Intermediate Care (PCIC) Clinical Board	£13,674
Specialist Services Clinical Board	£13,529
Clinical Diagnostics & therapeutics Clinical Board	£7,587
Mental Health Clinical Board	£6,091
Children and Women Clinical Board	£5,784
All Wales Genomic Service	£4,156
Surgical Clinical Board	£1,313
Grand Total	£357,284

- 2.6 Further analysis of the financial data displayed in Table 1 identified that legal spend (April 2024 to September 2024) has been paid as follows:
- £218,512 to Legal and Risk Services (NWSSP),
 - £88,791 to Barrister Chambers services (various),
 - £30,437 to external Solicitors on the NPS Framework,
 - £19,545 to various external Solicitors (not on NPS Framework).

Conclusion:

2.7 Our review has determined that since April 2024 to September 2024 the Health Board has spent approximately £357,284 on legal services. We have identified several opportunities that will help strengthen the arrangements in place. Whilst the legal spend budget sits with the Corporate Governance Team, areas of the Health Board are requesting and approving legal spend through their own budgets and this limits visibility of legal spend activity. Clinical Boards and Corporate Services are unaware of the processes to be followed. A Standard Operating Procedure should be developed with links to key information relating to the current Service Level Agreement in place with Legal and Risk Services (NWSSP) and external suppliers under the National Procurement Framework.

Objective 2: Establish the total level of funding for legal services within the Health Board.

2.8 Discussions with the Director of Corporate Governance and with the Head of Corporate Governance noted that legal service expenditure is core funded by the Health Board with the legal spend budget sitting within the Corporate Governance Team.

2.9 We were provided with the legal service budget for the Health Board for 2024/25 by the Finance Operations Manager and a review of the detail identified that whilst the largest portion of the budget resides with the Corporate Governance Team, additional budget allocations relating to legal service spend have been made for other parts of the Health Board. We compared the budget for the year for 2024/25 to the current expenditure levels and noted that the variance as at Month 6 stood at £117k overspent. Further detail has been set out in Table 2 below.

Table 2

Clinical Board/Corporate Service	Budget for the year 2024/25	Legal service spend to date (April 2024 - September 2024)	Variance as at Month 6 (September 2024)
Corporate Executives (Corporate Governance Team)	£244,217	£243,620	-£597
Capital, Estates and Facilities (CEF)	£12,661	£43,981	£31,320
Clinical Diagnostics and Therapeutics (CD&T)	£9,771	£7,587	-£2,184
All Wales Genomics	£4,156	£4,156	£0
Primary, Community and Intermediate Care (PCIC) Clinical Board	£940	£13,674	£12,734
Children and Womens Clinical Board	£630	£5,784	£5,154
Specialist Service Clinical Board	£0	£13,529	£13,529
Central & Reserves	-£32,663	£17,548	£50,211
Mental Health Clinical Board	£0	£6,091	£6,091
Surgical Services Clinical Board	£0	£1,312	£1,313
Grand Total	£239,712	£357,284	£117,572

Whilst the overall legal service spend position is £118k overspent, with the deficit likely to grow further by year end, we do acknowledge that forecasting for legal advice is a challenge considering the nature and complexity of some cases i.e. cases related to safeguarding, mental health, court proceedings etc. However, we note that Table 1 and Table 2 suggest that the current operating arrangements for legal service activity (requesting, authorising and approving of payment for legal services) are not fully centralised with areas of the Health Board operating in silos to request legal advice. Efficiencies could be realised by reviewing the current operating model and ensuring that there is more oversight for all legal service requests and a centralised flow of information.

(Opportunity Three)

Conclusion:

- 2.10 Whilst the legal service budget sits within the Corporate Governance Team, there are various budget allocations for this expenditure in other parts of the Health Board (see Table 2). The current arrangements prevent the Corporate Governance Team from overseeing and providing assurance that quality and value for money is being achieved with legal advice.

Objective 3: The process for engaging and authorising the use of legal services, including NWSSP Legal and Risk and external firms, within the Health Board is appropriate.

- 2.11 To inform this objective we held several meetings with senior management from our sampled areas, with senior and operational management from the Corporate Governance Team and with staff from the central Finance Team.
- 2.12 Discussions with the Director of Corporate Governance and with the Head of Corporate Governance confirmed that whilst the legal service budget sits with the Corporate Governance Team, the accountability and remit for authorising the initial requests sit with senior management of the relevant area of the Health Board from which the request is originating. As such the Corporate Governance Team is limited to ensuring that each request has been documented and has been duly authorised before approving the payment of legal service invoices from the Corporate Governance budget.
- 2.13 To confirm the arrangements in place for requesting and authorising the use of legal services, we selected a sample of 25 invoices paid across our selected areas (10 for CEF and 5 for each sampled Clinical Board). We selected 10 invoices from Capital, Estates and Facilities as the data indicated that the service uses Legal and Risk Services (NWSSP) and various external Solicitors, some of which are not on the National Procurement Service Framework. Our findings confirmed that all requisitions had been authorised by the Directors of Nursing and/or Directors of Operation. For CEF, all property-related legal service matters were requested by the Property and PFI Manager and approved by the Head of Capital Planning and/or the Director of Capital, Estates and Facilities. However, as part of the testing undertaken for CEF, we identified an

issue with a lack of costing information displayed on invoices from external firms which are on the NPS framework. **(Opportunity Four)**

Conclusion:

2.14 Our findings conclude that there are appropriate arrangements in place for requesting and authorising the use of legal services with approvals undertaken by Directors of Nursing, Directors of Operations or equivalent within CEF. We noted an issue with the level of detail provided on external Solicitor invoices which requires attention.

Objective 4: Effective monitoring of legal services usage and costs is undertaken with regular reporting to appropriate management within the Health Board.

2.15 The Director of Corporate Governance meets with representatives from Legal and Risk Services (NWSSP) on a quarterly basis to review legal service usage. At the meeting, Legal and Risk Services provide detailed activity reports on the number of matters/cases managed within the period. Discussions with the Director of Corporate Governance noted that the activity report information is not shared anywhere across the Health Board. Sharing of this information across Clinical Boards/Corporate Services could lead to better utilisation of legal services by sharing of lessons learnt and cost efficiencies by limiting duplication i.e. paying for legal advice already provided to another Clinical Board. **(Opportunity Five)**

2.16 A review of the Health Board Finance and Performance Committee and Senior Leadership Board meetings did not identify reports on use of legal services. Discussions with senior management from our sample of Clinical Boards/Corporate Services also confirmed that no standalone reports are generated on the cost of legal service spend as the reality is that the financial values of legal service expenditure are comparatively too small to warrant standalone reporting.

2.17 As stated within paragraph 2.1, the Corporate Governance Team have developed a spreadsheet to record all legal service invoices paid from the Team's legal service budget. Given our findings (Table 1 & Table 2) the information currently being captured by the Corporate Governance Team does not reflect the overall legal service spend for the Health Board. **(Opportunity Six)**

Conclusion:

2.18 Our findings conclude that whilst financial data concerning legal service spend is available from the finance system (general ledger code 34400) this is not being utilised by the Corporate Governance Team. Operational data concerning legal service use is also available to the Director of Corporate Governance on a quarterly basis however the data is not being shared across senior management of the wider Health Board.

Appendix A: Opportunities for improvement and development

Finding 1: Standard Operating Procedures and lack of awareness of Legal Advice Page	Residual Risk
Over the last 6 months, the Corporate Governance Team has made efforts to strengthen and improve the oversight and visibility of legal service expenditure across the Health Board. The Corporate governance Team have developed the Legal Advice intranet page to sign post all staff of the Health Board who require the use of legal advice. The webpage includes information on the following: • How to access legal services on employment matters, contracts and court of protection services; • Contacts for legal experts from Legal and Risk Services (NWSSP); • How to access legal services through external Solicitors via the National Procurement Service Framework; and • Templates for documenting legal advice requests for complex patient and commercial matters. Our discussions with senior management across our sampled areas identified a lack of awareness of the instructions and documents held on the Legal Advice page. As such areas have implemented localised arrangements for requesting and authorising legal service expenditure. This has resulted in legal service costs being channelled through the respective Clinical Board/Corporate Services as opposed to running through the assigned legal spend budget residing within the Corporate Governance Team. We also note that currently, there are no Standard Operating Procedures in place directing the processes to be followed. Saunders Nathan 08/05/2025 15:28:30	The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.

Opportunity 1		Priority
There is scope to formalise the process for requesting, authorising and approving legal service within a Standard Operating Procedure. This, in addition to links to the existing Legal Advice page, can be shared with all staff of the Health Board to raise awareness and further clarify the processes to be followed.		N/A - Advisory Review
Management Response 1	Target Date	Responsible Officer
Requesting Legal advice SOP to be developed and shared on Corporate Governance SharePoint page.	Q4 24-25	Head of Corporate Governance

Finding 2: Legal and Risk (NWSSP) Service Level Agreement and National Procurement Framework update	Residual Risk
The Legal Advice page contains information on how to access the external Solicitors through the National Procurement Service Framework and the agreed/contracted hourly rates for external Solicitors. Upon review, we note that the framework rates referenced on the Legal Advice page relates to an older version of the framework contract which expired in 2019. We are aware that the new framework contract was awarded in 2021 (NPS reference 2021/S 000-000102) but cannot confirm whether or not the rates have changed so it is advised that the Corporate Governance Team obtain the latest information and update the Legal Advice page accordingly. In addition to the above, a review of the information within the Legal Advice page (Health Board intranet) revealed that the pricing/costing information for using Legal and Risk Services (NWSSP) was incorrect. The	The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.

hourly rates detailed on the intranet page did not reflect the price increase that was agreed as part of the new SLA signed in May 2024. Whilst the 2024 rates represent a small increase per hour (4% uplift), we recommend that the information be updated on the Legal Advice page but also taken into consideration for the current budget profiling and future years budgets.		
Opportunity 2		Priority
It is advised that the Corporate Governance Team obtain the latest contractual documentation both for the Service Level Agreement in place with Legal and Risk (NWSSP) and also for the National Procurement Framework contract "Solicitors Services Framework" (000-000102) which was revised in 2021. Contractual obligations (costings and hourly rates) for these need to be included within a new Standard Operating Procedure (Opportunity One) and also updated within the Legal Advice Page. We also advise that the new hourly rates be considered for reprofiling for the current and future years legal service spend budget plans.		N/A - Advisory Review
Management Response 2	Target Date	Responsible Officer
Link the new Solicitors Services Framework" (000-000102) which was revised in 2021 on the corporate governance sharepoint page (<i>this was completed in December 2024</i>). Ensure the costings from this revised framework are outlined in the revised legal instruction form which will be completed on Microsoft forms.	Q4 – 24-25	Head of Corporate Governance

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Finding 3: Legal service arrangements model suitability		Residual Risk
Our analysis of the general ledger and affirmations by the central finance team confirmed that legal service spending is not always being channeled through the legal service budget which sits with the Corporate Governance Team. Whilst the largest share of the legal service budget sits within the Corporate Governance Team, there are allocated budget reservations for other areas of the Health Board. The current model does not allow for a flow of information or a central repository both for legal service spend and activity. The current arrangements prevent the Corporate Governance Team overseeing and providing assurance that quality and value for money is being achieved with legal advice being sought. This is extremely important given that the legal service spend as at September 2024 was £117k overspent against budget with a further 6 months left until the end of the financial year.		The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.
Opportunity 3		Priority
Executive leadership is required to evaluate the suitability of the current operating arrangements for requesting, authorising and approving legal service spend. Consideration is to be given to whether or not the current model provides for robust stewardship over quality of legal service provision and potential cost saving efficiencies through value for money.		N/A - Advisory Review
Management Response 3	Target Date	Responsible Officer
Corporate Governance are developing a Microsoft form which will replace the legal advice instruction form and automatically notify corporate governance of any new legal instructions	Q4 24-25	Corporate Archivist & Records Management Manager & Head of Corporate Governance

Approval process to be built into legal advice SOP which will be disseminated with all teams who request legal advice to ensure all legal spend is being approved correctly.		

Finding 4: External solicitors pricing		Residual Risk
A review of a sample of external Solicitor invoices, which are on the NPS Framework, could not verify if the hourly costs were in line with the agreed rates under the framework. This was due to a lack of costing detail/breakdown as invoices displayed amounts in totals and did not display the time taken for each matter (hours/minutes) or the hourly rate. This lack of detail can prevent the Health Board from verifying that the legal services are being charged accordingly and in line with the procured rates under the NPS framework.		The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.
Opportunity 4		Priority
We advise the Health Board to engage with external Solicitors on the NPS framework to ensure that detailed costing/breakdowns are provided and that these are verified against the framework to ensure that the legal services are being priced accordingly.		N/A - Advisory Review
Management Response 4	Target Date	Responsible Officer
Procurement to review the sample of legal invoices and challenge the costs with framework solicitors	Q4 24-25	Corporate Governance Procurement Business Manager

Finding 5: Financial and operational legal service data reporting and sharing across the Health Board		Residual Risk
The Director of Corporate Governance meets with representatives from Legal and Risk Services (NWSSP) on a quarterly basis to review legal service usage. At the meeting, NWSSP provide detailed activity reports on the number of matters/cases managed within the period. Discussions with the Director of Corporate Governance noted that the activity report information is not shared anywhere else within the Health Board. Sharing of this information across Clinical Boards/Corporate Services could lead to better utilisation of legal services by sharing of lessons learnt, and cost efficiencies by limiting duplication i.e. paying for legal advice already provided to another clinical board.		The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.
Opportunity 5		Priority
We note that the Corporate Governance Team's remit in the legal service process is to ensure requests from across the Health Board have received the proper authorisation. The Health Board should consider if the Corporate Governance Team should receive operational activity information from Legal and Risk Services (NWSSP) given their limited role and whether this information should be shared to senior management of Clinical Boards/Corporate services who are actively involved in the detail of legal matters/cases.		N/A - Advisory Review
Management Response 5	Target Date	Responsible Officer
To be picked up as part of the quarterly meetings between the DCG and NWSSP.		Director of Corporate Governance

Finding 6: Financial reporting and oversight		Residual Risk
As stated within paragraph 2.1, the Corporate Governance Team have developed a spreadsheet to record all legal service invoices paid from the Team’s legal service budget. Given our findings (Table 1 & Table 2) the information currently being captured by the Corporate Governance Team does not reflect the overall legal service spend for the Health Board as legal service expenditure is also channelled through Clinical Boards/Corporate Services. The financial reports we obtained from the finance team (general ledger download for cost code 34400) included all legal service spend for the Health Board.		The Health Board is unaware of the total level of spend on legal services within the Health Board; and The processes in place within the Health Board for engaging legal services are inadequate.
Opportunity 6		Priority
The Corporate Governance Team should engage with central finance team to obtain financial spend reports that encompass the legal service spend for the whole Health Board.		N/A - Advisory Review
Management Response 6	Target Date	Responsible Officer
Request quarterly updates from Finance to cross reference corporate governance expenditure on legal spend and what has been billed in Finance.	Quarterly from Q1 25-26	Corporate Archivist & Records Management Manager

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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Decision Making

Final Internal Audit Report (Advisory)

January 2025

Cardiff & Vale University Health Board



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University Health Board



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Fieldwork completion:	20 th December 2024
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Auditors:	John Cundy - Principal Internal Auditor Lucy Jugessur - Deputy Head of Internal Audit Ian Virgill - Head of Internal audit
Executive sign-off:	Matt Phillips - Director of Corporate Governance
Distribution:	Francesca Thomas - Head of Corporate Governance
Committee:	Audit & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Assurance Committee. Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Cardiff & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Cardiff & Vale University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

To assess the effectiveness and operation of the Health Boards decision making and including a review of the Clinical Board’s terms of reference (TOR).

Overview

As this is an advisory review no assurance rating is provided. We identified a number of internal control deficiencies relating to the following:

- The Health Board’s ‘Scheme of Delegation and Earned Autonomy Framework’ is complicated and not easy to follow.
- The terms of reference (ToR) for the Senior Leadership Board (SLB) and the Clinical Boards should provide more clarity on the items that should be taken to these forums for decisions to be made, in accordance with the Scheme of Delegation and Earned Autonomy Framework.
- Clinical Board ToR should be reviewed more regularly and a standardised template put in place for them.

In contrast to an assurance audit, we have not made formal recommendations but have identified opportunities that the Health Board may wish to take forward in order to address the deficiencies and further strengthen processes.

Report Classification

Assurance
not applicable

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Advisory Audit Objectives

Our review sought to ascertain and evaluate if:	
1	The Health Board’s Scheme is clear and up to date.
2	Staff awareness of the Scheme
3	Decisions made within the Health Board align to the requirements of the Scheme
4	Clinical board ToR support and empower Clinical Board Directors in making decisions
5	Decisions made by Clinical Board Directors are taken in line with the requirements of the Scheme

Opportunities:		Audit Objective
1	Review of the ‘Scheme of Delegation and Earned Autonomy Framework’	1 & 2
2	Senior Leadership Board delegation	3
3	Review of Clinical Board’s ToR and delegation	4

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1. Introduction

- 1.1 Our advisory audit of Decision Making was undertaken and completed in line with the 2024/25 Internal Audit Plan for Cardiff and Vale University Health Board (the 'Health Board').
- 1.2 Standing Orders are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 into day-to-day operating practice. Together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide regulatory framework for the business conduct of the Health Board.
- 1.3 The Scheme of Delegation and Earned Autonomy Framework (the 'Scheme') was reviewed and approved by the Board in November 2023 alongside the Standing Orders (SOs) and Standing Financial Instructions (SFIs). The Scheme includes a number of subject areas and within these are details of the delegated matters and who they are delegated to.
- 1.4 The Director of Corporate Governance is the lead for this review.
Advisory Audit Risks
- 1.5 The potential risks considered in this review are as follows:
 - Non-compliance with legislation or corporate and operations policies.
 - Inappropriate or unauthorised decisions made.
 - Inefficiency caused by perceived constraints on decision making.

2. Detailed Audit Findings

Objective 1: The Health Board's Scheme is clear, up to date and accurately covers all required delegated matters and appropriately details decision makers responsibilities.

- 2.1 The Health Board's 'Scheme of Delegation and Earned Autonomy Framework' was approved by the Board on the 30th November 2023. The Scheme was easy to locate on the Health Board's website, however, we found a number of older versions also retained on the website. **(Opportunity One)**
- 2.2 We reviewed the Scheme and identified that the document is complicated and difficult to follow. The Scheme is not clearly laid out and within the document there are specific areas highlighted and then a considerable number of delegated matters detailed under each of these areas. This could result in confusion if a staff member was accessing the document and searching for a particular area of responsibility. **(Opportunity One)**

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Safeguarding
Audit
Final

2.3 Although the Health Board's Scheme is a complicated document, it covers the following delegated matters which are categorised into specific sections including:

- Quality, Safety and Experience;
- Service;
- Commissioning and Provision of Services;
- Finance and Procurement;
- Workforce and Organisational Development;
- Corporate;
- Higher Degree of Delegation and Earned Autonomy at Level 2 and 3; and
- Executive Responsibilities.

2.4 We reviewed the Health Board's Scheme and compared it to equivalent documents from other Health Boards. We identified that one of the other Health Board's Schemes was more complete, easy to follow and provided a better fit with the way Directors operate and linked to their job descriptions.
(Opportunity One)

Conclusion:

2.5 The Health Board has a 'Scheme of Delegation and Earned Autonomy Framework' which was approved by the Board on the 30th November 2023. It is evident that the Scheme is difficult to follow and requires updating to ensure it is easier to understand and use.

Objective 2: Relevant staff are aware of the requirements of the Scheme.

2.6 We interviewed Clinical Board Directors and Directors of Operations, and other managers and programme leads. Overall, the awareness of the 'Scheme of Delegation Earned Autonomy Framework' was low. Most staff we discussed the Scheme with were unaware of the document. **(Opportunity One)**

2.7 All of the Board Directors and Directors of Operations confirmed that their job descriptions are where their authority comes from. It is what they work to and what their performance is assessed against.

2.8 We reviewed the job descriptions for the Clinical Board Directors, and Directors of Operations. It was evident that the organisational arrangements, job summary, general responsibilities and person specification are consistent for all Clinical Board Directors, and Director of Operations roles. However, the overall and individual responsibilities are not specific, nor are they fully linked to the Scheme e.g. the overall description of responsibility is stated as:

'All aspects of the delivery of safe, high quality, clinical care provided by the Clinical Board, working collaboratively with other Clinical Board colleagues to

ensure an integrated approach to planning and delivery of care at all times. Responsible for all staff employed within the Clinical Board’.

There is one listed item under Leadership and Strategic Responsibilities:

‘Ensure that an effective financial management and reporting plan is in place which ensures that all resources and transactions are conducted with probity and in accordance with approved policy’.

- 2.9 From discussions with the above staff, it was acknowledged that the Clinical Board Directors and Directors of Operations were aware of the budgetary spending limits imposed on them by the Standing Financial Instructions (SFIs) and that these limits are well known and fully understood.

Conclusion:

- 2.10 From discussions held with Clinical Boards Directors and Directors of Operations, there is a lack of specific knowledge of the Scheme. However, the overall intention of the delegated authority process is understood and adhered to.

Objective 3: Decisions made within the Health Board align to the requirements of the Scheme and where there are deviations from it these are identified and are subject to formal approval.

- 2.11 The main Board and its members retain overall responsibility and accountability for all decisions made within the Health Board. Through the use of the Scheme, they have empowered the Senior Leadership Board (SLB) as the main operational decision-making body, responsible and accountable for all aspects of the Health Board’s activities.
- 2.12 The SLB Terms of Reference (ToR) state that one of the purposes of the SLB is that it ‘will execute actions delegated from the Chief Executive and support the operational management of the organisation in accordance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation.’ However, there is no specific detail within the ToR as to how the SLB should operate or the type of decisions it can make. **(Opportunity Two)**
- 2.13 The SLB met according to its ToR. However, the ToR were last approved on the 22 December 2022 which is not in line with the narrative stating that they should be reviewed on an annual basis. **(Opportunity Two)**
- 2.14 We reviewed three of the SLB meetings by viewing the recordings. There were varying agenda items discussed within the SLB that required decisions, these included subjects covering additional capital funding to a banding dispute. It was evident from reviewing the recordings that there was a lot of collaboration between the Health Board Executive Directors and Clinical Board Directors in making decisions. Although all agenda items being discussed and decisions taken within SLB appeared appropriate, there is no clarity within the ToR

confirming what items should be taken to SLB for decision. **(Opportunity Two)**

- 2.15 Following each SLB meeting, a document is produced confirming the attendance and an Action/ Decision Log. It was acknowledged that decisions were made for most agenda items that were discussed within the SLB. However, there were agenda items that required further actions to be undertaken and therefore no specific decisions were made on these.

Conclusion:

- 2.16 The SLB is an effective, well-run decision making body and the Scheme is the source of the Committee's authority. It was recognised that the SLB were able to make appropriate decisions and there were actions if further work was required. However, there is no clarity as to the type of agenda items that should be coming to the SLB for decisions to be made.

Objective 4: Clinical Boards TOR support and empower Clinical Board Directors to fully utilise their delegated authority in making decisions.

- 2.17 We reviewed the ToR for a sample of the Clinical Boards senior management teams meetings that had been established as their decision-making groups.

- 2.18 The group's ToR are all similar in style and content. Some reference and or reproduce the Scheme within the ToR as the source of authority and state that they have been set up 'in line with Standing Orders and the UHB Scheme of Delegation, the Board approved the establishment of Clinical Boards which have been granted specific powers, authority and freedom to act'. As with the SLB terms of reference, there is no clarity as to the types of agenda items that should be taken to the Clinical Board Committees for decisions to be made. **(Opportunity Three)**

- 2.19 The ToR generally cover the operational management requirements of the Clinical Board, the roles and responsibilities of the members, and how it should operate in the achievement of its objectives. As with the job descriptions referred to in Objective 2, the requirements are more implicit than detailed and specified.

- 2.20 We note that some of the sampled ToR had not been reviewed for several years, given the continual pace of change within the Health Board they all should be reviewed regularly and have a next review date set. We have previously raised this as a finding in our Clinical Board Governance audits. **(Opportunity Three)**

Conclusion:

- 2.21 Although there is scope to review and realign the Clinical Boards ToR, they are supporting appropriate Clinical Board operation. The ToR confirms that the Board has approved the establishment of Clinical Boards in line with the Standing Orders and the UHB Scheme. However, there is no specific detail

within the ToR for the Clinical Boards as to the type of decisions that should be made at this level.

Objective 5: Decisions made by Clinical Board Directors are taken in line with the requirements of the Scheme.

- 2.22 Although, as identified under objective 2, awareness of the specifics of the Scheme is limited, all of the Directors we met for this review were aware of the limits of their authority and the decision-making requirements that are implicit in their roles.
- 2.23 Although there was some consideration that the process was sometimes impacted on by financial limits and the SFIs, all considered they could make the decisions that were required. In addition, there was unanimous agreement among those that we met that the Clinical Board decision-making processes were operationally effective where required. However, as stated in objective 4 there was little clarity within the ToR for the Clinical Boards and the Scheme as to the decisions that should be made by the Clinical Boards.
- 2.24 We further reviewed the Clinical Board meeting agendas, minutes and action logs. From review of the Clinical Board meetings, we were not always able to evidence where decisions were required to be made. However, we acknowledged that we were able to verify from the review that decisions were being made within the Committee meetings.

Conclusion:

- 2.25 We established from discussions with Clinical Board Directors and review of Clinical Board meetings that decisions made were done in line with the requirements of the Scheme. However, due to the lack of clarity within the Clinical Board ToR and Scheme, we could not evidence that the Clinical Boards were consistently making decisions at the correct level, in line with their delegation.

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Appendix A: Opportunities for improvement and development

Finding 1: Scheme of Delegation and Earned Autonomy Framework		Residual Risk																				
We reviewed the 'Scheme of Delegation and Earned Autonomy Framework' and it was complicated and has a considerable number of lines of delegated matter under each area heading as per the table detailed below: <table><tr><th>Area Heading</th><th>Delegated matter number of lines</th></tr><tr><td>Concerns and complaints</td><td>11</td></tr><tr><td>Incident management</td><td>22</td></tr><tr><td>Coroner</td><td>5</td></tr><tr><td>Welsh risk pool</td><td>3</td></tr><tr><td>Standards</td><td>2</td></tr><tr><td>Patient Safety alerts</td><td>3</td></tr><tr><td>NICE</td><td>4</td></tr><tr><td>Clinical audit</td><td>6</td></tr><tr><td>Count</td><td>56</td></tr></table> The Scheme also delegates to the body/staff member who is responsible within that area. The detail of how the delegated authority should actually be delivered may be more effectively communicated through appropriate policy documents, produced owned and operated by the body/ staff member. Only the Area should be detailed within the Scheme, as there could be confusion if a staff member was accessing the document and searching for a particular area of responsibility as there are so many different delegated matters recorded under each area. Whilst the current version of the Scheme is available on the Health Board's website, we noted that there were also a number of older versions included. Furthermore, from discussions with Clinical Board Directors and Directors of Operations it was acknowledged that there was a lack of awareness of the Scheme.		Area Heading	Delegated matter number of lines	Concerns and complaints	11	Incident management	22	Coroner	5	Welsh risk pool	3	Standards	2	Patient Safety alerts	3	NICE	4	Clinical audit	6	Count	56	Non-compliance with legislation or corporate and operations policies.
Area Heading	Delegated matter number of lines																					
Concerns and complaints	11																					
Incident management	22																					
Coroner	5																					
Welsh risk pool	3																					
Standards	2																					
Patient Safety alerts	3																					
NICE	4																					
Clinical audit	6																					
Count	56																					

We reviewed Schemes from other Health Boards and acknowledged that the formats of each of the Schemes were different. However, we identified that the Scheme from one of the Health Boards was more complete and easy to follow and it was a better fit with the way Directors operate and linked to their job descriptions.		
Opportunity 1		Priority
The 'Scheme of Delegation and Earned Autonomy Framework' should be reviewed and updated to ensure that it is effectively focussed on areas of operational activity and linked to the responsibilities of the Executive Directors. They could then in turn sub-delegate to their Operational Directors as permitted by the Scheme. Management should consider reviewing the Schemes of Delegation from other Health Board's to inform further development of the Cardiff and Vale Scheme. Only the current version of the Scheme should be made available on the Health Board's website and it should be communicated to appropriate personnel including Clinical Board Directors and Directors of Operations for Clinical Boards, to increase their awareness of the Scheme ensure that they are consistently operating in accordance with its requirements.		N/A - Advisory Review
Management Response 1	Target Date	Responsible Officer
CAUBUHB 'Scheme of Delegation and Earned Autonomy Framework' to be reviewed and updated in line with changes to the UHB planning process	March 2026	Director of Corporate Governance/ Head of Corporate Governance

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Finding 2: Senior Leadership Board delegation		Residual Risk
The Senior Leadership Board (SLB) Terms of Reference (ToR) state that one of the purposes of the SLB is that it 'will execute actions delegated from the Chief Executive and support the operational management of the organisation in accordance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation.' However, from further review of the ToR, there is no specific detail within the ToR as to how the SLB should operate in relation to the type of decisions it can make. The ToR for the SLB were last approved on the 22 December 2022 which is not in line with the narrative within the ToR that they should be reviewed on an annual basis. As detailed in Finding 1, the Scheme is a complicated document and is not easy to follow and therefore when we reviewed the SLB meetings we were unable to confirm whether the agenda items being discussed and requiring decisions had been appropriately taken to the SLB.		Inappropriate or unauthorised decisions made.
Opportunity 2		Priority
The ToR for the Senior Leadership Board should be reviewed in accordance with the stated frequency and should include more detail as to the agenda items that should be taken to SLB for decisions. The ToR should also provide more clarity on what should be taken to the SLB for decision making and the delegation limits of the SLB.		N/A - Advisory Review
Management Response 2	Target Date	Responsible Officer
SLB TOR to be reviewed following rapid planning event and refresh of UHB planning process.	March 2026	Director of Corporate Governance

Finding 3: Clinical Board Terms of Reference and delegation	Residual Risk
We reviewed the Terms of Reference (ToR) for the Clinical Boards, and it was evident that some have not been reviewed for several years. This issue has been previously identified in Clinical Board Governance audits. Although the ToRs are all generally consistent, we identified that there are differences in style and content between them. Although the Clinical Boards operate independently of each other there could be overall governance benefits if the same decision/action log template was used by all Clinical Boards, that could facilitate collation of all decisions for review and possible oversight for consistency and the identification of common issues. As identified in Finding 3, the SLB TOR do not provide clarity as to the types of agenda items that should be taken to the SLB for decisions to be made. This is also the same issue within the Clinical Boards as there is no clarity within the ToR for the Clinical Boards of what decisions they are able to make, and it is also not evidenced within the Scheme.	Inappropriate or unauthorised decisions made.
Opportunity 3	Priority
All Clinical Board's ToR should be subject to periodic review and kept up to date. We consider that there should be one standard ToR template for the Clinical Boards with set text for the areas of common operation. A common template for an action/decision log could be beneficial as it may facilitate the identification of common issues and provide a consistent record of decisions being taken. The ToR for the Clinical Boards should be reviewed and updated to confirm the types of decisions that can be made within the Clinical Board's delegation, in accordance with the Scheme.	N/A - Advisory Review

Management Response 3	Target Date	Responsible Officer
Clinical Boards Terms Of Reference to be reviewed following refresh of UHB TORs.	March 2026	Director of Corporate Governance/ Head of Corporate Governance

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



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

Date issued: January 2025

Document reference: 4679A2025

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

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

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About this document

- 1 This document provides the Audit and Assurance Committee with an update on our current and planned accounts and performance audit work at Cardiff and Vale University Health Board. We 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 Charitable Funds Accounts	Executive Director of Finance	To provide an audit opinion on the Health Board's Charitable Funds Accounts.	We have completed the audit fieldwork and are due to report our findings to the Board of Trustees. The audit remains open, and ongoing, to the date of certification.	The Board of Trustees is due to meet on 23 January 2025 to consider the audited accounts. The Auditor General is due to certify them on 24 January 2025.

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of the 2024-25 Annual Report and Accounts	Executive Director of Finance	To provide an audit opinion on the 2024-25 Annual Report and Accounts.	We anticipate undertaking our audit planning in February and March 2024.	To be covered in the detailed 2025 Audit Plan which is to be presented at the committee's next meeting in May 2025.

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	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 reviewed:	Complete Final report in today's papers.	February 2025

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		• Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.		
Review of Unscheduled Care	Chief Operating Officer	This work examines different aspects of the unscheduled care system and includes analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work included 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).	<u>Blog and data tool</u> published in April 2022 Part 1 – Complete Final report in today's papers.	February 2025

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		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).	Part 2 – Report drafting.	May 2025
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 examined the approaches NHS bodies are taking in respect of achieving cost improvements, efficiencies, and financial sustainability.	Complete Final report in today's papers.	February 2025
Planned Care Review	Chief Operating Officer	This work follows on from the national report on <u>tackling the planned care backlog</u> , and will consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and	Fieldwork underway	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		Use of the additional Welsh Government financial allocations to improve waiting lists.		
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 (2024 local work)	Chief Operating Officer	Following on from our report on orthopaedic services last year, we will review the Health Board's speciality with the highest level of waits - eye care services. 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	Fieldwork underway	To be confirmed

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Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
		include both community and acute eye care services within the scope of this work.		

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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>Cancer Services in Wales</u>	January 2025
<u>The National Fraud Initiative in Wales 2022-23</u>	October 2024
<u>Active Travel</u> (and <u>Data Tool</u>)	September 2024
<u>Affordable Housing</u>	September 2024
<u>NHS Wales Finances Data Tool</u>	August 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.

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Title	Publication Date
<u>Audit Quality Report 2024: Strengthening trust in audit</u>	January 2025
<u>Equality Report 2023-24</u>	November 2024
<u>Estimate of Income and Expenses for Audit Wales for the year ended 31 March 2026</u>	October 2024
<u>Interim Report 2024-25</u>	October 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.

Annual Audit Report 2024 – Cardiff and Vale University Health Board

Audit year: 2023-24

Date issued: January 2025

Document reference: 4624A2024

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This document has been prepared as part of work performed in accordance with statutory functions.

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

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

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Summary report

About this report

- 1 This report summarises the findings from my 2024 audit work at Cardiff and Vale University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:
 - examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
 - satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
 - satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.
- 2 I report my overall findings under the following headings:
 - audit of accounts; and
 - arrangements for securing economy, efficiency, and effectiveness in the use of resources
- 3 This year's audit work took place at a time when NHS bodies were continuing to respond to a broad set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.
- 4 We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.
- 5 The audited accounts submission deadline was shortened by two weeks from the previous year to 15 July 2024. The financial statements were certified on 12 July 2024, meaning the deadline was met. This reflects a great collective effort by both my staff and the Health Board's officers.
- 6 The focus and approach of my performance audit work continues to be aligned to the post-pandemic challenges facing the NHS in Wales and is conducted in line with INTOSAI¹ auditing standards.
- 7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

¹ INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

- 8 **Appendix 2** presents the latest position against the audit fee set out in the 2024 Audit Plan.
- 9 **Appendix 3** sets out the audit-of-accounts risks set out in my 2024 Audit Plan and how they were addressed through the audit.
- 10 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We will be presenting it to the Audit and Assurance Committee on 4 February 2025. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the [Audit Wales website](#) after the Board have considered it.
- 11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

- 12 I concluded that the Health Board's 2023-24 accounts² were properly prepared and materially accurate and I therefore issued an unqualified true-and-fair opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my financial audit).
- 13 However, I qualified my regularity opinion because the Health Board breached its revenue resource limit. For the three-year period 2021-22 to 2023-24, the Health Board expended £42.961 million over the three-year revenue limit that the Welsh Government had authorised. The Health Board did not exceed its authorised capital resource-limit for the for the three-year period 2021-22 to 2023-24.
- 14 I found no other regularity matters of a material adverse nature. I did, however, report that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2023-24 to 2025-26. This financial duty requires health boards to prepare, and have approved by the Welsh Ministers, a rolling three-year integrated medium-term plan.
- 15 I reported five audit recommendations to the Health Board's Audit and Assurance Committee. Management fully accepted all the recommendations and have put actions in place to implement them. I also reported that some past audit recommendations (i.e. prior to the 2023-24 audit) are ongoing actions and remain open. I will review the Health Board's progress with all new or ongoing actions as part of my 2024-25 audit.

² I audit and certify the Health Board's Performance Report, Accountability Report, and Financial Statements. 'Accounts' is a generic term.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- In terms of primary care, the Health Board is progressing work to improve strategic planning, cluster maturity, and leadership. However, capacity within the Health Board's central primary care team remains stretched, and more work is required to establish a financial baseline and strengthen its approach for evaluating and mainstreaming new ways of working. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, reporting on delivery of plans, patient experience, and primary care performance and outcomes needs strengthening.
- Whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.
- The Health Board has made reasonable progress in addressing our previous recommendations relating to discharge planning, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services.
- Whilst the Health Board met its agreed deficit target for 2023-24, it needs to strengthen its overall approach to the identification and delivery of recurrent savings and ensure its service transformation plans align with wider plans to return the organisation to financial sustainability and balance.
- The Health Board's corporate governance arrangements continue to operate effectively. The Health Board is taking positive steps to operationalise its long-term strategy, ensuring governance arrangements support its delivery. Whilst the Health Board has ambitions to achieve financial sustainability, the financial position remains challenging.

17 These findings are considered further in the following sections.

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Detailed report

Audit of accounts

- 18
- Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation’s financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use (‘regularity’) of public monies.
- 19
- My 2024 Audit Plan set out the key risks for audit of the accounts for 2023-24 and these are detailed along with how they were addressed in **Exhibit 4, Appendix 3**.
- 20
- My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2023-24 accounts

- 21
- I concluded that the Health Board’s accounts were properly prepared and materially accurate (true and fair), and I issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board’s internal controls (as relevant to my financial audit).
- 22
- I reported five audit recommendations, to management and to the Health Board’s Audit and Assurance Committee. Management accepted all the recommendations and formally agreed management actions and dates of implementation. I also reported on management’s progress with any recommendations from my previous audits, which are yet to be fully actioned. As part of my 2024-25 audit, I will review management’s progress with all my live recommendations.
- 23
- I must report issues arising from my work to those charged with governance (the Members of the Board), for their consideration before I issue my audit opinion on the accounts. My audit team reported these issues on 11 July 2024. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors’ comments
Uncorrected misstatements Saunders Nathan 08/05/2025 15:28:30	There was one uncorrected misstatement. I identified two buildings that had been demolished but not removed from the Health Board’s fixed asset register, financial ledger, and accounts. While the buildings had been fully depreciated, and had a nil net book value, the asset register and the accounts still incorrectly recorded their gross cost and accumulated depreciation of £1.091 million.

Issue	Auditors' comments
	Based on the audit work undertaken, we were satisfied that there was not a wider material risk to the 2023-24 accounts.
Corrected misstatements	I reported the six most significant areas of corrected misstatements. They related mainly to accounting classifications and disclosures. One of the matters related to a pay award that was confirmed by the Welsh Government after the Health Board's submission of the draft accounts, and therefore could not be known when the accounts were prepared by management.
Other significant issues	I reported five recommendations for improvement, with management's formal responses. Management formally accepted all the recommendations. On 3 September 2024 the Health Board's Audit and Assurance Committee considered the recommendations and management's responses.

- 24 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2024 and the return was prepared in accordance with the Treasury's instructions.
- 25 My separate audit of the Health Board's Charity's annual report and accounts is completed, and I reported my findings to Trustee Members on 23 January 2025. I expect to certify the annual report and accounts on 26 January. The Charity Commission's annual deadline is 31 January.

Regularity of financial transactions

- 26 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.
- 27 Where a Health Board does not achieve financial balance, its revenue and/or capital expenditure exceed its powers to spend, and so I must qualify my regularity opinion.

- 28 I qualified my regularity opinion, because the Health Board breached its revenue resource limit. For the three-year period 2021-22 to 2023-24, the Health Board expended £42.961 million over the three-year revenue limit that the Welsh Government had authorised.
- 29 The Health Board did not exceed its authorised capital resource limit for the for the three-year period 2020-21 to 2022-23. For the three-year period 2021-22 to 2023-24, the Health Board expended £201,000 below the three-year capital limit that the Welsh Government had authorised.
- 30 I have the power to place a substantive report on the Health Board's accounts, alongside my opinions, where I want to highlight an issue(s). Due to the regularity issue set out above, I issued a substantive report setting out the factual details of my qualification of my regularity opinion.
- 31 My substantive report also highlighted that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan in place for the period 2023-24 to 2025-26. This financial duty requires health boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. The duty is an essential foundation to the delivery of sustainable quality health services.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

- 32 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:
- assessing the extent to which the Health Board has implemented my 2018 recommendations on primary care, as well as the extent to which there is appropriate capacity and capability to deliver priorities as well as the extent to which the Board and/or its committees consider matters relating to primary care;
 - reviewing the effectiveness of the Health Board's arrangements, in partnership with social services, to support timely patient flow out of hospital across the Cardiff and Vale of Glamorgan region;
 - assessing the extent to which the Health Board has implemented my 2017 recommendations on discharge planning;
 - reviewing the effectiveness of the Health Board's cost savings arrangements; and
 - undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically;

33 My conclusions based on this work are set out below.

Primary care follow-up review

- 34 My review examined the extent to which the Health Board has implemented my previous 2018 recommendations relating to primary care. I also assessed the extent to which the Board and its committees regularly consider matters relating to primary care, and whether the Health Board's central primary care services team has the appropriate capacity and capability.
- 35 My work found that the Health Board is progressing work to improve primary care strategic planning, cluster maturity, and leadership. However, the capacity of the Health Board's central Primary Care Services Team remains stretched, and more work is required to establish a financial baseline and strengthen its approach for evaluating and mainstreaming new ways of working. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, reporting on the delivery of plans, patient experience, and primary care performance and outcomes needs strengthening.
- 36 The Health Board has addressed recommendations relating to primary care strategic planning and it has also taken positive steps to strengthen cluster maturity and support cluster lead training and development. Although the Health Board has shifted some resources from secondary to primary care, progress has remained slow. In addition, it has yet to establish a financial baseline to support this shift in resources and enable monitoring. The Health Board also needs to strengthen its arrangements for evaluating and mainstreaming new ways of working within primary care clusters.
- 37 Primary care is reflected in key Health Board strategies and plans. Whilst there is reasonable oversight and scrutiny of primary care at Board and committee meetings, there are opportunities to strengthen reporting around the delivery of primary care plans, the experiences of patients accessing primary care services, and primary care performance and outcomes.
- 38 Whilst the Health Board has increased the number of roles within its central Primary Care Services Team, capacity remains stretched due to increasing workloads associated with local and national priorities. Whilst there are good arrangements in place to support the development of staff within the team, its succession planning arrangements require strengthening.

Urgent and emergency care

- 39 My work examined different aspects of the urgent and emergency care system focused on patient flow out of hospital, progress against my previous discharge planning recommendations, and arrangements for managing demand. My work on arrangements for managing demand is due to be reported in February 2025.

Patient flow out of hospital

- 40 My regional review examined whether the Health Board and its social services partners have effective arrangements to ensure the timely discharge of patients out of hospital. It focussed on the scale of the challenge, and the factors impacting on effective and timely flow out of hospital. My work also considered the action being taken by the Health Board and its statutory partners, including through the Regional Partnership Board, and what more can be done to reduce some of the challenges currently being experienced by the health and social care system.
- 41 My work found that whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.
- 42 In line with trends across Wales, the numbers of patients whose discharge from hospital in the Cardiff and Vale region have grown significantly in recent years. Between April 2023 and February 2024, each month there were on average 194 medically fit patients whose discharge was delayed, with completion of social care assessments and social worker allocation the main causes for delay. While this position compares favourably to other health boards in Wales, it remains a cause for concern. For the period April 2023 to February 2024, the total number of bed days that had been lost to delayed discharges was 50,668 with a full-year cost equivalent of £27,637 million.
- 43 The Health Board has had significant success more recently in preventing delayed discharges from impacting on patient flow within its urgent and emergency care system. Its performance on metrics for waiting times in emergency departments and ambulance handovers has consistently been either the best in Wales or well above the all-Wales average performance. These have contributed to significant reductions in the number of emergency ambulance hours lost to handover delays. However, data indicates that the commitment to easing pressure on some aspects of urgent and emergency services at University Hospital Wales may be contributing to patient flow issues elsewhere within the hospital. For example, data indicates that access to beds on specialist wards, such as stroke, is inconsistent³ and that increasing numbers of scheduled (planned) care appointments are cancelled due to the lack of available beds within the hospital.
- 44 Several factors are contributing to delayed discharges. The region has an ageing population with a correlating increase in people who live with complex, long-term conditions including mental health problems. There are also workforce challenges

³ Between April 2022 and April 2023, performance for the Health Board was volatile with the percentage of stroke patients with direct access to a stroke ward within four hours fluctuating between a low of 3.3% and a high of 54%. Since April 2023 performance has improved, with performance ranging between a high of 72.5% in June 2023, and a low of 43.5% in April 2024.

within the social care sector, which is resulting in delays in the allocation of social workers and in completing social care assessments. My work also identified weaknesses in the practice and documentation of discharge planning and a need to include the Discharge to Recover and Assess (D2RA) model within Health Board policies. However, the region is successfully managing to meet demand for care support, and it is able to provide care in line with its commitment to providing domiciliary care over care home provision. This is something many other regions in Wales are finding challenging.

- 45 Improving patient flow is a key feature of plans across the partners which align to Welsh Government's six goals for urgent and emergency care. Partners are working together effectively, both strategically and operationally, to improve patient flow. Financial resources are being applied to improve discharge planning with evidence of evaluation of the impact of projects and initiatives. While there is regular monitoring of performance within individual organisations, partners lack arrangements to oversee patient flow across the whole health and care system. This limits opportunities to examine whole system solutions, embed learning and to focus on the impact of activity within performance and progress reports.

Discharge planning: progress update

- 46 In undertaking my regional review of arrangements to support patient flow, I have also taken the opportunity to consider progress made by the Health Board in addressing my previous 2017 recommendations relating to discharge planning.
- 47 My work found that the Health Board has made reasonable progress in addressing our previous recommendations, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services.
- 48 Specifically, my work found that:
- the Health Board has introduced mechanisms to monitor the use of community health and social care services and has taken action to improve staff understanding of the landscape of services, although it is not clear whether these actions are having the intended impact;
 - while the Discharge Policy was revised in 2020 it is unclear what impact the involvement of patients and carers had on changes, noting also that the policy is overdue for further review and there is a need to ensure the most recent version of the policy is on the Health Board's website; and
 - while the Health Board provides regular training related to discharge planning, we found limited evidence that it monitors completion rates for training.

Review of cost savings arrangements

- 49 My review examined whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. It

considered the impact these arrangements had on the Health Board's 2023-24 year-end financial position and highlighted where arrangements may need to be strengthened for 2024-25 and beyond.

- 50 My work found that whilst the Health Board met its agreed deficit target for 2023-24, it needs to strengthen its overall approach to the identification and delivery of recurrent savings and ensure its service transformation plans align with wider plans to return the organisation to financial sustainability and balance.
- 51 The Health Board has a good understanding of its cost drivers and has a clear process in place for identifying cost savings opportunities. However, the Health Board needs to improve the way it uses data and intelligence to identify sustainable savings opportunities and ensure its plans for service transformation are sufficiently well developed to support its wider plans for achieving financial sustainability.
- 52 The Health Board's 2024-25 savings target looks extremely challenging in the context of its recent poor record of delivering recurrent savings. To achieve its 2024-25 savings target, the Health Board needs to take action to strengthen accountability arrangements, set realistic and achievable targets for individual savings schemes, and enhance staff skills and capacity in respect of savings plans delivery.
- 53 The Health Board's arrangements for monitoring and reporting savings require strengthening to provide more robust assurance to the Board on delivery. In addition, the Health Board needs to improve the management of in-year savings risks and introduce a more systematic approach to learning lessons from savings planning and delivery.

Structured assessment

- 54 My 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 55 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

- 56 At the time of my structured assessment work, the Health Board was subject to Level 3 escalation for finance, strategy and planning under the Welsh Government's escalation and intervention arrangements.

Corporate approach to planning

- 57 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:
- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium Term Plan; and
 - overseeing the delivery of corporate strategies and plans.
- 58 My work found that arrangements for producing, overseeing, and scrutinising strategies and corporate plans continue to strengthen, and the Health Board is taking positive steps to operationalise and embed its refreshed strategic objectives.
- 59 The Health Board's corporate planning arrangements continue to strengthen. The Health Board has been focusing on operationalising its long-term strategy, which was approved by the Board in July 2023, by developing processes and systems to support its delivery and aligning wider governance arrangements. Other corporate plans, such as the 2024-25 Annual Plan, are appropriately aligned to and support delivery of the organisation's long-term strategy.
- 60 The Health Board continues to have good arrangements for maintaining Board oversight of key corporate strategies and plans. The 2024-25 Annual Plan contains a clear delivery plan, supported by new reporting arrangements; however, it is too early to comment on the effectiveness of these arrangements.

Board transparency, effectiveness, and cohesion

- 61 My work considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:
- Public transparency of Board business
 - Arrangements to support the conduct of Board business
 - Board and committee structure, business, meetings, and flows of assurance
 - Board commitment to hearing from staff, users, other stakeholders
 - Board skills, experiences, cohesiveness, and commitment to improvement
- 62 My work found that the Board and its committees continue to conduct their business transparently, operate effectively, and remain committed to continuous improvement. There are opportunities to improve some aspects of administrative governance and to enhance learning from patient safety walkabouts and Board effectiveness reviews.
- 63 The Board remains committed to conducting its business transparently, and it has enhanced its arrangements further this year by livestreaming and recording its public meetings. However, opportunities remain to improve some aspects of administrative governance related to keeping documents on the Health Board's

website updated. The Health Board's arrangements continue to support the effective conduct of Board business, and it has taken positive steps to improve its policy management process to tackle the backlog of outdated policies.

- 64 The Health Board is taking positive steps to ensure its committee structure is clearly aligned to its strategic objectives, strategic change portfolios, and strategic risks. In November 2024, the Board approved amendments to its committee arrangements to clarify oversight responsibilities for each strategic objective, and those areas of business which do not obviously fall within the remit of any of the current committees. Board and committee meetings continue to operate effectively and are supported by good quality, timely papers which focus on key matters.
- 65 The Health Board remains committed to hearing from service users and staff and is improving its processes to do so. But there is scope to enhance how learning is shared following patient safety walkabouts. The Health Board has managed changes to Board membership and the impact of Independent Member vacancies well. However, while the Board maintains a good focus on continuous learning and development, opportunities exist to better understand the impact of activities aimed at improving Board effectiveness.

Corporate systems of assurance

- 66 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:
- overseeing strategic and corporate risks;
 - overseeing organisational performance;
 - overseeing the quality and safety of services; and
 - tracking recommendations.
- 67 My work found that the Health Board continues to strengthen its corporate systems of assurance. There are opportunities to clarify oversight arrangements for strategic and corporate risks and to update the Performance Management Framework.
- 68 Whilst the Health Board continues to take positive steps to improve its strategic and corporate risk management arrangements, opportunities exist to clarify risk escalation and corporate risk scrutiny arrangements. The Board and its committees maintain good oversight of organisational performance, with steps taken to further improve the Integrated Performance Report. However, the Performance Management Framework requires updating.
- 69 The Board maintains appropriate oversight of the quality and safety of services and demonstrates a committed to improvement. However, establishing the Organisational Learning Committee, which is one of three sub-groups approved as part of the 2021-26 Quality, Safety, and Patient Experience Framework, has been delayed. The Health Board has indicated that arrangements for organisational learning will be developed through the Shaping Our Future Quality Excellence programme and become part of the Health Board's quality management system.

The Health Board is taking positive steps to further strengthen its arrangements for tracking audit and review recommendations.

Corporate approach to managing financial resources

- 70 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:
- achieving its financial objectives;
 - overseeing financial planning;
 - overseeing financial management; and
 - overseeing financial performance.
- 71 My work found that whilst the Health Board maintains clear processes for financial planning, management and monitoring, the financial position remains challenging. The Health Board must address overspends and strengthen its approach to the identification and delivery of recurrent savings in order to achieve its financial sustainability ambitions.
- 72 Although the Health Board met its agreed deficit target for 2023-24, it did not achieve its statutory financial duties in 2023-24 and it is unlikely to meet these duties in 2024-25. As a result, it urgently needs to address overspends and identify sufficient suitable savings schemes to meet its ambition to achieve financial sustainability by the end of 2025-26. The Health Board has a good approach to financial planning, but it needs to strengthen its approach for identifying and delivering recurrent savings as indicated earlier in this report.
- 73 The Health Board continues to strengthen its approach to overseeing and scrutinising financial management and controls. Whilst the Health Board continues to maintain robust arrangements for overseeing and scrutinising financial performance, there is scope to strengthen deep dives received by the Finance and Performance Committee and reporting on financial savings.

Saunders Nathan
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Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2024.

Report	Date
Financial audit reports	
Health Board: Audit of Accounts Report	July 2024
Health Board: opinion on the accounts	July 2024
Health Board: Audit of Accounts Addendum Report	August 2024
Charitable Funds: Audit Accounts Report (2022-23); and the opinion on the accounts.	January 2024
Performance audit reports	
Primary Care Follow Up Review	April 2024
Unscheduled Care: Flow out of Hospital – Cardiff and Vale Region	September 2024
Discharge Planning: Progress Update	September 2024
Review of Cost Savings Arrangements	September 2024

Report	Date
Structured Assessment 2024	October 2024
Other	
2024 Audit Plan	May 2024

My wider programme of national value-for-money studies in 2024 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the [Audit Wales website](#).

Saunders Nathan
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Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Urgent and emergency care: Arrangements for Managing Demand	April 2025
Review of Planned Care Services Recovery	April 2025
Review of Eye Care Services	June 2025
Review of Digital Transformation	July 2025

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Appendix 2

Audit fee

My 2024 Audit Plan set out my fee estimate of £465,673 (excluding VAT, which is not chargeable). I also set a fee estimate of £25,306 in the 2024 Audit Plan for my audit of the Health Board's charity's annual report and accounts. My staff will determine the final audit costs once all audits are fully concluded. My audit team will then notify management of the closing position, which I will set out as usual in my 2025 Audit Plan.

Saunders Nathan
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Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2024 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board’s 2023-24 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	I will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; • evaluate the rationale for any significant transactions outside the normal course of business; and • I may add additional procedures to address any specific risks of management override which are not addressed by the mandatory work above.	I reviewed numerous accounting estimates and samples of transactions, which included journal entries. I did not identify any significant transactions outside the normal course of business. No significant risks arose relating to management override. The overall results of my testing in in these areas was satisfactory.

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Audit risk	Proposed audit response	Work done and outcome
There is a significant risk that the Health Board will fail to meet its first statutory financial duty to break even over a rolling three-year period; against its revenue and capital resource limits. The reported revenue position at month 12 is a year-end deficit of £16.4 million for 2023-24, which would result in a deficit of some £43 million for the three years to 31 March 2024. The reported capital position at month 12 is a year-end surplus of £72,000 for 2023-24, which would result in a surplus of £201,000 for the three years to 31 March 2024. The current financial pressures increase the risk that management judgements and estimates could be biased in an effort to meet key financial targets such as its agreed control totals for 2023-24.	I will: • monitor the Health Board's financial position for 2023-24 and the cumulative three-year position to 31 March 2024. • consider the cumulative impact of any relevant uncorrected misstatements over the three years to 31 March 2024. • undertake cut-off testing around the year-end; and classification testing across revenue and capital expenditure. If the Health Board fails to meet the three-year resource limit for revenue and/or capital, I would expect to qualify my regularity opinion on the 2023-24 financial statements. I would also expect to place a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen.	As set out in this report, my audit confirmed that the Health Board met its three-year capital resource limit, but did not meet its three-year <u>revenue</u> resource limit. I therefore qualified my regularity opinion and placed a substantive report on the statements to explain the basis of the qualification and the circumstances under which it had arisen. I also reported on the fact that the Health Board did not meet its financial duty to have a Welsh-Government-approved three-year integrated medium-term plan, for the period 2023-24 to 2025-26.

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

Saunders Nathan
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Cardiff and Vale University Health Board

Outline Audit Plan 2025

Audit year: 2024-25

Date issued: January 2025

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

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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About Audit Wales

Our aims:

Assure



the people of
Wales that public
money is well
managed

Explain



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

Inspire



and empower
the Welsh public
sector to
improve

Our ambitions:



Fully exploit
our unique
perspective,
expertise and
depth of insight



Strengthen our
position as an
authoritative,
trusted and
independent
voice



Increase our
visibility,
influence and
relevance



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

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Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2025.



Adrian Crompton
Auditor General for
Wales

My audit responsibilities

Audit of financial statements

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

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

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

Performance audit work

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

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

Saunders Nathan
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Fees and audit team

In January 2025, I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates. My fee rates for 2025-26 have increased by an average of 1.7% because of unavoidable inflationary pressures.

I will provide an estimate of your fee in my Detailed Audit Plan in May 2025, following completion of my detailed risk assessment.

Your engagement team:

Dave Thomas	Engagement Director & Audit Director (Performance Audit)
Gareth Lucey	Audit Director (Financial Audit)
Rachel Freitag	Audit Manager (Financial Audit)
Darren Griffiths	Audit Manager (Performance Audit)
Rhodri Davies	Audit Lead (Financial Audit)
Urvisha Perez	Audit Lead (Performance Audit)

We confirm that our audit team members are all independent of the Health Board and your officers.

Saunders Nathan
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Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2025 Outline Audit Plan	January - February 2025	February 2025
2025 Detailed Audit Plan	February – April 2025	May 2025
Audit of financial statements work: - Audit of Financial Statements Report - Opinion on the Financial Statements.	May – June 2025	June 2025
Performance audit work: - Structured Assessment, incorporating a deeper dive into estates management. - All-Wales thematic review of cancer services, following on from my national report on the strategic leadership of cancer services in Wales. In terms of local project work, my early planning work suggests there would be value in following-up the recommendations I made in my 2019 Clinical Coding Follow-up Review or my 2022 Review of Quality	Timescales for individual projects will be discussed with you and detailed within the specific project briefs produced for each study.	

Governance Arrangements. However, my planning work might also highlight other areas worthy of review. Therefore, the exact focus of my local project work will be confirmed in my detailed Audit Plan in May 2025.

Saunders Nathan
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Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD¹ and our Chair acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2024](#).



Our People

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

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



Arrangements for achieving audit quality

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

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



Independent assurance

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

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

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¹ QAD is the Quality Assurance Department of ICAEW.

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Structured Assessment 2024 – Cardiff and Vale University Health Board

Audit year: 2024

Date issued: October 2024

Document reference: 4431A2024

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

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Summary report

About this report

- 1

This report sets out the findings from the Auditor General’s 2024 structured assessment work at Cardiff and Vale University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General’s statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.
- 2

Our 2024 Structured Assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.
- 3

The key focus of the work has been on the Health Board’s corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on;

 - corporate approach to planning;
 - board transparency, cohesion, and effectiveness;
 - corporate systems of assurance; and
 - corporate approach to financial management.

We have not reviewed the Health Board’s operational arrangements as part of this work.
- 4

Our work has been informed by our previous structured assessment work, which has been developed and refined over a number of years. It has also been informed by:

 - model Standing Orders, Reservation and Delegation of Powers
 - model Standing Financial Instructions
 - relevant Welsh Government health circulars and guidance
 - the Good Governance Guide for NHS Wales Boards (Second Edition)
 - other relevant good practice guides

We undertook our work between May 2024 and September 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was conducted in accordance with the auditing standards set by the International Organisation of Supreme Audit Institutions.

- 5 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

- 6 **Overall, we found that the Health Board's corporate governance arrangements continue to operate effectively. The Health Board is taking positive steps to operationalise its long-term strategy, ensuring governance arrangements support its delivery. Whilst the Health Board has ambitions to achieve financial sustainability, the financial position remains challenging.**
- We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. We found that arrangements for producing, overseeing, and scrutinising strategies and corporate plans continue to strengthen, and the Health Board is taking positive steps to operationalise and embed its refreshed strategic objectives.
 - We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently. We found that the Board and its committees continue to conduct their business transparently, operate effectively, and remain committed to continuous improvement. There are opportunities to improve some aspects of administrative governance and to enhance learning from patient safety walkabouts and Board effectiveness reviews.
 - We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. We found that the Health Board continues to strengthen its corporate systems of assurance. There are opportunities to clarify oversight arrangements for strategic and corporate risks and to update the Performance Management Framework.
 - We considered whether the Health Board has a sound corporate approach to managing its financial resources. We found that whilst the Health Board maintains clear processes for financial planning, management and monitoring, the financial position remains challenging. The Health Board must address overspends and strengthen its approach to the identification and delivery of recurrent savings in order to achieve its financial sustainability ambitions.

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Recommendations

7 **Exhibit 1** details the recommendations arising from our work. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2024 recommendations

Recommendations	
Annual Plan monitoring	
R1	To ensure ongoing scrutiny of the Annual Plan, as part of the Integrated Performance Report, the Health Board should reintroduce the quarterly high-level overview of achievements against Annual Plan milestones and highlight how delivery of the milestones is impacting performance in priority areas (see paragraph 20).
Administrative Governance	
R2	In order to strengthen its administrative governance arrangements, the Health Board should ensure that: R2.1 all relevant Board and committee meeting papers are publicly available and published on its website in a timely manner (see paragraph 26). R2.2 Standing Financial Instructions are reviewed annually and that changes are formally documented or equally that no amendments are required (see paragraph 30). R2.3 up to date Board and committee workplans are available to the public (see paragraph 36). R2.4 all Board and committee papers use the correct cover report template (see paragraph 39). R2.5 the public is signposted to the current Board Assurance Framework (see paragraph 55).
Patient Safety Walkabouts	
R3	As part of its review of arrangements for Patient Safety Walkabouts, the Health Board should consider how to ensure learning and resulting actions from walkabouts is reported to the Board (see paragraph 43).
Board effectiveness and improvement	

Recommendations

- R4 As part of its continuous approach to reviewing Board and committee effectiveness, the Health Board should capture and report improvement activities and consider whether they are achieving the intended benefit (**see paragraph 49**).
-

Risk management

- R5 The Health Board should ensure that arrangements for scrutinising strategic and corporate risks are clarified and consistent across all committees (**see paragraph 55**).
- R6 The Health Board should refresh the Risk Management Strategy to ensure it includes new arrangements for recording and escalating operational risks (**see paragraph 56**).
-

Finance and Performance Committee deep-dives

- R7 The operational performance deep dives received by the Finance and Performance Committee should be triangulated with financial performance information (**see paragraph 92**).

Saunders, Nathan
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Detailed report

Corporate approach to planning

- 8 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.
- 9 We found that **arrangements for producing, overseeing, and scrutinising strategies and corporate plans continue to strengthen, and the Health Board is taking positive steps to operationalise and embed its refreshed strategic objectives.**

Corporate approach to producing strategies and plans

- 10 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:
 - a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
 - the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
 - appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
 - the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.
- 11 We found that **the Health Board’s corporate planning arrangements continue to strengthen. Corporate plans are appropriately aligned to and support delivery of the organisation’s long-term strategy.**
- 12 In July 2023, the Board approved the Health Board’s refreshed long-term strategy, including its updated strategic objectives / wellbeing objectives. Since its approval, the Health Board has been focusing on operationalising its long-term strategy by developing processes and systems to support its delivery and aligning wider governance arrangements (see **paragraph 35**). Central to this is developing a strategic portfolio framework, which is a group of programmes aligned to six change portfolios¹ to support the achievement of the strategic objectives². This approach is designed to establish clear monitoring arrangements for the delivery of

¹ Our People and Culture; Our Population Health and Place Based Partnerships; Our Quality, Value and Sustainability; Our Clinical Services; Our Infrastructure and Our Future Generations

² Putting People First; Providing Outstanding Quality; Delivering in the Right Places; and Acting for the Future.

the long-term strategy, a clear line of sight between the programmes / portfolios and strategic objectives, and ensure a consistent approach to programme management. The Health Board has agreed appropriate governance arrangements to manage and monitor delivery of the strategic portfolios. Whilst it is too early to judge the effectiveness of these arrangements, we have seen evidence that the Board has been well engaged in the framework's development.

- 13 The 2024-25 Annual Plan (see **paragraph 15**) commits to launching the Health Board's 10-year Clinical Services Plan by Quarter 4. However, recent updates to the Board suggest the plan is more likely to be launched in Quarter 1 of 2025-26. This will be the first product from the Our Clinical Services strategic portfolio. The Board received an update at its April 2024 Board Developments Session, which included a commitment to continue to engage the Board at key stages of the plan's development. It also highlighted key risks to developing the plan on time; these relate to the organisation's limited capacity and capability in certain areas such as modelling and workforce planning. To mitigate these risks, the Health Board has extended the development timeline and revised the depth of the plan to make it a high-level, strategic plan. The Health Board reported that the plan would not be costed because it is designed to be high-level and also because there are several unpredictable variables, such as the availability of capital funding. However, our 2024 Review of Cost Savings arrangements in the Health Board recommends that once developed, plans underpinning the 10-year clinical services plan should clearly set out the costs and savings associated with transforming services.
- 14 The Health Board's strategic objectives are also its well-being objectives. Last year, we found that whilst the Health Board's new strategic objectives / well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development, for example, priorities relating to biodiversity or climate adaptation. The Health Board reported that work to broaden the coverage of its well-being objectives is in progress (see **Appendix 2 R1a 2023**). Some of the environmental aspects, such as biodiversity, are being incorporated in the Decarbonisation Action Plan. But overall, the Health Board intends to ensure all aspects of sustainable development are incorporated in the strategic portfolios. The re-established Well-being of Future Generations Group will also ensure the strategic portfolios support all aspects of sustainable development. It is clear in the 2024-25 Annual Plan how the Health Board's strategic objectives / well-being objectives align to the national well-being goals and to the well-being objectives of partners (see **Appendix 2, R1b 2023**).
- 15 The Health Board was unable to produce a Welsh Government approved Integrated Medium-Term Plan (IMTP) for 2024-27 due to its planned financial deficit. Therefore, it developed an Annual Plan for 2024-25. In August 2023, the Board set guiding principles for the development of the 2024-25 Annual Plan, namely that it should be set in the context of a low investment environment and focus on driving value and quality. Within that context, clinical boards and corporate teams identified their priorities for delivery. The 2024-25 Annual Plan was approved by the Board and submitted to the Welsh Government in March

2024. Welsh Government have received the Annual Plan and set accountability conditions related to delivering and improving on the deficit plan, further de-risking the financial plan to ensure the savings plan is delivered in-year, maximising opportunities for efficiency and productivity and progressing regional solutions for endoscopy and other clinical challenges. The Health Board intends on using the strategic portfolios to guide development of its 2025-28 IMTP.

- 16 In June 2024, Internal Audit issued a reasonable assurance report on the Health Board's IMTP / Annual Plan development process. The review found the Health Board has good governance arrangements to oversee the development of the Annual Plan, with good engagement from the Board and relevant committees. All areas reviewed received substantial or reasonable assurance, except for governance arrangements specifically relating to the Minimum Data Set, due to inadequate oversight. Overall, the review made two high and one medium priority recommendations.

Corporate approach to overseeing the delivery of strategies and plans

- 17 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:
- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART³ milestones, targets, and outcomes that aid monitoring and reporting; and
 - the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.
- 18 We found that **the Health Board continues to have good arrangements for maintaining Board oversight of key corporate strategies and plans. The 2024-25 Annual Plan contains a clear delivery plan, supported by new reporting arrangements, however, it is too early to comment on their effectiveness.**
- 19 Through its 2024-25 Annual Plan, the Health Board continues to focus on five key delivery priorities for the year⁴. For each delivery priority, the 2024-25 Annual Plan clearly sets out an aim, key areas of focus, the actions the Health Board intends to deliver, and the measures of success for each quarter. The 2024-25 Annual Plan continues to link to other corporate plans, such as estate, digital, decarbonisation, and people and culture, with appropriate, high-level actions included in the respective sections. Internal Audit's review of the IMTP / Annual Plan development

³ Specific, measurable, achievable, relevant, and time-bound.

⁴ Urgent and Emergency Care; Planned Care, Cancer, and Diagnosis; Specialist Services; Mental Health; and Children and Women.

process found that the plan included clear measurable targets and actions towards delivering the priorities set by the Cabinet Secretary for Health and Social Care⁵.

- 20 In May 2024, the Board received the Quarter 4 2023-24 Integrated Annual Plan delivery report. The report highlighted that of the 169 specific milestones in the 2023-24 Annual Plan, 78 were not achieved and have been rolled over into the 2024-25 Annual Plan. For 2024-25, the Health Board has stopped using the quarterly Integrated Annual Plan report. Instead, as reported to the Board in July 2024, going forward, the existing Integrated Performance Report (IPR) will be used to report the Annual Plan's delivery. As the IPR is a monthly report, this ensures more regular scrutiny of Annual Plan delivery. Whilst it is too early to comment on the effectiveness of the new arrangements, on reviewing the IPR received by the Board in September 2024, we found that having one performance report linking Annual Plan priority delivery alongside key performance measures reduces duplication (see **Appendix 2 R6 2023**). However, an obvious omission is the high-level quarterly overview of achievements against Annual Plan milestones, which the Health Board should consider reintroducing as part of the existing report. There is also opportunity to highlight how delivery of the milestones is impacting performance in priority areas. **(Recommendation 1)** We discuss the Integrated Performance Report further in **paragraph 59**.

Board transparency, effectiveness, and cohesion

- 21 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.
- 22 We found that **the Board and its committees continue to conduct their business transparently, operate effectively, and remain committed to continuous improvement. There are opportunities to improve some aspects of administrative governance and enhance learning from patient safety walkabouts and Board effectiveness reviews.**

Public transparency of Board business

- 23 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of:
- Board and committee meetings that are accessible to the public;
 - Board and committee papers being made publicly available in advance of meetings; and

⁵ The Cabinet Secretary for Health and Social Care has set six priority areas; these relate to improving delayed transfers of care, access to primary care services, urgent and emergency care, planned care, cancer, and mental health services.

- Board and committee business and decision-making being conducted transparently.

- 24 We found that **whilst the Board remains committed to conducting its business transparently, opportunities remain to improve some aspects of administrative governance to further increase public access to Board business.**
- 25 Since January 2024, the Health Board has enhanced public transparency of Board business by routinely live streaming public Board meetings and making the recordings available on its website shortly after (see **Appendix 2 R2 2023**). The Health Board also promotes public Board meetings on social media, which includes a link to the livestreamed meeting (see **Appendix 2 R3a 2022**). Committee meetings continue to be livestreamed and recorded; links for which are clearly signposted on the Health Board's website. Occasionally there are technical issues with recordings, and in these instances, a note is added on the website. The Health Board is taking steps to move to a more stable platform to support the recordings of meetings.
- 26 Board and committee papers remain accessible to the public and generally continue to be published on the Health Board's website seven days in advance of meetings. Occasionally, papers have not been published on the website in a timely manner or have been missing⁶. Whilst we appreciate the Health Board is quick to publish recordings, to maintain public transparency, the Health Board should ensure all public Board and committee meeting papers remain accessible to the public (**Recommendation 2.1**) In addition, whilst up to date Local Partnership Forum papers are available, the Stakeholder Reference Group papers have not been made publicly available since May 2023 (see **Appendix 2 2022 R3b**).
- 27 The Health Board continues to reserve private Board and committee meetings for sensitive matters. If a private meeting is scheduled, private agenda items continue to be published publicly. In most cases, a reason for why the item was discussed in private is provided, for example due to commercial sensitivity or ongoing legal cases. In our 2022 Structured Assessment report, we recommended that the Health Board should make abridged minutes of private Board and committee meetings available publicly. Whilst the Health Board has not adopted this approach, it has processes in place to ensure appropriate decisions are made in public where initial discussions are held in private sessions. (see **Appendix 2 2022 R3c**).

⁶ Papers for the July 2024 Special Board and Audit and Assurance Committee meetings have not been published, but papers can be requested from the Corporate Governance Team. As at 03/10/2024 the following committee papers are not available on the Health Board's website: no supporting documents for the Audit and Assurance Committee held on 20/05/2024, and no papers for the Digital and Health Intelligence Committee held on 28/05/2024, the Finance and Performance Committee held on 17/04/2024 and 19/06/2024, and the People and Culture Committee held on 10/09/2024.

Arrangements to support the conduct of Board business

- 28 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:
- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
 - formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
 - formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.
- 29 We found that **arrangements continue to support the effective conduct of Board business, and the Health Board has taken positive steps to improve its policy management process to tackle the backlog of outdated policies.**
- 30 The Health Board continues to review its Standing Orders, and Scheme of Reservation and Delegation at least annually to ensure it reflects current arrangements, and we continue to see evidence of compliance. The Board approved amendments to its Standing Orders in January, May and November 2024 to reflect, respectively, changes to its financial delegations, the establishment of the Joint Commissioning Committee⁷ and updated committee arrangements (see **paragraph 35**). The Standing Financial Instructions (SFIs) were reviewed in July 2023. Whilst there have not been any amendments to the SFIs it would be good practice to review annually and formally document whether changes are required or not. (**Recommendation 2.2**) The most recent versions of the Standing Orders (see **Appendix 2 R3 2023**) and SFIs are available on the Health Board's website. During quarter 3 2024-25, Internal Audit plans to undertake an advisory review of the Health Board's Scheme of Reservation and Delegation.
- 31 We continue to observe declarations of interest requested routinely in all Board and committee meetings. Since our previous structured assessment, the Health Board has updated its oversight process for declarations of interests, gifts, and hospitality⁸. The Audit and Assurance Committee will now receive the Declaration of Interest, Gifts and Hospitality Tracking Report annually, instead of at most meetings, with in-year exception reports if needed. An up-to-date register of

⁷ In April 2024, the NHS Wales Joint Commissioning Committee replaced the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU).

⁸ The Health Board uses the Electronic Staff Record to record declarations of interests, gifts, and hospitality.

interest for all staff continues to be published on the Health Board's website. Unlike staff, Board members are required to declare their interests annually. Last year, we highlighted that the separate register for Board member interests on the Health Board's website was out of date. This has now been resolved as Board member interests are included in a single register alongside staff interests. We are assured that the Health Board is following procedures for Board members to declare interests annually as this is reviewed to support our annual audit of accounts.

- 32 In May 2023, Internal Audit issued a limited assurance report on the management of policy documents, which highlighted the Health Board's substantial backlog of outdated policies. Since then, the Health Board has made substantial progress in addressing the findings and Internal Audit's follow-up review in May 2024 gave a reasonable assurance rating. The Health Board now uses the Audit Management and Tracking (AMaT) system to host and manage its policies. This is a positive development, as it streamlines and automates policy management. By July 2024, all 401 policies had been transferred to AMaT, of which 65% were overdue for review. The Health Board continues to identify policy owners to ensure out of date policies are reviewed as clear policy ownership should reduce the risk of policies becoming out of date and leading to a breach of regulatory and statutory requirements. The Health Board is also conducting an exercise to ensure all policies on its website are the most recent version.

Effectiveness of Board and committee meetings

- 33 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:
- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
 - Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
 - well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge;
 - committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board; and
 - clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

- 34 We found that **the Health Board is taking positive steps to ensure clear alignment between its committee structure and strategic objectives, change portfolios, and risks. Board and committee meetings continue to operate**

effectively, supported by good quality, timely papers that focus on key matters.

- 35 The Health Board has reviewed its committee arrangements (see **Appendix 2 R4 2023**) as part of work to strengthen the line of sight and alignment between the committees and the strategic objectives, strategic change portfolios, and strategic risks (see **paragraph 54**). The committee structure remains largely unchanged, except for establishing a Digital and Infrastructure Committee⁹, and the names of the Quality, Safety and Experience and Mental Health Legislation and Mental Capacity committee have been shortened to the Quality and Mental Health Legislation committees respectively. Amendments to the committee arrangements, associated updates to the Standing Orders and new Terms of Reference were approved by the Board in November 2024 (see **Appendix 2 R1c 2022**). The Health Board reported that the amendments will clarify oversight responsibilities for each strategic objective, and for some areas, such as matters relating to the estate and public health which do not obviously fall within the remit of any of the current committees. Board members we spoke to reported that they have been fully consulted, both through Board Development Sessions and individually.
- 36 The Health Board has an up-to-date Board and Committee Forward Workplan, but its website is showing Board and committee workplans for the previous year. **(Recommendation 2.3)** Positively, the Forward Workplan is now a live and dynamic document, which is updated straight after Board and committee meetings. It is accessible by all staff and also includes the workplan for Board Development Sessions. The amendments to committee arrangements provide a good opportunity to review the Forward Workplan to ensure committees fulfil their new remits in a way that does not overburden them.
- 37 We have continued to observe well-chaired committee meetings, which follow agreed processes, run to time, and are well supported by the Corporate Governance Team. We noted new processes in place to help the efficient running of meetings, for example the Teams Chat is used to support time keeping for each item, and committee chairs are now provided with annotated agendas to guide them through the meeting. Independent and Executive Board Members provide good challenge, delivered in a constructive, supportive way. There continues to be a healthy relationship between Executive and Independent Board Members, which is encouraging given recent changes within the Executive Team (see **paragraph 47**).
- 38 The Health Board's arrangements continue to support good flows of information, and where appropriate, cross referral of matters between committees and escalation to the Board. Independent Members continue to meet prior to each Board meeting (Governance Co-ordinating Group) and hold a further monthly meeting. These meetings ensure all Independent Members are kept up to date on key matters, can ask questions and raise any issues.

⁹ This replaces the Digital and Health Intelligence Committee.

- 39 The Health Board continues to produce good quality meeting papers, which focus on key matters. Whilst the cover report template has been updated to reflect the refreshed strategic objectives, it is not being used consistently. **(Recommendation 2.4)** The Health Board continues to use a publicly available 'supporting documents' folder to support the streamlining of Board papers. This process has been extended to committee meetings to reduce the volume of papers. The Health Board has also started to use a hybrid approach to producing minutes, where discussion points and decisions are briefly noted, with an accompanying link to the recorded discussion.

Board commitment to hearing from patients/service users and staff

- 40 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:
- the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.
- 41 We found that **while the Health Board remains committed to hearing from service users and staff and is improving its processes to do so, there is scope to enhance how learning is shared following patient safety walkabouts.**
- 42 The Board continues to open each meeting with a patient story, which focuses on a range of services and service users. The Health Board ensures a balance of positive and negative stories. Relevant committees also continue to hear stories as appropriate to their remit. The Quality, Safety, and Experience Committee now also hears a patient story at most meetings (see **Appendix 2 R5 2023**) which is told as part of the Clinical Board Assurance Report. This ensures good coverage as each clinical board is scrutinised on a rotational basis. However, there is potential to extend patient and / or staff stories to more committees to give Board members further opportunity to hear from a range of stakeholders and understand the impact of its decisions on service delivery.
- 43 Board members continue to conduct Patient Safety Walkabouts, which were temporarily paused for Independent Members to prevent overburdening them while there were vacancies amongst the Independent Member cadre (see **paragraph 48**). Board members continue to value the opportunity to visit services. Walkabout notes are recorded on the Tendable App¹⁰, reviewed through Clinical Board Executive Reviews, and made available for Board members to access through the Admin Control¹¹ system. The Health Board is planning on reviewing its Patient

¹⁰ Tendable is an application used to record, report, and manage health care quality inspections in real time.

¹¹ Admin Control is a system used to manage meeting papers.

Safety Walkabouts to clarify the purpose both for those conducting the walkabout and for operational staff. As part of this review, the Health Board should consider how learning and resulting actions from walkabouts are reported more formally to the Board. **(Recommendation 3)**

- 44 The Health Board is also investing in its speaking up safely process by investing in a third-party system called 'Working in Confidence'. It is hoped the new system will give staff the confidence to raise concerns, as it is not managed by the Health Board and is anonymous. This is a positive development, especially given some of the negative trends seen in the recent NHS staff survey results for the Health Board¹², which indicate an increase in reporting of incidences of bullying and harassment.

Board cohesiveness and commitment to continuous improvement

- 45 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:
- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
 - the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
 - a relevant programme of Board development, support, and training in place.
- 46 We found that **the changes to Board membership and the impact of Independent Member vacancies are well managed. While the Board maintains a good focus on continuous learning and development, opportunities exist to better understand the impact of activities aimed at improving Board effectiveness.**
- 47 The Executive Team has seen several changes over the past year. In the latter part of 2023, the Health Board had already welcomed a new Executive Director of Public Health and Director of Corporate Governance. The Executive Medical Director and Executive Director for Therapies retired in March and April 2024, respectively. The Executive Director of Strategic Planning was seconded to the NHS Wales Joint Commissioning Committee in March 2024, and has since secured a new role elsewhere. The Health Board has managed these changes well, and most posts have been filled on a substantive basis, except for the Executive Director of Strategic Planning which is being covered on an interim basis. Given the recent changes, the Health Board is taking the opportunity to consider some amendments to executive portfolios.

¹² The Health Board had a 21.4% participation rate for the 2023 NHS Staff Survey.

- 48 Over the year, the Health Board has needed to manage Independent Member vacancies, but this position is settling. Three new independent members joined the organisation in April 2024, October 2024 and January 2025 respectively. Positively, in the interim, Independent Members have continued to work well together to ensure meetings remained quorate. As reported in previous years, Independent Members continue to feel supported by the Chair. The Health Board has developed an induction pack for new independent members, which gives a good overview of key information, for example about the long-term strategy, the Board, Welsh Government and NHS Wales.
- 49 The Board maintains its focus on continuous learning and development and continues to hold bi-monthly Board Development Sessions. The Health Board has moved away from annual Board and committee effectiveness surveys, instead reviewing Board effectiveness as part of routine business at the end of each meeting. From our observations of public Board and committee meetings, members rarely comment on their effectiveness, although we understand there are opportunities to provide feedback informally after meetings. Twice a year, Board Development Sessions have an agenda item related to Board effectiveness. In June 2024, focus was given to personal and team resilience, with a follow-up session planned for December 2024. The Chair's report to the Board includes a brief overview of Board Development Sessions. But it should develop a way of capturing and reporting on how its improvement activities are making a difference to Board and committee working. **(Recommendation 4)**

Corporate systems of assurance

- 50 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.
- 51 We found that **the Health Board continues to strengthen its corporate systems of assurance. There are opportunities to clarify oversight arrangements for strategic and corporate risks and update the Performance Management Framework.**

Corporate approach to overseeing strategic and corporate risks

- 52 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks to the delivery of strategic priorities / objectives. We were specifically looking for evidence of:
- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all of the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
 - the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.

53 We found that **the Health Board continues to take positive steps to improve its strategic and corporate risk management arrangements. However, opportunities exist to clarify risk escalation and corporate risk scrutiny arrangements.**

54 Last year, the Health Board updated its Board Assurance Framework (BAF), aligning its existing strategic risks with its new strategic objectives and workstreams. In May 2024, Internal Audit issued a reasonable assurance report on Risk Management and the BAF. Positively, it found that strategic risks are aligned to the strategic objectives, were well-articulated, and clearly linked to key operational areas. The review is also complimentary about the BAF being a live document with clear links to the corporate and operational risk registers. In September 2024, the Board approved a new BAF as part of its work to better align governance arrangements to support the long-term strategy (see **Paragraph 12** and **Appendix 2 R1a 2022**). The BAF now comprises six strategic risk groups: quality, health equity, people, digital, infrastructure and sustainability, which are split into delivery or enabling risks¹³. Each of the risks has a risk appetite, defined as either 'open' or 'cautious'¹⁴. The new BAF is logical, maintains good alignment with the strategic objectives and it is easy to understand which committee is responsible for each risk area.

55 At each meeting, the Board continues to receive the BAF for assurance and the Corporate Risk Register (CRR) for information. The BAF is in the public domain as part of the bi-monthly Board papers, and the Health Board's website also includes a standalone link to the BAF, but this is not kept up to date. **(Recommendation 2.5)** Each strategic and corporate risk area has a lead committee, but oversight arrangements differ between committees and are not explicitly clear. **(Recommendation 5)**

56 Internal Audit's risk management and BAF review made three recommendations, relating to some operational risks being out of date, delays in escalating relevant operational risks to the CRR and the use of excel spreadsheets to manage risks. On the latter point, the review highlights that the Health Board has approximately 70 individual operational risk registers to manage, which is time consuming and

¹³ Quality and health equity have been classed as 'delivery risks', and people, digital, infrastructure and sustainability have been classed as 'enabling risks'.

¹⁴ An 'Open' risk appetite is defined as 'willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)' and a 'A Cautious' risk appetite is defined as 'reference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward'.

creates the risk of making errors. In August 2024, the Health Board started work to create a risk management module on AMaT, which will be piloted on the CRR before being rolled out further. Creating a digital solution should lead to improved risk management processes. The Risk Management Strategy was last reviewed in March 2023; it will need to be refreshed once the AMaT risk module has been implemented. **(Recommendation 6)**

Corporate approach to overseeing organisational performance

- 57 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:
- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
 - the Board and committees providing effective oversight and scrutiny of organisational performance.
- 58 We found that **while the Board and its committees maintain good oversight of organisational performance, with steps taken to further improve the Integrated Performance Report, the Performance Management Framework requires updating.**
- 59 The Health Board does not have an up-to-date Performance Management Framework (PMF). Its PMF was last approved in 2020, which means it is not supporting the monitoring and delivery of the refreshed strategy. Nor does it support the updated committee scrutiny arrangements or any subsequent changes to operational performance management, for example clinical board escalation arrangements (see **paragraph 77**). Our recommendation from 2022, which the Health Board should expedite, remains open (see **Appendix 2 R1b 2022**).
- 60 In August 2024, Internal Audit issued a reasonable assurance report on performance reporting, specifically focused on the Integrated Performance Report (IPR). The Board receives the IPR each month through the Finance and Performance Committee, Board meetings and Board Development Sessions. At Board, Executive Directors continue to show collective leadership by providing updates for areas of work within their remits. Internal Audit made four medium priority recommendations related to data accuracy, timeliness of data, finalising guidance, and establishing a structured approach to reporting underperformance.
- 61 In April 2024, the Board Development Session and Finance and Performance Committee both received a paper detailing changes to the IPR for 2024-25. Some of the changes were based on the recommendation we made last year. Recognising that improving the IPR is an iterative process, we note that progress to address this recommendation is ongoing (see **Appendix 2 R6 2023**), specifically:

- Internal Audit's review found an inconsistent approach to reporting on underperformance.
- The report is clearer about whether metrics in one section of the IPR are on target or not, but not consistently across the report (for example in the people and culture, and finance sections).
- On the whole data charts are provided for each metric, and where there is a gap, a reason is provided.
- There is little benchmarking data provided within the IPR. A link to the National Performance Framework¹⁵ monitoring data is provided, but the link is not publicly accessible.

Corporate approach to overseeing the quality and safety of services

62 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

63 We found that **there is appropriate oversight of the quality and safety of services, and the Health Board is committed to improvement, however establishing the Organisational Learning Committee has been delayed.**

64 'Providing Outstanding Quality' is one of the Health Board's four strategic priorities. There is a strategic programme, 'Shaping our Future Quality Excellence', in place to support its delivery. At each Board meeting, the Chief Executive's Report focuses on one of the four strategic priorities. In September 2024, the focus was on quality, specifically on the Health Board's plans to build an effective quality management system.

65 The Health Board continues to embed the duties set out in the Health and Social Care (Quality and Engagement) Act (2020). In compliance with the Duty of Quality, the 2023-24 Annual Quality Report, which outlines the Health Board's achievements and ambitions set against the Health and Care Standard's, was presented at the Annual General Meeting held in July 2024. The Quality, Safety, and Experience (QSE) Committee maintains oversight of quality and safety of

¹⁵ The link provides access to National Performance Framework monitoring data available from Digital Health and Care Wales (DHCW), which shows relevant performance data for health boards and trusts in Wales.

services and, where appropriate, assurance reports are themed around the six domains of quality¹⁶. The committee continues to receive Clinical Board Assurance Reports at each meeting, and a deep dive at every other meeting¹⁷. At alternate meetings, the committee continues to receive the Quality Indicators Report, which provides updates against key quality metrics¹⁸. The Quality Indicators Report continues to be data rich and supported by a cover report drawing attention to key issues and notable information. The Board and appropriate committees continue to receive assurances related to the Duty of Candour, for example the IPR includes a section on the Duty. The QSE Committee also routinely receives updates through the quality indicators report, Clinical Board Assurance reports and minutes of clinical board QSE committees.

- 66 The QSE Committee also maintains oversight of the Health Board's 2021-26 Quality, Safety, and Patient Experience Framework. In February 2024, the committee received an effectiveness review which provided an update on the framework's implementation. The Health Board reported that of the three sub-groups approved as part of the framework, two are well established, these being the Clinical Effectiveness Committee and Clinical Safety Group. But there have been delays in establishing the Organisational Learning Committee. The Health Board reported that arrangements for organisational learning will be developed through the Shaping Our Future Quality Excellence programme and become part of the Health Board's quality management system.

Corporate approach to tracking recommendations

- 67 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:
- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.
- 68 We found that **the Health Board is taking positive steps to further strengthen audit and review recommendation tracking arrangements.**
- 69 Last year, we reported that whilst the Health Board has strong arrangements for tracking audit and review recommendations, there were opportunities for

¹⁶ Safe, Timely, Effective, Efficient, Equitable and Person-Centred care.

¹⁷ Deep dives this year have covered topics such as never events, nationally reportable incidents and medication safety.

¹⁸ The Quality Indicator Reports includes data on nationally reportable incidents and never events, infection prevention and control, medication incidents, patient safety solution, progress against Health Inspectorate Wales recommendations, clinical effectiveness, mortality, Covid-19 investigations, data from the Tendable quality improvement auditing app and patient experience data. including App.

enhancement. Specifically, to formally refer recommendations and/or audit and review reports to relevant committees. We have seen evidence that limited assurance reports are referred for deeper scrutiny to appropriate committees (see **Appendix 2 R7a 2023**). We also recommended developing a report for the Audit and Assurance Committee pulling together common themes, issues and learning from audit and review recommendations. This work is in progress (see **Appendix 2 R7b 2023**).

- 70 The Health Board is now using AMaT to manage its recommendations tracking process, with most trackers now uploaded to the system. As with other digital systems introduced by the Health Board, this should streamline and automate audit tracking, and the system could potentially provide a platform to pick out trends/themes in audit/review recommendations. As part of the process, the Health Board is also working to either update or close down, as appropriate, Internal Audit recommendations made prior to 2022. This validation process should ensure that recommendations remain relevant and provide an opportunity to refocus where progress has been slow.
- 71 Frequency of reporting to Audit and Assurance Committee has also been updated. The committee now receives the full recommendation trackers; internal, external and regulatory compliance, at every other meeting, with a highlight report at the meetings in between. In November 2024, the committee will receive all three tracking reports using the new AMaT system. In July 2024, there were 21 open Audit Wales recommendations, 8 partially complete, and 13 with no action taken.

Corporate approach to managing financial resources

- 72 We considered whether the Health Board has a sound corporate approach to managing its financial resources.
- 73 We found that **whilst the Health Board maintains clear processes for financial planning, management and monitoring, the financial position remains challenging. The Health Board must address overspends and strengthen its approach to the identification and delivery of recurrent savings in order to achieve its financial sustainability ambitions.**

Financial objectives

- 74 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:
the organisation meeting its financial objectives and duties for 2023-24, and
the rolling three-year period of 2021-22 to 2023-24; and

- the organisation being on course to meet its objectives and duties in 2024-25.

75 We found that **the Health Board did not achieve its financial duties in 2023-24 and is unlikely to meet its duties for 2024-25. Furthermore, it urgently needs to address overspends and identify sufficient suitable savings schemes to meet its ambition to achieve financial sustainability by the end of 2025-26.**

76 The Health Board did not meet its financial duties in 2023-24. Like the previous year, it did not operate within its resource limit for the year or within its cumulative resource limit for the three-year rolling period 2021-22 to 2023-24. However, as agreed with Welsh Government, the Health Board met its revised planned deficit¹⁹ of £16.4 million. The Health Board continues to meet its financial duties against its capital resource limit.

77 In recent years, the Health Board has been unable to submit a balanced financial plan to support its IMTP. The Financial Plan for 2024-25 sets out a forecast deficit of £15.9 million. The Health Board, therefore, is working to an Annual Plan instead and is unlikely to meet its financial duties for 2024-25. It has ambitions to stabilise the financial position and achieve financial sustainability by the end of 2025-26. To achieve this, the Health Board has set itself an ambitious savings target of £47.2 million in 2024-25. At Month 7 2024-25, the Health Board reported a £22.2 million overspend, £12.9 million above the planned deficit for the month. Given the Health Board's ambitious financial plan, it needs to urgently address operational overspend (£5.2 million) and unidentified savings (£7.6 million) to achieve its 2024-25 planned deficit (see **paragraph 81**). To help achieve the savings plan, our 2024 Review of Cost Savings Arrangements highlights the need to strengthen accountability arrangements, set realistic and achievable targets for individual savings schemes, and enhance staff skills and capacity on delivering savings plans. The Health Board has introduced an internal escalation process²⁰ to manage and support underperforming clinical boards.

Corporate approach to financial planning

78 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;

¹⁹ In October 2023, the Health Board's revised its planned deficit from £88.4 million to £16.4 million. This was based on receiving £63.1 million funding from Welsh Government and the Health Board achieving an additional £8.8 million in savings, in addition to its £32 million savings programme.

²⁰ There is one escalation level, 'enhanced monitoring'.

- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

79 We found that **whilst the Health Board has a good approach to financial planning, it needs to strengthen its approach for identifying and delivering recurrent savings.**

80 The Health Board continues to have a robust and integrated approach to developing its financial plan, with appropriate Board and operational level engagement. Like last year, from December 2023, the Finance and Performance Committee discussed the Financial Plan's development at its private meeting, with the final version reviewed at its public meeting in March 2024. The Board has also been engaged in the plan's development through Board Development Sessions. The Board approved the final plan in March 2024, alongside the approval of the 2024-25 Annual Plan.

81 In 2023-24, the Health Board delivered £40.6 million savings, against an overall target of £40.8 million. This total reflects the Health Board's original £32 million savings target for 2023-24, plus an additional £8.8 million savings required to meet the Health Board's £16.4 million revised planned deficit. The Health Board did not update its savings target to include the additional requirement. Our 2024 Review of Cost Savings Arrangements found that whilst the Health Board met its agreed deficit target for 2023-24, it needs to strengthen its approach to identifying and delivering recurrent savings and ensure its service transformation plans align with wider plans to return the organisation to financial sustainability. As at Month 7 2024-25, the Health Board had a £7.6 million savings plan shortfall compared to the forecast position. Performance against savings targets continue to be scrutinised at the monthly Finance and Performance Committee.

82 The Health Board has drafted a long-term financial model, which the Board discussed at its Board Development Session in June 2024. Once approved, the model will be used to inform next year's financial and investment plans (see **Appendix 2 R1d 2022**).

Corporate approach to financial management

83 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;

- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.

84 We found that **the Health Board continues to strengthen its approach to overseeing and scrutinising financial management and controls.**

85 As reported in previous years, the Audit and Assurance Committee routinely receives assurance reports on financial controls, related to counter fraud, procurement compliance, including single tender actions, losses and special payments, and over payments of Health Board salaries.

86 The Health Board continues to improve its procurement processes²¹. For example, on identifying the high volume of decisions taken via Chair's Actions²² last year, it has strengthened its procurement decision making processes and decisions taken via Chair's Actions have recently started to reduce²³. The Health Board is also strengthening financial controls by extending the use of the Docusign e-approval system. Initially introduced for procurement, Docusign is now also used to approve Chair's Actions and legal and estate related decisions. This system, which the Health Board intends to roll out further, provides an evidence trail of decisions. In April 2024, Internal Audit completed a review of core financial systems, specifically focusing on asset register management. This received substantial assurance.

87 Our 2024 Review of Cost Savings Arrangements found that the Health Board has a good understanding of its cost drivers, which are clearly set out in the 2024-25 Annual Plan. Based on feedback from clinical boards, management of cost pressures has improved. This year, the process provides more clarity about which cost pressures clinical boards are expected to manage within their budgets, and which will be supported corporately. There is potential to further improve this approach, as recommended in our 2024 Review of Cost Savings Arrangements, by issuing clinical boards with accountability letters.

88 The Health Board submitted its draft 2023-24 Financial Statements within the required timescales, and they were received by the Audit and Assurance Committee and the Board in July 2024. We issued an unqualified true and fair audit

²¹ In 2021, the Health Board identified procurement breaches on some capital expenditure projects. Since then, it has been working through a procurement improvement plan.

²² Last year, the Health Board reviewed Board approvals for 2021-22 and up to December 2022. In April 2023, the Audit and Assurance Committee received a report highlighting that in 2021-22 of 72 approvals 70 were via Chair's Actions, and that by December 2022 (2022-23) of the 36 approvals sought so far, 34 were via Chair's Actions.

²³ The following Chair's Actions have been reported at Board meetings so far during 2024-25: May 2024 – none, July 2024 – two and September 2024 – two.

opinion, except for a qualified regularity opinion because the Health Board did not meet its revenue resource allocation over the three-year period.

Board oversight of financial performance

- 89 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:
- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
 - the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.
- 90 We found that **whilst the Health Board continues to maintain robust arrangements for overseeing and scrutinising financial performance, there is scope to strengthen deep dives received by the Finance and Performance Committee and reporting on financial savings.**
- 91 The Finance and Performance Committee continues to receive the finance report at each of its monthly meetings. The report is written clearly and continues to provide a clear and open narrative on the Health Board's financial performance, risks, and challenges. The finance report also provides a progress update against achieving financial sustainability by the end of 2025-26, which shows the Health Board's commitment to this ambition. The Board continues to receive assurance from several reports such as the Finance and Performance Committee Chair's Report, the committee's minutes, and the finance section of the Integrated Performance Report, which the Executive Director of Finance presents. Our 2024 Review of Cost Savings Arrangements makes recommendations to strengthen reporting on financial savings.
- 92 The Finance and Performance Committee continues to receive deep-dives, although it is unclear how often these are expected. The committee received its last deep-dive in March 2024. This year's deep dives have focused on operational performance such as diagnostics and mental health. Given the committee's remit, there is scope to strengthen operational performance deep dives by triangulating with financial performance information, for example performance against budgets and actions to achieve savings targets. **(Recommendation 7)**

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Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit and Assurance Committee • Digital Health Intelligence Committee • Finance and Performance Committee • Mental Health Legislation and Mental Capacity Act Committee • Quality, Safety and Experience Committee; and • People and Culture Committee

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Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of Board • Chief Executive Officer • Executive Director of Finance • Executive Director of Strategy and Planning (Interim) • Director of Corporate Governance • Vice Chair • Chair of Audit and Assurance Committee • Chair of Finance and Performance Committee • Independent Member (Local Government)

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Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structure assessment reports.

Recommendation	Description of progress
2023 Structured Assessment R1 Whilst the Health Board’s new well-being objectives are underpinned by clear priorities, they do not encompass all aspects of sustainable development. Furthermore, the Health Board has not aligned its objectives to the national well-being goals or to the well-being objectives of partner organisations. The Health Board, therefore, should: a) consider incorporating additional priorities that encompass all aspects of sustainable	See paragraph 14: • R1a – In progress • R1b – Complete

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development, particularly those that relate to the environment; and b) set out how each individual well-being objective aligns to the national well-being objectives and the well-being objectives of its partners.	
2023 Structured Assessment R2 The Health Board should improve public access to Board meetings by: • livestreaming and recording public Board meetings; and • making the recordings available on the Health Board's website shortly after each meeting.	Complete – see paragraph 25
2023 Structured Assessment R3 The Health Board should review its website, ensuring the latest versions of governance documents and papers are available.	Superseded – see Recommendation 2 2024 (administrative governance)
2023 Structured Assessment	

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R4 The Health Board should review the effectiveness of its new committee structure. The review should pay particular attention to whether: - the committee structure supports sufficient oversight of the refreshed strategic objectives; - committee terms of reference and workplans adequately cover all aspects of Board business; - there is merit in instigating a regular meeting for committee chairs; - there is an appropriate training and development for new committee chairs and new committee members; and - officers and Members have the capacity and resources to support more frequent committee meetings.	In progress – see paragraph 35.
2023 Structured Assessment R5 The Quality, Safety and Experience Committee should start every other meeting with a patient story to usefully set the tone for the remaining meeting and to ensure that members hear about patient experiences and related learning.	Complete – see paragraph 42.

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2023 Structured Assessment

- R6 The Health Board has improved its Integrated Performance Report (IPR). Whilst we recognise it is a new and evolving report, we have found potential to enhance it by:
- a) strengthening its links with the Annual Plan Delivery Report to ensure the relationship between some of the delivery milestones and key performance indicators is clearer; having a more consistent focus on actions being taken to tackle underperformance in both the IPR and its cover report;
 - b) being clearer about whether the metrics in section two of the IPR are on target or not;
 - c) being consistent in providing reasons why data charts are unavailable in section two of the IPR, instead of leaving the section blank; and
 - d) providing benchmarking data (where available) to show how the Health Board compares to other health bodies.

In progress

- R6a – **In Progress** – see paragraph 20.
- R6b – **Complete** – see paragraph 61.
- R6c – **In Progress** – see paragraph 61.
- R6c – **In Progress** – see paragraph 61.

2023 Structured Assessment

- R7 The Health Board should:
- a) formally refer recommendations and/or audit and review reports to relevant committees for

See paragraph 69.

- R7a – **Complete**
- R7b – **In Progress**

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deeper scrutiny, with the committees reporting back to the Audit and Assurance Committee for assurance, and b) develop a report for the Audit and Assurance Committee pulling together common themes, issues and learning from the internal, external and regulatory compliance reports.	
2022 Structured Assessment R1 The Health Board plans to refresh its ten-year strategy by 2023. It should seek to use this opportunity to review and reshape its wider processes, structures, resources, and arrangements, to ensure they are fully aligned to the organisation's refreshed strategic objectives and associated risks, with a particular focus on its: a) Board Assurance Framework b) Performance Management Framework c) Committee structures, terms of reference, and workplans d) Long-term financial plan	In progress • R1a – Complete - see paragraph 54. • R1b – No Progress - see paragraph 59. • R1c – In Progress - see paragraph 35. • R1d – In Progress - see paragraph 82.
2022 Structured Assessment	

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R2 The Integrated Performance Report provides a good overview of the Health Board's performance. However, details of the actions being taken to sustain or improve performance that falls below target appear in some sections of the report but not others. The Health Board, therefore, should ensure this information is provided consistently throughout the report to strengthen the assurances provided to the Board that appropriate action is being taken to sustain or improve performance.	Superseded by Recommendation 6 2023.
2022 Structured Assessment R3 The Health Board, therefore, should: a) post more frequent reminders about Board and committee meetings on social media and provide links to papers; b) ensure the papers for all Advisory Group meetings are published on the Health Board's website in a timely manner; and c) make abridged minutes of private Board and committee meetings available publicly as soon as possible after each meeting;	In progress • R3a – Complete – see paragraph 25. • R3b – Superseded – see Recommendation 2 2024 (administrative governance) • R3c – Complete – see paragraph 27.

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Appendix 3

Management response to audit recommendations

Exhibit 4: Cardiff and Vale University Health Board response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	Annual Plan monitoring To ensure ongoing scrutiny of the Annual Plan, as part of the Integrated Performance Report, the Health Board should reintroduce the quarterly high-level overview of achievements against Annual Plan milestones and highlight how delivery of the milestones is impacting performance in priority areas.	This will be reviewed in line with the lessons taken form the rapid planning event held in Dec 24.	Jul 25	Interim pending review of Exec roles is Director of Finance and COO

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	R2.5. the public is signposted to the current Board Assurance Framework.	2.5 The latest set of Board papers will be the correct point of reference.	Jul 25	Senior Governance Officer
R3	Patient Safety Walkabouts As part of its review of arrangements for Patient Safety Walkabouts, the Health Board should consider how to ensure learning and resulting actions from walkabouts is reported to the Board.	These will be reviewed in a Board Development Session.	Jul 25	Executive Director of Nursing
R4	Board effectiveness and improvement As part of its continuous approach to reviewing Board and committee effectiveness, the Health Board should capture and report improvement	A periodic report will be taken to Board and put in the public papers.	Jul 25	Director of Corporate Governance

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	activities and consider whether they are achieving the intended benefit.			
R5	Risk management The Health Board should ensure that arrangements for scrutinising strategic and corporate risks are clarified and consistent across all committees.	Strategic risks, via the BAF, will be addressed at Committees as part of the reinvigoration of the structure. Corporate risks will feature if required, but following the transfer to AMAT will be dealt with at Clinical Board and SLB level.	Dec 25	Head of Corporate Governance
R6	Risk management The Health Board should refresh the Risk Management Strategy to ensure it includes new arrangements for recording and escalating operational risks.	This will follow the completed transfer of all registers to a single one on AMAT	Dec 25	Head of Corporate Governance

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	Finance and Performance Committee deep-dives The operational performance deep dives received by the Finance and Performance Committee should be triangulated with financial performance information.	Triangulation of deep dives with financial performance will take place in the meetings between the Chair and DoF which in turn will update the forward plan.	Jul 25	Director of Finance

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

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Nathan

Urgent and Emergency Care: Flow out of Hospital – Cardiff & Vale Region

Date issued: September 2024

Document reference: 4460A2024

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Summary report

About this report

- 1 Once a patient is considered medically or clinically well enough to leave hospital (referred to as clinically optimised or medically fit) the timely discharge of that patient to the right setting for their ongoing needs is vital. Timely, effective, and efficient moving of patients out of an acute hospital setting holds important benefits for patient care and experience as well as for the use of NHS resources.
- 2 When the discharge process takes longer than it should there can be significant implications for the patient in terms of their recovery, rehabilitation, and independence. Delayed discharges will also have implications for other patients coming into the unscheduled care system¹ who need a hospital bed. Poor patient “flow” creates bottlenecks in the system that contribute to well documented problems such as over-crowded emergency departments and an inability to secure timely handover of patients from ambulance crews.
- 3 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The approach we adopted to deliver our work is detailed in **Appendix 1**.
- 4 This work is part of a broader programme of work the Auditor General is currently undertaking in respect of urgent and emergency care services in Wales. We are also examining the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. The findings from that work will be reported separately in 2024.
- 5 The Auditor General’s work on urgent and emergency care is designed to help discharge his statutory duties. Specifically, this work is designed to satisfy the Auditor General that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources, as required by Sections 17 and 61 of the Public Audit Wales Act 2004. This report sets out the findings from the Auditor General’s review of the arrangements to support effective flow out of hospital in the Cardiff & Vale Region (the region). The region encompasses:
 - Cardiff & Vale University Health Board (the Health Board) and
 - City of Cardiff Council; and

¹ Urgent and emergency care describes any unplanned, urgent, and emergency care provided by health and social care services. The urgent and emergency care system is complex with numerous organisations involved in providing services and it deals with acutely unwell, vulnerable, and distressed people in need of urgent assistance.

- Vale of Glamorgan Council.
- 6 In undertaking this work, we have also considered progress made by the Health Board against previous recommendations made in our 2017 report on [discharge planning](#). Our findings from this work are set out in a separate report to the Health Board.

Key messages

- 7 Overall, we found that **whilst the volume of patients experiencing delayed discharge remains a concern, there have been notable improvements in ambulance handover and emergency department waiting time performance in the region. However, patient flow within hospitals is impacting negatively on other pathways of care, and regional partners will need to maintain their joint commitment to secure the improvements which are necessary.**
- 8 In line with trends across Wales, the numbers of patients whose discharge from hospital in the Cardiff and Vale region have grown significantly in recent years. Between April 2023 and February 2024, each month there were on average 194 clinically optimised patients whose discharge was delayed, with completion of social care assessments and social worker allocation the main causes for delay. While this represents the best position in Wales, except for Powys, it remains a cause for concern. For the period April 2023 to February 2024, the total number of bed days that had been lost to delayed discharges was 50,668 with a full-year cost equivalent of £27,637 million for the Health Board.
- 9 The Health Board has, in recent months, had significant success in preventing delayed discharges from impacting on patient flow within its urgent and emergency care system, with performance across metrics for waiting times in emergency departments and ambulance handovers consistently either the best in Wales or well above the all-Wales average performance. In January 2024, lost ambulance hours accounted for 834 hours, compared to 2,722 in August 2022. However, data indicates that the commitment to improving waits at either end of the hospital within urgent and emergency services may be impacting on flow within the hospital. Data indicates that access to beds on specialist wards, such as stroke, is inconsistent and that greater numbers of scheduled (planned) care appointments are cancelled due to the lack of available beds within the hospital.
- 10 Several factors are contributing to delayed discharges. The region has an ageing population with a correlating increase in people who live with complex, long-term conditions including mental health problems. There are also workforce challenges within the social care sector, which is resulting in delays in the allocation of social workers and in completing social care assessments. Our work also identified weaknesses in the practice and documentation of discharge planning and a need to include the Discharge to Recover and Assess (D2RA) model within its policies. However, the region is successfully managing to meet demand for care support, with it able to provide care in line with its commitment to providing domiciliary care

over care home provision. This is something many other regions in Wales are finding challenging.

- 11 Improving patient flow is a key feature of plans across the partners which align to the Welsh Government's six goals for urgent and emergency care². Partners are working together effectively, both strategically and operationally, to improve patient flow. Financial resources are being applied to improve discharge planning with evidence of evaluation of the impact of projects and initiatives. There is regular monitoring of performance within individual organisations and with partners, but we found scope for further opportunities to examine whole system solutions, embed learning and to focus on the impact of activity within performance and progress reports.

Recommendations

- 12 Recommendations arising from this audit are detailed in **Exhibit 1**. The combined management response by the statutory bodies included in this review to these recommendations will be summarised in **Appendix 4** once considered by the relevant committees.

Exhibit 1: recommendations

Recommendations	
Addressing key gaps in social care capacity	
R1	To help inform discussions around discharge, the local authorities should capture the risks associated with social care capacity on the provision of services at a local and regional level, including the impact on patient flow out of hospital.
Improving compliance with policies and guidance	
R2	The Health Board, working with local authorities, should update its discharge policy and associated policies, including the choice of accommodation policy, to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly defined roles and responsibilities, and

² Further information on the Welsh Government six goals for urgent and emergency care can be found via <https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update>

expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers.

- R3 The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.

Improving the quality of information

- R4 The Health Board should improve record keeping by:
- 4.1 ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.
 - 4.2 establishing a programme of case-note audits focused on the quality of record keeping.

Maximising weekend discharges

- R5 The Health Board, in partnership with its local authorities, should ensure it has the necessary arrangements in place to embed and deliver a 7-day working week approach to hospital discharge to minimise unnecessary stays in hospital.

Increase clarity of intended outcomes for pathways of care action plan

- R6 The region should ensure its action plan for pathways of care is clearer on the intended outcomes from the actions it has identified. It should also undertake regular review to assess whether outcomes are being achieved.

Maximising the use of the Regional Integration Fund

- R7 To help inform decision-making and discussions, the Health Board and local authorities should ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages

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Detailed report

What is the scale of the challenge?

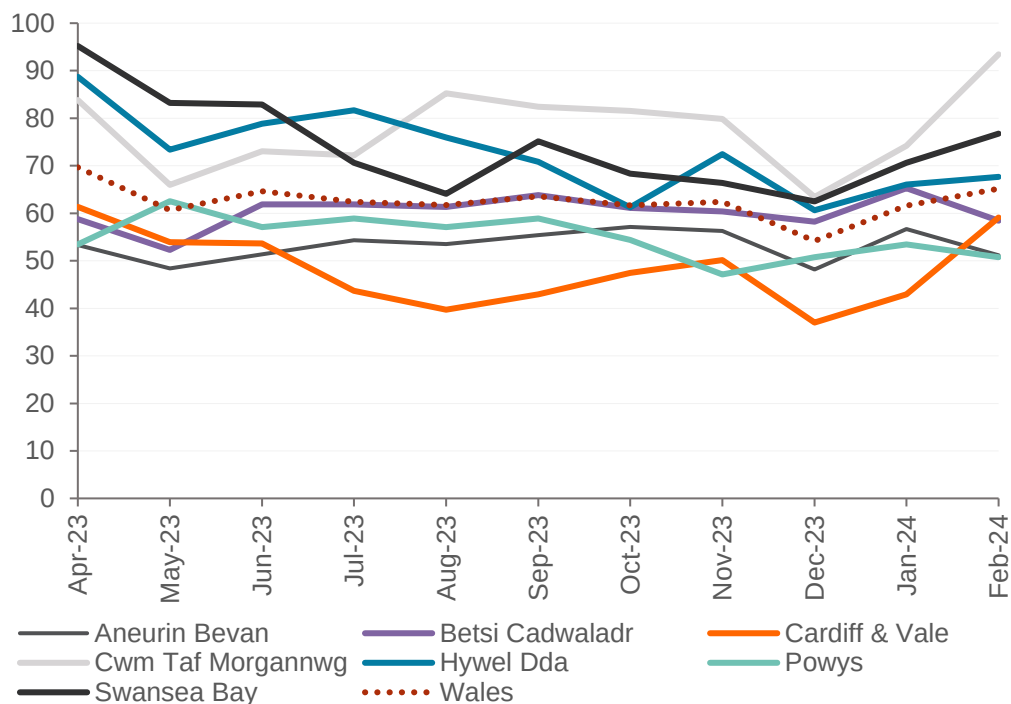
- 13 This section sets out the scale of the challenge that the region is facing in respect of delayed discharges and the subsequent impact on patient flow and the patient experience.
- 14 We found that **the region generally performs better than the all-Wales position for measures related to unscheduled care and discharge planning, though this focus may be impacting its ability to move patients to the most appropriate setting within the hospital.**

Delayed discharges

- 15 We found that **the region has comparatively lower rates of delayed discharges, with an improving trend in 2023-24, though those experiencing delays wait longer than the all-Wales average.**
- 16 Delays discharging patients from hospital has been a longstanding issue for bodies in Wales and other parts of the UK. The available data shows that this issue has become significantly worse in recent years.
- 17 **Exhibit 2** sets out the number of delayed discharges experienced by the Health Board between April 2023 and February 2024, compared with other NHS bodies across Wales. These relate to patients who are considered clinically optimised but remain in a hospital bed 48 hours after the decision is made that they were well enough to leave hospital. As can be seen in the exhibit, the rate of delayed discharge is well below the all-Wales average and the lowest for six of the 11 months shown.

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Exhibit 2: number of delayed discharges per 100,000 head of population (April 2023 – February 2024)



Source: Welsh Government

- 18 Since the pandemic, the way in which delayed discharges are measured has changed. No data on delayed discharges was formally reported between the period March 2020 and March 2023. Prior to the pandemic, delayed discharges were reported as 'delayed transfers of care' which were defined as those who continue to occupy a bed after the date in which the patient is declared to be ready to move on to the next stage of their care. This compares with the current method for counting delays which focuses on those who remain in a hospital bed 48 hours after being identified as clinically optimised.
- 19 Although not a direct comparison, in February 2020, the Health Board reported 30 delayed transfers of care. The position at the end of February 2024 of 238 delayed discharges equates to 13.7% of the Health Board's total bed capacity³. Whilst significant, this was the lowest percentage in Wales, with the all-Wales average being 17.9% (ranging between 13.7% and 31.3%).

³ Based on general and acute bed availability data in July 2023, StatsWales website (<https://stats.wales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site>)

20 The top five reasons for delayed discharges at the Health Board compared to the all-Wales position is set out in **Exhibit 3**, with the most common reasons being awaiting completion of assessment by social care and awaiting social care allocation, both of which are higher than the all-Wales average. A full list of reasons for delays are set out in **Appendix 2**.

Exhibit 3: top 5 reasons for delayed discharges (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting completion of assessment by social care	31.5	15.7
Awaiting social worker allocation	15.5	8.5
Awaiting completion of arrangements prior to placement	10.9	3.5
Awaiting joint assessment	4.6	9.0
Awaiting completion of clinical assessment (nursing / allied health professional / medical / pharmacy)	4.2	10.3

Source: Welsh Government

- 21 This data is also broken down to a local authority level, which is demonstrated in **Appendix 2**. Data shows that there are consistent challenges across the region, with awaiting completion of assessment by social care and social worker allocation the highest causes of delay in both local authority areas, accounting for 46% and 51% of all delays in Cardiff and Vale of Glamorgan respectively.
- 22 Bed days lost due to delayed discharges are a cause of significant financial inefficiency across Wales. For the region, data reported in February 2024 showed that the total number of delayed patients for that month accounted for 5,460 bed days. Based on a typical cost per bed day of £500,⁴ this equates to costs in the region of £2.730 million. A total of 50,668 bed days were lost for the period April 2023 – February 2024. This is equivalent to £27.637 million for the year.

Impact on patient flow

- 23 We found that **whilst the Health Board’s performance compares favourably on most urgent and emergency care performance metrics, there are indicators that onward flow through the hospital is challenging which is impacting**

⁴ Based on £500 per bed-day as set out in the NHS Confederation [briefing for the statement by the Minister for Finance and Local Government on the 2023-24 financial position](#)

admission of stroke patients and resulting in increased cancellation of planned care treatments.

- 24 Delays in discharging patients from hospital have consequences for patient flow and in particular, the ability for patients to access services when they need them. Beds being used by patients who no longer need them means that they are not available for those who do, resulting, for example, in longer waits in emergency departments. This in turn impacts on the ability for ambulance crews to handover patients and respond to 999 calls in the community.
- 25 **Appendix 3** sets out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022. In summary:
- the percentage of ambulance red calls responded to within eight minutes has been consistently better than the all-Wales position but has not reached the national target of 65% since July 2022 (**Exhibit 15**);
 - the median amber response time is longer than the national target of 20 minutes, however, is consistently better than the all-Wales average, except for January 2024 (**Exhibit 16**);
 - the percentage of ambulance handovers within 15 minutes is broadly in line with the all-Wales average, but falls well short of the national target of 100% at around 20% (**Exhibit 17**);
 - the percentage of ambulance handovers taking over one hour at the Health Board's major emergency department has improved dramatically, reducing from around 50% in August 2022 to 11% in January 2024. This is the best position in Wales by a significant margin, though it remains above the national target of zero (**Exhibit 18**);⁵
 - the total number of hours lost following notification to handover over 15 minutes is significantly better than the all-Wales average, steadily reducing from 2,722 in August 2022 to 834 hours in January 2024 (**Exhibit 19**);
 - once the patient is in the emergency department, the median time from arrival to triage has reduced and is consistently better than the all-Wales position at 19 minutes in January 2024 (**Exhibit 20**);
 - the median time from arrival at an emergency department to assessment by a senior clinical decision maker has been better than the all-Wales average, with one exception in 2022, and has improved from 105 minutes in April 2022 to 59 minutes in January 2024 (**Exhibit 21**);
 - the percentage of patients seen within four hours in a major emergency department has fluctuated since April 2022 between 58-75%. Performance

⁵The target for no patient handover to take longer than one hour was introduced as an additional metric by Welsh Government within the NHS planning framework in 2023/2024 as part of work to try and reduce the increasing trend of lost hours.

is better than the all-Wales average but remains below the national target of 95% (**Exhibit 22**);

- the percentage of patients seen within 12 hours in a major emergency department is better than the all-Wales position, as of January 2024 these figures were 92%, just short of the national target of 100% (**Exhibit 23**); and
- the percentage of bed days accrued by people with a length of stay over 21 days was in-line with the all-Wales average between April 2022 and April 2023 at between 55 and 65% (**Exhibit 24**).

- 26 The Health Board's total bed capacity has fluctuated over recent years, with 1,779 total beds available in 2022-23, with just under half allocated to acute medicine (903). Bed occupancy in the acute medicine beds has been at 89.6%, compared with an optimal level of 85%. The Health Board is one of three health boards that does not have community hospital beds managed by GPs, however it does have access to Health Board step down community hospital beds as well as Local Authority commissioned step down care home beds.
- 27 Pressure on available beds because of delayed discharges means that health boards are not always able to ensure that patients are placed on the best wards for their clinical needs. For example, health boards will usually hold vacant beds on stroke units to ensure that stroke patients have fast and direct access, enabling them to access stroke specialists and equipment.
- 28 Health boards have increasingly experienced difficulties in admitting stroke patients to a stroke ward as problems with patient flow and bed availability mean that these beds have been needed for urgent non-stroke patients. Between April 2022 and April 2023, performance for the Health Board was volatile with the percentage of stroke patients with direct access to a stroke ward within four hours fluctuating between a low of 3.3% and a high of 54%. Since April 2023 performance has improved, with performance ranging between a high of 72.5% in June 2023, and a low of 43.5% in April 2024.
- 29 During 2022-23, 456 planned care admissions were cancelled due to the lack of an available ward bed in the Health Board. For the period, 2023-24 up to and including February 2024, 579 planned care admissions were cancelled. This compares to 413 for the same period in 2022-23. This level of cancellation represents poor patient experience and risks the conditions of planned care patients further deteriorating while they wait for their treatment to be rescheduled.

What is impacting effective and timely flow of patients out of hospital?

- 30 This section sets out the issues impacting on effective discharge planning and the timely flow of patients out of hospital across the region.

- 31 We found that **the region is effectively supporting people to return home, but faces challenges due to social care capacity issues, inconsistent discharge policy application, and rising demand from an aging population.**

Volume and complexity of demand

- 32 We found that **rising age demographics and increasing physical and mental health needs are placing increasing demands on regional health and social care services.**
- 33 In the Cardiff and Vale region people between the age of 65 and 84 accounted for 14% of the population as of 2019, but that figure is expected to increase to 16.2% by 2039⁶. As people live for longer, there is a correlating increase in the numbers of people who live with multiple long-term conditions and complex health needs and who will therefore need to rely on health and care services for support.
- 34 COVID-19 exacerbated this increase in complex demand. During the pandemic demand for emergency departments declined rapidly, as people followed national advice to only access urgent and emergency care if truly needed in order to protect core frontline services. In addition, families provided additional care and support to avoid their loved ones being admitted to hospital or long-term care out of fear of contracting COVID-19.
- 35 According to data gathered by the region, in 2017-18 71.6% of older people living in the region rated their well-being as 'good' or 'very good' prior to the COVID-19 pandemic. This has since decreased and in 2022 stood at 52.8%. In addition, only 47.7% of older people in Cardiff and 50.2% in the Vale of Glamorgan reported that they live free from a limiting long-term illness. This inevitably means there will be a greater reliance on the regions' health and social services than in previous years, including urgent and emergency care services. Those we spoke to during the fieldwork cited a specific increase in mental health demand since the beginning of the pandemic and data shows that within the region the number of older adults living with severe dementia is predicted to double by 2040⁷.

Workforce capacity

- 36 We found that **there have been high levels of vacancies in social care which have had an impact on delays in discharging patients.**
- 37 Across Wales, the staff involved in discharge planning are increasingly finding their capacity stretched due to factors such as high vacancy rates and unplanned absence rates. Reduced numbers of staff leads either to a reliance on agency staff and/or to fewer permanent staff attempting to manage increasingly complex

⁶ Cardiff and Vale Regional Partnership Board Joint Area Plan 2023-28 [About – CAVRPB](#)

⁷ Cardiff and Vale Market Stability Report, 2022

patients and organise the ongoing care they need for discharge. High usage of agency staff has inevitable impacts on continuity within the workforce.

- 38
- Within the region, capacity issues have been greater within social care than in health services. As of March 2024, the Health Board was reporting very few vacancies as a percentage of its total establishment, with nursing and midwifery vacancies at 2.4%, compared to 6.5% at an all-Wales level, and zero vacancies for medical staff. The unplanned absence rate for the Health Board in March 2024 was broadly in line with the all-Wales position at 5.9%, with the absence rate for nursing and midwifery at 6.9%, slightly below the all-Wales position of 7.1%. The medical unplanned absence rate was low at 1.4% compared to the all-Wales average of 2.2% figure. The use of agency staff accounted for 0.91% of the Health Board’s total pay bill in March 2024, down from 3.8% in March 2023.
- 39
- According to the most recent publicly published data, as of June 2023, both Cardiff Council and the Vale of Glamorgan Council were reporting high vacancies in adult social services, with the highest rate of vacancies in Cardiff at 39%⁸. In February 2024, the unplanned absence rate in adult social services was above the all-Wales position in Cardiff, but below in Vale of Glamorgan, as shown in **Exhibit 4**. We have seen more recent data which indicates vacancies have reduced within the Vale of Glamorgan, supported through long-term agreements with agency contracts. Data on agency use has not been reported since June 2023, but up until that point, the use of agency staff in Cardiff Council was well above the all-Wales average at 11% (compared to 2% across Wales). The use of agency staff in Vale of Glamorgan was at 3%.

Exhibit 4: percentage unplanned absences in adult social services (June 2023)

Local authority	Unplanned absence
Cardiff	7
Vale of Glamorgan	5
All-Wales average	6.4

Source: Welsh Government

- 40
- Some of the staff challenges associated with social services correlate with the issues highlighted in **Exhibit 3** where delays due to waiting social care assessments or receiving a social worker allocation together accounted for 47% of delayed discharges across the region in February 2024. **Exhibit 5** sets out the

⁸ Cardiff 39%, Vale of Glamorgan 21%. No data has been made available since June 2023.

extent to which adult social services in the region can meet demand for assessment.

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Exhibit 5: number of social care assessments completed and awaiting to be completed per 100,000 head of population (February 2024)

Local authority	Social care assessments completed	Adults waiting for a social care assessment	Percentage of adults waiting that are in hospital
Cardiff	116	60	28.4%
Vale of Glamorgan	153	63	38.2%
All-Wales average	250	125	8.7%

Source: Welsh Government

- 41 Both the number of completed assessments and the waiting lists for social care assessments are significantly less than the all-Wales average. In fact, data since November 2022 shows that Cardiff regularly had the lowest number of assessments completed per 100,000 head of population in Wales at 80 per month. The number of social care assessments completed in Cardiff for February 2024 was higher than usual. While waiting lists for social care assessments in the region have generally been below the all-Wales average, the waiting lists are almost half the level of monthly activity which suggests there are potential pressures on capacity to meet demand. In addition, a significant percentage of the adults awaiting a social care assessment are those waiting in a hospital bed, with figures in this region among the highest in Wales.
- 42 We are aware that the region has been working to respond to its workforce challenges. A Pathways of Care Delays action plan in place for 2024-25 clearly demonstrates efforts to mitigate the delays in progressing assessments. Actions included screening referrals, streamlining the assessment process and additional supervision and accountability to ensure services are timely.

Care sector capacity

- 43 We found that **the region places a strategic emphasis on its domiciliary care services to support patients when they leave hospital and is currently successfully meeting that higher demand.**
- 44 Availability of home (domiciliary) care packages and long-term residential care home accommodation are a key cause of discharge delay across Wales. Within the Cardiff and Vale region, there is greater commitment to support people to return home with support than to place them into care homes. **Exhibit 6** sets out the number of adults receiving care sector support and the extent to which there are waits for provision. **Appendix 4** sets out waiting list performance for social care assessments and care packages since November 2022.

Exhibit 6: number of adults receiving (and waiting for) care packages and placements per 100,000 head of population (February 2024)

Local authority	Domiciliary care ⁹ in receipt (waits)	Reablement ¹⁰ in receipt (waits)	Long-term care home accommodation ¹¹ receipt (waits)
Cardiff	807 (0)	44 (6)	317 (7)
Vale of Glamorgan	973 (13)	34 (2)	515 (3)
All-Wales average	665 (34)	46 (9)	536 (11)

Source: Welsh Government

- 45
- The region appears to be managing the demand for supporting people to return home well. The exhibit shows the number of adults in receipt of domiciliary care in the region is significantly higher than the all-Wales average, whilst the numbers waiting for care are low. This correlates with data shown in **Exhibit 3**, that as of February 2024, awaiting start of a new care package accounted for only 4.2% of delayed discharges. The number of adults in receipt of reablement per 100,000 head of population is broadly in line with the all-Wales average and the number of adults in receipt of long-term care home accommodation per 100,000 head of population is mixed, with the Vale of Glamorgan in line with the average all-Wales figure while Cardiff consistently has the lowest figure in Wales. Waiting lists across all three means of ongoing support are lower in the region than at an all-Wales average.
- 46
- Exhibit 7** indicates the extent to which there are unfilled domiciliary hours, and the average number of hours provided per adult.

Exhibit 7: unfilled domiciliary hours and average hours of domiciliary care provided per adult, per 100,000 head of population (February 2024)

Local authority	Hours waiting to be filled	Average hours per adult
Cardiff	0	16.3
Vale of Glamorgan	160.4	15.7
All-Wales average	352.6	13.2

⁹ Includes domiciliary care both provided and commissioned by local authorities.

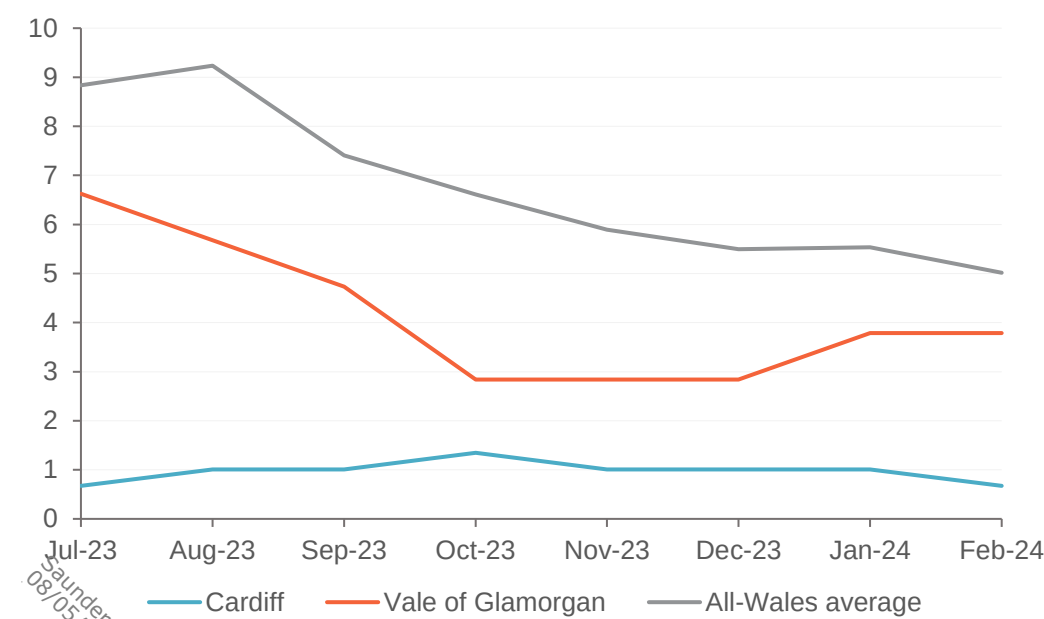
¹⁰ Includes reablement provided by local authorities.

¹¹ Includes long term care home accommodation commissioned by local authorities.

Source: Welsh Government

- 47
- The number of domiciliary care hours waiting to be filled per 100,000 head of population in Cardiff has been at zero for ten of the past sixteen months and has been very low in the other six. The number of hours waiting to be filled within the Vale of Glamorgan has decreased significantly from nearly 2,000 in November 2022 to a low of 57 in January 2024 before rising again to 160 in February 2024. Both areas in February 2024 were significantly lower than the all-Wales average. The region also purposefully provides a higher number of domiciliary care support hours on average per person than at an all-Wales level. This again shows that, while the region relies heavily on domiciliary care, it is successfully able to deal with the current levels of demand.
- 48
- Exhibit 8** sets out the extent to which unplanned short term care home accommodation is used across the region. Since November 2022, the region has had some of the lowest numbers of adults per 100,000 head of population in unplanned short term care home accommodation in Wales. This is a result of management of the domiciliary care market in reducing the need for short-term care home placements

Exhibit 8: number of adults per 100,000 head of population in unplanned short term care home accommodation for three or more months, with no end date (July 2023 – February 2024)



Source: Welsh Government

- 49 Whilst Cardiff is among the Council areas with the largest overall number of care home beds in Wales, as of July 2023, it had the lowest number of people per 100,000 head of population receiving care home provision. This, along with the fact there are generally low or no waiting lists for domiciliary care, means Cardiff Council does not rely on unplanned accommodation for a period of 3+ months in the same way as other regions and therefore fewer people are placed in unplanned temporary accommodation. The Vale of Glamorgan has significantly less care home beds than Cardiff and has a higher number of people placed in unplanned temporary accommodation for three or more months, although this is still consistently better than the all-Wales position per 100,000 head of population.

Discharge process

- 50 We found that **there is variation in adhering to the Health Board's discharge policy, with evidence of incomplete documentation.**
- 51 Awaiting joint assessment and completion of a clinical assessment by a health professional accounted for a much smaller proportion of discharge delays according to the data shown in **Exhibit 3**. However, our review found other health specific factors that lead to discharge delays.
- 52 Good discharge planning is reliant on good communication and co-ordination across different professional groups, with consideration of discharge as soon as a patient is presented to services. Good discharge planning is also facilitated by having clearly documented processes which are shared with all staff involved to promote understanding and awareness of the different roles in the discharge process.
- 53 The Health Board has a discharge policy. The discharge policy we reviewed was comprehensive and provided clarity on the various roles and responsibilities of team members to discharge patients. It promoted a co-ordinated multi-disciplinary team approach and highlighted the importance of good communication with the patient and/or their representatives. However, in our 2017 review we recommended the Health Board ensure its upcoming revision of the policy involved patients and carers. While the policy was revised in 2020, it is not clear to what extent this revision was informed by collaboration with patients and carers. The policy was again due to be revised in 2023 but this has not yet happened.
- 54 An Internal Audit report in 2020 highlighted issues with adherence to the Health Board's discharge processes. The report found variation in its review of whether staff were adhering to the Health Board's process and highlighted instances where the process had not been applied correctly. Examples included patient discharge information leaflets not distributed, lack of up-to-date Predicted Dates of Discharge and incomplete discharge checklists.
- 55 The findings of the internal audit report in 2020 were mirrored in our hospital patient case note review. Our case note review analysed a sample of patient notes from October 2022 with a length of stay beyond 21 days. We found variable quality

and completeness of discharge documentation between clinicians and wards.

Some of the key findings included:

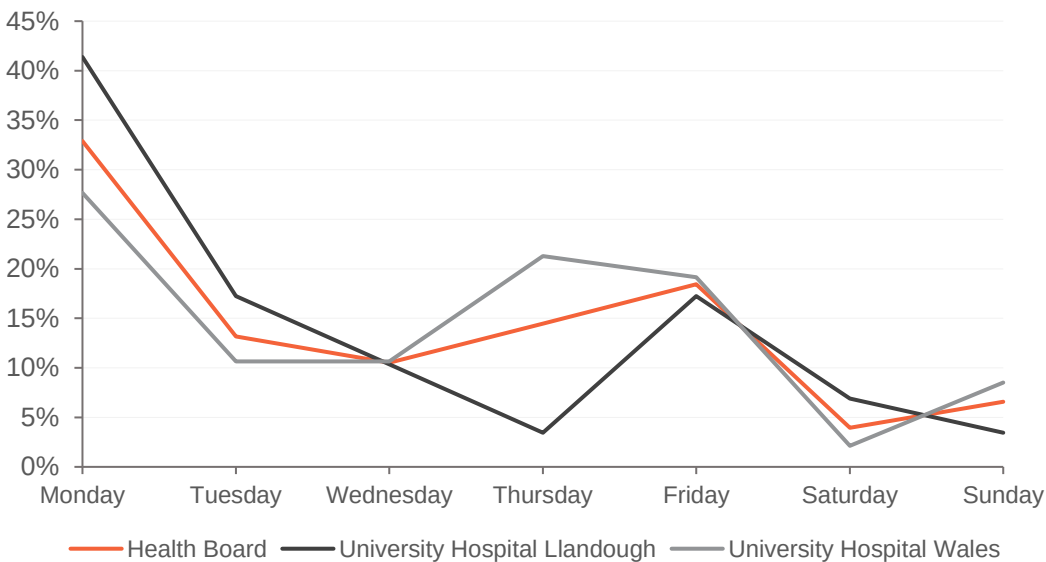
- No evidence of an expected date of discharge within 48 hours of admission in 14 of the 17 cases (82%) reviewed;
- Lack of documentation for What Matters Conversations within any of the case notes reviewed, and under half of the case notes (47%) showed the family were involved and kept informed of the patient's care plans.
- Evidence of a documented statement that the patient is clinically optimised for discharge in just over half (56%) of case notes; and
- Evidence of regular discussion and review of discharge planning during ward rounds in 58% of the case notes.

Whilst it is possible that arrangements may have changed since October 2022 the Health Board has not undertaken any recent audits to demonstrate improvements and it is likely that many of these issues remain.

- 56 In most of the case notes we reviewed, the main cause of delay in discharge was due to a delay in securing a social worker assessment. Many case notes showed that a referral was required for professionals including physiotherapists, occupational therapists, psychologists and dieticians. Positively, where referrals were needed, we found helpful and complete documentation. However, once discharges were progressing, logistical arrangements were rarely described i.e., whether the patient required transport or whether their medications had been prepared.
- 57 We also noted that discharging patients from hospital remains an activity which largely takes place on weekdays, with very few (and mostly simple) discharges occurring on weekends due to staff working patterns in both health and social care. Our data from October 2022 showed that only 3.9% of discharges occurred on Saturdays (**Exhibit 9**). During the week, discharges peak on a Monday across both sites, with a third of all discharges occurring on this day. This may be reflective of consultants' weekly working patterns at the time the data was captured (noting the Health Board's plans to introduce 7-day consultant working as described in **paragraph 71**). It may also reflect the availability of services to support discharge over the weekend.

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Exhibit 9: day of discharge of all patients discharged from acute hospital sites in October 2022, as a percentage of total discharges¹²



Source: Audit Wales analysis

- 58 We were told that there are different discharge processes in place for patients from Cardiff and Vale of Glamorgan, such as the single points of contact services. We heard during our fieldwork that staff within the Health Board are not always aware of differences between social services' processes, which can lead to delay. Staff also spoke of a culture of risk aversion, whereby staff are reluctant to discharge patients because they fear the patient may not cope as well at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Keeping patients in hospital for longer than they clinically need has a negative impact on patient experience and outcome as well as broader patient flow within the hospital. While many we spoke to recognised the negative impact of delayed discharges on the independence and wellbeing of patients, there is a continued reluctance to take measured risks and to recognise the significant knock-on impact delayed discharges have on patient flow and the wider system.
- 59 In 2018, the Welsh Government introduced the Discharge to Recover then Assess (D2RA) model, which is designed to support people to recover at home before being assessed for any ongoing need, thereby reducing length of stay in hospital. Implementation of the model was accelerated during the pandemic, and the Welsh Government has subsequently supported regions with additional monies to embed D2RA further, with updated national guidance being issued in December 2023.

¹² Excludes patients who died.

While staff we spoke to during our fieldwork demonstrated an awareness of the model and its principles, we found no references to D2RA within the discharge policy we reviewed.

What action is being taken?

- 60 This section considers the actions being taken by the statutory organisations, including through the Regional Partnership Board to improve the flow of patients out of hospital.

Strategic and operational plans

- 61 We found that **partners demonstrate a clear focus on jointly developed strategic and operational planning to improve patient discharge**
- 62 We reviewed relevant health board and local authority plans and found that plans in the region reflect a good understanding of the challenges affecting the flow of patients out of hospital. Plans also reflect the commitment of partners to resolve some of the key challenges related to flow such as workforce gaps. Plans, including the 2023 [Joint Area Plan](#) are informed by data and demand projections and reflect key Welsh Government planning requirements, including the six goals for urgent and emergency care¹³.
- 63 The Health Board's delivery plan for the six goals for urgent and emergency care 2024-25 sets out existing and new initiatives to support delivery of the six goals programme. Our review found it to be a comprehensive and well-set out plan. The Health Board has consolidated the Welsh Government six goals for urgent and emergency care into four workstreams, the fourth of which is optimising hospital flow and discharge. The action plan identifies ambitions to improve discharge arrangements through measures such as 7-day working for consultants, a reshaped frailty pathway and expansion of community services to enable a pull of patients from secondary care.
- 64 Partners in the region have also developed a joint action plan for Pathways of Care Delays. This action plan clearly sets out individual actions, responsible officers, timescales and progress updates. The version we reviewed, of January 2024, showed good progress across most actions, with particular success in terms of arrangements for regular engagement between partners to review and discuss challenges and improvements. However, we did note that a significant number of actions largely related to the establishment of meetings, with less focus on the impact and outcomes of such engagement work.

¹³ Introduced in 2021, the national six goals for urgent and emergency care programme contains two goals that are directly linked to improving discharge: 'goal five - optimal hospital care and discharge practice from the point of admission', and 'goal six: home first approach and reduce risk of readmission'

- 65 The region recognises that a key shared challenge is recruiting qualified community-based staff to support hospital discharge, including carers and occupational therapists. In 2022 the region undertook a Strengths, Challenges, Opportunities, Threats (SCOT) analysis to inform its advertising campaign, titled 'Join our Caring Community' which is designed to utilise several methods to attract applicants to roles as they appear. Cardiff Council are also working to address the shortages within domiciliary care services by launching their own Cardiff Cares Academy to train people, as well as creating a 'Grow Your Own' programme which is a pathway to becoming a qualified carer.
- 66 The Health Board's winter plan for 2022-23 was developed with partners across the region. The plan was informed by an internal demand and capacity exercise conducted by the Health Board to compare the available bed base against best, worst and pre-covid average scenarios. The plan predicted a potential bed gap during peak pressures of 152 beds. Partners then sought to mitigate this gap via initiatives described within a supporting joint action plan between the Health Board and the two local authorities. The actions include further employment of social workers, overseas recruitment and sponsorship, and increasing bed capacity and step-down facilities, including the Lakeside facility¹⁴. RPB papers from 2023 and 2024 show that these projects were successful in mitigating the challenges of winter pressures, with success of initiatives in 2022 laying a good foundation for further success in winter 2023.

Partnership working

- 67 We found that **there is clear evidence of partnership working both strategically and operationally within the region, which is leading to positive change.**
- 68 At a strategic level, there is evidence of regular engagement and partnership working between the Health Board and the two local authorities. The Health Board Chief Executive Officer and the Directors of Social Services attend monthly Strategic Leadership Group (SLG) meetings and bi-monthly Regional Partnership Board meetings. Our observations of meetings reflected constructive discussions taking place at these forums, with clear evidence of collaboration on items and good discussion including constructive challenge.
- 69 Operationally, staff we spoke to said they had witnessed a culture shift during 2022 between health and social care staff where they now saw each other as working towards a common goal. This has led to a much-reduced tendency to revert to a blame culture where another professional is deemed the cause of a delay.
- 70 Partners invest their time heavily in facilitating timely flow and we observed a range of operational meetings including ward rounds, site manager meetings and DTOC

¹⁴ <https://calyb.hb.nhs.wales/files/board-and-committees/quality-safety-and-patient-experience-committee-2021-22/241c-appendix-3-final-lakeside-wing-uhw-announced-scrutiny-visit-report1/>

meetings which include a wide range of professionals. There are also regular meetings between the Health Board and the local authorities to escalate and manage delayed discharges.

- 71 The Trusted Assessor Model was first established as part of the COVID-19 hospital discharge service requirements set out by the Welsh Government in 2020. Trusted Assessor refers to someone acting on behalf of and with the permission of multiple organisations carrying out an assessment of health and/or social care needs in a variety of health or social care settings. The model has the potential to support a more efficient and timely service response. Due to slow progress in implementing the model across Wales, in February 2023 Welsh Government set a requirement for regions to review and implement a Trusted Assessor Action Plan. The region reports good progress against its action plan, with increasing numbers of occupational therapist posts supporting trusted assessment.
- 72 A key action within the Health Board's six goals plan for 2024-25 included the pursuit of 7-day working for consultants. Several of those we spoke to discussed the challenges in facilitating weekend discharges during our fieldwork, as discussed in **paragraph 58**. While it's positive to note that the Health Board is taking action to address this, it is likely that improvements will be limited unless 7-day working is pursued with other professionals and undertaken in collaboration with partners. For example, if care homes or domiciliary care are unable to accommodate patient discharge over weekends the initiative may fail to achieve the full potential impact.

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Operational structures

- 73 We found that **operational structures across the region and within the Health Board are providing a positive focus on patient flow.**
- 74 The Health Board's four workstreams for the six goals for urgent and emergency care are managed by groups which meet monthly to monitor the delivery of plans. Effective senior ownership of each workstream is secured via allocated clinical and operational leads. The workstreams report into the Cardiff and Vale Six Goals Delivery Board, which is chaired by the Health Board's Chief Operating Officer which, in turn reports into the Health Board's Senior Leadership Board. These arrangements demonstrate good senior ownership of the six goals agenda to drive change.
- 75 At a regional level, the activity mostly associated with improving flow out of hospital is overseen by the @Home Delivery Programme Board within the Regional Partnership Board structure. The @Home Delivery Programme contains a good mix of health and social care colleagues. Our meeting observation found evidence of effective collaboration and positive engagement between members.
- 76 The Programme Board leads the strategic development and oversight of regional programmes and their supporting projects.. The Programme Board reports to the RPB's Strategic Leadership Group (SLG), which in turn reports to the RPB. We found that membership of both the SLG and RPB included an appropriate split of representatives and seniority from partners, showing a clear focus and intent of partners to engage with and support improvements to long-standing challenges, including those relating to flow out of hospital. This was demonstrated in the partnership working to respond to the Welsh Government 1,000 bed challenge¹⁵. The Welsh Government requirement was for the region to establish 163 of the 1,000 beds or equivalent services by the end of March 2023. Welsh Government reports show that the region identified 112 beds or equivalent services. This largely mirrors the picture across Wales which saw many regions make progress but ultimately fail to achieve their notional target due to factors such as staff shortages.

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¹⁵ In July 2022 the Health and Social Care Minister set a challenge for Health Boards and Local Authorities to establish an additional 1,000 bed spaces or their equivalents to support timely discharge <https://www.gov.wales/written-statement-six-goals-urgent-and-emergency-care-programme-update>

Information sharing

- 77 We found that **the Health Board is further strengthening its processes for collating and analysing information, including revising discharge forms and developing digital solutions to support effective discharge**
- 78 Professionals within and across organisations will typically be required to share information about the patient to facilitate appropriate discharge arrangements and ongoing care, especially where the patient has more complex needs. During our fieldwork, we found that arrangements for collecting information generally work well, with a good range of data available to staff.
- 79 However, challenges occur because of the patient data needed to support effective discharge being held in several IT systems. In addition, we heard that capacity constraints mean staff find it difficult to keep electronic systems up to date which can mean patients ready for discharge are not identified as early as possible. Recognising these challenges, the Health Board is rolling out a system called STAMP¹⁶ across its wards. STAMP is a digital system for monitoring and tracking patients to enable health staff to understand a patient's status in real-time. It automates the pulling of information from various sources to free up the time of staff. The Health Board had also commissioned work from data analysis agency, Lightfoot which was providing helpful insights into existing data.
- 80 During our fieldwork, staff also told us that poor referral paperwork means social services receive unhelpful or inaccurate information about a patients' needs. The Health Board had recognised weaknesses in the documentation and was planning to develop a new referral form to provide better quality information regarding patient's needs.

Use of funding

- 81 We found that **the region demonstrates strategic planning in its use of RIF and takes care to evaluate performance and measure outcomes for patients**
- 82 The region makes use of the Health and Social Care Regional Integration Fund (RIF) to support schemes aimed at improving discharge planning. The RIF is a Welsh Government 5-year fund to deliver a programme of change from April 2022 to March 2027. The aim of the fund is to establish and mainstream at least six new national models of integrated care to provide a seamless and effective service for the people of Wales. Two contain a clear link to improving flow out of hospital for patients, namely: Home from Hospital Services; and Accommodation Based Solutions.
- 83 There is a clear expectation within the RIF guidance that partners 'match fund' projects up to 50% by the end of year 5, with Welsh Government funding for each project tapering each year to allow for successful projects to become business as

¹⁶ STAMP: System for Tracking and Managing Patients

usual. However, due to the financial pressures that the NHS is currently facing, this expectation has been relaxed.

- 84 The region received £19.2 million of RIF funding in 2022-23 and £19.4 million in 2023-24. About two fifths of the allocation is dedicated to its @Home Programme which sits under the Ageing Well priority of the RPB and supports the delivery of the national Home from Hospital Services model. The @Home Programme brings together six projects to enable older people to access the support they need, when and where they need it. In 2023-24, these included community support in hospital to support patient discharge and establishment of an MDT cluster approach including social discharge follow-up. There is regular oversight of the @Home Programme through update reports which set out how patients are accessing the services provided.
- 85 The region submits financial information on how it is managing the RIF to Welsh Government each quarter. For 2023-24 the RPB identified a forecast overcommitment of the RIF of circa £1.8 million at the beginning of the financial year. This was due to agreed expenditure to sustain the additional capacity brought in as part of the 1,000-bed challenge to create additional step-down capacity during winter 2022-23. However, a quarterly finance report from September 2023 shows that several projects were underspending due to vacancies or delayed recruitment. During our fieldwork we heard that it often takes longer to establish a project once it has been approved, including time to recruit, which can cause delays. The report also shows that partners in the region had committed £11.7 million match-funding, with £2.6 million for schemes within the Home from Hospital model.
- 86 The RPB's Annual Reports in 2022-23 and 2023-24 provide data and case studies on how the @Home Programme has benefited patients, including by providing access to intermediate care services to over 6,000 patients and achieving 70% of referrals to its 'Hospital to Home' project triaged within one day. The region also developed a case study report in 2022-23 which demonstrated the real impact of projects on the patients that received the funded services.

Scrutiny and assurance

- 87 We found that **there is reasonable scrutiny of issues relating to discharge planning within each partner organisation.**
- 88 We reviewed the level of information that partners' committees, Board and Cabinet receive in relation to flow out of hospital. The Health Board receives regular performance and risk reports which provide an insight into improvements related to patient flow via the Board and its committees. The Health Board demonstrates a focus on monitoring performance relating to urgent and emergency care services, and specifically patient flow through those services. The Board and the Finance Committee regularly monitor metrics including the following:
- Median emergency response time to amber calls;

- Median time from arrival at an emergency department to assessment by a senior clinical decision maker (minutes)
- Number of ambulance patient handovers over 1 hour;
- Patients waiting over 24 hours in the Emergency Department;
- Attendances at Same Day Emergency Care units;
- Length of stay for patients in acute beds;
- Pathways of care delays.

89 Performance reports clearly demonstrate how performance compares to targets, including ministerial priorities or the Health Board's annual plan commitments, using data and analysis to identify trends. The Finance Committee also periodically provides a focus on areas relevant to patient flow, such as in November 2023 when it received a report on length of stay and in September 2023 when it received an overview of the financial performance of the RIF and the funded initiatives for 2023-24. The Health Board also takes steps to ensure the Board are informed of progress relating to the six goals for urgent and emergency care programme, including a comprehensive presentation at its Board Development session in February 2024. There is a clear focus on impact within reports using data and trends compared to clearly defined targets.

90 In addition, the Board and the Quality, Safety and Experience Committee monitor the corporate risk associated with patient flow. The second corporate risk listed on the Health Board's register relates to patient harm due to overcrowding in the 'Emergency and Acute Medicine footprint' resulting in 'the inability to provide and maintain key quality standards. Current actions have reduced the risk score from the maximum of 25 down to 20 but it is yet to reach the target risk score of 15.

91 Both local authorities also demonstrate a focus on issues which relate to patient flow. For example, the Cardiff Adult Social Services Scrutiny Committee regularly scrutinises performance reports. Minutes from meetings evidence scrutiny with a strong focus on the social care workforce, considering capacity, recruitment, the Trusted Assessor Model and levels of sickness absence and vacancies. The committee receives a quarterly performance report which includes a range of metrics such as the number of people in residential care aged 65 or over per 100,000 population, average number of days between referral and start of package in domiciliary care, longest time between referral and start of package in domiciliary care (in days) and the average number of people waiting for domiciliary care at month end. The performance report also includes a broader section on hospital discharge, tracking packages of care delays and the reasons for delays as well as the percentage of clinically optimised people assigned to a D2RA pathway within 72 hours of triage.

92 The Vale of Glamorgan Council's Healthy Living and Social Care Scrutiny Committee also monitors key metrics such as the number of adults waiting for domiciliary care and waiting for a social care needs assessment. The council's Annual Delivery Plan sets out to reduce waiting list for domiciliary care packages

including discharges, which they reduced to zero at the end of year for 2023-24. In addition, each January, the council receives an update on the work of the RPB including use of the RIF, winter planning and the broader RPB work programme. However, there are no risks on either of the local authorities' risk registers relating to adult social services or hospital flow.

- 93 The RPB receives regular updates on RIF progress and periodic papers on key priority areas but does not receive regular operational performance reports. Consideration of performance reports would be valuable in understanding the impact of RIF activities on addressing long-standing performance challenges.

What more can be done?

- 94 There is a clear recognition by regional partners of the problems associated with discharge and a desire to sort them out aided by strategies and operational plans, and the use of funding targeted schemes. Collectively, this approach appears to be driving sustainable improvement in the overall position. Our work has found that there are several further actions that could be taken which would further help improve timely and effective flow out of hospital across the region and reduce some of the challenges currently being experienced by the health and social care system. These actions are explored in the following exhibit and align with the recommendations that are set out earlier in the report.

Exhibit 10: further actions for partners to help tackle the challenges for patient flow out of hospital

Improving compliance with policies and guidance	A more consistent application of intended discharge processes will be assisted by staff having access to up to date jointly agreed guidance which clearly sets out roles and responsibilities, and expectations around when and how staff should share information. In addition, having a regular cycle of audit would allow partners to assess the effectiveness and consistency of the application of discharge policies and guidance.
Improving the quality of information	Having clear and comprehensive information within patient case-notes which sets out the actions being taken to support discharge, enables a clearer understanding of what is happening with a patient and supports effective discharge planning by all professionals involved in the care of patients whilst in hospital.

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Maximising weekend discharges

Developing **7-day services** supports the discharge of patients over the weekend, reducing unnecessary stays in hospital.

Maximising the use of the Regional Integration Fund

Regularly considering **operational performance** at a regional level, enables more effective decision making across partners when considering how best to use the regional funding.

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Appendix 1

Audit methods

Exhibit 11 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from these methods.

Exhibit 11: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board, Cabinet, and committee papers; • Updates on the six goals programme and urgent and emergency care to committees; • Operational and strategic plans relating to urgent and emergency care; • RPB papers, including case studies; • Discharge procedure; and • Corporate risk registers.
Interviews	We interviewed the following: • Director of Adults Housing and Communities, Cardiff; • Senior Nurse Integrated Discharge; CVUHB • Director of Social Services, Vale of Glamorgan; • Head of Adult Services and Vale Alliance; • Director of Social Services Adults, Cardiff; • Operational Manager Adults Community Services, Cardiff and Operational Manager Independent Living Services, Cardiff; • Managing Director Acute Services; CVUHB • Head of Operations Patient Flow and Site Services; CVUHB • Head of Integrated Care; CVUHB • Service Improvement Programme Manager; CVUHB • Chief Operating Officer; CVUHB • RPB Lead; • Director of Operations; CVUHB • Deputy Director of Nursing; CVUHB • Executive Lead of Strategic Planning; CVUHB • Community Health Council Chief Officer; and

Element of audit methods	Description
	• Programme Manager for Six Goals. CVUHB
Observations	We observed the following meeting(s): • Bed meeting, University Hospital of Wales; • Strategic Leadership Group; • @Home Programme Board; and • Regional Integrated Management Team. We also observed the following individual: • Discharge Coordinator.
Data analysis	We analysed the following national data: • Monthly social services dataset submitted to the Welsh Government; • Monthly delayed discharges dataset submitted to the NHS Executive; • StatsWales data; and • Ambulance service indicators. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died)
Focus groups	We undertook focus groups with social workers from each of the local authority areas.
Case note review	We reviewed a sample of 20 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

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Appendix 2

Reasons for delayed discharges

The following exhibit sets out the reasons for delayed discharges in the Health Board compared to the all-Wales position.

Exhibit 12: reasons for delayed discharges as a percentage of all delays (February 2024)

Reason for delay	Percentage delayed	All-Wales average
Awaiting completion of assessment by social care	31.5	15.7
Awaiting social worker allocation	15.5	8.5
Awaiting completion of arrangements prior to placement	10.9	3.5
Awaiting joint assessment	4.6	9.0
Awaiting completion of clinical assessment (nursing /allied health professionals /medical /pharmacy)	4.2	10.3
Awaiting start of new home care package	4.2	8.0
Patient / family refusing to move to next stage of care/ discharge	3.4	1.6
Awaiting transfer to intermediate care bedded facility	2.9	4.0
Court of protection delays	2.9	0.6
No suitable abode	2.1	2.3
Awaiting extra care/supported living availability	1.7	0.9
Awaiting nursing care home manager to visit and assess (Standard 3 residential)	1.7	2.1
Awaiting restart of previous home care package	1.7	0.5
Homeless	1.7	0.9
Awaiting continuing healthcare (CHC) assessment	1.3	1.7
Mental capacity	1.3	2.1
Patient / family choice related issues	1.3	0.9

Source: Welsh Government

Note: where the reasons for delay relate to two or less patients, these have been excluded to minimise any risk of identifying individual patients.

Top five reasons for delayed discharges by local authority

The following exhibits set out the top five reasons for delayed discharges for each of the local authorities compared to the Health Board wide and all-Wales position.

Exhibit 13: top five reasons for delayed discharges as a percentage of all delays
(February 2024) – Cardiff

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of assessment by social care	30.9	31.5	15.7
Awaiting social worker allocation	15.4	15.5	8.5
Awaiting completion of arrangements prior to placement	9.9	10.9	3.5
Awaiting completion of clinical assessment (nursing /allied health professionals /medical /pharmacy)	4.9	4.2	10.3
Awaiting start of a new home care package	4.3	4.2	8.0

Source: Welsh Government

Exhibit 14: top five reasons for delayed discharges as a percentage of all delays
(February 2024) – Vale of Glamorgan

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of assessment by social care	35.1	31.5	15.7
Awaiting social worker allocation	16.2	15.5	8.5
Awaiting completion of arrangements prior to placement	12.2	10.9	3.5
Awaiting joint assessment	6.8	4.6	9.0
Awaiting start of a new home care package	5.4	4.2	8.0

Source: Welsh Government

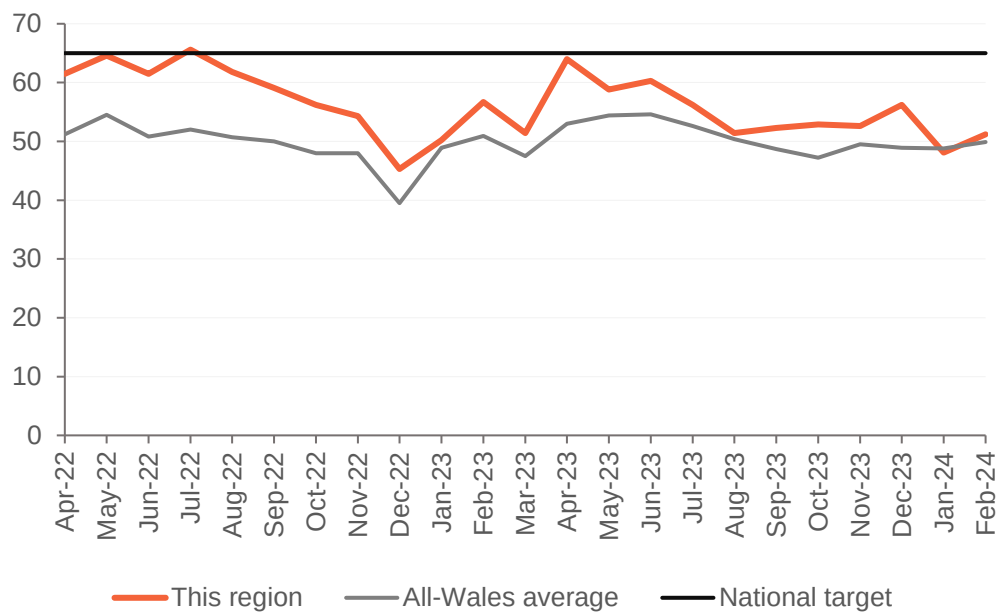
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Appendix 3

Urgent and emergency care performance

The following exhibits set out the region’s performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022.

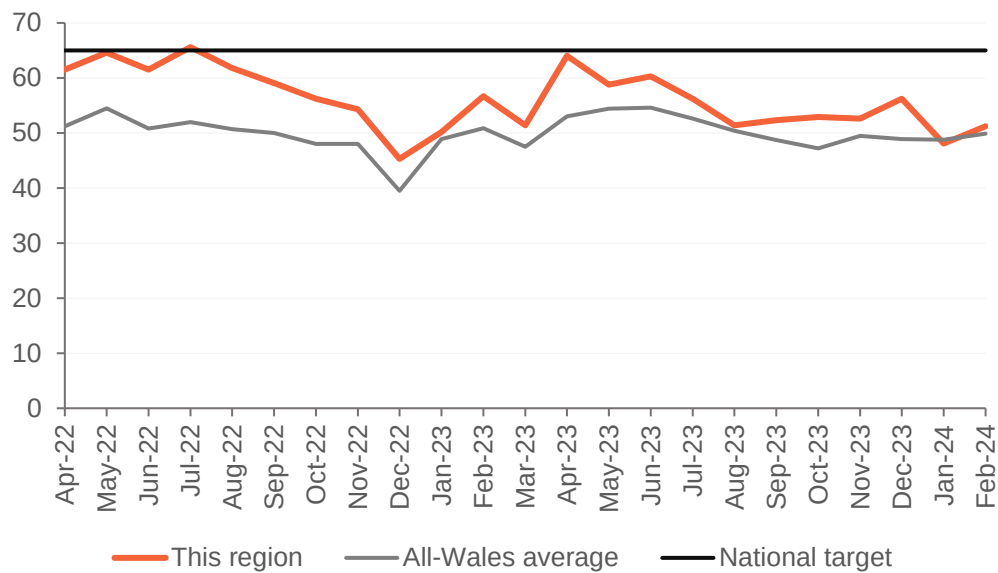
Exhibit 15: percentage of emergency responses to red calls arriving within (up to and including) 8 minutes – national target of 65%



Source: StatsWales

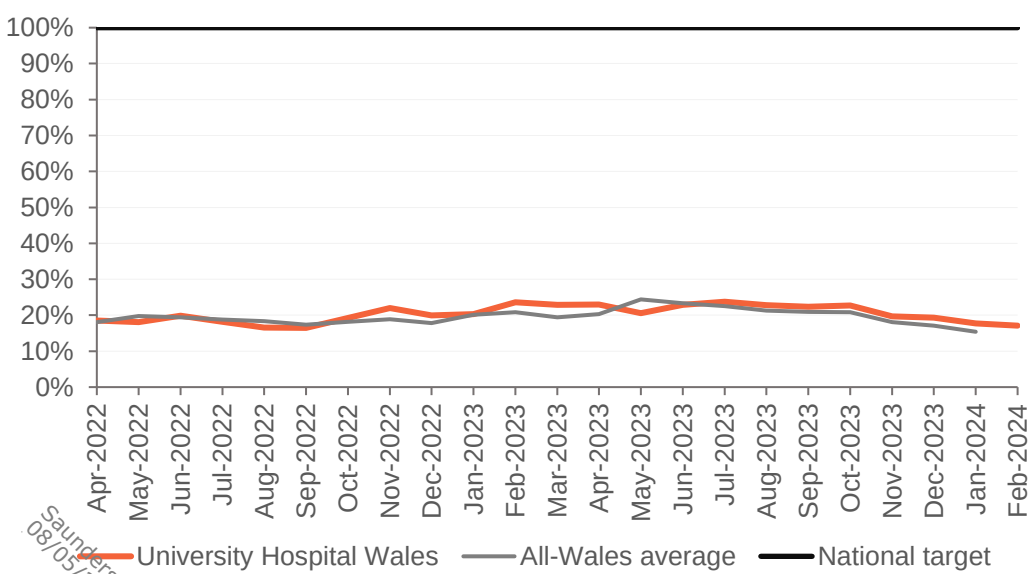
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Exhibit 16: median response time for amber calls (minutes) – 50th percentile – national target of 20 minutes



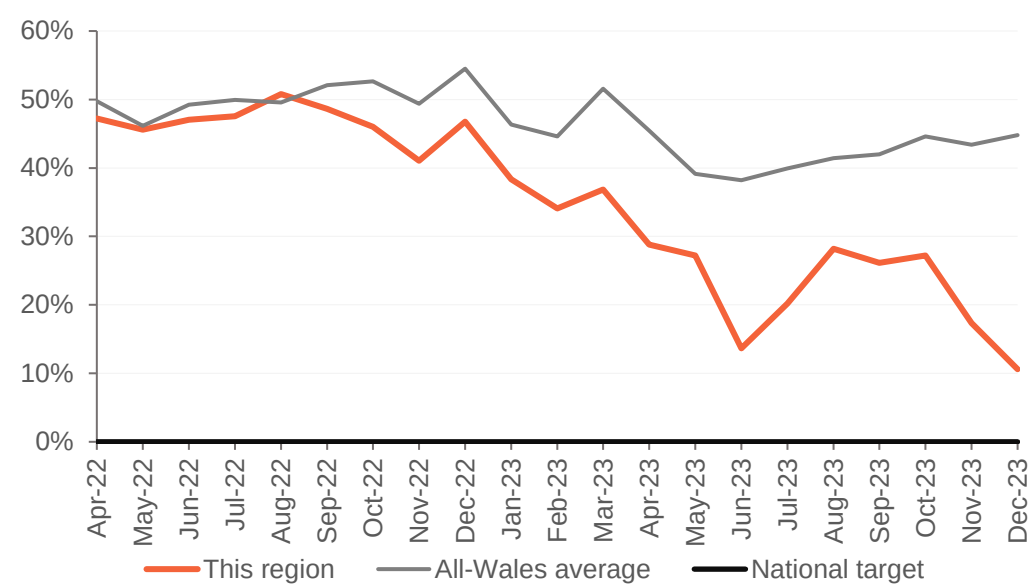
Source: Ambulance Services Indicators

Exhibit 17: percentage of ambulance handovers within 15 minutes at a major emergency department – national target of 100%



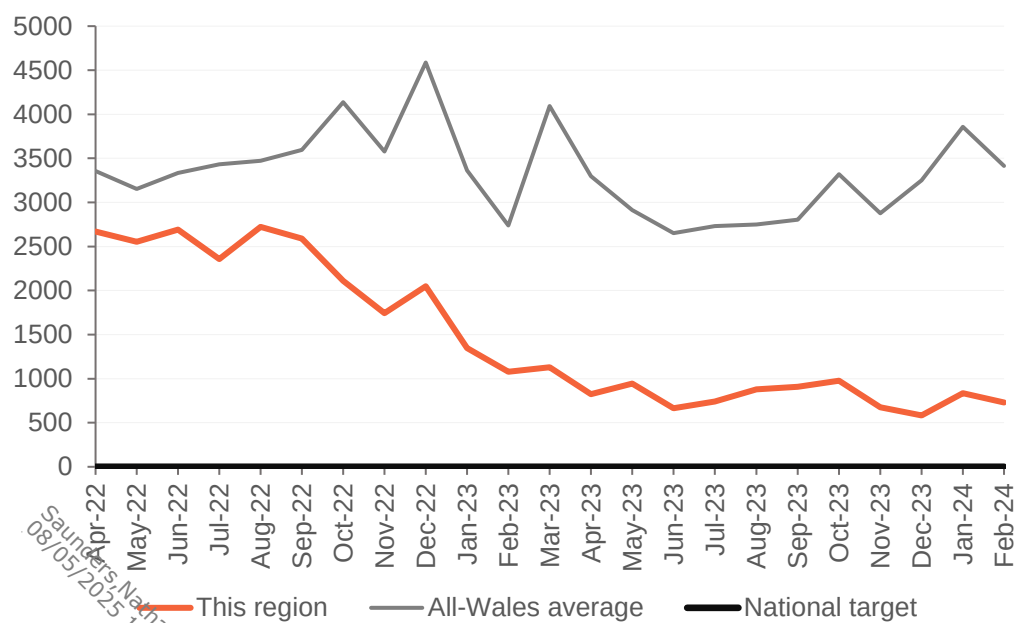
Source: Ambulance Services Indicators

Exhibit 18: percentage of ambulance handovers over 1 hour – national target of zero



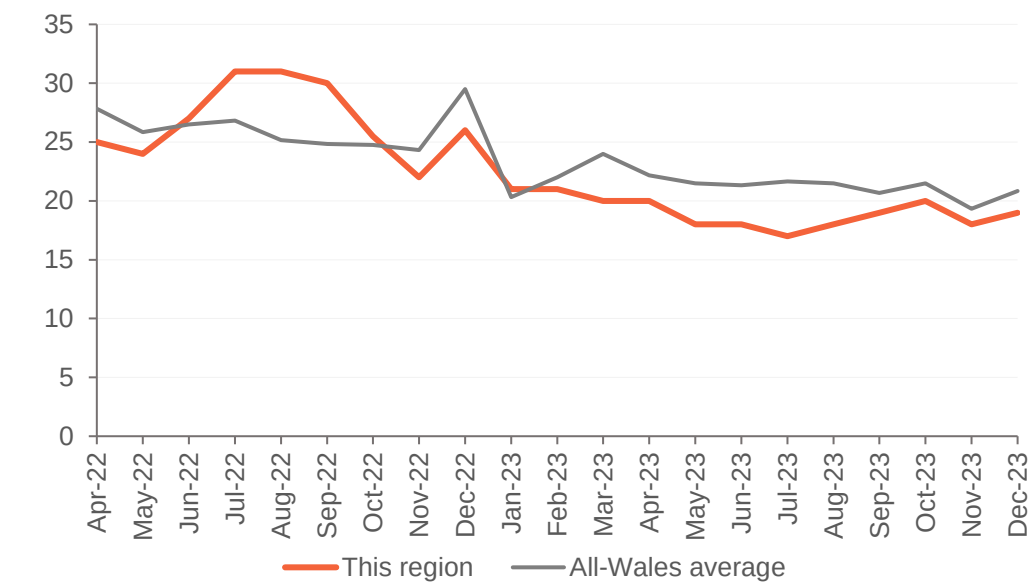
Source: Ambulance Services Indicators

Exhibit 20: total number of hours lost following notification to handover over 15 minutes



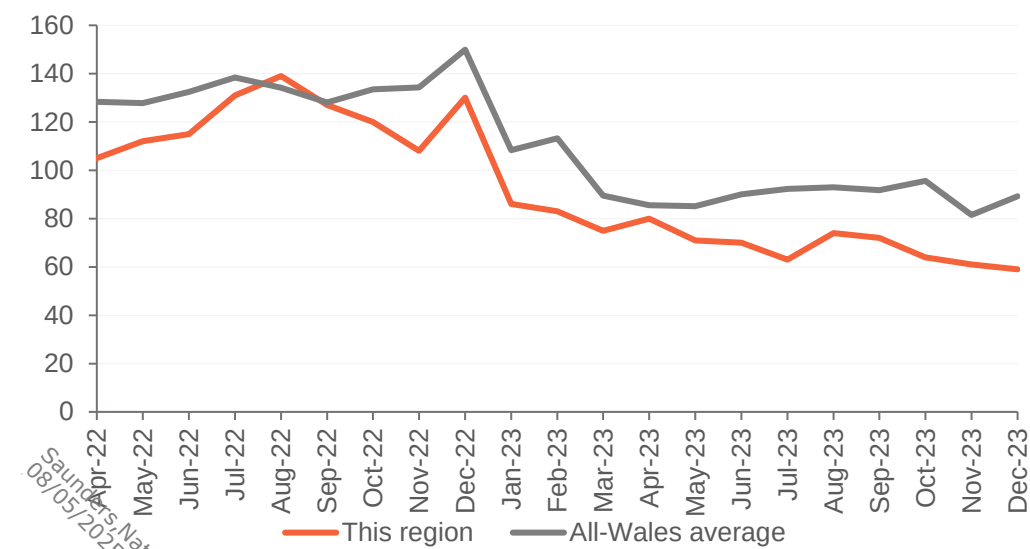
Source: Ambulance Services Indicators

Exhibit 21: median time (minutes) from arrival at an emergency department to triage by a clinician) – national target of 12-month reduction



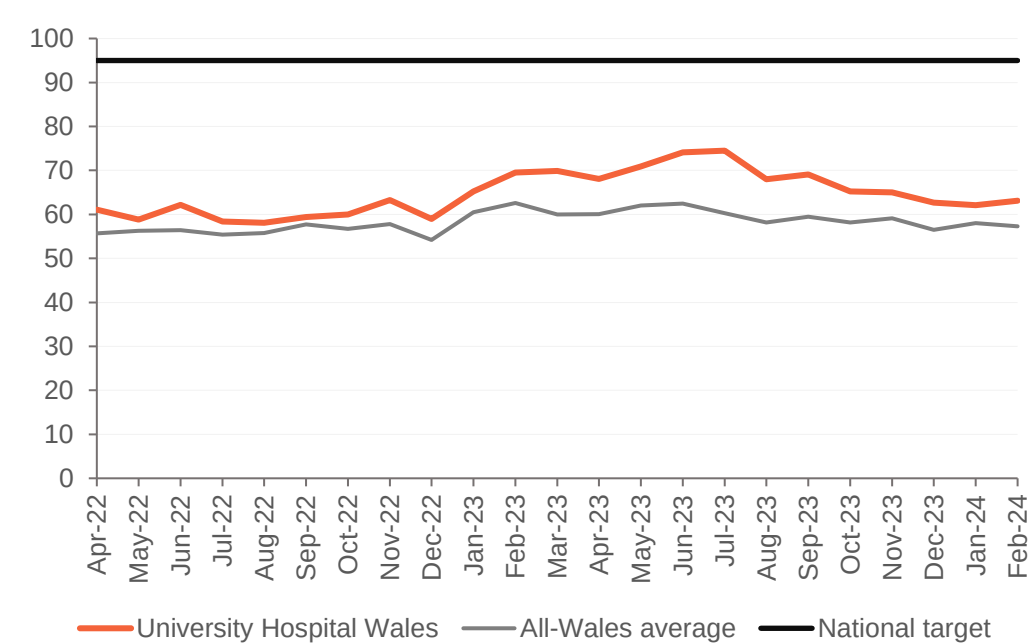
Source: Health Board performance reports

Exhibit 22: median time (minutes) from arrival at an emergency department to assessment by senior clinical decision maker – national target of 12-month reduction



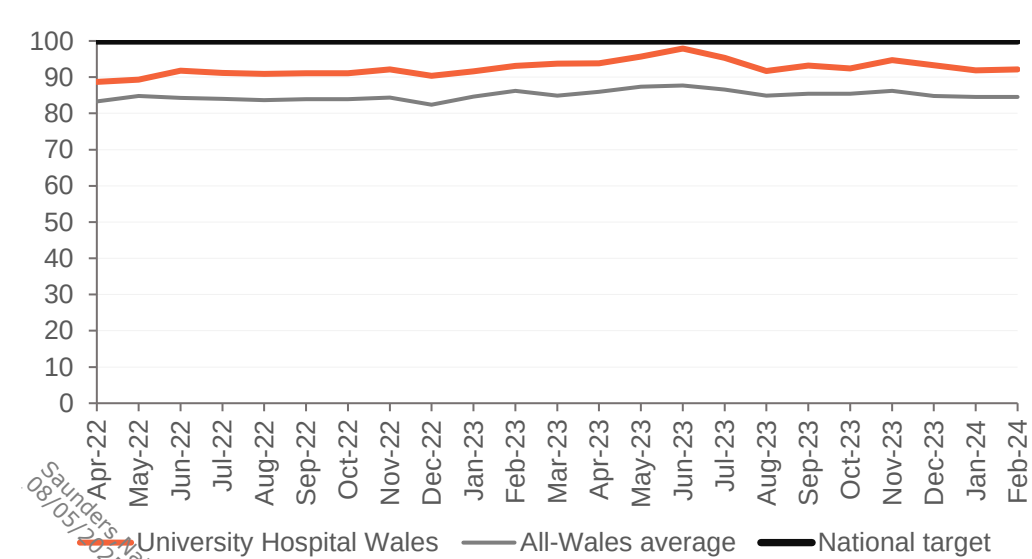
Source: Health Board performance reports

Exhibit 23: percentage of patients spending less than four hours in a major emergency department – national target of 95%



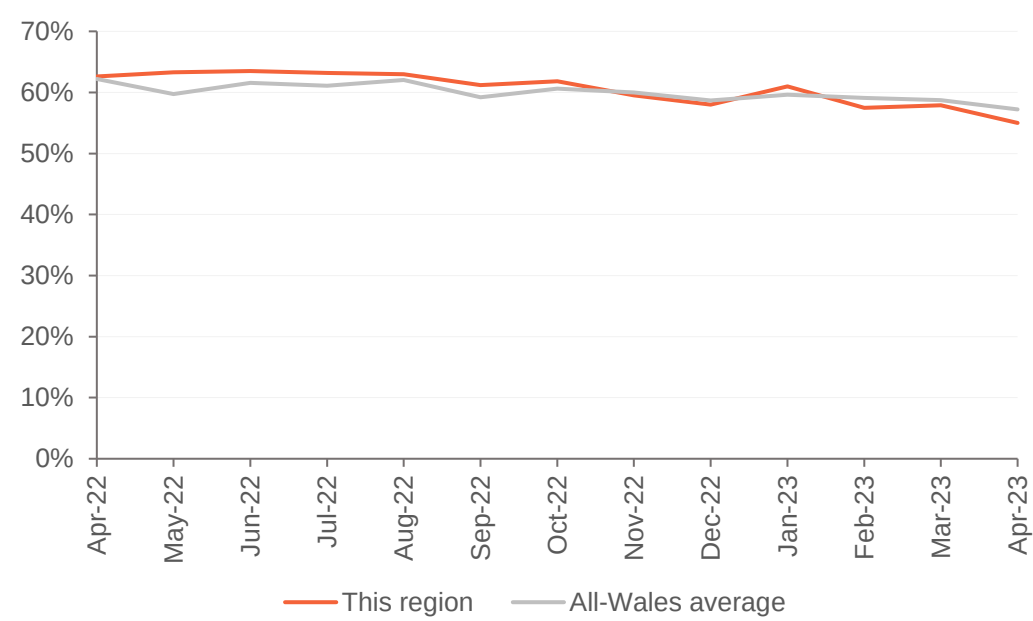
Source: StatsWales

Exhibit 24: percentage of patients spending less than 12 hours in a major emergency department – national target of 100%



Source: StatsWales

Exhibit 25: percentage of total emergency bed days accrued by people with a length of stay over 21 days – national target of 12-month reduction



Source: Health Board performance reports

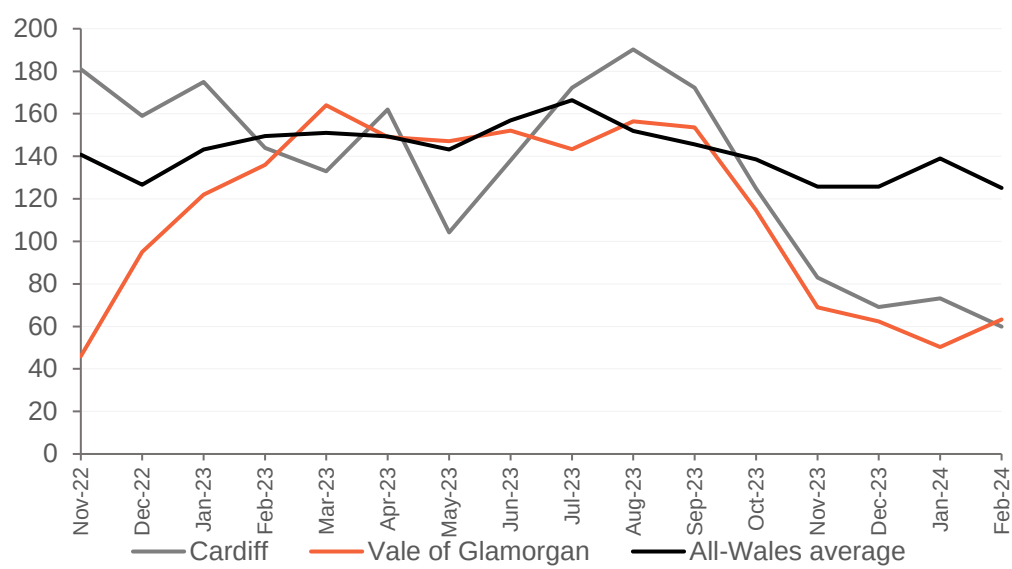
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Appendix 4

Waits for social care assessments and care packages

The following exhibits set out the region’s waits performance for social care assessment and receipt of a range of care packages in comparison to the position across Wales since November 2022.

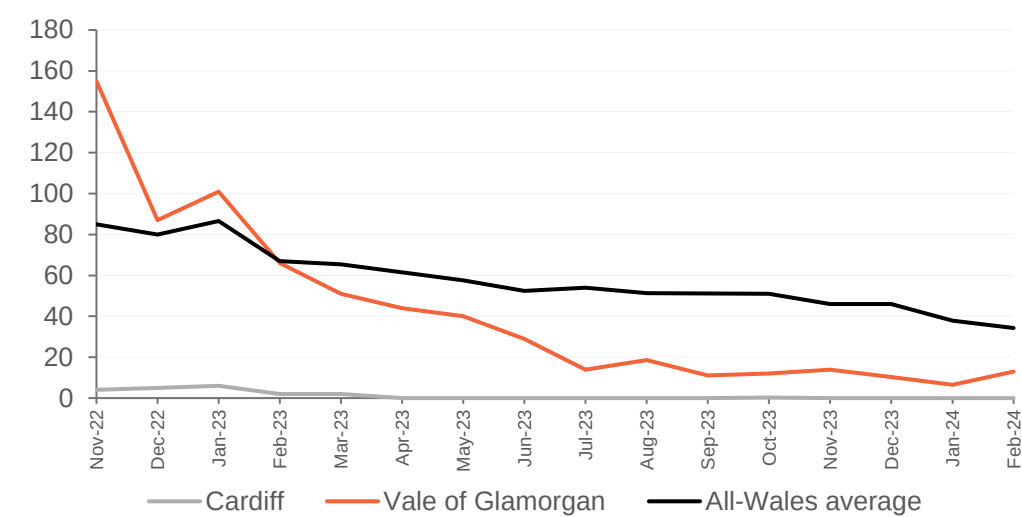
Exhibit 26: number of adults waiting for a social care assessment (per 100,000 head of population)



Source: Welsh Government

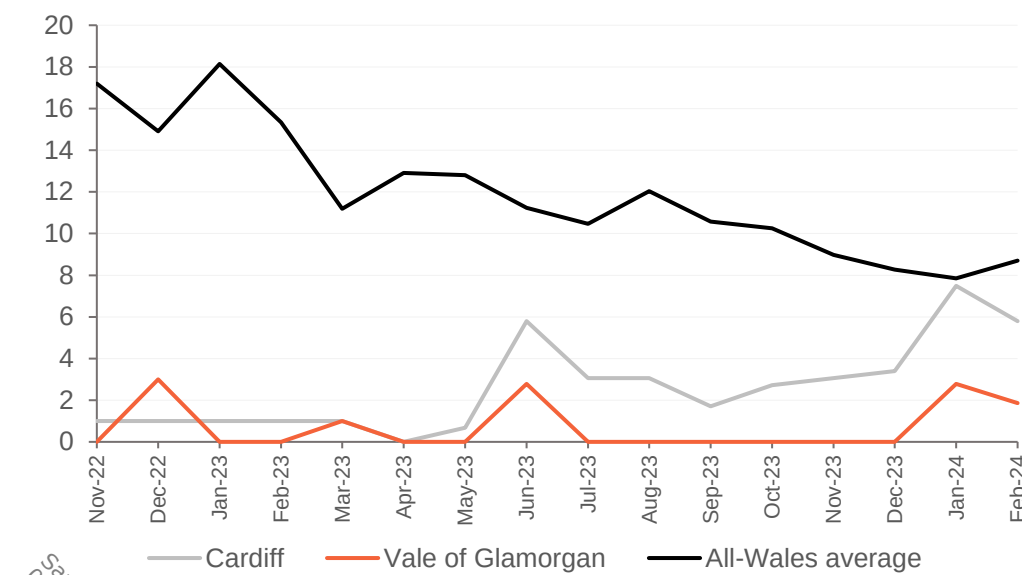
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Exhibit 27: number of adults waiting for domiciliary care (per 100,000 head of population)



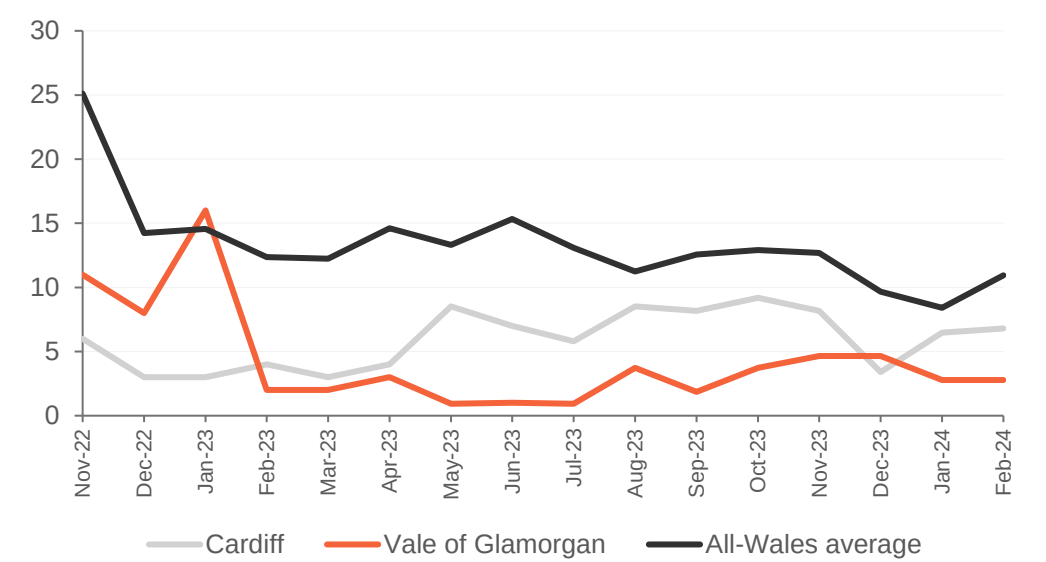
Source: Welsh Government

Exhibit 28: number of adults waiting for reablement (per 100,000 head of population)



Source: Welsh Government

Exhibit 29: number of adults waiting for long-term care home accommodation (per 100,000 head of population)



Source: Welsh Government

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Appendix 5

Combined management response to audit recommendations

Exhibit 30: combined management response

Exhibit summary (to make your document accessible, provide a short summary (in addition to the title) to explain what the table represents)

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R1	To help inform discussions around discharge, the local authorities should capture the risks associated with social care capacity on the provision of services at a local and regional level, including the impact on patient flow out of hospital.	i. Capacity is monitored and reported to Welsh Government on a monthly basis via 2 routes: • Social care checkpoint data which has a RAG rating • PoCD regional meetings which relate directly to hospital flow Issues can then be escalated through local or regional governance.	Already in place	LA Heads of Adult Services

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Ref	Recommendation	Organisational response	Completion date	Responsible officer
		ii. Local Authorities have existing internal risk monitoring and management arrangements. iii. The RPB undertakes a 5-yearly Market Stability Report to inform care commissioners of social care market sufficiency and stability. A Regional Commissioning Board is in place to monitor capacity and address identified issues.		
R2	The Health Board, working with local authorities, should update its discharge policy and associated policies, including the choice of accommodation policy, to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly	i. The Health Board is developing a new discharge policy to include the key elements from the most recent national discharge guidance in September 2024. The policy is being developed with input from local authorities. ii. The policy will be reviewed by the partnership governance	April 2025	Head of Integrated Discharge

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Ref	Recommendation	Organisational response	Completion date	Responsible officer
	defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers	arrangements through the Strategic Leadership Group. iii. Advice and support will be sought from Llais on involvement of patients and carers.		
R3	The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.	The Health Board will complete a baseline using the ward-based audit tool, Tendable, prior to adoption of the new policy and then review monthly to assess impact.	June 2025	Head of Integrated Discharge
R4	The Health Board should improve record keeping by: 4.1 ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes	i. This is being incorporated into the rolling programme of education for ward teams. In addition, there is a pilot underway in which a discharge booklet is being trialled on the winter ward in UHL to support clear documentation of discharge processes in patient case notes.	June 2025	Head of Integrated Discharge

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Ref	Recommendation	Organisational response	Completion date	Responsible officer
	to support effective discharge planning. 4.2 establishing a programme of case-note audits focused on the quality of record keeping.	ii. The Health Board will assess the best tools and process for auditing record keeping and, if appropriate, roll this out with ongoing training and audit cycles.		
R5	The Health Board, in partnership with its local authorities, should ensure it has the necessary arrangements in place to embed and deliver a 7-day working week approach to hospital discharge to minimise unnecessary stays in hospital.	Consultant 7-day working in the acute footprint is now in place to support weekend discharge. In addition, there is a 7-day working group set up to embed the improvements and look to develop this further as part of the ministerial initiative 50-day winter challenge.	Already in place	Chief Operating Officer
R6	The region should ensure its action plan for pathways of care is clearer on the intended outcomes from the actions it has identified. It should also undertake regular review to assess whether outcomes are being achieved.	i. A detailed POCD action plan is in place. ii. POCD action plan is reviewed monthly through a local partnership forum and is reviewed quarterly by WG in line with the Care Action	Already in place.	Head of Integrated Discharge

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Ref	Recommendation	Organisational response	Completion date	Responsible officer
		Committee Cabinet Secretary priorities. iii. The Care Action Committee reviews the impact and outcomes achieved by the plan on a monthly basis as one of its three national priorities. iv. The national Six Goals for Urgent and Emergency Care team undertakes a detailed review of POCD data with the local team and supports identification of priorities for action locally. We will continue with these governance arrangements and monitor the impact on an ongoing basis. v. The impact of the action plan and associated data are regularly reviewed through partnership governance arrangements		

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Ref	Recommendation	Organisational response	Completion date	Responsible officer
R7	To help inform decision-making and discussions, the Health Board and local authorities should ensure that the Regional Partnership Board has routine access to key performance indicators relevant to effective and timely flow out of hospital, including urgent and emergency care performance within the Health Board and waiting lists for social services and care packages	i. POCD data is currently regularly shared with the RPB Strategic Leadership Group through both specific programme reporting and CAC priority briefings. ii. The RPB team will review the key performance indicators already collected and ensure they are shared in the appropriate forums.	April 2025	Director of Health and Social Care Integration

Exhibit source: Cardiff and Vale Regional Partnership Board partners.

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

Discharge Planning Progress Update – Cardiff & Vale University Health Board

Date issued: September 2024

Document reference: 4470A2024

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

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Summary report

About this report

- 1 In 2017, the Auditor General reviewed discharge planning across all Health Boards in Wales. That work focussed on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements. Our [2017 report on discharge for Cardiff and Vale University Health Board](#) (the Health Board) found that **'The Health Board has robust discharge improvement plans, strong performance management arrangements and performance overall is improving, but there is scope to improve ward staff training and awareness of policies and community services.'** We made several recommendations for the Health Board to address, which are set out in **Appendix 1**.
- 2 The Auditor General had originally included work in his 2021 local audit plans to examine whole system issues affecting urgent and emergency care services, including the discharge of patients from hospital. The COVID-19 pandemic resulted in this work being postponed and brought back on stream in 2023. Our work has sought to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. The findings from that work are set out in a separate report to the Health Board and its local authority partners in the Cardiff & Vale region. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.
- 3 As part of our regional review, we have sought to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against the recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.
- 4 We have undertaken the follow up work and our wider regional review to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies and local authorities have proper arrangements to secure economy, efficiency, and effectiveness in their use of resources, as required by the Public Audit Wales Act 2004. In addition, to support our previous work on discharge planning, we produced ['What's the hold up? Discharging patients in Wales'](#) which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

- 5 Data from February 2024 showed that across the Health Board's main hospital sites, there were 238 patients whose discharge had been delayed beyond 48

hours. Approximately 6% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

- 6 In overall terms, **the Health Board has made reasonable progress in addressing our previous recommendations, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services.** Our 2017 report made four recommendations that set out six specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:
- no progress has been made against one action;
 - work is still ongoing against two of the actions; and
 - three of the actions have been implemented.
- 7 Specifically, we found that:
- the Health Board has introduced mechanisms to monitor the use of community health and social care services and has taken action to improve staff understanding of the landscape of services, although it is not clear whether these actions are having the intended impact;
 - while the discharge policy was revised in 2020 it is unclear what impact the involvement of patients and carers had on changes, noting also that the policy is overdue for further review and there is a need to ensure the most recent version of the policy is on the Health Board's public website; and
 - while the Health Board provides regular training related to discharge planning, we found limited evidence that it monitors completion rates for training.
- 8 The following sections of this report set out our follow up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

- 9 Our follow up work and wider regional report on patient flow have identified some fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.
- 10 Recommendations arising specifically from this follow up work are set out in **Exhibit 1**. The Health Board's response to these updated recommendations is captured in **Appendix 3**. Recommendations arising through our wider regional report on patient flow which are relevant to, and have replaced, the recommendations from our 2017 work are set out in **Exhibit 2**. The Health Board should respond to these recommendations as part the finalisation of the regional report.

Exhibit 1: new recommendations arising from this follow up work

Recommendations	
Staff understanding of landscape of community services	
R1	The Health Board should assess whether recent activities to signpost and streamline access to information on community health and social care have resulted in better awareness of the landscape of services outside of hospital across various staff groups.
Policy review	
R2	The Health Board should ensure the revised discharge policy is updated on the Health Board's website.
R3	The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible.
R4	The Health Board should ensure that attendance at training is captured on the electronic staff record, to help monitor attendance levels and ensure all relevant staff are receiving training.

Source: Audit Wales

Exhibit 2: recommendations included in the regional report on discharge planning replacing previous 2017 recommendations

Regional recommendations	
R3	The Health Board, working with local authorities, should update its discharge policy to provide clarity to all staff on how the discharge planning process should work across the region. This should be based on the national guidance issued in December 2023, set out clearly defined roles and responsibilities, and expectations, and reflect the Discharge to Recover then Assess model. The process for updating the policy should include patients and carers.
R4	The Health Board should embed a regular cycle of audit to assess the effectiveness and consistency of the application of the discharge policy and associated training programmes.

Source: Audit Wales

Detailed report

Implementation of previous audit recommendations

- 11 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:
- information on community health and social care services (Recommendations 1a and b);
 - policy review (Recommendation 2);
 - staff awareness of policies and pathways (Recommendation 3); and
 - discharge planning training (Recommendations 4a and b).
- 12 Overall, we found that **the Health Board has made reasonable progress in addressing our previous recommendations, but there remains more to do, including ensuring the discharge policy is up to date and that training and awareness raising activities are resulting in improved understanding of the landscape of community health and social care services.**

Information on community health and social care services

- 13 We considered whether the Health Board has:
- developed a system to enable staff to access information about community health and social care services (2017 Recommendation 1a); and
 - reviewed the range and frequency of data collated about community health and social care services. For example, waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated (2017 Recommendation 1b).
- 14 We found that **the Health Board has introduced mechanisms to monitor the use of community health and social care services and has taken action to improve staff understanding of the landscape of services, although it is not clear whether these actions are having the intended impact.**
- 15 The Health Board states that it provides staff with up-to-date information relating to community health and social care systems via its intranet. It has first point of contact officers who provide information to ward staff, individuals and their families. A single point of access for referrals has been established through the Integrated Discharge Hub for referrals to services in the Cardiff local authority area and Contact OneVale (C1V) for referral to service in the Vale of Glamorgan local authority area. The Health Board also incorporates information about community services as part of ongoing training to hospital and community staff. We therefore consider **recommendation 1a implemented.**
- 16 However, our fieldwork found variable levels of knowledge on the breadth of out of hospital services amongst staff. Staff who worked out in the community, such as community occupational therapists and hospital staff felt reasonably well informed about community health and social services. Yet hospital staff we spoke to as part

of our fieldwork said they were not confident they had good knowledge of the landscape of services available outside of hospital. The Health Board advised us during our fieldwork that it had plans to strengthen these arrangements, such as by appointing an administration manager to manage the Integrated Discharge Service website and a discharge pathway manager. We were unable to assess the impact of these actions at the time of our work, and therefore recommend that the Health Board undertake activity to assess whether these activities have resulted in better levels of awareness of community services **(2024 Recommendation 1)**.

- 17 To monitor information on demand and access to community health and social care services, the Health Board informed us that it holds regular multiagency meetings. During these meetings the Health Board can review capacity and waiting times for community support services, in particular Community Resource Teams in Cardiff and the Vale of Glamorgan Community Resource Services. As we reported in our regional report, the region has some of the lowest waiting lists for domiciliary care and reablement packages in Wales. We therefore consider that **recommendation 1b implemented**.

Policy review

- 18 We considered whether the Health Board has:
 - involved patients and carers in the process to develop and revise the Health Board's policy in relation to discharge planning (2017 Recommendation 2)
- 19 We found that **while the discharge policy was revised in 2020 it is unclear what impact the involvement of patients and carers had on changes, and the policy is overdue for further review with a need for the Health Board's website to be updated to include the most recent version**.
- 20 At the time of our 2017 review, the Health Board was planning to refresh its discharge policy. The Health Board's discharge policy was subsequently revised in September 2020 although we note that that Health Board's website still contains the 2017 version. This should be updated **(2024 Recommendation 2)**. The Health Board informed us that during the revision process, the patient experience team sent copies to the Carers and Young Carers groups for consultation and an Equality Health Impact Assessment was completed. However, there is no record of any changes made because of this consultation. There are very few differences between the 2017 and 2020 discharge policy, and though the 2020 version includes a small section on carers and young carers, it is not clear if this was informed by its consultation activities. We found no evidence to suggest that the choice of accommodation policy, which supports the discharge policy, has been revised since 2017.
- 21 The policy was due for further review in 2023 which has yet to be completed. Given that there have been several changes to discharge planning since 2020, including the introduction of the Discharge to Recover than Assess (D2RA) model by Welsh Government, the Health Board should prioritise updating its policy. This is particularly important given Welsh Government issued national guidance on

discharge planning in December 2023. We recommend that, during the next revision to the policy, that the Health Board ensures it undertakes meaningful collaboration with patients and carers and records the impact of that work. We therefore consider that there is **ongoing action to address recommendation 2 (replaced with 2024 Regional Recommendation 3)**.

Discharge planning training

22 We considered whether the Health Board has:

- undertaken training and awareness raising following the finalisation of the revised discharge policy to ensure all staff involved in discharge planning understand how to use it (2017 Recommendation 3);
- explored developing an e-learning course for discharge planning which ward staff may find more accessible (2017 Recommendation 4a); and
- ensured that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring (2017 Recommendation 4b).

23 We found that **while the Health Board provides regular training related to discharge planning, we found limited evidence that it monitors completion rates for training**

24 The Health Board informed us that it provides regular training to staff, including for new starters and ongoing SNAP¹ training on the ward. These training programmes include information for staff on how to access relevant pages on the intranet which include policies and information on pathways and services. The Health Board's Integrated Discharge Services staff also provide demonstrations on how to access the policies on the intranet via the clinical workstation.

25 Outside of its own hospitals, the Health Board says that it has offered training sessions to care home staff, though it is unclear how many of these sessions have been provided or how many staff have attended. The Health Board's has also run workshops on its "Get Me Home" programme which have included sessions for social service staff, care home managers and the voluntary sector. The Health Board does monitor how many discharge training sessions have been delivered for new starters. However, it is not clear how many staff have completed this training. In addition, an e-learning course for discharge planning has not been made available. We therefore consider **recommendation 3 implemented, no action has been taken on recommendation 4a (replaced with 2024 Recommendation 3), and ongoing action is needed to address recommendation 4b (replaced with 2024 Recommendation 4)**.

26 In addition, our regional review found weaknesses in the way the discharge process is applied, including incomplete discharge documentation and a lack of

¹ Support Needs Approach for Patients

understanding of various roles involved in discharge planning, suggesting there is a potential to measure the success of training and consider whether changes or additional activity is necessary **(2024 Regional Recommendation 4)**.

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Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Operational and strategic plans relating to urgent and emergency care • Updates on the six goals programme and urgent and emergency care to committees; and • Discharge procedure
Interviews	We interviewed the following: • Senior Nurse Integrated Discharge; • Managing Director Acute Services; • Head of Operations Patient Flow and Site Services; • Head of Integrated Care; • Chief Operating Officer; • Director of Operations; • Deputy Director of Nursing; • Executive Lead of Strategic Planning; and • Programme Manager for Six Goals.
Observations	• We observed a bed meeting at the University Hospital of Wales; We also observed the following individual: • Discharge Coordinator.
Data analysis	We analysed the monthly delayed discharges dataset submitted to the NHS Executive. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022

Element of audit methods	Description
	with a length of stay greater than 21 days (excluding those who died).
Case note review	We reviewed a sample of 20 case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Source: Audit Wales

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Appendix 2

Summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress

Recommendations	Progress
Information on community health and social care services R1a Develop a system where ward staff are able to access up-to-date information about community health and social care services. R1b Review the range and frequency of data collated about community health and social care services. For example, waiting times for some services and the frequency data on services available through other NHS bodies and housing options is collated.	Implemented – see paragraph 15 Implemented – see paragraph 17
Policy review R2 The Health Board should seek to involve patients and carers when the next policy revisions are due.	Ongoing – see paragraph 21 (replaced with 2024 Regional Recommendation 2)
Staff awareness of policies and pathways R3 The Health Board should undertake training and awareness raising once the draft discharge policy has been finalised to ensure all staff involved in discharge planning understand how to use it.	Implemented – see paragraphs 24-25

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Recommendations	Progress
Discharge planning training R4a Explore developing an e-learning course for discharge planning which ward staff may find more accessible. R4b Ensure that attendance at training is captured on the electronic staff record, which will help to improve compliance monitoring.	No action – see paragraphs 24-25 (replaced with 2024 Recommendation 3) Ongoing – see paragraphs 24-25 (replaced with 2024 Recommendation 4)

Source: Audit Wales

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Appendix 3

Management response to audit recommendations

Exhibit 2 sets out the Health Board's response to our audit recommendations.

Exhibit x: management response

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Ref	Recommendation	Organisational response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should assess whether recent activities to signpost and streamline access to information on community health and social care have resulted in better awareness of the landscape of services outside of hospital across various staff groups.	i. The rolling ward-team education sessions continually evaluate the knowledge and skills of staff to inform training. There are a number of key mechanisms for training, including: • Cardiff First Point of Contact Officers working with ward teams • Rolling programme of discharge planning education • Increasing the profile of discharge services ii. The Integrated Discharge Hub provides a fully centralised source of expertise on the range of out of hospital resources to support people to return home from hospital.	Already in place	Head of Integrated Discharge
R2	The Health Board should ensure the revised discharge policy is updated on the Health Board's website.	We have a plan in place to ensure the policy is updated by April 2025 when we will then add to Health Board website.	June 2025	Head of Integrated Discharge
R3	The Health Board should explore developing an e-learning course for discharge planning which ward staff may find more accessible.	i. The Health Board discharge learning lead will explore the feasibility and opportunity of an e-learning course. This was previously considered prior to COVID-19 but this was not taken forward. ii. Face-to-face practice-based learning is already in place (see R1)	June 2025	Head of Integrated Discharge

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R4	The Health Board should ensure that attendance at training is captured on the electronic staff record, to help monitor attendance levels and ensure all relevant staff are receiving training.	The Integrated Discharge Service has a training database for staff who have attended any session that has been delivered regarding the discharge process. In addition, all-day training (once a month) is also put onto ESR. There are no plans to increase recording of training as current record keeping has been assessed as sufficient for the Health Board requirements.	Already in place	Head of Integrated Discharge

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

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Nathan

Review of Cost Savings Arrangements – Cardiff and Vale University Health Board

Audit year: 2023

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Summary report

Introduction

- 1 NHS Wales is facing unprecedented financial challenges. The continuing impact of the COVID-19 pandemic on service demand and provision; the rising costs associated with staffing, energy, medicines, and maintaining an ageing estate; and tackling the complex health conditions associated with an ageing population all contribute to the worsening financial situation across the NHS.
- 2 Despite the Welsh Government making an additional £425 million available to the NHS in October 2023, the 2023-24 year-end position for NHS Wales was a collective deficit of £183 million. Whilst some NHS bodies were able to achieve year-end financial balance, the position for others - particularly some Health Boards - was challenging with several not being able to deliver the control total¹ deficit expected by Welsh Government.
- 3 The position for 2024-25 is equally, if not more challenging. Health bodies will need to ensure that they have robust approaches in place to identify and deliver in year cost improvement opportunities and to also take a longer-term approach to achieving financial sustainability that moves away from short-term approaches to ones where savings are achieved by transforming service models and ways of working.

Objectives and scope our work

- 4 Given the challenges outlined above, the objective of our review has been to examine whether the Health Board has an effective approach to identifying, delivering, and monitoring sustainable cost savings opportunities. The detailed audit criteria are set out in **Appendix 1**.
- 5 The work has been undertaken to discharge the Auditor General's statutory duty under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure economy, efficiency, and effectiveness in its use of resources.
- 6 We undertook our work between December 2023 and March 2024. The methods we used to deliver our work are summarised in **Appendix 2**. Our work comments on the approach within the Health Board to identifying, delivering, and overseeing cost saving opportunities. It considers the impact these arrangements had on the 2023-24 year-end position and highlights where arrangements may need to be strengthened for 2024-25 and beyond.

¹ Revised deficit positions for 2023-24, known as 'control totals', were allocated to Health Boards by Welsh Government in November 2023 following the provision of additional funding to support their financial positions.

Key findings

- 7 Overall, we found that **whilst the Health Board met its agreed deficit target for 2023-24, it needs to strengthen its overall approach to the identification and delivery of recurrent savings and ensure its service transformation plans align with wider plans to return the organisation to financial sustainability and balance.**
- 8 The findings that support our overall conclusions are summarised below under the following headings:
 - Identifying cost savings opportunities.
 - Delivering cost savings plans.
 - Monitoring and oversight of savings plans.

Identifying cost savings opportunities

- 9 We considered whether the Health Board:
 - has a clear understanding of the factors that are driving its costs;
 - routinely uses a range of data and intelligence to help identify cost savings opportunities; and
 - has an effective approach to selecting cost savings opportunities.
- 10 We found that the **Health Board has a good understanding of its cost drivers, and a clear process for identifying cost savings opportunities. However, it will need to improve the way it uses data and intelligence to identify sustainable savings opportunities and ensure its plans for service transformation are sufficiently well developed to support the Health Board's wider plans for achieving financial sustainability.**

Understanding the drivers of costs

- 11 The Health Board has a good understanding of the factors driving its costs, which are clearly set out in its 2024-25 Annual Plan. These include NICE (National Institute for Health and Care Excellence) and high-cost drugs, commissioned activity, local investments, Continuing Health Care, prescribing and non-pay inflation pressures, Welsh Risk Pool, and the ongoing costs associated with responding to the legacy of the COVID-19 pandemic. These cost pressures along with service developments² are key factors contributing to its increasing underlying deficit.
- 12 While the Health Board achieved its control total deficit of £16.4 million in 2023-24, its underlying financial deficit deteriorated and now stands at £60.9 million. The Health Board has submitted an Annual Plan for 2024-25 with a recurrent savings

² Service developments include unavoidable growth and a range of investments in national and regional services, for example, tertiary services, such as specialist services for children, and essential investment in Velindre University NHS Trust services, including innovative new cancer drugs.

target of £47.2 million. The Health Board is aiming to stabilise its financial position during 2024-25 and has set an ambition to deliver a £15.9 million deficit position. It aims to achieve financial balance by 2025-26.

- 13 The Health Board recognises that its needs to transform its services to better control its cost drivers and achieve long-term financial sustainability. It is therefore developing a programme of core efficiency and transformational savings that align to the themes / workstreams of the national Value and Sustainability Board (VSB)³. The Health Board is also committed to driving further cost reduction across six key areas:
- reducing reliance on high cost agency;
 - strengthening 'Once for Wales' arrangements to key workforce enablers such as recruitment and digital;
 - maximising opportunities for regional working;
 - redistributing resources to community and primary care;
 - reducing unwarranted variation and low value interventions; and
 - increasing administrative efficiency.
- 14 Delivering some of these savings opportunities will require implementation of new models of care and the redesign of existing care pathways to improve flow and reduce sub-optimal performance around length of stay. Furthermore, the timescales associated with transforming services will require the Health Board to continue identifying and delivering savings, particularly in the short-term. The Health Board is currently developing its 10-year Clinical Services Plan⁴ which it aims to launch by Quarter 4 of 2024-25. While the Health Board has indicated that the high-level 10-year plan will not be costed, there will still be a need to clearly set out the costs and savings associated with transforming its services and ensure that the timescales for service transformation supports the Health Board's plans to place its finances on a more sustainable footing. **(Recommendation 1)**

Using data and intelligence to identify and select cost savings opportunities

- 15 The Health Board's arrangements for using data and intelligence to inform cost savings identification and selection require strengthening. While it uses data and

³ The national Value and Sustainability Board (VSB) was set up by Welsh Government and is chaired by NHS Executive to focus on specific themes to deliver possible pan Wales efficiencies. The workstreams include Continuing Health Care, Medicines Management, Workforce, Non-Pay, and Clinical Variation.

⁴ The 10-year Clinical Services Plan will describe the Health Board's long-term ambition for its services and its journey to get there.

intelligence from some sources such as CHKS⁵, VAULT⁶, GIRFT⁷ reviews and local Value-Based Healthcare reviews, this is primarily in relation to a small number of priority areas at present, such as the Health Board's bed closure programme. There is scope, therefore, for the Health Board to increase its use of data and intelligence across a wider range of services to maximise the identification and selection of cost savings opportunities. **(Recommendation 2.1)**

- 16 Furthermore, while the Health Board is developing a local repository to help capture this information more systematically, it is not fully realising the benefits available from benchmarking its data sources at present which inhibits its ability to identify and select cost savings opportunities. **(Recommendation 2.2)**

- 17 While the Health Board has a programme, processes, and tools in place to canvas, capture and assess cost savings opportunities as outlined in its long-term strategy - 'Shaping Our Future Wellbeing' - and the Value in Healthcare Programme, it doesn't currently have systematic arrangements in place for seeking cost savings ideas from all sources, including its service users and wider stakeholders. **(Recommendation 2.3)**

- 18 The Health Board has also established a Value in Health Programme and dedicated team to use organisational resources more equitably, sustainably, and transparently to achieve better outcomes and service user experiences. During 2024-25, the team aims to build capacity and capability to apply values-based healthcare principles in practice; embed measurement and report patient, financial, and societal outcomes; and establish a value-based healthcare approach to strategic planning and operational delivery. Whilst the Value in Health Team has developed a strategy to support the embedding of the Value Based Healthcare principles and start to facilitate benefit realisation, it will also need to clearly demonstrate a return in investment in practice by ensuring that it is achieving meaningful cost reductions and savings. **(Recommendation 3)**

Selecting cost savings opportunities

- 19 The Health Board has reasonably effective arrangements for selecting cost savings opportunities. The Health Board follows both a top-down and bottom-up approach to capturing and appraising potential cost savings opportunities underpinning its strategic intent. Senior Responsible Owners (SROs) are tasked with setting up regular meetings to drive opportunities flagged within each Clinical Board, liaising with relevant personnel, developing detailed action plans, and assessing the validity of plans and expected savings, splitting between recurrent and non-recurrent opportunities, cost avoidance. and budgetary reduction. While each

⁵ Cope Knowledge HealthCare Systems (CHKS) is a provider of healthcare intelligence, benchmarking, and quality improvement services.

⁶ The Value, Allocation, Utilisation and Learning Toolkit (VAULT) is managed by the NHS Executive to support and improve resource utilisation across the Welsh NHS.

⁷ Getting it Right First Time (GIRFT) is a programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

savings scheme should be assessed via the 'Quality Impact Assessment' tool where necessary and tested to ensure they do not adversely impact on the strategic aims and overall performance standards agreed through the Health Board's Annual Plan / Integrated Medium-Term Plan, there is a need for greater consistency in application. **(Recommendation 4)**

Delivery of cost savings opportunities

- 20 We considered whether the Health Board has:
- a good track record of delivering savings plans and cost improvements;
 - clear plans in place to deliver the cost savings opportunities it identifies; and
 - the necessary skills and capacity to deliver its agreed cost savings opportunities.
- 21 We found that **the Health Board's 2024-25 savings target looks extremely challenging in the context of its recent record of delivering recurrent savings. To achieve this, it needs to strengthen accountability arrangements, set realistic and achievable targets for individual savings schemes, and enhance staff skills and capacity in respect of savings plans delivery.**

Track record of delivery savings plans and cost improvements

- 22 As shown in **Exhibit 1**, the Health Board's ability to deliver its overall savings targets has varied in recent years. Whilst it has come close to delivering its overall savings target in the last three years, the majority of the savings delivered were non-recurrent in nature. Recurrent savings (as a percentage of total savings) amounted to 44% in 2023-24, 38% in 2022-23, and 43% in 2021-22. Furthermore, it has still not reached the level of recurrent savings achieved during the pre-COVID years. The £18.2 million of recurrent savings delivered in 2023-24 was the highest the Health Board has achieved in recent years and illustrates the extent of the challenge it is facing in 2024-25, where a recurrent savings target of £47.2 million has been identified.

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Exhibit 1 - Health Board’s savings track record between 2018 and 2024

Year	Overall Savings Target (£M)	Actual overall savings delivered (£M)	Recurrent savings as a % of overall savings target	Delivered non-recurrent savings (£M)	Delivered recurrent savings (£M)
2018-19	33.8	25.6	51%	8.3	17.3
2019-20	26.1	23.2	56%	8.7	14.5
2020-21	29.0	5.1	11%	1.9	3.2
2021-22	16.0	15.7	43%	8.9	6.8
2022-23	19.4	18.2	38%	10.8	7.4
2023-24	32.0	41.4	58%	22.7	18.7

Source: Welsh Government Monthly Monitoring Returns and Health Board Finance Reports

23 The Health Board’s track record of delivering recurrent savings in 2023-24 would have been worse than reported if it had reflected the additional 10% savings requirement of £8.8 million in its overall savings target. The Welsh Government savings requirement of an additional 10% was set to deliver the Health Board’s 2023-24 control total deficit of £16.6 million. Whilst the Health Board reported the need to deliver the additional 10% requirement in overall terms, its original savings target of £32 million was not updated to reflect this additional element. Whilst the Health Board exceeded its original 2023-24 savings target and achieved its 2023-24 control total, incorporating the additional savings target would have provided a more accurate picture of the overall savings required for 2023-24. This addition would have resulted in a savings target of £40.8 million and a reduction in the percentage of delivered recurrent savings from 58% to 46%. **(Recommendation 5)**

Approach to delivery of savings plans

- 24 The Health Board has adequate arrangements in place for turning its high-level savings requirements into deployable savings plans. Corporately, the Executive Director of Finance and Chief Operating Officer hold budget setting meetings with each Clinical Board. These meetings are maintained throughout the year with routine reporting of financial performance, including savings, to the Sustainability Programme Board, the Finance and Performance Committee, and Board (see **paragraph 31**). While the Health Board has indicated that financial accountability is a key aspect of job descriptions and the performance appraisal process, there is opportunity to further strengthen these arrangements by issuing accountability letters to Executive Directors and Clinical Boards to formalise financial performance and savings delivery expectations. This remains more important given the increasing financial pressures and ambitious cost savings requirements of £47.2m for 2024-25. **(Recommendation 6)**
- 25 Savings targets are set out by themed areas such as medicines management, reducing length of stay, and procurement, alongside a 1.5% housekeeping target⁸. The Health Board identifies cross-cutting cost saving themes at senior and corporate levels. Senior staff are cognisant of the financial challenges. Nevertheless, the Health Board is striving to communicate operational costs savings plans with its key internal stakeholders through the formal meetings structures. However, our work has identified a need to strengthen engagement below corporate and senior management levels to raise awareness operationally at all levels across the Clinical Boards. **(Recommendation 7)**
- 26 The performance of individual savings schemes during 2023-24 suggests there is scope for the Health Board to set more realistic and achievable targets for some of its schemes going forward. For example, it experienced some significant savings shortfalls against themes such as length of stay, continuing healthcare, and procurement. However, this did not materially impact delivery of the overall savings target as it was offset by over-delivery of savings in other areas, namely workforce efficiencies (£9.3 million against a target of £8 million), and additional savings with no target such as review of investments, commissioning and non-recurrent opportunities (£0.680 million, £0.730 million, and £3.3 million, respectively). **(Recommendation 8)**

Skills and capacity to deliver savings opportunities

- 27 The Health Board has an overall skills and capacity gap in respect of the financial and transformational aspects of savings delivery. Aside from the Value in Health Team (see **paragraph 18**), the Health Board has limited innovation and improvement resources at its disposal. Furthermore, while the role of the Finance

⁸ Housekeeping savings targets refer to mandated cost reductions typically delivered through efficiencies in non-core or supporting service elements thereby minimising impact on direct service provision.

Business Partners⁹ is highly regarded, there was wide recognition of a more general skills and capacity gap to deliver on operational cost savings. A planned training programme with Health Education and Improvement Wales (HEIW) was reported as work in progress along with options to use the Healthcare Financial Management Association training resources. The Health Board has also put corporate structures and resources in place to assess the effectiveness of the corporate savings Project Initiation Documents¹⁰ (PIDS). However, at the time of our review, it was too early to assess the impact of these changes.

- 28 In addition, the Health Board has not demonstrated a complete understanding of the skills and capacity it requires to deliver system wide transformational change which will be crucial to it delivering the efficiencies and savings required to achieve long-term financial sustainability. This is an area that will need to be addressed if the Health Board is going to be successful in moving away from its approach of delivering short term non-recurrent savings to one where more complex transformational areas of change help deliver its future financial targets.

(Recommendation 9)

Monitoring and oversight of cost savings delivery

- 29 We considered whether the Health Board:
- Has an effective approach to reporting and monitoring the delivery of its cost savings plans;
 - Identifies risks to the delivery of savings plans and actions to mitigate those risks; and
 - Applies learning where cost savings plans have not been achieved.
- 30 We found that **the Health Board's monitoring and reporting arrangements require strengthening to provide more robust assurance on savings delivery. In addition, opportunities exist to improve the management of in-year savings risks and introduce a systematic approach for learning lessons from savings planning and delivery.**

Reporting and monitoring the delivery of savings plans

- 31 The Health Board's arrangements for monitoring and reporting delivery of savings requires strengthening. At a corporate level, financial performance, including savings, is reported to the Board, the Finance and Performance Committee, the Executive Team, and the Sustainability Programme Board. Financial performance

⁹ The finance business partner model ensures engagement on financial management and provides a good link between services and corporate finance. The financial business partners are financial accountants who have responsibility for supporting services, financial reporting and providing an advisory role.

¹⁰ The Project Initiation Document (PID) defines a project, outlines its management approach, the risks and assesses overall success, ensuring a solid foundation before committing to major expenditures.

updates are tailored to each forum and in general provide a high-level overview which predominantly focus on savings identified for its 'red', 'amber' and 'green' savings schemes as opposed to actual savings delivered during the year. While the information in the reports is sufficient to oversee the Health Board's progress in identifying savings to meet overall targets, it does not allow Senior Leadership or Board to scrutinise or recommend action where individual savings schemes are off-track. There is also an opportunity to provide clearer information and explanation of technical accounting transactions or issues that may result in revised end of year savings forecasts and performance. **(Recommendation 10)**

Identification of risks to savings plans delivery

- 32 The Health Board has adequately documented the risks around its wider financial position. Its ability to meet its statutory financial duties, produce a balanced three-year plan, and deliver a recurrent cost improvement programme feature as significant risks within its Board Assurance Framework (BAF) and Corporate Risk Register (CRR). Finance risks are also set out in the routine finance reports to the Finance and Performance Committee along with the controls and remedial action the Health Board is taking to address the risks.
- 33 Like all NHS Bodies in Wales, the Health Board assesses (RAG¹¹ rates) its savings schemes to determine the extent of risk of non-delivery. At Month 3 2023-24, the Health Board identified that 22% of its savings schemes were 'amber'. Welsh Government requires 'amber' schemes to turn to 'green' schemes (i.e. a strong likelihood of delivery) within three months. The Health Board's finance report to the Finance and Performance Committee identified that it was expecting to develop increased certainty on 'amber' schemes so that they turn 'green.' Positively, four months later, at Month 8 2023-24, the Health Board reported that only 13% of its savings schemes remained 'amber' demonstrating that it was addressing savings risks quickly. The Health Board also identifies 'red' savings schemes in its finance reports to the Finance and Performance Committee which shows pipeline opportunities that need to be converted into deliverable plans. At Month 12 2023-24, the Health Board reported that £32 million of 'green' rated schemes had been achieved, and a small number of 'amber' schemes remained totalling £0.498 million. There were no 'red' pipeline opportunities awaiting conversion into deliverable plans.
- 34 While the Health Board significantly increased its savings delivery during 2023-24, it is facing a more challenging situation during 2024-25. The latest update to the Finance and Performance committee in August 2024 assesses failure to achieve the Health Board's savings / cost improvement target as a significant risk, indicating that it has only identified £18 million (38%) recurrent 'green' and 'amber' savings schemes against its £47.2 million savings target. The Health Board is taking several reactive actions to address the risk including enhanced monitoring of the delegated financial position, monthly finance meetings with each Clinical

¹¹ 'Red', 'Amber', 'Green'

Board, weekly savings meetings with budget holders, and bi-weekly multi-leadership Sustainability Programme Board meetings.

- 35 Going forward, the Health Board will need to take more proactive action in its savings planning and delivery arrangements to mitigate in-year savings risks and achieve both its operational and overall savings targets. This should include a dynamic process of reserve (Red) savings schemes with sufficient detail to activate them within a short timescale when required. These could also feed into a rolling programme of savings schemes beyond the immediate financial year thereby ensuring they start each financial year with the majority of requisite savings identified. **(Recommendation 11)**

Applying learning

- 36 During 2023-24, the Health Board demonstrated that it was able to respond at pace to changing financial circumstances. It rapidly identified £16 million of both recurrent and non-recurrent additional actions to recover its savings deficit and deliver its revised forecast £16.4 million control total deficit. It would not have achieved this had it not identified additional savings or expanded key workstreams to consider savings from other aspects of the Health Board’s business. The Sustainability Programme Board played a key role in monitoring progress in developing plans for these additional actions ensuring that they transitioned from their initial ‘red’ RAG rating through to ‘amber’ and ‘green’ to provide assurance on their delivery. The Health Board, therefore, should seek to identify the key lessons from this experience and apply the learning to its future approach to financial savings. **(Recommendation 12)**

Recommendations

Exhibit 2 details the recommendations arising from this audit. The Health Board’s response to our recommendations is summarised in **Appendix 3**.

Exhibit 2: Recommendations

Recommendations	
R1	The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them. (Paragraph 14)

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Recommendations

- R2 The Health Board should make improvements to how it uses data and intelligence to inform its savings identifications and selections arrangements by:
- R2.1 Extending its use of data and intelligence across a wider range of services. **(Paragraphs 15)**
 - R2.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data. **(Paragraph 16)**
 - R2.3 Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas. **(Paragraph 17)**
- R3 The Health Board should assure itself that its investment in the Value in Health Team is supporting service improvement, delivering improved outcomes, and achieving cost reductions. **(Paragraph 18)**
- R4 The Health Board should strengthen both its guidance and governance around the Quality Impact Assessment processes for savings. This will ensure a consistent and clearly documented and understood approach for considering quality, patient safety, and intra Health Board impacts of savings decisions. **(Paragraph 20)**
- R5 The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total. **(Paragraph 23)**
- R6 The Health Board should strengthen accountability for savings delivery by issuing accountability letters to Executive Directors and Clinical Boards which provide clarity around roles, responsibilities, and financial targets. **(Paragraph 24)**
- R7 The Health Board should strengthen its arrangements for communicating its cost savings plans to staff. **(Paragraph 25)**

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Recommendations

- R8 The Health Board should set challenging but realistic targets for its individual savings schemes and manage risks to under-delivery more effectively. **(Paragraph 26)**
- R9 The Health Board needs to identify sufficient capacity and capability to deliver longer-term service objectives (including in the fields of innovation and improvement) to effectively deliver its operational savings plans and longer-term service transformation. **(Paragraph 28)**
- R10 The Health Board should strengthen its financial reporting on savings by including actual savings delivery progress for each scheme during the year to provide stronger assurances that savings plans are delivering as intended. Financial reports should also include a short technical appendix to provide clearer information and explanation of technical accounting transactions or issues that may result in revised end of year savings forecasts and performance. **(Paragraph 31)**
- R11 The Health Board should ensure earlier savings planning preparation for the 2025-26 financial year and develop a rolling programme of reserve savings schemes to help mitigate any risks to savings under-delivery or where savings requirements change in-year. **(Paragraph 34)**
- R12 The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach. **(Paragraph 36)**

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Appendix 1

Audit criteria

Exhibit 3 below sets out the detailed audit criteria for this review.

Identifying cost savings opportunities

Area	Audit Criteria
Understanding the drivers of cost	• The organisation's opening balance sheet is true and fair. • The organisation has effective arrangements in place for identifying and analysing the full range of pay and non-pay factors driving its costs in the short, medium, and long-term. • The organisation has a good understanding of the scale of cost savings required to achieve financial sustainability in the short, medium, and long-term and has set realistic and achievable targets accordingly. • The Board is appropriately involved in overseeing, scrutinising, and challenging the organisation's financial analysis and cost savings targets.
Using data and intelligence to identify cost savings opportunities	• The organisation routinely accesses and uses benchmarking information from a range of sources (e.g. NHS Benchmarking, CHKS, Medicines Management KPIs) • The organisation routinely accesses and uses efficiencies data and information from a range of sources (e.g. NHS Wales Efficiency Framework / VAULT, GIRFT reviews, local Value-based Healthcare reviews / opportunities)

- The organisation has clear processes in place to canvas, capture, and assess ideas and suggestions on cost savings opportunities from staff, service-users, and other stakeholders on a regular basis.
- The organisation has clear processes in place for responding to centrally identified cost savings opportunities from the NHS Wales Value and Sustainability Board.

Selecting cost savings opportunities

- The organisation has a clear and iterative process in place to appraise all potential cost savings opportunities for achievability and for impact on delivering the organisation's strategic aims, well-being objectives, population health, the quality and safety of services, and ability to meet performance targets / service specifications in the short, medium, and long-term.
- The organisation has a clear and iterative process in place for scrutinising, agreeing, and approving cost savings opportunities, which also involves the Board and its relevant committee(s).
 - The organisation's agreed cost savings opportunities:
 - are realistic, achievable, and focus on maximising value to the health of the population being served;
 - cover the breadth of the organisation's clinical, administrative, and technical functions;
 - balance one-off non recurrent savings with more sustainable saving opportunities;
 - incorporate productivity savings, but recognise these will not lead to a reduction in monetary terms;
 - focus on medium- to longer-term transformation, as well as short-term and incremental opportunities; and
 - have been scaled and targeted appropriately across all parts of the organisation (rather than a standard percentage applied across all parts.)

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Delivery of cost savings opportunities

Area	Audit Criteria
Approach to delivery of savings plans	• The organisation has plans in place for delivering cost savings opportunities which clearly set out: – the financial savings that will be delivered and how they will be measured; – the anticipated impact on strategy, quality, and / or performance; – the key risks, controls, and mitigating actions; – any interdependency with other cost savings plans; – any dependency on other organisational work streams and strategies; – key delivery milestones; and – which senior officer is responsible and accountable for delivery. • The organisation has effective arrangements in place for managing cross-cutting cost savings plans. • The organisation has appropriate arrangements in place to communicate its cost savings plans to staff, service-users, and other stakeholders.
Skills and capacity to deliver savings opportunities	• Roles and responsibilities in relation to delivering cost savings plans at all levels of the organisation are clearly documented and understood. • The organisation has assessed the skills / capability and capacity required to deliver its cost savings plans at both a corporate and operational level and has put appropriate arrangements in place to address any shortfalls and gaps (including the appropriate use of external capacity / expertise.) • The organisation has appropriate corporate structures and resources in place (such as a Programme Management Office) to:

	– keep delivery on track, – provide challenge when needed, – support corporate and operational staff to manage delivery risks, and – provide an agile and timely response to under-performance / under-delivery.
Track record of delivery savings plans and cost improvements	• Cost savings plans in recent years have been largely achieved. • There is evidence of learning being applied where cost savings plans previously haven't been achieved.

Monitoring and oversight of cost savings delivery

Area	Audit Criteria
Monitoring the delivery of savings plans	• The organisation has clear arrangements in place for monitoring delivery which reflect the timescales and risks associated with delivering individual plans and the overall cost savings target. • The organisation has selected appropriate key KPIs and has put effective controls in place to ensure the quality of underlying data are reliable for effective monitoring and reporting. • The organisation's approach to monitoring and tracking delivery of its cost savings plan is appropriately aligned to its broader financial management arrangements (e.g., Standing Financial Instructions, Schemes of Reservation and Delegation, budget allocations.) • The organisation produces tailored reports that meet the differing needs of users in the governance chain. • The organisation ensures that delivery of cost savings is accurately reflected in finance reports presented to the Board and / or its relevant committee(s).
Identification of risks to savings plans delivery	• The organisation has identified and documented the key risks to delivery in the appropriate risk registers (operational, corporate, and Board Assurance Framework.)

- The organisation is actively managing / mitigating the risks at the appropriate level.
- The organisation has appropriate arrangements in place to identify and escalate cost savings plans that are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.
- The organisation takes appropriate action in a timely manner where cost savings plans are off-track and / or having an adverse / unanticipated impact on strategy, quality, and / or performance.

Applying learning

- The organisation seeks assurance on its arrangements by using internal audit, or a similar independent and objective reviewer.
- The organisation appropriately evaluates its approach to achieving cost savings.
- The organisation actively uses its own evaluation(s) and assurances provided by internal audit to identify lessons learned and to change / improve its arrangements.
- Lessons learned and changes / improvements are reported to the Board and / or its relevant committee(s) to enable an agile response in-year.
- The organisation has appropriate arrangements in place to fully transfer and / or integrate changes arising from its cost savings plans to its business-as-usual operations and activities.

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Appendix 2

Audit methods

Exhibit 4 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Self-assessment	Completed self-assessment questionnaire and supporting documents were reviewed
Documents	We reviewed a range of documents, including: • Board and Committees agenda's, papers, and minutes; • Key organisational strategies and plans; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports in relation to organisational finances; • Reports prepared by the Internal Audit service.
Interviews	We interviewed the following:

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Appendix 3

Element of audit approach	Description
	• Assistant Director of Finance - Business Partner (3 x Clinical Boards) • Director of Workforce and Financial Performance (Medicine) • Deputy Director of Finance / Strategic Planning • Deputy Director People and Culture • Director of Operations – Women & Children’s Clinical Board • Executive Director of Finance • Chief Operating Officer
Observations	We observed Board meetings as well as meetings of the following committees: • Public Board • Special Board Meeting • Finance and Performance Committee

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Management response to audit recommendations

Exhibit 5: Health Board’s Management response to our audit recommendations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)

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Appendix 3

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)

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

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Management response form



Report title: Review of Cost Savings Arrangements

Completion date: 7th January 2025

Document reference: 4504A2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should ensure that its service transformation plans more explicitly set out how they will help the organisation achieve financial sustainability in terms of the savings that will be generated and the timescale for achieving them.	Work is ongoing on a long-term financial model for the health board to support the financial sustainability agenda. Value and transformation offers great opportunities to deliver services that are more effective and offer greater value for money albeit this does not always offer a scale of savings to address the University Health Board's (UHB)'s annual requirement of savings.	June 2025 and ongoing as long-term financial plans evolve and flex	Deputy Director of Finance
R2	The Health Board should make improvements to how it uses data and intelligence to inform its savings			

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	identifications and selections arrangements by: R2.1 Extending its use of data and intelligence across a wider range of services. R2.2 Rapidly progressing work on its local data repository to facilitate the systematic capture of benchmarking data.	The UHB has good sources of data on Benchmarking via its Value Team including CHKS and the Financial Delivery Unit Vault data. The Finance Team is developing a more balanced monthly resource report pack to introduce key CHKS opportunities data into monthly reporting in 2024-25 as part of its 'Changing the Conversation' reporting programme. The local data repository development plan includes delivery of a stable Local Data Repository infrastructure (currently in proof of concept) and integrating new systems including Electronic Prescribing and Medicines Administration (EPMA e-prescribing), Patient Reported Outcome measures (PROMS) and	May 2025 June 2025	Deputy Director of Finance Director of Digital

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	R2.3 Developing a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas.	AQUA Theatreman (theatres system). Longer term plans are to ingest many more different data sources. A Data Insights Programme Board has been established, chaired by Director of Digital & Health Intelligence, the aim of which is to oversee and sign off internal data insights and reporting capabilities with broad representation from across corporate services and clinical boards. This plans to train up business intelligence partners and to deploy and train appropriate staff on Power BI as well as pursuing the data democratisation agenda.	March 2025 into 2027-28	Director of Digital
R3	The Health Board should assure itself that its investment in the Value in Health Team is supporting service improvement,	Value business cases are subject to the Investment Board process that includes a significant benefits realisation process and post	March 2025	Director of Finance/Investment Group

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	delivering improved outcomes, and achieving cost reductions.	implementation review that are identified during the business case approval process		
R4	The Health Board should strengthen both its guidance and governance around the Quality Impact Assessment processes for savings. This will ensure a consistent and clearly documented and understood approach for considering quality, patient safety, and intra Health Board impacts of savings decisions.	Quality Impact Assessments (QIAs) have been more extensively used in assessing potential actions that support annual plan delivery and financial sustainability in 2024-25. They have been subject to pre-scrutiny by the Chief Operating Officer (COO) and are considered through the Sustainability Board chaired by the Chief Executive Officer (CEO). The extended use of QIAs has resulted in a new standard template being developed by the Director of Nursing which is now utilised as a starting point form QIAs	December 2024	Director of Nursing

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	The Health Board should ensure that future savings reports clearly articulate all the savings it needs to deliver in a given year to meet its Welsh Government control total.	The savings programme is hard wired into the UHB's annual financial plan and is a key objective in delivering the Welsh Government's control total. The totality of savings plans will be reported in plans and financial reports unlike 2023-24 when the Going Further savings requirements were reported separately.	March 2025 as part of the 2025-26 Financial Planning	Deputy Director of Finance
R6	The Health Board should strengthen accountability for savings delivery by issuing accountability letters to Executive Directors and Clinical Boards which provide clarity around roles, responsibilities, and financial targets.	Budget holders are aware of savings targets as these are discussed, shared and devolved through the planning and form part of rolling monthly meetings and accountability meetings such as the monthly Executive Performance Reviews and the Monthly Finance- Ops meeting. Accountability letters have previously been considered and not pursued. They will be considered again as part of the 2025-26 Financial plan Process	For consideration in financial planning and budget setting for 2025-26 Consideration by April 2026	Director of Finance and Chief Executive Officer

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R7	The Health Board should strengthen its arrangements for communicating its cost savings plans to staff.	The UHB engages its staff through multiple communication points, in the context of the financial outlook and the need to identify and deliver Costs Reduction Programmes. The UHB seeks will seek to ensure that these initiatives are continued and strengthened and the need for increased focus is communicated clearly to all staff members. • Financial Sustainability Communications Working Group • Corporate SharePoint page and internal communications • Financial Sustainability – You Said, We Did, communications • Staff emails shared on key internal communications messages relating to Financial Sustainability.	June 2025	Whole UHB Leadership teams including but not exclusive to Executive Directors, Corporate Functions, Clinical Board management teams and Finance Leads

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		• Communications support to individual portfolios in Medicines management, Workforce and Procurement • All Staff Engagement through 'Ask Suzanne' • Viva Engage • Local Partnership Forum • Clinical Board Executive Reviews In addition to these UHB/Corporate initiatives each Clinical Board delivers a raft of measures to communicate the financial challenge and the need for efficiencies within their own reporting structures. These have been provided to Audit Wales colleagues.		

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R8	The Health Board should set challenging but realistic targets for its individual savings schemes and manage risks to under-delivery more effectively.	This has been a communicated position in savings delivery aspirations to date recognising the risk that not all schemes will be delivered or, if delivered, not necessarily within the timescale or value initially projected. The savings tracker that is updated weekly, using the Green/Amber/Red ratings assurance, is used nationally within Wales. Based on a rolling scrutiny and reporting cycle, a re- energisation process takes place in year to secure new schemes to replace deficits.	April 2025	Deputy Director of Finance and Budget-holders
R9	The Health Board needs to identify sufficient capacity and capability to deliver longer-term service objectives (including in the fields of innovation and improvement) to effectively deliver its operational savings plans and longer-term service transformation.	There has been a rolling expansion in personnel in the Chief Operating Officer's department to help better deliver performance in activity and effective use of resources. The UHB continues to support a Shaping Change and an Innovation team. These have been heavily involved in delivering a pan UHB Rapid	January 2025	COO's Office Shaping Change Team Innovation Team

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		Delivery Event in December 2024 involving 200 leadership colleagues.		
R10	The Health Board should strengthen its financial reporting on savings by including actual savings delivery progress for each scheme during the year to provide stronger assurances that savings plans are delivering as intended. Financial reports should also include a short technical appendix to provide clearer information and explanation of technical accounting transactions or issues that may result in revised end of year savings forecasts and performance.	Actual monthly savings are reported the monthly monitoring returns to Welsh Government through the Health Board savings tracker process. The point raised on technical accounting issues can be reviewed to ensure reporting consistency across the multiple audiences. This is highlighted as a separate item in the monthly Welsh Government monitoring returns.	March 2025	Deputy Director of Finance
R11	The Health Board should ensure earlier savings planning preparation for the 2025-26 financial year and develop a rolling	That is always the intention. Internal planning guidance issued for 2025/26 aims to bring the planning timetable forward with an ambition of	March 2025	Deputy Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	programme of reserve savings schemes to help mitigate any risks to savings under-delivery or where savings requirements change in-year.	having a fully developed savings plan in place prior to 1st April.		
R12	The Health Board should identify the key lessons from its approach to identifying and delivering savings at pace during 2023-24 and apply the learning to its future approach.	Our approach to savings identification and delivery remains agile to ensure we maximise lessons learnt in previous years. Our approach entering a new financial year is discussed through both Management Executive and the Board to ensure that the UHB can deliver and maximise financial opportunities driving best value.	March 2025	Executive Team

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Report Title:	Procurement Compliance Report				Agenda Item no.	2.4	
Meeting:	Audit Committee	Public	X	Meeting Date:	4 th February 2025		
		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 when individuals act outside Procurement Regulations and Standing Financials Instructions which need to be reported as a non-compliant process, which is a direct breach, and could compromise competition and value for money. There are some exemptions within these breaches in relation to unforeseen/unplanned circumstances, emergencies and more recently, Covid-19.

Should Non-Compliant Activity occur a letter from the Director of Finance will be sent to the Clinical Director/Department Head and copied to the relevant Executive Director to seek assurance that measures will be put in place to ensure that a breach does not occur again. If repeated breaches continue this will be escalated to the CEO.

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

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
Winter project for Grow Cardiff	£10,728.00	12 months	PCIC	No engagement with Procurement	have spoken to the service and advised if this is an on going requirement then we will need to ensure that we look at the correct procurement route going forward. Service is meeting to discuss all on going and upcoming projects.
Cardiff West Social Prescribing - funded by Cluster Funds 1st May 24 - 31st March 25	£55,000.00	12 months	PCIC	No engagement with Procurement	Adding to current contract
Invoice 1427908 - CUBRI Scan study 433	£7,500.00	7 days	Specialist	No engagement with Procurement	Service are in discussions with finance due to corporate finance said that going forward for CU staff time we could just give them the information and they would add to the CU recharge payments that go over monthly
Provision of Clinical Coders via Agency Providers VENN (one coder)	£28,334.88	6 months	Clinical Diagnostics & Therapies	No engagement with Procurement	have spoken to the service and advised if this is an on going requirement then we will need to ensure that we look at the correct procurement route going forward. Service is meeting to discuss all on going and upcoming projects.
Provision of Clinical Coders via Agency Providers QCI (one coder)	£65,000.00	6 months	Clinical Diagnostics & Therapies	No engagement with Procurement	As above
Mappress Stainless Steel Pipe and fittings for A&E CT Scanner AHU	£5,254.82	One off requirement	Capital Planning Estates and Facilities	Emergency estates maintenance	Closed – one off requirement
96 Needle head with spiral needles for all porvair evaporation	£4,200.58	One off requirement	Clinical Diagnostics & Therapies	No engagement with Procurement	Closed – one off requirement
Invivioscribe tube labels	£5,175.00	One off requirement	AWMGS	No engagement with Procurement	Conversation ongoing with the service to establish a contract - given nature of the reagents and several suppliers on the market

					a tender exercise will be necessary
SALTING AT UHW - WINTER PERIOD 2024/2025	£9,186.00	One off requirement	Capital Planning Estates and Facilities	No engagement with Procurement	Closed – one off requirement
Accommodation Internationally Educated Nurses. 30 Nights from 17/9/24-17/10/24	£14,400.00	1 month	Executives	No engagement with Procurement	Liasing with end user to try and see if a bigger contract can be put in place to make some savings and review to see if True Cardiff is the best deal.
Accommodation internationally educated Nurses. 61 nights from 17/10/24-17/12/24.	£43,920.00	2 months	Executives	No engagement with Procurement	Liasing with end user to try and see if a bigger contract can be put in place to make some savings and review to see if True Cardiff is the best deal.
Secondment fees. Provision of lived experience. JJ and ST. Quarter 1 & 2.	£27,639.57	8 months	Executives	No engagement with Procurement	adding to the work plan for review, conversations with end user will follow
Instrumentarium OP 300	£6,894.55	One off requirement	Surgery	No engagement with Procurement	Closed - One off requirement
BMJ Subscription Provision	£27,749.15	5 months	Executives	No engagement with Procurement	5 month period reported to AC, DCO implemented via NICE Framework for prospective period to cover remainder of the 12 months. To be reviewed prior to expiry for renewal status.
Accommodation for Internationally Educated Nurses 17/10/24-15/11/24.	£5,560.00	1 month	Executives	No engagement with Procurement	Liasing with end user to try and see if a bigger contract can be put in place to make some savings and review to see if True Cardiff is the best deal.
UHW-Dialysis Roof – Access Platform to flat roof and additional lift for box gutter approx. 18M X 4 Lifts and 1 Lift Buttress REF: SMS/UHB/010	£5,650.61	One off requirement	Capital Planning Estates and Facilities	No engagement with Procurement	Closed – one off requirement
Overdue Invoices	£60,449.99	Retrospective POI	Executives	No engagement with Procurement	liasing with end user, potentially putting an interim contract put in place to help mitigate the high tariff that we are on. looking into a longer term contract.
Salting at Llandough Hospital Winter 2024-2025	£5,600.00	One off requirement	Capital Planning Estates and Facilities	No engagement with Procurement	Closed – one off requirement
Investigators for consulting	£9,5112.73	One off requirement	Children and Women	No engagement with Procurement	Closed – one off requirement
Whole School Approach to Emotional and Mental Wellbeing in respect of	£23,254.95	6 months	Public Health Local	No engagement with Procurement	Please refer to AC (C&V 2023-24) - 149 & AC (CAV 2023-24) - 206

salary costs for Q1 and Q2 for Lisa Lewis. Venue, refreshment and supply costs for special school event (x2). Please refer to AC (C&V 2023-24) - 149 & AC (CAV 2023-24) - 206			Commissioning		
Purchase MR A R INTMED SEMI T X2 10.12.24 U127770 SL REF 311303011 & 3113004	£4,627.77	One off requirement	Surgery	No engagement with Procurement	Closed - One off requirement,
Academy recruitment of middle grade Drs for MCB	£15,000.00	One off requirement	Medicine	No engagement with Procurement	Looking into putting a contract in place
Open Dialogue Training Supervision	£9,600.00	One off requirement	Mental Health	No engagement with Procurement	awaiting to hear from end user to see if this is a regular requirement.
DBT 2 day online skills training essentials	£10,900.00	2 days	Mental Health	No engagement with Procurement	awaiting to hear from end user to see if this is a regular requirement.
Vascular Network - ASPIRE 7 Course March 2024	£8,882.66	Retrospective POI	Surgery Services	No engagement with Procurement	Closed - One off requirement, stakeholders reminded to engage with Procurement for compliance early when requirement is known
Payment of Invoices (Send out Tests)	£56,100.00	Retrospective POI	AWMGS	No engagement with Procurement	Procurement now in contact with the department to put compliance in place for future orders.
Accommodation for Internationally Educated Nurses 22/10/24-22/12/24	£39,530.00	2 months	Executives	No engagement with Procurement	Liaising with end user to try and see if a bigger contract can be put in place to make some savings and review to see if True Cardiff is the best deal.
Accommodation for Internationally Educated Nurses. 26 NOV 24 TO 26 JAN 25	£25,620.00	2 months	Executives	No engagement with Procurement	As above
NHS Wales App Volunteer Scheme - Pilot	£7,365.00	One off requirement	PCIC	No engagement with Procurement	Pilot - have discussed with end user is this will be on going then governance needs to be put in place
Payment of invoice Helideck Firefighter revalidation 2 day course	£6,785.00	2 day course	Capital Planning Estates and Facilities	No engagement with Procurement	Have discussed with end user and governance will be put in place for further services
Hard Box Items	£6,198.75	One off purchase	AWMGS	No engagement with Procurement	Will link in with the department due to tender required to be issued
Mobile Height Adjustable Shield 0.5mm PB Acrylic Top Section	£4,310.83	One off purchase	WEQAS	No engagement with Procurement	

Year 2 train the trainers in Peer Centred open dialogue	£10,000.00	One off requirement	Mental Health	No engagement with Procurement	Closed - One off requirement but funding through HEIW have spoken with the team surrounding next years funding
Ulster University	£9,255.55	One off requirement	Clinical Diagnostics & Therapies	No engagement with Procurement	Closed - one off requirement that has already taken place.
POMH Membership renewal	£6,400.00	One off requirement	Mental Health	No engagement with Procurement	awaiting to hear from end user to see if this is a regular requirement.
Case Note Folders C&V Main	£34,317.00	One off requirement	Clinical Diagnostics & Therapies	No engagement with Procurement	no procurement involvement until the order was raised and nothing could be sorted in the period that we had before the order was required.
Payment of invoices for hotel accommodation	£12,722.00	One off requirement	Specialist	No engagement with Procurement	No procurement involvement, staff already on training course and supplier requires urgent PO.
Expenditure Statement 7977 RB	£13,125.00	3 months	Specialist	No engagement with Procurement	Service are in discussions with finance due to corporate finance said that going forward for CU staff time we could just give them the information and they would add to the CU recharge payments that go over monthly
Invoice for admin support to palliative care consultant and wider palliative care team from 01.04.23 - 31.03.24	£16,295.00	12 months	Children and Women	No engagement with Procurement	Agreement to be put in place for 2025/26
THE SOCIAL APPROACH Videography Services to include filming, editing, social mediate formatting, associated expenses, bilingual translation services Welsh Govt funding relating to Food Partnerships	£8,450.00	One off requirement	Executives	No engagement with Procurement	Have discussed with end user and governance will be put in place for further services

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

Contract Title	Value at Risk Excl VAT	Contract Expiry	Length at risk/Breach	Clinical Board	Reason	Action /Status
INR EQA Material (Lot Code PT13C) (1) (PT13C)	£13,290.00	Contract Value breach	2 months	Clinical Diagnostics & Therapies	Delays in renewal contract evaluation - additional samples requested, however urgent orders needed before Christmas break, the interim period before	Agreed to approve the PO for the interim period before the contract is awarded. Rationale for

					the contract will be awarded. Failure to receive this order will result in a loss of income as they will not be able to complete their testing.	approval based on mitigating the risk of a loss of income as they will not be able to complete their testing.

Other Non-Compliant Activity (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
Working accreditation assessments	£14,400.00	One off requirement	WEQAS	Exemption	Closed - One off requirement
Elipse R&D Project	£297,585.56	10 months	Executives	Exemption	Meeting set up with Corporate Governance, Procurement and R&D to map out processes and agree compliant way to procure for research projects
Financial audit work and performance audit work. 2024/25	£454,848.00	12 months	Executives	Exemption	No breach, however, undertaken approval without Procurement engagement.
Law Employment Tribunal Invoice payment for RG Case ref: 288110	£15,000.00	One off requirement	Executives	Exemption	exempt due to legal appointment
Employment Tribunal Invoice for AA	£8,540.00	One off requirement	Executives	Exemption	exempt due to legal appointment
Legal fees for fire safety issues	£7,440.57	One off requirement	Executives	Exemption	exempt due to legal appointment
FIRE SAFETY ISSUES legal advise	£7,440.57	One off requirement	Executives	Exemption	exempt due to legal appointment
NO 5 Barristers Chambers Employment Tribunal Invoice - SS8 868887-47 650 3204	£7,200.00	One off requirement	Executives	Exemption	exempt due to legal appointment
IMC St Davids Annual Ins. Renewal PFI - J Nettleton	£31,352.49	One off requirement	Capital Planning Estates and Facilities	Exemption	Exempt - PFI agreement (annual lease)

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 – (Return)

The report outlines all SQA/STA (0) requests during the period the 1st October 2024 to 31st December 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 October 2024 to 31st December 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
AWMGS	HRH Logistics	AWMGS Lab Relocation	£50,000.00	Specialist Maintenance and Repairs
Executives	Empyrean Digital	NHS Wales Executive - Male Suicide Webpage	£14,525.00	Bespoke software support and/or licences

Clinical, Diagnostics and Therapies	M&M Medical Ltd	External Laboratory gas regulators and manifold replacement	£7,995.00	Compliance / Regulatory Requirements
Clinical, Diagnostics and Therapies	M&M Medical Ltd	Internal Laboratory gas regulators and manifold replacement	£18,218.00	Compliance / Regulatory Requirements
AWMGS	Multiple	Decommissioning of Lab Equipment	£117,893.00	Specialist Maintenance and Repairs
Clinical, Diagnostics and Therapies	TCS Biosciences	Interim EQA Material Purchase	£35,928.80	Standardisation of goods or services
Clinical, Diagnostics and Therapies	Ideagen	Quality Management Software for Clinical Diagnostics and Therapeutics	£404,623.94	Standardisation of goods or services
Clinical, Diagnostics and Therapies	Leica	Rental of an automated, high-capacity digital Pathology scanner GT450	£87,937.44	National Programmes
Clinical, Diagnostics and Therapies	Solventum	Upgrade of existing Medicode Clinical Coding software to Medicode 360 + Technical Support for server move	£53,379.00	Bespoke software support and/or licences
Clinical, Diagnostics and Therapies	The Gambica Association Ltd.	MEDLAB EVENT 2025	£6,675.00	Standardisation of goods or services
Executives	Sensory Integration Education	Sensory Integration Education Postgrad Courses - L7	£29,022.50	Trials, Testing and Education Programmes

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	10	0
Children and Women	2	0	0	3	0	0	4	0
Capital Planning, Estates and Facilities	3	2	1	2	3	0	13	7
Clinical, Diagnostics and Therapies	2	0	0	11	4	0	22	3
Executives	8	5	0	21	9	0	27	18
Medicine	2	1	0	1	0	0	2	0
Mental Health	0	0	0	2	1	0	15	0
PCIC	0	0	0	2	0	0	8	0

Specialist	3	1	0	10	1	0	9	2
Surgery and Dental	9	1	0	10	0	0	8	1
TOTALS	31	10	1	63	18	0	118	31

STA/SQA's by Department

Clinical Board	2022/23		2023/24		2024/25 (YTD)	
	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached	No. of SQA's/STA's	SQA/STA's Breached
AWMGS	3	3	0	0	4	1
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	24	0
Executives	23	1	13	2	13	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	3	0
Grand Total	117	13	54	3	55	1

Recommendation:

The Board / Committee are requested to:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration		Involvement	
Impact Assessment: <i>Please state yes or no for each category. If yes please provide further details.</i>									
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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STA/ SQA	SQA/STA Number	Contract Folder Number	Procurement Officer	Date Received	Clinical Board Requestor	Clinical Board	Proposed Supplier	Name of Project	Total Value of Contract excl VAT	Annual Cost excl VAT	Retrospect ive?	Retrospect ive Value of Contract	Start Date of Contract	End Date of Contract	Extension Option	Type	Category of STA/QSA for Audit Paper	Reason Detail for STA	Long Term Solution	Date passed into Head of Procurement	Date Approved & Returned to Procurement	Action Following Return from Corp	Processed via Bravo	Credit/ Non Covid Activity	Expenditure Type		Audit Committee within Month reported	on- Monthly Highlight	on- Monthly Highlight	Quarter		
CAV	(2024/25) 50	CR191	RW	02/10/2024	Matthew Corrin	AWMGS	HRH Logistics	AWMGS Lab Relocation	£50,000.00	£60,000.00	No	£0.00	01/11/2024	20/12/2024	No	Capability with existing equipment or service	Specialist Maintenance and Repairs	Specialist Lab relocation for AWMGS	No required - one off for laboratory move		03/10/2024	04/10/2024	RFA to be issued		No	Non Covid Activity	Revenue		Feb-25			
NHS Executive	(2024/25) 51	QU312	MB	08/10/2024	Claire Corrie	Executives	Empryan Digital	NHS Wales Executive - Male Suicide Webpage	£14,525.00	£17,430.00	No	n/a	14/10/2024	31/03/2025	6 months	Sole Supplier of Goods or Services	Bespoke software support and/or licences	Supplier is already contract for main website						No	Non Covid Activity	Revenue		Feb-25				
CAV	(2024/25) 57	QU435	SD	10/10/2024	Nigel Roberts	CD&T	M&M Medical Ltd	External Laboratory gas regulators and manifold replacement	£7,995.00	£7,995.00	No	n/a	One off	One off	no	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Supplier is the laboratory service provider	Not applicable		10/10/2024			No	Non Covid Activity	Revenue		Feb-25				
CAV	(2024/25) 58	QU436	SD	10/10/2024	Nigel Roberts	CD&T	M&M Medical Ltd	Internal Laboratory gas regulators and manifold replacement	£18,218.00	£18,218.00	No	n/a	one off	One off	no	Sole Supplier of Goods or Services	Compliance / Regulatory Requirements	Supplier is the laboratory service provider	Not applicable		10/10/2024			No	Non Covid Activity	Revenue		Feb-25				
CAV	(2024/25) 60	AWMG09	OM	22/10/2024	Matthew Corrin	AWMGS	Multiple	Decommissioning of Lab Equipment	£117,893.00	£141,471.60	No	no	11/11/2024	01/12/2024	No	Capability with existing equipment or service	Specialist Maintenance and Repairs	New service for one off	One off Service to decommission lab								Feb-25					
CAV STA	CR16	CW	28/10/2024	Samantha Beccaloni	CD&T	TCS	Interim Q&A Material Purchase	£15,928.80	£45,114.56	No	no	one off	One off	No	Sole Supplier of Goods or Services	Standardisation of goods or services	Interim payment whilst contract										Feb-25					
CAV STA	CR1201	CW	03/11/2024	Beccaloni	CD&T	Interim	Quality Management Software for Clinical	£894,621.94	£485,548.73	No	no	TBC	TBC	No	Sole Supplier of Goods or Services	Standardisation of goods or services	Incumbent supplier moved to										Feb-25					
CAV	(2024/25) 74		SY	03/12/2024	Scott	CD&T	Leica	Rental of an automated, high-capacity digital	£87,937.44	£105,524.93	No	N/A	09/12/2024	31/03/2026	No	Capability with existing equipment or service	National Programmes	The NHS Executive have worked with the supplier to ensure the	This falls into the existing digital		03/12/2024	06/12/2024	RFA to be issued		No	Non Covid	Revenue		Feb-25			
CAV	(2024/25) 80		NP		Daniel	CD&T	Solventum	Upgrade of existing Medicode Clinical Coding	£53,379.00	£64,054.80	No	N/A	16/12/2024	£46,006.00	Not	Sole Supplier of Goods or Services	Bespoke software support and/or	Gambica is the appointed organisation responsible for the commercial arrangements for the whole exhibition / event. They make a block booking at exhibition to keep costs as low as possible.	One time purchase		TBC	TBC		TBC	N/A	Non Covid Activity			Feb-25			
CAV	(2024/25) 86	QU387	ST	12/11/2024	Laura Lloyd-Lewis	CD&T	The Gambica Association Ltd.	MEDLAB EVENT 2025	£6,675.00	£6,675.00	No	N/A	03/02/2025	06/02/2025	N/A	Sole Supplier of Goods or Services	Standardisation of goods or services	Gambica is the appointed organisation responsible for the commercial arrangements for the whole exhibition / event. They make a block booking at exhibition to keep costs as low as possible.	One time purchase		TBC	TBC		TBC	N/A	Non Covid Activity			Feb-25			
CAV	(2024/25) 79	CR1250	BD	12/11/2024	Lisa Franklin	Executives	Sensory Integration Education	Sensory Integration Education Postgrad Courses - L7	£29,022.50	£34,827.00	No	N/A	02/01/2025	31/03/2025	No	Sole Supplier of Goods or Services	Trials, Testing and Education Programmes	Essential requirement that the training is accredited at level 7 as it will be training Occupational Therapy staff in advanced skills. Proposed supplier is most cost effective option - V&M selected	Potential renewal following STA process, will review within contract period.		TBC - AWAITING MORE INFO FROM END USER			No	Non Covid Activity	Revenue		Feb-25				

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Report Title:	Internal Audit Tracker Update Report			Agenda Item no.	2.5
Meeting:	Audit and Assurance Committee	Public	x	Meeting Date:	04.02.2025
		Private			
Status:	Assurance	x	Approval	Information	
Lead Executive:	Director of Corporate Governance				
Report Author:	Corporate Governance Officer				

Main Report

Background and current situation:

The purpose of the report is to provide Members of the Audit and Assurance Committee (“the Committee”) with assurance on the implementation of recommendations which have been made by Internal Audit.

This report provides an update on the Internal Audit Tracker, providing a brief overview of the work that has been underway since the previous Audit and Assurance Committee as outlined below.

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

Internal Audit Tracker Update

Digital migration onto AMAT (Audit Management and Tracking System)

Since the previous Audit Committee, all open internal audit reports since 2021/22 have been uploaded onto the AMAT system. AMAT now holds all open Internal Audit reports from 2021-2025. Any new Internal Audits will be added to AMAT following Audit Committee.

Support Staff with using AMAT

To support staff with understanding what, why and how AMAT is being used to manage the Internal Audit Tracker, a comprehensive AMAT Guide has been created to support colleagues assigned as action leads who are responsible for updating the AMAT system. This guide, included as an appendix to the report, outlines the importance of audits for the UHB and the benefits of using the AMAT system to manage actions. The guide is available on the Audit section of the Corporate Governance SharePoint page which is under development and will grow to provide toolkits and support for staff. This guide is evolving as we engage with teams to ensure they understand the ask to manage their audit actions on AMAT and to determine local approval processes for actions. To date, feedback has been positive and teams are engaged to update their actions in real time on the electronic system.

Oldest open actions update

An action from the previous Audit Committee was to review the oldest outstanding actions from 2022. We identified 16 outstanding actions from 2022 and undertook engagement exercises with the responsible action leads to understand the position of the action and update. All but two have been closed. The remaining two actions now have revised implementation dates to reflect their position on why the action remains open.

The next phase of our work involves reviewing the outstanding actions from 2023 (39) and training and supporting action leads to update the AMAT system. We will continue to engage with the assigned action leads to explain the purpose of our work and to understand the importance of auditing, and ensure they understand their responsibility in keeping the system updated to ensure the UHB continues to learn and improve from audits.

Internal Audit monitoring

We have established monthly meetings with Internal Audit for assurance to discuss internal audits and a new system is in place to discuss any matters arising, such as extended dates for audit actions, and confirming action closures at a higher level.

AMAT data Key	Description
Due date	Date agreed with audit for UHB to complete action
Date last updated	Date the action was last updated on AMAT
Action Rating	Red = Action priority is high Yellow= Action priority is medium Green= Action priority is low
Progress Status	Fully complete (Approved)= Action Lead completed action & approved locally- no further action Fully complete (awaiting approval)= Action Lead completed action & waiting for local approval Partially complete= Action Lead updated part of the action some elements remain outstanding Partially complete (overdue)= Action Lead updated part of the action and due date of action expired In progress= action updated and within due date timeframe Overdue= action passed due date
Comments/Updates	Action status/updates provided here with date of update.

Current Internal Audit Tracker Statistics

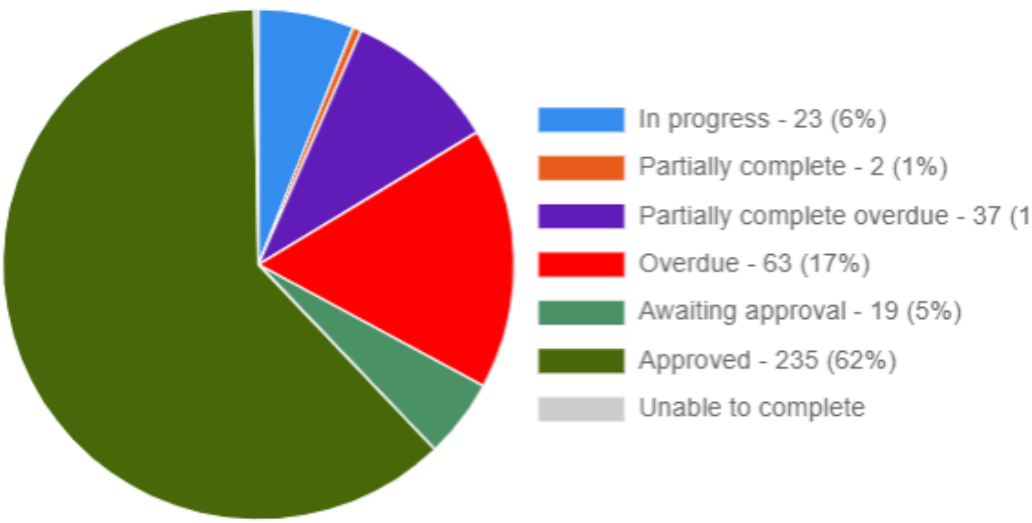
As of the 29th of January 2025, there are 125 actions outstanding:

- 39 are High Priority
- 86 are Medium Priority

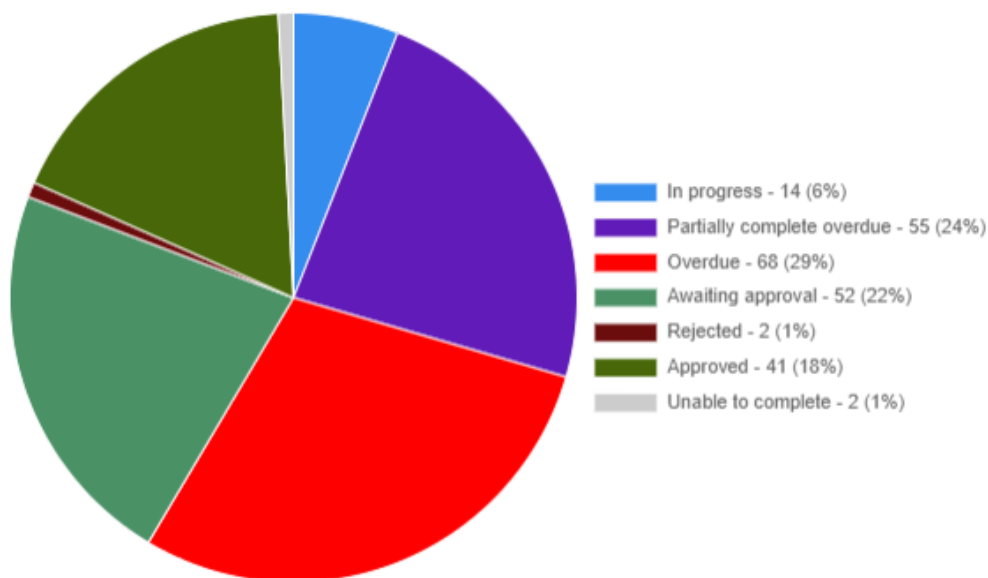
The oldest actions are now from 2023 audits, of which there are 32 outstanding actions of which:

- 8 are High Priority
- 24 are Medium Priority

The image below displays the current data extracted from AMAT detailing the status of the actions.



This can be compared with the chart below presented at the previous Audit and Assurance Committee in November 2024.



Appendix 1 demonstrates all actions from 2022 which have been reviewed and updated since the last Audit Committee meeting.

Appendix 2 demonstrates all open actions from Internal Audits. This overview provides an insight into the age of these actions and when they were last updated.

Appendix 3 is the guide which has been developed to assist colleagues with using AMAT to manage their audit actions.

Next Steps

- Corporate Governance we will be moving into the next phase of engaging with action leads to understand and update outstanding actions from the 2023 internal audits.
- Discussions are ongoing with the AMAT team to enhance the user friendliness of the system to manage audit trackers for colleagues and also for Audit Leads to have visibility of actions for their areas. It is positive that other health boards across Wales are also engaging with AMAT to improve the tracker functionality in this regard. Updates are due to be provided to the AMAT system in Q3 for 24-25 which will include a days overdue function and audit outcome category.
- By the next committee, there will be an additional focus on the Audit Wales tracker being utilised in AMAT following recent discussions with Audit Wales.
- Moving forwards, it is intended that the Audit Trackers will be shared at Audit Committee 3 times a year, unless there is a business need to sight them more frequently.

Recommendation:

The Committee are requested to:

- Note and receive assurance from the progress which has been made in completing management actions that continues to be monitored and updated made by Internal Audit
- Note and be assured by the progress which has been made on transferring to the AMAT system.

Impact Assessment:

Risk: Yes/No

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

Safety: Yes/No

N/A	
Financial: Yes/No	
N/A	
Workforce: Yes/No	
N/A	
Legal: Yes/No	
N/A	
Reputational: Yes/No	
N/A	
Socio Economic: Yes/No	
N/A	
Equality and Health: Yes/No	
N/A	
Decarbonisation: Yes/No	
N/A	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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Inspection Title	Recommendation	Action	Due Date	Date Last Updated	Action Rating	Progress Status	Comments/Updates
Internal Audit - Welsh Language Standards	To ensure complete implementation of Welsh Language Standard 79, the Welsh Language Policy (UHB 462) should be published and available to staff. A review of the Policy would benefit from: - Further signposting to supporting procedures and written control documents; and - The supporting documents should also be clearly dated, also noting the date of next review and the link to the Welsh Language Policy.	Continue review of policy, including supporting documentation. Present initially to Strategy and Delivery Committee for consideration and recommendation to the Board. Present to Board for approval. Upload to website.	15/03/2022	16/01/2025	Amber	Fully complete (Approved)	July 2023 Audit Committee Update - Recommendation re-added following Internal Audit Recommendation. Work is being undertaken with the Shaping Change team to improve the way that risks are managed. January 2025: UHB 462 Welsh Language Corporate Policy in place (approved in May 2022). UHB 513 Welsh Language Inpatient Policy in place (approved February 2024).
Internal Audit - Retention of Staff	The available resources to deliver the Nurse Retention Action Plan and associated workstreams requires review, to determine if current capacity will facilitate effective delivery of the plan and improve nurse retention, if it is a Health Board priority.	The Nurse Retention Steering Group has struggled due to the operational pressures from COVID and Winter. We are optimistic that the pressures will stabilise by the end of March, which will allow the Workstream Leads to take forward the actions that have been agreed. Actions: • Steering Group to continue to meet monthly, these meetings need to have minutes and actions captured. • Workstream Leads will update the Retention Action Plan with key objectives, timescales, progress, etc. • Progress with the plan will be reported into the monthly meetings with the Executive Director of People & Culture in accordance with the theme 'Attract, Recruitment & Retain'.	31/03/2022	16/01/2025	Amber	Fully complete (Approved)	May 2024 IA tracker update: 8a. Update March 2024 Retention Lead appointed and commenced role in Feb 2024, this is a significant forward step. HEIW Self Assessment completed and submitted 31/03/24 meeting the Welsh Government action deadline. This encompassed the whole UHB for nursing. Post assessment completion, a workshop will be held to engage with stakeholders followed by Project Board to identify area to prioritise. ATM these are potentially HCSW across the UHB, MH and MCB. HEIW have appointed the National Retention lead for Wales who started on 01/04/24, UHB retention lead will feed into HEIW and will to a certain extent be driven by that work but we will continue with the local plan. The UHB retention group will be superseded by new workstreams and stakeholders. January 2025 - this recommendation has been superseded by the Nurse Retention Action Plan and the appointment of a Retention Lead, and can be closed. Reporting is taking place through the Non-Pay Elements of the Pay Deal 2022-23 Task 8. Final Grouped is reported to Welsh

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Internal Audit - Welsh Language Standards	As proposed by management, a Resource Needs Analysis to facilitate implementation, compliance and assurance with the Welsh Language Standards should be undertaken.	Undertake a demand, capacity and resource review. Report initial findings to ESWLSG to shape recommendations / actions.	30/04/2022	16/01/2025	Amber	Fully complete (Approved)	Sep 2022 Audit Committee update - Develop, own and report upon progress at the ESWLSG meetings. Action plan templates are currently being drafted. Clinical Boards have begun to appoint Welsh language ambassadors January 2025 - Benchmarking was undertaken in July 2023. This recommendation is no longer relevant and has been superseded. The department have a work plan, objectives and report annually through the Welsh Language Annual Report. The Translation Service has been introduced and the shape of the team has changed slightly. They recommend this action is closed.
Internal Audit - Welsh Language Standards	To continue as planned to ensure there are Welsh Language Champions across all Clinical Boards and Corporate Departments, to facilitate, support and ensure compliance with the Welsh Language Standards.	Create an agreed role description for the Welsh Language Champions. Support CB and Corporate Departments to introduce and embed, learning lessons from areas where this is already in place.	30/04/2022	16/01/2025	Amber	Fully complete (Approved)	July 2023 Audit Committee Update - The Organisational Development Manager has been working with the Welsh Language Team to develop a Resource Needs Analysis. The document is to be reviewed and once agreed will meet the recommendation set. January 2025 - Inclusion Ambassadors in place which includes Welsh Language. Big push undertaken with Clinical Boards and engagement undertaken. It was discussed regularly at ESWLSG between 2022-23.
Internal Audit - Welsh Language Standards	To enhance the maturity of the risk management arrangements, the recording of the risks associated with the Welsh Language Standards should be strengthened to include risk mitigation and the nature of the risk score, to better inform the oversight and assurance forums.	Develop an enhanced dashboard to reflect recommendations. Present to ESWLSG for comment / agreement. Finalise for effective updating and reporting of risk.	30/05/2022	16/01/2025	Amber	Fully complete (Approved)	January 2025 - the creation of a dashboard has not proved possible - to raise with IA.

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Internal Audit - Waste Management	6.1 - Waste signage at storage locations should be reviewed and improved to ensure clear, accurate instructions are provided for waste segregation and disposal. 6.2 - Waste yards should be maintained to an appropriate standard and ensure that waste is correctly stored and segregated	6.1 - Agreed, a review of all bin signage/labelling (ref MA6), will be undertaken. 6.2 - Agreed.	31/08/2022	16/01/2025	Amber	Fully complete (Approved)	Nov 2023 Audit Committee update: Many contract change over has taken place and has resulted in main storage and segregation areas being redesigned. Currently mapping new signage requirements to fit with changes and the increase in waste streams January 2025: waste rooms are labelled. Working with medical illustrations & Comms around waste signage. Corporate H&S have done their first inspection and scored 93%. Waste yards have improved hugely in the past year.
Internal Audit - Waste Management	The UHB should conclude the formulation and operation of Key Performance indicators in respect of contracted parties to complement contractual arrangements.	Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts are currently going through procurement, there is therefore an opportunity to now build these in.	31/08/2022	16/01/2025	Amber	Fully complete (Approved)	Nov 2023 Audit Committee update: Agreed, KPIs to be set for external contractors (ref MA5). A number of contracts have been processed via procurement, and agreed data/kpis are in place. January 2025: complete, all in place.
Internal Audit - Waste Management	Budget processes should be defined, including cost allocation, query, and escalation mechanisms.	Agreed. Process map finance - budget allocation, issues, errors etc., to be detailed (ref MA2). Some areas have already been mapped out since the completion of the audit fieldwork.	31/08/2022	16/01/2025	Green	Fully complete (Approved)	Nov 2023 Audit Committee update: Working with Finance department to realign budgets against individual waste streams. January 2025 - complete, monthly meetings with Finance are held. Paper due to come forward to the Investment Board. Presentations were given via SLB in April and December 2024 around the waste regulations.

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Internal Audit - Implementation of National IT Systems (WNCr)	All digital projects should be subject to a formal governance structure.	A formal project governance structure has been put in place including risk monitoring for the whole of the programme including digital. Formal monitoring will be provided via the WNCr Board meetings and any digital risks arising will be reported upwards to exec director level and, if necessary, to the Senior Leadership Board (formerly HSMB). Regular updates will also be submitted to the Digital & Health Intelligence committee.	31/10/2022	24/01/2025	Amber	Fully complete (Awaiting approval)	July 2024 IA tracker update: June 2024 - Audit completed by external supplier. Report submitted to network team to indicate extent of WiFi coverage. For network team to progress this work. Jan 2025 - ToR of programme board and governance structure previously shared as part of external audit. Updates provided to Nursing and Midwifery Board. WNCr programme progress also monitored by digital PMO and updates to digital advisory board
Internal Audit - Medical and Dental Staff Bank	Management need to ensure that they meet regularly with Medacs, in accordance with the requirements of the Framework Agreement, so that the performance is regularly reviewed, and any issues can be discussed during the meeting.	These meetings are now scheduled monthly. Audience to include, Head of Medical Resourcing and Systems, Deputy Director of People & Culture, Deputy Medical Director and Medacs Healthcare.	31/10/2022	16/01/2025	Green	Fully complete (Approved)	Nov 2023 Audit Committee update: No updates received. January 2025 - complete. Daily discussions are ongoing.
Internal Audit - Medical and Dental Staff Bank	Rota-Coordination need to ensure that shifts are made available in a timely manner on the Envoy system to ensure a greater chance of take up by Bank Staff. In instances where the Rota-Coordinator is unavailable, contingency and cover arrangements should be considered.	Short term absence will inevitably take place which will not always allow for a shift to be put on prospectively e.g. same day sickness etc. There will also be occasions whereby a locum will be required over a weekend/bank holiday that was not planned within the week and as the rota co-ordinator only work M-F/BH this will require action on their return. We can adopt a measure that all retrospective shifts are to be put on no later than 72 hours. The Medical and Dental Staffbank team will create a communication to go out to all service areas to update them of the above and will monitor over the next quarter to monitor adherence and report into MWAG.	31/10/2022	16/01/2025	Amber	Fully complete (Approved)	Nov 2023 Audit Committee update: Communication was sent out. New Patchwork system introduced (in place of Envoy). Updates provided to MWAG January 2025 - complete.

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Internal Audit - Medical and Dental Staff Bank	Management need to review the 'Recruitment of Locum Doctors and Dentists Operational Procedure' (UHB 131), which has been superseded by online resources and consider whether they update it in line with current processes.	The 'Recruitment of Locum Doctors and Dentists Operational Procedure' to be deleted off the online resources as the new Terms of Business for the Medical and Dental Staffbank now override.	31/10/2022	16/01/2025	Green	Fully complete (Approved)	Nov 2023 Audit Committee Update: Old documentation deleted. All locum provision is actioned via the Medical Managed Bank. All current documentation can be easily accessed via the Internet/SharePoint. Rescinded in the People & Culture Committee in January 2024.
Internal Audit - Medical Equipment	The Medical Equipment Group should seek assurance from its members that they have raised the awareness of the revised policy and procedure within their areas of the Health Board, to ensure staff are aware of any changes to their responsibilities.	Add agenda item to next MEG and MDSO meeting, asking membership to disseminate Policy and Procedure to ensure their staff are aware of the new versions. Senior Leadership Board to discuss policy and disseminate the revised policy.	07/12/2022	17/01/2025	Amber	Fully complete (Approved)	Jan 2025: All actions above are now complete.
Internal Audit - Implementation of National IT Systems (WNCr)	A project plan should be developed that shows the scheduling of wards, and the processes required to implement within wards, along with the timescales and resource requirements.	There are two components to this recommendation: 1. Development of an implementation schedule A provision roll-out schedule was devised in March 2022. This schedule indicated the data for implementation and equipment required on each ward. However, further WNCr implementation is unlikely to progress in the UHB until April 2023. This pause is necessitated to accommodate the launch of another digital platform Safecare. The UHB will also enter its ePMA implementation phase in April 2023. Actions: - Revise the WNCr roll out schedule in response to the Safecare and ePMA schedule (in to prevent wards having to adopt more than one digital platform at a time). Include within this schedule: • Number of colleagues to train • Quantity/type of equipment to deliver • Training times • Post 'go live' support times	31/12/2022	24/01/2025	Amber	Fully complete (Awaiting approval)	July 2024 IA tracker update: June '24 - Managed devices, using cisco solution and DHCW provided KPI certificates, are being tested. Further configuration required, but ePMA demo event and e-triage have needed to be prioritised for past 2months. Hoping device management team will be able to support imminently. Awaiting business continuity solution to be signed off by IG/Cyber. January 2025- Roll out complete at community hospitals and UHL. UHW implementation expected completion by May 2025. Progress is tracked at national service management board for WNCr.

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Internal Audit - Waste Management	A critical review of waste volumes and types across the UHB should be considered, to identify potential for waste minimisation in accordance with WHTM 07-01 (5.3 - 8)	Agreed. A critical review of waste volumes and types across the UHB will be considered to identify potential for waste minimisation. This is currently in progress.	31/12/2022	16/01/2025	Green	Fully complete (Approved)	Nov 2023 Audit Committee Update: A review of waste streams has been underway and linked with procurement tendering process for many waste streams 23/24 will be a year of collating data on all waste streams inclusive of increased recycling of UHB wastes January 2025: reduced black bag waste by 40%. They do monitor through KPIs all of their recycling and clinical waste. Monitored monthly. Rollout of new recycling requirements by April 2026, meaning month on month the recycling targets will be increased.
Internal Audit - Implementation of National IT Systems (WNCR)	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue. The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; • Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months.	31/12/2022	08/01/2025	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - WNCR continues to progress from a Digital point of view with the deployment of the first 50 iPads and testing. The rest of the devices are scheduled to be deployed subject to approval of testing in Q2/3 2024.

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Internal Audit - Medical Equipment	A periodic review of the Medusa medical equipment database should be undertaken to ascertain the status and current use of loaned medical equipment items. At the next review, the Management of Medical Equipment Procedure should be revised to provide guidance relating to the recording, oversight and active management of externally loaned medical equipment items.	The commissioning process for long term loan equipment will be changed to record information regarding the basis of the loan where available. Users will be reminded via the MEG and MDSO groups to record or share this information. The action in recommendation 4 will serve to audit old, loaned equipment.	01/02/2023	20/01/2025	Amber	Fully complete (Approved)	Nov 2023 Audit Committee update: Recommendation re-added following Internal Audit Recommendation. [EC aDoTH 10/23] Please could we extend implementation date to May 24. Discussed loaned equipment at December 2022 MEG, and requested that users inform CE of basis of loan agreements. Medical Equipment Procedure is currently being updated to include guidance to capture information as required in the recommendation. [Jan 2025] Closed, Medical Equipment Policy will be updated with the guidance and the equipment lists will be sent out.
Internal Audit - Medical Equipment	All medical equipment items that have undergone local decontamination prior to submission to the Clinical Engineering Department should be supported by a completed Contamination Status Clearance Certificate and the issuing book should be retained by the Emergency Unit. Additionally, the Management of Medical Equipment Procedure should be revised and updated to reflect the Ward/Unit based decontamination processes.	Clinical Engineering will work with the EU management to ensure decontamination certificates are available and completed. The Medical Equipment and Devices task and finish group will include the decontamination process in their revisions of the Policy and Procedure.	01/04/2023	20/01/2025	Amber	Fully complete (Approved)	Recommendation re-added following Internal Audit Recommendation. [EC aDoTH 10/23] The revision of the policy is a significant piece of work, would a draft version containing this process would be sufficient evidence, otherwise and extension to December 2024 may be required. EC (aDoTH Med Equip) met with EU manager Craig Davies to discuss decontamination and cleaning equipment in the EU. There is now a HCA with responsibility for medical equipment who will assist the department in meeting this recommendation. Explicit guidance on the need for decontamination certificates will be included in the revised Med Equip Procedure. Jan 2025, Medical Devices procedure will be updated as above.

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Internal Audit - Implementation of National IT Systems (WNCR)	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCR implementation - Use of WNCR analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	03/08/2023	24/01/2025	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - Ongoing. Awaiting WNCR roll out January 2025- implementation to UHW beginning. Benefits realisation ongoing and can not be completed until roll out concluded. MSc student undertaking benefits realisation work relating to pressure damage. DHCW have undertaken initial baseline work to support.
Internal Audit - Medical Equipment	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	31/01/2025	17/01/2025	Amber	Partially complete	Nov 2023 Audit Committee update: Implementation date moved to December 2023 EC aDoTH 10/23] Practice education meeting has been re-instated, meeting was held 09/10/23, waiting to get ToR and attendance. SBAR for staff resource not proceeded with in current financial climate, review in next FY. Initial discussions seem to indicate Allocate (Health Roster) already has the competency module. Recommend moving implementation date forward 12 months to Dec 2025 or closing. We can provide evidence of training for high risk devices, ECOD do not have records themselves as far as we are aware. Progress report 06/2023, EC (aDoTH, Med. Equip.) is working with colleagues in Clinical Engineering and senior nurses in CD+T to re-establish the practice development network, linking in with ECOD. An SBAR for staffing resource to support a training records system is going to be produced. Recommend making this action a longer term goal, December 2024.

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Internal Audit - Medical Equipment	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	30/06/2025	20/01/2025	Amber	Partially complete	Nov 2023 Audit Committee update: No, a further extension to the implementation date is required. Feb 2024. [EC aDoTH 10/23] Please extend to May 2024 . The member of staff tasked with this (and other actions) has left since the July update and we are recruiting a replacement. Some preparatory work has begun on the audit, but operational pressures and lack of staff resource have delayed further progress. Implementation date changed to May 2023 to allow time to train staff and carry out work. [Jan 25] PowerBI software enviroment now working correctly, new target date of 30/06/25

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Inspection Title	Recommendation	Action	Due Date	Date Last Updated	Action Rating	Progress Status	Comments/Updates
Internal Audit - Implementation of National IT Systems (WNCR)	Noting the improvements in communications with DHCW. The UHB should build on this by ensuring it is aware of the 3-5 year DHCW plan and the level of expected resource commitment from the Health Board for each item. This should feed into the C&V planning process.	Working with DHCW executive director colleagues, the national DHCW plan will be reviewed to ensure there is alignment with C&V's own strategic plans. Once the DHCW plan is available to C&V, we will incorporate into our strategic roadmap and planning process. The existing communication arrangements will continue. The process established includes: • Digital Directors Peer Group. At which DHCW provide an update of their plans and ongoing work; • Quarterly planning sessions with the Health Board and DHCW. These are two way and aim to ensure that plans are synchronised and allow the Health Board to influence and help inform the DHCW plans; • Informal executive to executive meetings planned for every 3 months.	31/12/2022	08/01/2025	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - WNCR continues to progress from a Digital point of view with the deployment of the first 50 iPads and testing. The rest of the devices are scheduled to be deployed subject to approval of testing in Q2/3 2024.
Internal Audit - Staff Wellbeing Culture and Values	The 'Board Assurance Framework Risk: Staff Wellbeing', should be reviewed to ensure key actions being taken to address the Occupational Health referral wait times are included. Where gaps in controls and assurances are identified these should be considered too.	Development is underway to ensure the KPIs of the People Health Services Team, which includes Occupational Health, Physiotherapy, and Employee Wellbeing Services are reported upon monthly as part of the wider reporting within People and Culture. This will be added onto the Board Assurance Framework. It is important to note that the issue is exacerbated by absence within the team due to sickness absence, and the relevant support is being provided to staff to enable timely return to work, including phased return etc.	31/01/2023	03/12/2024	Amber	Partially complete (Overdue)	IA May 2024 tracker update: Following the implementation of the new Occupational Health software system, monthly KPI reporting has been recommenced for the majority of reports and work is ongoing to develop further. These KPIs are aligned to the national Occupational Health framework which is currently in development with Welsh Government, Trade Union, Workforce Directors and Occupational Health involvement. Long term sickness absence continues to impact on service delivery, however waiting times for management referrals are currently being mitigated with support from CTM Occupational Health Service as part of the collaboration. The format of the UHB BAF is currently in review and being overseen by the Executive Director of Corporate Governance.

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Internal Audit - Staff Wellbeing Culture and Values	The monitoring arrangements for the Wellbeing Plan should be enhanced to ensure the timely delivery of agreed actions, within agreed funds available.	The UHB are currently developing the Wellbeing Strategy and Framework, which will include information on measures and monitoring. This will be put to Board for approval in February 2023. The Assistant Director of OD, Wellbeing and Culture is currently working with the Innovation and Improvement Team to develop the monitoring mechanism for the wellbeing projects, which will align with the measurements under the P&C Plan.	28/02/2023	03/12/2024	Amber	Partially complete (Overdue)	IA May 2024 tracker update: Emerging priorities including cultural work have led to a delay in the development of the H&WB Framework. A Working Group has been established and an initial conceptualisation meeting held. The working group includes a cross-section of representation from the H&WB Steering Group, including TU Partners. Development work is planned for April/May 2024, with a framework to be presented to P&C Committee in July 2024.
Internal Audit - Charitable Funds	An annual operating plan for the fundraising department should be submitted to the Charitable Funds Committee at the beginning of each financial year. The plan should provide specific details regarding the structure of the department, individual staff costs and also non staff costs. Details should also be provided of an estimate of staff costs that can be recharged to specific appeals and funds that the fundraising staff support noting the net costs that can be expected to be recharged to the 'general fund'. An update on the plan should be reported at each meeting of the Charitable Funds Committee noting any changes to the structure that will impact on the 'recharge' to the general fund.	The Health Charity is currently reviewing its strategy and in line with good practice has been engaging with CFC members and others to review and redevelop it collaboratively. Part of the strategy review entailed a recognition to include an Annual Operational Plan. This will be developed in Quarter 1 of 2023 and will be reviewed agreed via the Charitable Funds Committee and be embedded as part of its annual governance reporting mechanisms. This will include staff structure, costings and projections on any identified changes to the core staff establishment that require additional funding. Operational changes to staffing, responding and reacting to workforce or project requirements that do not require additional funding from general reserves, specific funds or have external funding will continue to follow the current reporting mechanisms and sign off via the Day to day operational responsibilities of the Director of Communications and sign off by the lead Executive as identified under section 2.27 above.	01/04/2023	21/11/2024	Red	Partially complete (Overdue)	8 July 2024 The Health Charity Strategy and Operational Plan has been paused whilst the team go through an Operational Change Process (OCP) The Health Charity has developed a draft Operational Plan for 2023/24 which has been submitted to the quarterly Charitable Funds Committee meeting scheduled for 20.06.23*. The plan includes projected income/expenditure and current/projected staff costs for this period. The Health Charity and Charitable Funds Finance team are working collaboratively to ensure that the projected financial plan is regularly revised and updated to reflect actual income/expenditure, which will be reported back to the CFC meetings via a newly developed Events reporting template. This template will also be used to report operational staff changes. *Subsequent annual reports will be submitted to the CFC meeting in the first quarter of each year, i.e. Jan - March, outlining the plan for the following financial year.

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Internal Audit - Core Financial Systems (Treasury Management) Jan 2023	The Treasury Management (Incorporating Cash Forecasting and Bank Account Controls) Financial Control Procedure should be strengthened as follows: - The requirements of the Standing Financial Instructions, section 7.3.1 (d) Banking Procedures should be addressed; - Consideration of developing, if not included within the FCP, a separate procedure to cover the access and control arrangements of the online banking system, Bankline; and - To enhance resilience, the inclusion of the process for developing the monthly cashflow forecast, which is a key document used to inform Welsh Government on a monthly basis of the Health Board's cash requirements.	- Agreed to revise FCP to include the requirements of 7.3.1 (d) also addressed in point 2 on management actions. - Agreed FCP to be updated to include control arrangements for access, inputting and authorisation of the online banking system. - Agreed to update the process document for developing the monthly cashflow	31/05/2023	05/12/2024	Amber	Partially complete (Overdue)	Action points 1 & 2 have been completed in full. Point 3 - Monthly Cashflow - The FCP has been updated to address the points outlined in the internal report. The department has commenced a review of the cashflow process; it has become apparent that this review is quite extensive, taking into account the modernisation agenda and priority areas for improvement in the current system. Therefore, taking all these factors into account, it has been identified that cashflow modernisation/ review will be an ongoing process for the remainder of this financial year. An interim SOP has been developed as of April 2024, while the cashflow review is ongoing. The cashflow review will recommence post yearend, July 2024. July 2024 - The new "monthly cashflow" model is currently being parallel run for 3 months, alongside the existing (historical) cashflow process. The trial period shall run until 31.10.24, if successful, the changes
Internal Audit - Inclusion and Equality	Management should ensure that a robust process is in place to enable the required action plans to be effectively developed and delivered. This should include effective structures to support the Inclusion and Equality Team, including development of the Inclusion Ambassadors and Equality sub-groups.	The review and refresh of the TORs of the ESWLSG (Action 1), will reinforce the reporting and local accountability against equality actions, while enabling a forum that shapes strategic direction against EDI (and Welsh Language). The reviewed TORs will include reporting accountability for Clinical and Service Boards, along with reporting to the People and Culture Committee, and Board.	31/05/2023	05/12/2024	Amber	Partially complete (Overdue)	May 2024 IA tracker update: A Terms of Reference for a future iteration of ESWLSG has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. Awaiting a decision from the Director of Corporate Governance.
Internal Audit - Community Patient Appliances (Specialist Services CB)	The Service should review the reporting capabilities of the BEST system to improve the level and type of management information being made available to management so that issues are identified and addressed.	1. Provide a report of repair status at fortnightly PMS Operational Meetings (as per action 5b) 2. Ensure audit of repair jobs in BEST as part of ISO 9001 audit cycle.	30/06/2023	22/11/2024	Amber	Overdue	

Internal Audit - Inclusion and Equality	A review of the Terms of Reference along with the membership and remit of the ESWLSG is required by management, along with the formation of subgroups to facilitate decision-making and implementation.	The Terms of Reference, including membership and governance requirements of the ESWLSG are currently under review. This review will be informed by the governance surrounding the UHB's Equality, Equity and Experience Framework (currently at consultation), the requirements of the People and Culture Committee and the outcome of this audit. This review will include the identification of any required sub groups / steering groups / working groups and subsequent membership requirements and TORs.	31/07/2023	05/12/2024	Amber	Partially complete (Overdue)	May 2024 IA tracker update: The Terms of Reference for a future iteration of ESWLSG has been drafted for consideration by the Health Board. However, a decision regarding the future of the group is currently on hold whilst considerations regarding the future of equity, equality, inclusion and its management within the Health Board are underway. In the meantime, matters in relation to equity, inclusion and the Welsh language are reported directly to the People & Culture Committee. The Head of Equity & Inclusion is a regular attendee at the committee. Awaiting confirmation from the Director of Corporate Governance.
Internal Audit - Data Warehouse	As the LDR is developed, the department should prioritise the development of replacement feeds from the LDR for those feeds that are currently a manual process.	An assessment of manual data feeds will be undertaken to identify and document which would be suitable for and benefit from migrating to the LDR. Note actual redevelopment of feeds would be subject to resource and prioritisation in the longer term.	31/07/2023	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - No Update Mar 2024 - new data feeds are assessed for their suitability to be managed via the LDR however resource constraints in both the warehouse and LDR teams mean replacing existing manual feeds are not currently a priority.
Internal Audit - Data Warehouse	The database should be upgraded. A patch strategy should be defined and implemented.	The PMS database is planned for upgrade in September/October 2023. Following the upgrade of PMS, the Data Warehouse database will also be migrated to the latest Oracle database and be included within our new Oracle Goldengate infrastructure. A patching strategy will be implemented for both the PMS and Data Warehouse databases.	31/07/2023	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: July '24 - This work cannot start until the PMS migration completes. We are not expecting this to complete until the later this year (Oct/Nov) Mar '24 - Further delays, again outside our control, have put the migration on hold. The PMS 11g database must be patched to allow Goldengate to be implemented. The SBAR has been presented and approved, work is scheduled to restart with Oracle 15th April.

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Internal Audit - UHW Hybrid and Major Trauma Theatres	1. The SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. The UHB should confirm that appropriate insurances are in place in respect of the SCP. 3. At future projects Contracts should be executed prior to the commencement of works / duties. 4. At future projects All contracts should be dated.	1. Agreed - the SCP Call off Contract will be resubmitted for signature by the UHB Chair. 2. Agreed the UHB will confirm at the earliest opportunity that appropriate insurances are in place in respect of the SCP. 3. Agreed -Future Projects Contracts will be signed prior to the commencement of works. 4. Agreed - Future Projects - Contracts will be dated.	31/07/2023	22/11/2024	Amber	Partially complete (Overdue)	Items 1 & 2 will be addressed when the scheme re-commences. Items 3 & 4 being addressed at all future projects
Internal Audit - New IT service Desk System	1.1 A Standard Operating Procedure should be developed for the monitoring of open calls and calls set to 'Waiting for Customer' status. Customers with calls set to 'Waiting for Customer' status should receive two reminders, and these calls should be closed if the customer fails to respond after the second reminder. 1.2 Consideration should be given to making the target resolution date a mandatory field for all calls.	1.1 Service Desk Standard Operating Procedures have been created as part of the implementation. Standard reporting within the software has been configured to report Incidents and Service Requests which has passed baseline SLAs. Advanced reporting is currently being installed and configured using dynamic Microsoft Power Business Information reporting tools. 1.2 Target resolution date is already configured within the system, as this is linked to the SLA. Inclusion of a target resolution date is difficult to predict for nonstandard requests due to external factors, however, an indicative date will be included.	31/07/2023	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: June '24 - Open calls can be reported on through the PowerBI setup available on Teams but waiting on calls is in development. We are looking to automate the reminders. Target date is a predefined field and exists on all calls. SLTs for service requests - service level target dates and SLAs for incidents. These need to be agreed with other teams and departments.

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Internal Audit - Community Patient Appliances (Specialist Services CB)	Stock counts of the Treforest Unit Stockroom should be undertaken on a monthly basis, and the results shared with Finance and senior leads from the service to ensure prompt investigation into stock balance issues.	1. Recruitment underway to support increased staffing in PMC stock, as well as introducing more senior roles to provide greater cover, which in turn will allow regular rolling stock takes across the year culminating in comprehensive annual stock takes at year end. We have also been working closely with the Directorate Accountant who is supporting with our end of year stock take. 2. Governance: - We will adhere to the Corporate stock take guidance issued by Financial Accounts (including the use of sequential numbered stock-count sheets).Evidence: Comprehensive guidance from Financial Accounts has been distributed to senior management as well as stock leads. This is evidenced through emails as well as F2F and team meetings. There is an exception which should be highlighted in relation to numbered stockcount sheets, whereby this is not possible for wheelchairs due the barcoded system. We do however have another robust procedure planned at month end, which will be implemented in	31/07/2023	22/11/2024	Red	Overdue	
Internal Audit - Implementation of National IT Systems (WNCr)	The baseline assessment should be fed into a benefits register, and a benefits assessment and realisation process should be included within the project plan.	A benefits register will be developed to record: - Digital skills of nursing workforce - Comparison of documentation completion rates before/after WNCr implementation - Use of WNCr analytics to inform improvement work - Staff feedback - Patient feedback (undertaken by patient experience team) - Cost savings (based on removal of paper documents) - Time savings	03/08/2023	24/01/2025	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - Ongoing. Awaiting WNCr roll out January 2025- implementation to UHW beginning. Benefits realisation ongoing and can not be completed until roll out concluded. MSc student undertaking benefits realisation work relating to pressure damage. DHCW have undertaken initial baseline work to support.
Internal Audit - UHW Hybrid and Major Trauma Theatres	The UHB should consider putting in place a dedicated Project Board for this scheme ahead of the Construction phase commencing to ensure appropriate oversight.	Agreed – Director of Capital, Estates & Facilities to initiate discussions with an aim to take forward within the UHB. This will not be finalised until Welsh Government approval of funding has been approved, therefore target date will need to be reviewed.	31/08/2023	22/11/2024	Amber	Partially complete (Overdue)	A dedicated Project Board will be established following approval of the scheme by WG

Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	The Directorate General Manager should ensure that there is a job plan on the Allocate e-Job Planning system for all Consultants.	Orthopaedics - Missing consultants are currently being added to eAllocate, and their job plans will be signed off by 30/09/2023.	30/09/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update - All consultants are on eAllocate in T&O.
Internal Audit - Inclusion and Equality	To ensure compliance with the organisation's objectives and legislative requirements, management should undertake a review of the responsibilities of the team members and the structures in place within the Health Board to support the team.	The People and Culture Directorate will commence a benchmarking exercise to assess the effectiveness of current capacity compared to other NHS organisations. This is not restricted to the Equity and Inclusion Team, but also looking at Welsh Language, and Education, Culture and OD. This is being looked at alongside the UHBs commitment to delivering the SEP, meeting its SocioEconomic Duties, and responding to WG direction, including the Anti-Racist Wales Action Plan; WRES etc. This will be completed, and the UHB will be presented with a paper, outlining the findings, team capacity findings highlighting any areas of risk / any short-falls. This will go to the People and Culture Committee in the first instance.	30/09/2023	05/12/2024	Red	Partially complete (Overdue)	May 2024 IA tracker update: The benchmarking exercise has been completed and a paper discussed with the Executive Director of P&C in the first instance. Current organisational demands have highlighted areas of risk around organisational development, culture, leadership, workforce planning and analytics. Work is currently underway to prioritise organisational to inform further investment. Business Case currently in development to be presented April 2024. The department recognises a limited resource within Equity & Inclusion; however, the current financial climate impacts on the ability to move forward with this. This will continue to be logged as a risk. with a view to revisit in 2024. The business case to be presented to the IG in October 2024.
Internal Audit - Capital Systems 2023/24	Project Issues Form's will be completed for all project changes to demonstrate compliance with delegated limits.	Agreed – the Health Board have already commenced transitioning to this approach.	30/09/2023	10/07/2024	Amber	Overdue	
Internal Audit - Capital Systems 2023/24	Project officers should ensure that returned contracts and Chair's action are signed, initialled, and dated consistently.	Guidance will be issued across the Project Management and Executive cohort to remind approvers of the importance of clearly dating formal documents when signing.	31/10/2023	10/07/2024	Amber	Overdue	
Internal Audit - Data Warehouse	Leads for data use should be identified within Clinical Boards in order to facilitate better links with Digital. Lead contacts for each Clinical Board should be defined within Digital, within the constraints of the staff resource available.	List of current digital coordinators in clinical boards will be reviewed and gaps identified. D&HI will work with Clinical Boards who haven't nominated a coordinator to demonstrate the benefits of the approach.	31/10/2023	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - No update Mar '24 - New business structure4 to support additional reporting being developed to include dedicated BI partners aligned to each Clinical Board (May '24)

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Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	General Surgery - The General Surgery Directorate Manager should consider whether the Administrator role could be allocated to existing Directorate staff on a temporary basis, until a permanent Administrator is recruited, to ensure that monitoring of delivery of agreed sessions is undertaken. Orthopaedics - The Orthopaedic Surgery General Manager should ensure that the monitoring of Consultant activity is undertaken regularly for all Consultants, and a record is maintained to evidence all monitoring undertaken.	General Surgery Monitoring exercise complete. Includes data from other clinical boards, where activity also takes place. Orthopaedics I don't necessarily agree with the following: "we were unable to obtain evidence that monitoring is being undertaken for all Consultants on a regular basis". Monitoring is performed every week within the 6-week planning cycle. Consultants, unless on leave, will be booked for all their clinical commitments, and said schedule won't change unless there is sickness or emergency leave. If a consultant's session cannot be delivered as expected, it will be converted in something else that is of good use for the service. It is a "never event" that a consultant does not deliver their DCC despite being scheduled for them. It has happened on rare occasions in the past, and disciplinary procedures were triggered immediately. The recommendation was referring to the fact that an audit trail of the monitoring is not kept retrospectively. We agreed that we	31/10/2023	20/01/2025	Amber	Partially complete (Overdue)	July 2024 IA tracker update: Monitoring is performed every week within the 6-week planning cycle. Consultants, unless on leave, will be booked for all their clinical commitments, and said schedule won't change unless there is sickness or emergency leave. If a consultant's session cannot be delivered as expected, it will be converted in something else that is of good use for the service. It is a "never event" that a consultant does not deliver their DCC despite being scheduled for them. It has happened on rare occasions in the past, and disciplinary procedures were triggered immediately. The recommendation was referring to the fact that an audit trail of the monitoring is not kept retrospectively. We agreed that we will link with General Surgery and will implement their template.
Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	Orthopaedics and General Surgery - Whilst it is acknowledged that Covid has had an adverse impact on Consultant job planning, it is an important process, and greater efforts should now be made to get Consultant job planning back on track through the undertaking of annual reviews when they become due.	Orthopaedics The current service changes have slowed down this process and we are now catching up with updating all of them on eAllocate. General Surgery Consultants were job planned between May 2022 and September 2022, the new round of job planning is currently taking place. Need to have 1 year of monitoring to be able to inform the job plan discussion. Unable to rectify appropriate start date. There was also a transition in practice for the emergency work as SDEC was opened in July last year which is why job plans weren't signed off straight away as this needed to be agreed by the consultant body and the clinical board.	31/10/2023	20/01/2025	Red	Partially complete (Overdue)	

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Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	3a - Orthopaedics and General Surgery All Consultant job plans with more than 12 sessions per week should be approved in line with the Consultant Job planning Procedure. The approval should be evidenced on the Allocate system using the third sign off field.	3a Orthopaedics Consultants who are working on a 12 sessions job plan were authorised in previous years, and as service changes did not impact their sessional allocation, it has not been changed. However, as per the audit team request, we will action 2.1 a and b and make sure a third sign-off function is enabled. General Surgery Discussed with the CBD and the AMD for workforce, this was fed back on many occasions to the MD's office. A number of General Surgeons also have extra sessions in their job plans for external duties/responsibilities with Welsh Government, MoD and the University.	11/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: 3a Orthopaedics - this change would affect the entire organisation and possibly compliance will decrease. This function won't be enabled at present, at it showed as not bringing any added value.
Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	Orthopaedics and General Surgery - Directorate management should ensure that all Consultant job plans include personal outcomes and service (Clinical Board) outcomes, and that personal outcomes are linked to service outcomes.	Orthopaedics Once clinical board outcomes are assigned to each consultant, the personal outcomes will be specified and attached to them. General Surgery Clinical Board Outcomes to be set by Clinical Board Triumvirate. Team job planning will inform the service outcomes along with expectations for delivery following annualization.	11/11/2023	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: 2a - The system does not send reminders, however it will move expired job plans into the "Expired" category, which will trigger a job planning meeting. In terms of compliance, all job plans have been defined, however on e Allocate only 19/35 have been signed off. 11 awaiting clinician sign off, 5 in discussion, however will be sent for sign off soon.

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Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	There should be a review of the level of Programme governance activities required, and the viability of progressing with the aim of developing a SOC, until wider concerns over affordability / funding models have been addressed: to be approved at Board / SOFH Committee level.	Agreed. This will be informed by the outcome of the clinical review and attendance at WG IIB. Executives met with WG at the beginning of September to understand likelihood of funding. There is currently no line of sight to funding but have been invited to an IIB in on 13/11/23. Programme Boards and Project Boards have been stood down. The outcome of discussions with WG along with the Nuffield report should drive a review of next steps and Governance (including frequency) and the assistance of the Corporate Governance team will be requested. This said, communication from WG was pointing to funding before the NHS Wales cost pressures changed messaging to be less certain of funding the SOC. The SRO and PD had been keen to maintain rhythm of governance within C&V and the need for SOFH to be progressed given unsustainable estate condition. The members of the Programme Board attended monthly meetings reliably, however given the	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.
Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Noting the current wait for funding, it is timely to evaluate terms of reference and governance structures to ensure each forum is appropriately focused.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB. The SOC production is considered a project and was being reported into the Programme Board. As the only project, it was the only Project Board. It is acknowledged that it is in the programme's early stages and the only group meeting, the Project Board was also covering more general ground by updating stakeholders on matters.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.

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Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	The above review may include consideration of reinstatement of the SOFH Committee, or utilisation of an existing Committee, to provide periodic scrutiny and oversight of programme activities.	Agreed. This will be informed by the outcome of the clinical review and forthcoming attendance at WG IIB.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.
Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	A Programme / Project -specific Scheme of Delegation should be developed.	Agreed.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.
Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	The workstream governance structure should be clearly and consistently presented in key governance documents.	Agreed - the observation is understandable. The inconsistency reflects work that was in flight when documents were provided for the audit - where the PID hadn't caught up with the sub-documents having been updated.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.

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Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Working groups should be clearly defined, with terms of reference in place to identify memberships, governance arrangements etc. These should be distinct from normal UHB operations, to ensure the Programme receives the necessary focus and to support clear monitoring and reporting performance.	Agreed. Terms of reference were developed for workstreams and presented at the May project board during/post the audit review. Given the expectation of funding, it was prudent to plan the SOC to be efficient with time so we were relying on existing leaders to spare the time to assist and participate. In the absence of confirmed funding, there has been limited time colleagues have been able to commit alongside the 'day-job.' Receipt of funding would have enabled the recruitment of dedicated resource for SOFH (and SOFCS) work. Our approach did see planning progressing at differential paces and in the future needs either dedicated time from matrixed resources or dedicated resources from the workstreams assigned to the programme. To be considered as part of the governance and resource review recommended in this report.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.

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Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	There should be a detailed review of the resources required as the UHB moves through the Programme, from SOC, to OBC and onwards, using an activity-based resource schedule. Resource schedules should be agreed with key departments and individuals to ensure risks and limitations are fully understood. Where funding bids are adjusted downwards, reporting to key forums should be clear as to the gaps this will leave in skills / capacity and the associated risks to programme delivery.	Agreed. Our plans did acknowledge the pre-requisites of the Clinical Model and Estate baseline work as early pre-requisites. The approach to understanding the estate condition has changed, with the SOC initially expected to rely on existing data. More recently, with a potential for consideration of a do minimum option, we recognise there is a need to update this data to accurately reflect current risks. When funding was looking likely to arrive, preparing to procure an external advisor was work that was decided could start. Preparing for this exercise was right at the time and was happening in parallel with planning. This procurement work is now on hold and no tender will or can be progressed without a plan being complete and committed to along with a clear line of sight to funding. The point about a low level of resource request is noted and has been a subject of ongoing internal discussions since submission. We will consider our options upon the imminent receipt of a report from the Nuffield Trust on the clinical model described in our PBC.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.
Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	Governance forums should receive clearly distinguishable highlight / flash reports focusing on the assigned responsibilities of the reporting forum. Workstream highlight reports should be enhanced to clearly present performance information and associated risks.	Agreed.	30/11/2023	05/12/2024	Amber	Overdue	July 2024 IA tracker update: The team has been disbanded and handed over to Director CEF. An IIB was held on 30/5/24. Outcome awaited regrading the progress on funding a condition survey and a masterplan. Formal governance arrangements to be determined.

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Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	2a - Orthopaedics and General Surgery Directorate management should review the current process for agreeing and signing off Consultant job plans with a view to streamlining the process. Arrangements should be put in place to ensure that all Consultants within Orthopaedics and General Surgery have up to date, signed off job plans as soon as practicably possible. Given the delays in agreeing and signing off job plans, consideration should be given to the feasibility of recording the end date of job plans as 12 months from the date they were agreed and signed off, rather than 'ongoing'. 2b - Orthopaedics and General Surgery All job plans should include Clinical Board (service outcomes), the achievement of which should be subject to annual assessment.	2a - Orthopaedics All job plans will be signed off by the 31/10/2023, including the newly added ones. End dates will be set up so that a reminder of job plan renewal and update will be triggered after 12 months of sign-off date. Because of the recent changes in the service, numerous consultants are still in the process of signing off. 2b - Orthopaedics Outcomes and objectives will be assigned to each job plan, and will be aligned to the clinical board deliverables for the current financial year. 2a - General Surgery In General Surgery there is a process in place for job plan sign off, however not all job plans have been straightforward and have been complicated by enforced regionalisation. Start dates on the Allocate system were incorrect, this has been rectified by the project manager for Allocate. All job plan meetings had taken place (8 signed off, 6 consultant need to send through but still haven't this has been	31/12/2023	05/12/2024	Red	Overdue	July 2024 IA tracker update: T&O 2a - The system does not send reminders, however it will move expired job plans into the "Expired" category, which will trigger a job planning meeting. In terms of compliance, all job plans have been defined, however on e Allocate only 19/35 have been signed off. 11 awaiting clinician sign off, 5 in discussion, however will be sent for sign off soon. 2b - Specific directorate service outcomes and deliverables have been added to eAllocate for each consultant, linked too Board outcomes. Only two consultants have personal outcomes, however if no specific are added by the consultants, service outcomes will become part of their objectives.
Internal Audit - University Hospital Llandough Endoscopy Development	The UHB should liaise with NWSSP Accounts Payable to highlight the importance of project payments being made in line with contractual terms, and identify whether a solution is feasible.	Agreed. Contact will once again be made.	31/01/2024	16/10/2024	Amber	Overdue	

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Internal Audit - University Hospital Llandough Endoscopy Development	On completion of the project, management should undertake a review of how the design / change process has been managed, with any lessons learnt identified for application at future projects.	Agreed. The Project Director has already challenged the number of PIFS raised at this project and requested a postproject review. However, it is important to note the project remains within budget and the finished product will meet the service requirements. The approach taken was tailored to the style of the project contractor. We are also reviewing our approach to budget management with this Contractor: preparing our own estimates rather than awaiting the Contractor to cost the PMIs. This will improve our ability to make informed decisions based on greater cost certainty surrounding.	31/01/2024	16/10/2024	Amber	Overdue	
Internal Audit - University Hospital Llandough Endoscopy Development	The UHB and external Project Manager should support the change management process by completing the following activities in a timely manner: • approving PIFs; • accepting quotes (via PMN); and • ensuring PMNs are not issued until PIFs have been approved.	Agreed. As referenced at management response 5.1, we are implementing a new process of forecasting PIF costs internally, rather than awaiting contractor quotations. This will allow a more timely review of the change and likely budget implications, with the instruction issued once the quotation is received and agreed.	31/01/2024	16/10/2024	Amber	Overdue	

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Internal Audit - University Hospital Llandough Endoscopy Development	1. The warranty arrangements for the main equipment should be confirmed by the UHB, including confirmation as to whether extended warranty cover is required: with retention of associated documentation. 2. At future projects, the risks associated with the equipment approach (e.g. storage / warranties) should be included on the project risk register to ensure visibility at Project Team / Project Board. 3. At future projects, where risks are taken in the early procurement of significant values of equipment (e.g. long periods of storage / warranty implications), these should be clearly understood and set out in the Procurement Report and Request for Approval.	1 - Agreed. We have received verbal assurance from the Endoscopy Department that the warranty period is three years, therefore there is no risk to this expiring prior to installation. 2 - Agreed. We recognise this would be an enhancement at future projects, where applicable. 3 - Agreed	31/01/2024	05/12/2024	Amber	Overdue	
Internal Audit - University Hospital Llandough Endoscopy Development	1. Capital, Estates & Facilities should develop an internal mechanism for monitoring and reporting contractor, adviser and UHB internal team performance at projects. 2. Consideration should be given to utilising the NEC Professional Services Contract alongside Framework Service Level Agreements for external advisers, where appropriate.	1 - Agreed. We have commenced maintenance of KPIs, based on the Designed for Life Framework as a starting point, and will work on enhancing this process as it progresses. The process includes reporting to the Director of Capital & Estates, with an escalation process where needed. 2 - Agreed - recognising this will be tailored to each project and advisors as appropriate – less complex schemes / appointments can still be managed via the SLA.	31/01/2024	05/12/2024	Amber	Overdue	
Internal Audit - Chemocare IT System Follow-up	System owners should coordinate with both IT department and CIS to configure an auto alert system or an exception report to timely identify interface failures.	Discussions are still ongoing, as there is a lack of clarity over where alerts should come from with the position being monitored via regular discussions with supplier and IT.	31/01/2024	05/12/2024	Amber	Overdue	July 2024 IA tracker update - No update provided.
Internal Audit - Chemocare IT System Follow-up	Finalise the review of the BCP.	Agreed. The BCP will be completed.	31/01/2024	05/12/2024	Amber	Overdue	July 2024 IA tracker update - No update provided.

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Internal Audit - Estates Condition	1.1 - The lead executive should approve the proposed approach to the surveys, recognising any benefits/limitations of the approach taken 1.2 Surveys should be carried out on the UHB estate with the results informing both an updated estates strategy and EFPMS returns	Agreed - Condition surveys were tendered in November 2023. The tenders received did not provide a competitive response. Therefore, the tender is being re-issued in Jan 2024. It is anticipated that the surveys and completion of the reports will not be achieved until July 2025. EFPMS will continue to be updated, until after the condition survey update, using informed data.	29/02/2024	06/12/2024	Amber	Partially complete (Overdue)	Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025.
Internal Audit - Shaping Our Future Wellbeing - Future Hospitals Programme Forward Look Governance Review	The team should move forward with development of a Communications Plan as soon as possible.	Agreed.	04/03/2024	05/12/2024	Amber	Overdue	July 2024 IA tracker update: Comms plan contingent on a clear and funded way forward.
Internal Audit - Infection, Prevention & Control	The IPC Group Terms of Reference should be reviewed annually.	The IPC Group Terms of Reference will be reviewed and taken to the IPC Cell at the beginning of February for discussion. The document will be taken to the March IPC Group meeting for comment and ratification.	24/03/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: The IPCG TOR were supposed to have been shared in March 2024 however was cancelled due to Doctor IA. Therefore the TOR will now go to the IPCG in June 2024.
Internal Audit - Estates Condition	The Estate strategy should be updated to reflect items including performance indicators linked to reducing High/Significant backlog maintenance, opportunities linked to space utilisation etc.	Agreed in principle - The estates strategy has constantly been reviewed, with many aspects within the document updated to provide responses to previous Board queries and the Welsh Government requests. The condition survey findings will help inform the direction of investment in relation to backlog maintenance, space utilisation, functional suitability and investment strategies. This information, along with reviewing the IMTP of clinical departments and the strategic direction of the Board will help inform the Estates Strategy.	31/03/2024	06/12/2024	Amber	Partially complete (Overdue)	Funding has been approved for the commencement of the Business Case Enabling Works to provide information on the UHB Buildings to support and inform future Business Case developments. The surveys are due to commence in January 2025. The completion of the 2024/25 IMTP will also help inform the prioritisation of capital investment within the UHB Estate.

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Internal Audit - Estates Condition	Recognising the limited progress reporting to the Board on the delivery of its Estates Strategy objectives for the period 2018-2022 and the recent (February 2023 – Board development session) red status reported against the mid-point delivery of the Estate Strategy objectives; the Board or nominated committee should receive regular updates on the delivery of the Estate Strategy and 10-year capital programme (particularly any risks/impact resulting from delay/non delivery).	Agreed in principle. The Board is updated in many areas in relation to the requirements of the estate and the funding implications thereof. The Board will be further informed of the continuing shortfall in availability of funding and the need to address ongoing financial implications of the estate at regular intervals. A programme of update reports will be agreed to be included in the future Board agendas.	31/03/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: No update received.
Internal Audit - Estates Condition	A full review should be undertaken of the Estates workforce to analyse the current position in terms of capability and capacity. Following this, a clear financial model for the revenue support needed to manage the estate should be developed.	Agreed in principle - 12 months data has been collated and reports are being run to establish the various levels of staffing required.	31/03/2024	06/12/2024	Red	Partially complete (Overdue)	The formulation of available data has been completed and this has been analysed to provide supportive conclusions to the level of Work force required within Estates. This information along with recent findings associated with the workforce directive within estates has led to a paper being drafted for consideration by the UHB. This paper is currently in draft format with operational leads.
Internal Audit - Cancer Services	Risk management and risk reporting approach for the Cancer Services Team be agreed and as a minimum consider the arrangements for: • Identifying the risk; • Analysing the risk; • Prioritising the risk; • Treating the risk; and • Monitoring / escalating the risk as appropriate	The Lead Cancer Nurse will create a unified risk register for cancer which will be governed via the Executive Cancer Board. This will be compiled in accordance with the Clinical Boards identifying, risk reviewing and unifying all relevant risks from within their individual risk registers, as well as risks identified internally from within Cancer Services. Those risks identified as most vulnerable will be reviewed at Cancer Executive Board with an expectation that remedial actions be identified and implemented at the point of presentation.	31/03/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: Priorities 1. Clinical Board triumvirate contact to inform of Cancer Services risk register and request sharing of the risks held relating to cancer. In accordance with Clinical Boards, populate risk assessments on the Cancer Services risk register by end July 2024 2. Scope risk assessment training needs within Cancer Services and arrange training June 2024 3. Gather risk assessments to populate Cancer Services risk register end July 2024 4. Share with Cancer Services senior leadership team August 2024 5. Present at Executive Cancer Board September 2024

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Internal Audit - Estates Condition	The UHB should clearly defined a process for monitoring and reporting the estates condition on a periodic basis (minimum annually) including the backlog maintenance position.	Agreed in principle. The appropriate timing will be agreed with information governance and a report generated in accordance with the recommendation, on an annual basis.	31/03/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: No update received.
Internal Audit - Estates Condition	The Board will be provided with assurances on the effectiveness of the identified actions to reduce the capital asset risks.	Agreed in principle. There is an existing agreed capital investment review that is issued to the Board, via the updates provided by the Capital Management Group, and the investment undertaken and the impact thereof on the current estate. What will be included in the future is the impact of this investment on the overall capital requirements of the estate, including understanding depreciation of the estate in the same period of the investment. This will be provided an annual basis. A programme of these updates will be agreed and formulated for the future Board agenda.	31/03/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: No update received.
Internal Audit - Data Warehouse	A skills framework should be developed that identifies the required skills within the department that are needed to deliver a modern information and analytics service. This should be underpinned by a development plan setting out how skills will be brought in, either by development of staff, recruitment, or by partnering with other organisations eg Cardiff University.	Training plan for existing Informatics and BI staff is in place which will become the departments standard training pack for new starters going forward. Training will be delivered on-line via UDEMY+K65+G66	31/03/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - Capacity is still a constraint due to pressure of workload priorities but some individuals have started to progress Power BI training.
Internal Audit - Data Warehouse	A data strategy should be fully defined, along with a supporting roadmap. This should consider the appropriateness of the warehouse for the future. We note that there is a large amount of valuable information and reporting being provided from the data warehouse. To start anew would be a resource intensive undertaking, however the warehouse may not be able to fully provide a modern analytics function. As such the capability of Jupyter workbooks should be fully assessed to ensure it is capable of meeting the demands of the organisation.	We are committed to and are working to develop a data strategy which will address the warehouse issue raised but also the wider issue of providing data to those that need it.	31/03/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - No Update Mar '24 - Data strategy being developed and led by the CCIO feeding into the data Insights work programme.

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Internal Audit - Technical Continuity	The risk relating to geographical resilience and the impact on All Wales services should be appropriately included within the risk register.	Added to the Digital Risk Register (Confirmation required it is already in the Server Team Risk Register).	01/04/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - Limited progression made on this recommendation due to UPS and electrical work requirements in UHL. UHL is expected to be operation for the placement of servers and backups from Q2/3 2024.
Internal Audit - Information Governance	1. Management should consider undertaking a full assessment of needs and resources to identify potential gaps and risk areas upon which capacity and resilience can be appropriately measured.	The Cardiff and Vale UHB Information Governance workforce resource since 2018, remains limited, especially in comparison with other Welsh Health Boards of a similar size. However, this capacity is being well used and core legislative functions are being performed but we accept that there are some gaps in the proactive work that we should be undertaking. To some extent, and linked to recommendation 2.1, the department has recently started work on how to improve some of these gaps including seeking funds to secure additional IG training for 3 team members. A full gap analysis will be performed during Q1 of 2024/25. This will also consider the departments resilience to ensure it can still function should any staff leave their current roles.	01/04/2024	10/07/2024	Amber	Overdue	

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Internal Audit - Information Governance	Management should consider identifying appropriate IG Leads / Champions within the Health Board, and to support the IG team by promoting good information governance practice.	With the existing limited capacity, ensuring that other departments have staff with specific data protection responsibilities is desirable but we need to ensure that this doesn't adversely impact their primary roles which, in the main, are already under strain. One role that needs to be conducted is the role of a Information Asset Owner (IAO) who should be responsible for completing a Information Asset Register (IAR) for their area. It would therefore make sense to explore whether the scope of this role could be extended to also include other data protection responsibilities, such as breach reporting/management and a general IG point of contact for their department.	01/04/2024	10/07/2024	Amber	Overdue	
Internal Audit - Technical Continuity	The record of hosted services should be updated to include consideration of RTO/RPO, and all services required to complete the HBA which includes an assessment of impact.	Migration of existing RBAC spreadsheet to Online dynamic forms for all servers and applications.	01/04/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - RBAC spreadsheet has been uploaded into SharePoint although the content has not been fully "Digitised". This further work has been stalled due to resourcing within the team. It is functional but not ideal and is expected to be completed Q4 2024.

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Internal Audit - Financial Management within Clinical Boards	Clinical Board Finance Senior Management need to work with Heads of Services/Departments to identify deliverable savings schemes in order to meet its delegated savings target for Corporate Central Savings Themes. Where existing savings schemes are failing to deliver their planned savings in total, Finance and Senior Management need to work with Heads of Services/Departments to identify actions that can be introduced to deliver the delegated savings targets. Where it has been identified/confirmed that identified schemes will not deliver expected savings then Heads of Services/Departments should ensure that additional deliverable savings schemes are identified to address the shortfall. Where non recurrent savings have been identified management should review schemes to ascertain if they could be made recurrent, or identify additional schemes.	The responsibility for delivery of the financial savings target is a key objective for the senior leadership team in each Clinical Board with the support and key input of the respective Finance Business Partner / Head of Finance. All savings targets for the UHB in the financial year are allocated to a Clinical Board level in the annual budget setting exercise as part of the development of the UHB financial plan. Finance Business Partners work with the Clinical Board leadership teams to continually develop savings ideas for Month 1 and then throughout the financial year. The Chief Operating Officer and Director of Finance, alongside the planning functions, ensure that the savings targets are shared and that plans are actively developed before the beginning of the financial year, and onwards into the financial year where shortfalls still exist. The delivery of the cost savings target is a fundamental, high risk, component of the financial strategy of the UHB and this is reflected in the UHB's Risk Register, monthly reports to the Finance Committee and Welsh Government. Alongside this the	01/04/2024	15/10/2024	Amber	Overdue	
Internal Audit - Technical Continuity	The DR plan should be updated to include: • Procedures or signposting to procedures for varying failure types • Updating for the new architecture • Prioritised order of restoration, which is agreed with services • Explicit consideration of RTO/RPO Services should be requested to provide DR plans that synchronise with the Digital Directorate. As part of this the RTO/RPP provided by digital should be agreed.	As part of the NIS 2 Directive there is an expectation that all "Critical" systems have resilience. Often this is overlooked due to cost and lack of technical information provided at the point of implementation. A task to go through all the systems and confirm resilience, RPO and RTO abilities has started and will continue for the foreseeable future.	01/04/2024	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: June 2024 - The revised DR plan is currently under review and being updated by the CAV IT/Cyber team.

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Internal Audit - Technical Continuity	Ivanti should be further developed to include fields for recording of the detail of a root cause analysis and for improvement actions. A formal procedure or guide for incident handling should be developed.	Mar 2024 Root Cause is being captured as part of the normal Problem Management process. This is being enhanced with a more specific data collection post Major Incidents and Problems. These changes will be update in the Incident and Problem Management documentation. - Q1 2024	01/04/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: Mar 2024 - Root Cause is being captured as part of the normal Problem Management process. This is being enhanced with a more specific data collection post Major Incidents and Problems. These changes will be update in the Incident and Problem Management documentation. - Q1 2024
Internal Audit - LIMITED Surgery Clinical Board - Consultant Job Plans	Consideration should be taken to assess whether Consultant team job plans can be utilised within the two Directorates.	Orthopaedics We will try to implement this function within the Spines Team first, and then extend it to Orthopaedics. General Surgery Going forward within the next round of job planning, team job plans will be considered for managing delivery of capacity along with the annualization process. However this cannot be the only form of job planning as there are individual considerations for each job plan including those who have contracts externally to the HB e.g. Cardiff University, Welsh Government and the MoD.	01/04/2024	05/12/2024	Amber	Overdue	July 2024 IA tracker update: T&O - From a directorate perspective, on call teams are job planned as a team, otherwise we would not be able to optimise their schedules. We don't record this anywhere at present, but we will try to roll this out in Spines first once the pilot in Medicine has ended.
Internal Audit - Paris System	Management should liaise with Civica with a view to moving system back-ups off-site.	We strongly agree with this recommendation, in fact it was identified during a recent hardware refresh but no suitable offsite location was found due to numerous reasons (CRI lacking capacity and Woodlands House lacking redundant power). We will use this recommendation as a springboard to address the matter urgently however, the target date will be within 6 months due to factors such as complexity, availability and financial constraints. We will work with the head of digital operations and Civica to identify a suitable offsite backup location and relocate. We will also look to identify if there are any immediate actions that we can take to mitigate the risk in the meantime.	01/04/2024	16/08/2024	Red	Overdue	Jun'24: Contract still to be finalised, once finalised we will look to move this forward with CIVICA. In the mean time we will liaise with digital ops team to determine if any offsite locations have suitable capacity. Hardware migration is completed and decommissioned. Aug'24: Application Manager in talks with Digital Ops and Civica to arrange. CRI has been identified as a suitable location but we have been told this will likely come at a cost to set up.

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Internal Audit - Infection, Prevention & Control	The IPC policies and procedures that have passed their review dates should be reviewed and updated as a matter of urgency. Review dates should be accurately recorded on the reviewed documents. A log of all IPC policies and procedures should be maintained that records the review dates. All IPC policies and procedures should be posted on Sharepoint as soon as is practicably possible.	The 3 procedures that have passed the review date are currently under review and drafts will be circulated to the members of the IPCG for review. All complete policies and procedures will be reviewed and updated to the correct Health Board format. This will be complete by the March 2024 meeting of the IP&C Group. Once updated to the correct format they will be updated to Sharepoint and out of date procedures will be removed.	30/04/2024	05/12/2024	Red	Partially complete (Overdue)	30/09/2024 - The needlestick injury and TB procedures were approved at the IPCG meeting on 24/09/2024 The Incident and Outbreak procedure needs a couple of amendments and will be sent out to members of the IPCG for comments in the next couple of weeks 3 named polices have been updated and due to IPCG in June 2024. All IPC policies and procedures are in the process of being reviewed to ensure compliance with UHB format. All up to date procedures have been reviewed, are in the correct format and are available on Sharepoint A log of all IP&C procedures with review dates is available
Internal Audit - Cancer Services	Management should consider the purpose and operating arrangements of the weekly cancer tracker meetings and clarify these and the roles of those in attendance in documented terms of reference/operating arrangements.	Standard Operating Procedure and Terms of Reference documents to be created in collaboration with appropriate clinical board managers outlining the scope and purpose of the cancer tracking meetings. This document should also include a roles and responsibilities component for the relevant Cancer Services and Clinical Board staff.	30/05/2024	05/12/2024	Amber	Partially complete (Overdue)	July 2024 IA tracker update: 1. The existing terms of reference including roles and responsibilities has been recirculated through the Executive Cancer Oversight meeting to reiterate requirements for the daily cancer oversight meeting. The revised terms of reference for the bi weekly cancer tracking meetings are currently in progress. 2. The document will be circulated by COP 14/06/2024. 3. There are no challenges currently affecting the ability to circulate this document.

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Internal Audit - Cancer Services	1. A system-wide project should be undertaken with the aim of improving integrity/quality for Suspected Cancer Pathway data. 2. Management should undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.	1. Cancer Services, led by the General Manager for Cancer Services will deliver on a continual improvement plan for refining and improving the quality of the SCP cancer data set. Aspects of this are outlined within the digital plan within the cancer strategy. 2. The Cardiff and Vale UHB Cancer Strategy 2023-2028 identifies "Adopting Digital First" as a key component. In December 2023 the 1, 3 and 5 year priorities were presented and agreed outlining the direction towards refining and improving the IT infrastructure, reducing duplication and automation of data collection. As part of this work, a gap analysis was undertaken specifically around digital requirements. The Executive Cancer Board will act as the overriding governance structure monitoring the delivery against these key objectives.	30/05/2024	19/12/2024	Red	Partially complete (Overdue)	This action reflects a continual pathway of improvement that will be gradually implemented over a period of 5 years. Implementing next steps is reliant on completion of the CANISC replacement. This action will be continually revisited through the executive cancer board July 2024 IA tracker update: 1. Implementing this action is dependent on the wider digital transformation programme which we are supporting from a cancer perspective. A meeting was held 05/06 to establish the vision for automation of cancer tracking which will resolve many of the challenges outlined by removing the need for manual trawling of separate data systems. This work is achievable but reliant on the completion of the current CANISC replacement project. This is a 1.5/2 year planned programme of work but will carry many benefits including enhanced data accuracy, timeliness of tracking and staff resource. 2. progress against this action will be delivered ahead of 2028. 3. The primary challenge for this action is
Internal Audit - LIMITED Decarbonisation	1.1 - The Terms of reference for both groups should be reviewed and updated with version control information including date of document and next review date. 1.2 - Meetings should be held in line with the TOR and management should ensure that they are quorate.	1.1 - These have been amended and will be shared at the next Decarbonisation Delivery and Working Groups 1.2 - Noted that meetings need to be quorate.	18/06/2024	16/01/2025	Amber	Overdue	

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Internal Audit - LIMITED Decarbonisation	The reasons for the likely failures to achievement of the decarbonisation reduction targets should be identified and articulated as appropriately scored risks which are then recorded on the appropriate risk registers, with a summary escalation to the board assurance framework if appropriate.	It has already been recognised that climate risk needs to be raised as a Board level risk and will appear on our BAF under a theme of Equity. The BAF is being re-engineered at the time of writing by our Corporate Governance team to better align with the SOFW strategy.	18/06/2024	17/01/2025	Red	Overdue	Jan 2025: Sustainability Strategic risk added to the Board Assurance Framework in September 2024- Risk description: If the organisation cannot protect the environment and take the steps required of it regarding waste, carbon footprint and other deliverables, it will not be an efficient service and will jeopardise the health of future generations. Decarbonisation portfolio to be re-distributed to a new Strategic portfolio lead given the departure of the Executive Director for Strategic Planning to commence work to address UHB decarbonisation reduction targets.
Internal Audit - LIMITED Alcohol Standards	1.1 - Health Board should compile guidance which aligns to the NICE recommendations on detailing the screening process, the brief interventions that will be followed, and who should be targeted and action that should be taken. 2.2 - the fact that alcohol related harm is a major health problem, internal reporting within the Health Board should be undertaken to ensure that Senior Managers are aware of the number of patients who are presenting with alcohol issues.	Funding for fixed term post (to March 2025) for Alcohol Programme Manager secured to support the implementation of management actions: 1.1 - Guidance for the screening process, the brief interventions to be followed and 2.2 - who should be targeted will be produced and disseminated to relevant staff. The collation of data from the screening process will be standardised and reported quarterly to the appropriate Senior Managers.	30/06/2024	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: 1. WG funding secured for Alcohol Programme Manager post. Preparing for recruitment of post.
Internal Audit - Mortality Reviews	The Health Board should attempt to: • Clear the backlog of open cases as soon as possible, ideally by its intended deadline of March 2024. • Ensure that new cases are reviewed and responded to on a timely basis.	1) Delivery of C&V scrutiny panel to review all cases referred from ME 2) Development of reporting measures to ensure timely internal responses to ME referrals.	30/06/2024	10/07/2024	Amber	Overdue	
Internal Audit - LIMITED Alcohol Standards	Management should consider completing a resource needs analysis to ensure that the SMLT are meeting the demand, and they are providing an effective service to meet needs of patients who have substance misuse issues.	SMLT to review where resource within the team is currently being utilised via a resource needs analysis and where there are currently gaps and proposals to address these, either singularly or in partnership with MH Liaison Team.	30/06/2024	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: 1. Resource review undertaken, and recommendations being considered. 2. No change to implementation date. 3. No. 4. N/A

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Internal Audit - LIMITED Alcohol Standards	Management should implement the referral form as soon as possible in order to provide a consistent approach to the referral process and enable an audit trail of all referrals that have been made.	Referral processes to be standardised and recorded for all referrals made. To include reason and type of referral, any action taken, further referrals onwards or interventions given. Processes to be simple to follow and easily retrieved and accessible for monitoring and reporting purposes.	30/06/2024	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: 1. Substance Misuse Liaison Team (SMLT) have made improvements to the referral process. The Alcohol Programme Manager will continue to work on this action for further improvements.
Internal Audit - Medical Records Tracking (CD&T CB) Follow-Up	Management should ensure that on establishment of the new Clinical Information Programme Board, a system is put in place to oversee the 'Tracking of Medical Record Learning and Improvement Proposal' when the proposal is developed.	The improvements within the 'Tracking of Medical Record Learning and Improvement Proposal' will be incorporated within the workstreams of the Clinical Information Programme, with progress against these monitored by the Clinical Information Programme Board.	30/06/2024	21/11/2024	Amber	Overdue	
Internal Audit - Patient Safety Incident Management	1. Management should review the Incident, Hazard and Near Miss Reporting Policy and Procedure and update accordingly. 2. Management should ensure that the out-of-date Incident, Hazard and Near Miss reporting Policy and Procedure are removed from the intranet and only the current policy and procedure is made available.	1. Terminology to be updated as per recommendations. Section 4.1 covers general incident reporting. A paragraph is to be added to include the role of QSE meetings in monitoring and learning from incidents. 2. Out of date policies to be removed from SharePoint – Patient Safety Team to contact Corporate Governance Team to action.	31/07/2024	15/10/2024	Amber	Overdue	
Internal Audit - Medical Records Tracking (CD&T CB) Follow-Up	Management, in relation to their previous management response, should ensure that the new Clinical Information Programme Board develop a Communications Strategy to remind staff of their responsibilities to return and record health records, in line with the points within the letter from the Ombudsman.	As part of the Clinical Information Programme Board's communication campaign, responsibility for the appropriate handling and transfer of clinical records will be emphasised widely across the UHB. These obligations will also be reinforced through the Medical Director's new Clinical Information Management Group.	31/07/2024	21/11/2024	Red	Overdue	

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Internal Audit - IMTP Development Process June 2024	It is recommended that the Strategy Development and Delivery Group Terms of Reference state: • The date that they have been approved and who approved them. • The date of next review and version number. • A clearly defined review procedure including auditable approval documents e.g. meeting minutes.	- Terms of Reference are under review and will be presented to and signed off by Senior Leadership Board. - The approval date and approving body will be noted on the new terms of reference including the date of next review. - The terms of reference will include a review procedure. - Auditable documents will include meeting papers and action and decision notes.	01/08/2024	14/10/2024	Amber	Overdue	
Internal Audit - Medical Records Tracking (CD&T CB) Follow-Up	Management should ensure that the terms of reference for the new group is produced, and the group is established as soon as possible to provide effective oversight of medical records matters.	Terms of reference for the Clinical Information Management Group will be agreed by the Interim Medical Director prior to being formally taken to the Group's inaugural meeting. A schedule of future meetings will be arranged, within which the terms of reference will be approved.	31/08/2024	21/11/2024	Amber	Overdue	
Internal Audit - Mortality Reviews	Ensure that the key priorities for 2024 are effectively implemented.	1 – Delivery of C&V scrutiny panel to review all cases referred from ME. 2 – Setting up a Mortality and Morbidity (M&M) Group is in progress. 3 – Making information from the Medical Examiner process available is in progress in conjunction with delivery of ME scrutiny panel. 4 – Bereavement processes T&F group in progress.	01/09/2024	10/07/2024	Amber	Overdue	
Internal Audit - IMTP Development Process June 2024	Management should ensure that in future plans are identified to deliver the full annual savings requirement at the point that the MDS is provided to Welsh Government.	Stronger emphasis on savings plans up front in the planning process (July - September) and increased scrutiny of the plans earlier in the process (October).	30/09/2024	14/10/2024	Red	Overdue	

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Internal Audit - PCIC Governance Arrangements	All TOR for the groups within the PCIC Clinical Board should be reviewed to assess whether they are up to date, updated where necessary and then formally approved. As part of the review, consideration should be given to whether attendees are core or optional and this should be clearly stated.	All Terms of Reference to be reviewed, updated and formally approved highest priority to be given to: • PCIC SMT • PCIC QS&E • PCIC Clinical Board • PCIC Local Partnership Forum • Current Clinical Services Reference Group • Primary Care Panel Consideration to be given to timescale for reinstatement of PCIC IG Group and review and formal approval of Terms of Reference.	30/09/2024	15/10/2024	Amber	Partially complete (Overdue)	ToR for all key groups referenced in action plan have been reviewed and signed off. Consideration still being given to re-establishment of PCIC IG Group
Internal Audit - Performance Reporting 2024	Management should ensure that information/data submitted for publishing within the IPR has undergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	Agreed. The over 65's data will now be included and the age range renamed to adult mental health (18-65).	30/09/2024	16/10/2024	Amber	Overdue	
Internal Audit - Performance Reporting 2024	Management should ensure that information/data submitted for publishing within the IPR has undergone the relevant checks to confirm that it is accurate prior to submission to the Information team.	The Information team will communicate the requirement for services to carry out relevant checks prior to submission for inclusion with the IPR document.	30/09/2024	16/10/2024	Amber	Overdue	
Internal Audit - IMTP Development Process June 2024	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	30/09/2024	14/10/2024	Red	Overdue	

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Internal Audit - Financial Management within Clinical Boards	The Clinical Board Finance Teams should review the 'reports database' to ensure that all budget holders details are up to date and take appropriate action to remove those staff that are no longer budget holders and if applicable add the details of any budget holders that are missing. Consideration should also be given that the Financial Systems Team issue the report to each Clinical Board Finance Team on a quarterly basis for review.	The Reports database is not the only platform for availability and review of financial information and support teams follow up with primary budget holders in monthly (or more often) meetings. Finance support teams will review their distribution at the same time as they liaise with budget holders on information needs to ensure that distribution lists are appropriate and up to date.	30/09/2024	15/10/2024	Amber	Overdue	
Internal Audit - LIMITED Alcohol Standards	The Health Board should introduce an appropriate alcohol screening tool, in order to provide a more consistent approach to noting patient information and assisting in identifying people who potentially have an alcohol-use disorder.	Consistent recording mechanism for the chosen screening tool implemented and rolled out to all relevant teams. E.g. Electronic workstation	30/09/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: 1. This action will be undertaken by the Alcohol Programme Manager post.
Internal Audit - IMTP Development Process June 2024	Prior to resubmission of the IMTP and MDS to the WG the Board should undertake the following: • The IMTP/MDS data should be reconciled. • Prior to submission to the Board, it should be reviewed and signed off by an appropriate delegated authority. • The IMTP planning process should be revised to include appropriate reconciliation checks.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	30/09/2024	14/10/2024	Red	Overdue	
Internal Audit - IMTP Development Process June 2024	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Reconciliation checks - Arrange for an internal team independent of the core team that input the data and write the narrative plan to review the final MDS and reconcile back to the narrative before it is submitted in February/March to SLB, Finance and Board.	30/09/2024	14/10/2024	Amber	Overdue	

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Internal Audit - Medical Staff Additional Sessions	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	Further discussions with the AMD workforce and Medical Director are required to decide if appropriate to pay a % of the WLI consultant rate.	30/09/2024	16/10/2024	Amber	Overdue	
Internal Audit - IMTP Development Process June 2024	Prior to resubmission of the IMTP to the WG the Health Board should undertake the following: • Prior to submission to the Board, the Annual Plan/MDS should be reviewed and signed off by an appropriate delegated authority. • The annual planning process should be revised to include appropriate reconciliation controls.	Delegated Authority - Finance and Performance Committee to be given delegated authority for the MDS submission - Proposal to Director of Corporate Governance and Committee Chair.	30/09/2024	14/10/2024	Amber	Overdue	
Internal Audit - Medical Staff Additional Sessions	1. Establish a clear and approved pay rate for junior doctors, specifying whether they should receive the full contract rate or a percentage of it. This must be reflected in the WLI procedure and communicated to all relevant staff. 2. Rota Co-ordinators and authorising officers need to ensure that all WLI sessions shift grade are correctly classified within the system, regardless of who performs the work. 3. Conduct regular audits to ensure compliance with the junior doctors WLI pay rate and to address any discrepancies promptly.	3.1 would need to be addressed and approved/implemented. Bank team to provide reports to AMD workforce or representative on a quarterly basis	30/09/2024	16/10/2024	Amber	Overdue	

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Internal Audit - Infection, Prevention & Control	The format and content of the IPC Annual Programme should be reviewed and updated. This should include setting of targets for the number of pro-active audits to be carried out in clinical areas. The Head of Nursing for IPC should also seek Clinical Board input when compiling the IPC Annual Programme and should request each Clinical Board to prepare their own IPC annual plans. The annual IPC Programme should be completed and submitted to the IPC Group for approval every year prior to the start of the year.	The Annual IPC Programme is being reviewed and will be presented to the IPCG June 2024/	30/09/2024	05/12/2024	Red	Partially complete (Overdue)	July 2024 IA tracker update: The Annual IPC programme is being reviewed and will be presented to the IPCG June 2024.
Internal Audit - LIMITED Alcohol Standards	Management should review the current process and consider implementing a central database that includes the records of all appropriate staff across the organisation and detailing the alcohol awareness training undertaken, the date provided and the date for renewal.	Embed alcohol training within current training schedule for relevant staff and trainees. Ensure training records centralised and kept up to date, including dates for refresher training when required and what areas the staff work in.	30/09/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: 1. This action will be undertaken by the Alcohol Programme Manager post. 2. No changes to implementation date 3. None. 4. N/A
Internal Audit - Paris System	The monthly Leavers Report provided by the IT Security team should be re-instated as soon as possible. Alternatively management should liaise with Workforce colleagues to obtain a weekly leavers report. Receipt of the Leavers Report each week should be monitored.	The monthly leavers report is not an accurate source of information due to there being no link with NADEX accounts. For example, Joe Bloggs has left the organisation but there are 4 Joe Bloggs on the PARIS system, it could be impossible to determine which one. However, we do agree with the recommendations but note that they affect most digital systems in the UHB, I will work with departmental colleagues to resolve the issue department wide.	01/10/2024	16/08/2024	Amber	Unable to complete	Jun'24: Dependency is elsewhere within D&HI and is an ongoing piece of work for M365 team. This incentive is actively monitored by SMT.

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Internal Audit - Safeguarding	1. The Chair should formally check and confirm that meetings are quorate prior to the start of each meeting, and this should be recorded in the meeting minutes. 2. The membership of the SSG should be reviewed.	The UHB are satisfied with the SSG membership, having the Local Authority and police in attendance when they are available is deemed good practice to promote UHB transparency. However, it may need to be clear that attendance by both agencies is not a requirement. The SSG minutes will in future clarify which CB the attendees are representing.	31/10/2024	16/10/2024	Amber	Overdue	
Internal Audit - Performance Reporting 2024	Management should ensure that staff responsible for collating the information provide it in line with the timetable so that all periods are reported on.	The IPR is a monthly report and should not be delayed due to services not submitting their data on time. The IPR schedule will be recirculated widely, so that services are clear on the timetable and requirements. Previously the general consensus was that in the event of data being unavailable, the information team used the last set of data submitted. The executive leads will be asked to ensure that the requested data as per the publication schedule is followed and any exceptions managed to ensure timely submission of data, avoiding gaps or reliance on previous data.	31/10/2024	16/10/2024	Amber	Overdue	
Internal Audit - Performance Reporting 2024	In accordance with the Audit Wales Structured Assessment recommendation, Management should agree on a consistent approach to address (agreeing on tolerance level) and monitor the underperformance of relevant performance measures. This can be further strengthened with the inclusion of the agreed approach within relevant sections of the guidance document.	Where there are no targets set (usually indicated by TBC), the information team will go back to the KPI owner and ask for an update to set these targets. Where there has been "no explanation for under performance or possible actions within the cover paper", guidance will be issued to clarify that it is the responsibility of the information provider to offer these explanations.	31/10/2024	16/10/2024	Amber	Overdue	
Internal Audit - Safeguarding	Ensure that the actions identified within the Improvement Plan are effectively implemented as planned and progress is regularly reported to the SSG.	The JIPA improvement plan will be a standard item on the SSG agenda whilst improvements are required to satisfy the UHB that any safeguarding risk is mitigated.	31/10/2024	16/10/2024	Amber	Overdue	

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Internal Audit - Performance Reporting 2024	Management should ensure the guidance document is finalised and brought into use as it would support in mitigating some of the exceptions highlighted within the report and support the production of a robust IPR.	The IPR has changed significantly since the audit in 2021/22. A revised guidance document will be produced to reflect the staff roles/responsibilities, governance arrangements and associated processes for managing under-performance.	30/11/2024	16/10/2024	Amber	Overdue	
Internal Audit - LIMITED Temporary Staffing Costs	A consistent approach to roster management should be implemented within Capital, Estates and Facilities to ensure compliance with the Health Board wide Rostering Procedures.	The E-Rostering team are working closely with Heads of Service within CEF to prepare the service for the implementation of HealthRoster. However, it is recognised that there is significant work in rolling out the roster within CEF due to the differing shift patterns that are present across the services and within the individual services. This will require a significant time commitment from the services within CEF and therefore cost, whilst still trying to deliver operational services. CEF is committed to complete the implementation within the next 6 months.	31/12/2024	04/11/2024	Amber	Overdue	

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Internal Audit - Patient Safety Incident Management	Management should ensure that incidents are processed within the expected timeframes and reported as stated in the Welsh Government policy, Welsh Government supporting documents and Health Board policy and procedure. Management should also review the incident process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. The Health Board should ensure where lessons learnt have occurred improvement plans are completed. With the continuous adoption and use of AMaT by the Health Board, it would be good practice to indicate within Datix that the incident has an improvement plan recorded on AMaT. Also, in situations where improvement plans have been developed in themes rather than the identifiable incident ID number, a means of identification would be helpful to link the	1a. Quarterly emails to incident managers from the Datix Central Team to highlight overdue incidents. 1b. Patient Safety Team and Clinical Board QSE leads with support from Superusers to identify and support incident managers with long standing overdue incidents to support them in managing and closing their incidents. 1c. Management of overdue Datix Incidents has been identified as a performance measure for 2024 /2025 with a goal to reduce incidents open for over 90 days by 60% from the April 2024 bench mark by the end of Q3 1d. Executive Performance Reviews to include need for assurance on timely incident management within the 1e. Clinical Boards, queue position to be added to the assurance report. 2. Datix team to explore with Datix Central Team the inclusion of an additional field to reference AMAT entry. Explore with Clinical Assurance Team the inclusion of a Datix reference onto AMAT.	31/12/2024	10/07/2024	Amber	Overdue	
Internal Audit - LIMITED Decarbonisation	5.1 - To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not. 5.2 - The amount of potential CO2e saving per action should be recorded and linked to the potential cost as per action. This could inform and support the prioritisation of delivery of the action.	5.1 - The actions required to hit 2030 are profound and transformative to C&V. We have not been in a position to develop a plan, though we now broadly know what to do. What we need to do isn't covered by a stand-alone carbon plan however, but an overall operational transformation as described by SOFW (that hits our operational efficiency, financial sustainability, prevention agenda and our estates, plus others). This will be done through the portfolio approach being led by the Dir Strategy where the delivery of the portfolio will in aggregate deliver against our commitments such as 2030. Also note that actions that relate to improving on our carbon emissions don't necessarily need specific money (infrastructure aside).	31/12/2024	16/01/2025	Red	Overdue	

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Internal Audit - LIMITED Alcohol Standards	Management should consider the current situation and with alcohol levels rising and an increase in alcohol specific deaths there is a need for more leaflets and information to be available for patients at the Emergency Department and across the Health Board. There is also a need to have visible signposts to websites where more advice can be sought relating to the dangers of alcohol and where they can seek further advice or intervention.	Public Health Team to identify or produce resources (leaflets, posters, scratchcards, electronic materials/screens) on alcohol and signposting for patients. Alcohol Programme Manager to identify areas for these materials to be best placed for patients.	31/12/2024	05/12/2024	Red	Overdue	July 2024 IA tracker update: 1. Not yet started.
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	6.1 - This will be taken forward and immediately actioned.	31/12/2024	21/01/2025	Red	Overdue	The action-plan for INNU has been lightly discussed at CTG in December but the meeting was short of time. Re-discussing in Feb CTG meeting which will hope to discuss and support the reporting and monitoring process. This may impact the distribution list. Work has been progressed nationally with some interventions and coding and clinical guidance will be issued ~Feb. This may mean additions to the distribution list.

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Internal Audit - LIMITED Decarbonisation	5.1 - To aid the Health Board in identifying the commitment required to meet the WG 2030 Decarbonisation target, an assessment of those initiatives that can be quantified should take place and a costed plan developed. Initiatives that cannot be quantified should be recorded as unquantifiable, but with a brief assessment to identify if the investment could be significant or not. 5.2 - The amount of potential CO2e saving per action should be recorded and linked to the potential cost as per action. This could inform and support the prioritisation of delivery of the action.	5.2 - Noted for when 5.1 is formed. Given the transformative, new and novel approaches required to reduce carbon emissions by such large amounts, it might not be possible to attribute carbon savings up front. This is why in our action plan we have stated that many actions will likely have carbon savings, but not able to be committed to up front.	31/12/2024	16/01/2025	Amber	Overdue	
Internal Audit - Management of Health Board Policies Follow-Up	Work should continue to be undertaken to get all Health Board policies up to date as soon as possible.	Review of all policies will continue; all policies are now on AMaT and regular email notifications for over due items are being triggered these will continue to be monitored and chased for updates	31/01/2025	21/11/2024	Amber	In progress	

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Internal Audit - Medical Equipment	The Medical Equipment Group should review the current arrangements in place for evidencing and verifying that appropriate training of medical equipment is taking place, particularly for equipment classified as high risk.	The recording of medical equipment training will be discussed at the next MEG to agree on the best way forward and gather evidence of best practice. The existing training on high-risk devices such as Defibrillators, Infusion Devices, POCT and US will be shared with the MEG and MDSO groups to increase awareness. ECOD have some training records on ESR which will be evidenced on as part of this action.	31/01/2025	17/01/2025	Amber	Partially complete	Nov 2023 Audit Committee update: Implementation date moved to December 2023 EC aDoTH 10/23] Practice education meeting has been re-instated, meeting was held 09/10/23, waiting to get ToR and attendance. SBAR for staff resource not proceeded with in current financial climate, review in next FY. Initial discussions seem to indicate Allocate (Health Roster) already has the competency module. Recommend moving implementation date forward 12 months to Dec 2025 or closing. We can provide evidence of training for high risk devices, ECOD do not have records themselves as far as we are aware. Progress report 06/2023, EC (aDoTH, Med. Equip.) is working with colleagues in Clinical Engineering and senior nurses in CD+T to re-establish the practice development network, linking in with ECOD. An SBAR for staffing resource to support a training records system is going to be produced. Recommend making this action a longer term goal, December 2024.
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	1.1 - A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy. 1.2 - Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns. 1.3 - Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.	1.2 - The INNU Policy is due for revision Q2-2025 however activities commenced early (2023) to respond to the WG Guidance letter as referenced above. Clinical leads of each speciality area have been notified of the procedures within their respective areas listed in the Welsh Government (WG) issued 'INNU New National Approach' guidance. They have been requested to provide approval for the procedures to be included in the CAVUHB policy and to confirm the narrative attached to each procedure is appropriate. This activity is scheduled to be completed by end of Q4 24/25, however there is still a requirement for an evidence review to be completed from HTW prior to publishing.	31/03/2025	10/12/2024	Amber	In progress	

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	1.1 - A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy. 1.2 - Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns. 1.3 - Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.	1.3 - Revision of the INNU policy will include revision of the OPCS codes for each procedure. Where there are no codes available, our digital and informatics team will determine if there are appropriate codes to utilise. If not, we will raise this with the National Clinical Effectiveness team.	31/03/2025	10/12/2024	Amber	In progress	
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	2.1 - Progress regarding the All Wales IPFR policy should be monitored so that resolution of the discrepancies is promptly identified. When this occurs, the amended policy should be presented to the Quality, Safety and Experience Committee for adoption, and then made available on the Health Board's intranet and public website. 2.2 - The link to the NHS Wales IPFR Application Form on the public website should be updated so that it works correctly.	2.1 - The JCC (formerly WHSSC) met with panel chairs on the 18th of September to discuss the discrepancies with the updated IPFR policy. A number of wording discrepancies in the IPFR policy were identified. The IPFR Policy is currently being reviewed, and the final version of the IPFR Policy will be shared and sent to the Health Boards for approval. The Lead for Clinical Commissioning/IPFR has not confirmed a completion date or when we are likely to receive a final version of the IPFR Policy.	31/03/2025	08/01/2025	Amber	In progress	Gemma Farley-Holland to be added as action leads once Gemma has created an AMAT account.

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	3.1 - The reason for data being changed should be identified and corrective action taken as this should not occur. 3.2 - The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved. 3.3 - Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards. 3.4 - Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	3.1 - CAVUHB, as with all other health boards across Wales, are experiencing challenges within clinical coding workforce capacity. There is a National and local programme of work underway to address this. Whilst the programme of work progresses, review of procedure numbers will be reviewed against 4 months prior for any additions and process will be followed as per 4.3.	31/03/2025	10/12/2024	Amber	In progress	
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	3.1 - The reason for data being changed should be identified and corrective action taken as this should not occur. 3.2 - The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved. 3.3 - Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards. 3.4 - Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	3.2 - Action being taken is described in 1.1. Included within this is a revision and update of the Health Board's report once codes have been identified.	31/03/2025	10/12/2024	Amber	In progress	

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	3.1 - The reason for data being changed should be identified and corrective action taken as this should not occur. 3.2 - The difference in the number of INNU procedures between the Health Board's report and its policy list should be reviewed and resolved. 3.3 - Where significant numbers of INNU cases are recorded, they should be investigated, and corrective action taken where necessary by the Clinical Boards. 3.4 - Where 'dummy' clinicians are listed, they should be investigated, corrected and action taken to prevent recurrence.	3.3 - The INNU procedure monitoring list will be reviewed by the Value in Health Programme monthly. Quarterly, each clinical board will be required to review the top 5 interventions with the highest procedure count over the period. They will be requested to review the appropriateness of these procedures against the INNU policy and provide feedback and an action plan if needed to the INNU working group.	31/03/2025	10/12/2024	Amber	In progress	
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	4.1 - For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy has been met. 4.2 - Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	4.1 - We will work with clinical leads to ensure that a clear record is retained within the patient record to demonstrate compliance with the INNU policy if there is a clinical exception.	31/03/2025	10/12/2024	Red	In progress	
Internal Audit - LIMITED Decarbonisation	Management should ensure that staff complete the sustainability courses on ESR and also raise awareness of the availability of the training modules.	We have been advertising the existence of training but as its not mandatory, we have limited influence to make more people do it. An action in the 24/25 action plan is to re-consider making it mandatory.	31/03/2025	16/01/2025	Amber	In progress	

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	4.1 - For those patients where it is deemed that an INNU intervention is necessary, a record, such as a checklist should be retained on their patient file demonstrating that the criteria set out in the INNU policy has been met. 4.2 - Consideration should be given to the need for an independent check to be made and/or approval to be granted, if it is believed the patient meets the INNU criteria, prior to adding them to a waiting list.	4.2 - We will work with the clinical leads to develop an appropriate process to do this. We will consider good practice existing within the health board, such as the tonsillectomy pathway to inform the process we will take across the piece.	31/03/2025	10/12/2024	Red	In progress	
Internal Audit - Mortuary Refurbishment at University Hospital Wales	The UHB should liaise with the relevant frameworks and obtain assurance that appointed advisers hold (and maintain) appropriate Professional Indemnity Insurance for the period of the contract and thereafter.	The UHB will ensure a process is in place with procurement, so on further schemes insurances documents are included from the outset.	31/03/2025	23/01/2025	Amber	In progress	
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	6.2 - As per response in 3.3	31/03/2025	10/12/2024	Red	In progress	

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	6.3 - As per response in 3.3	31/03/2025	10/12/2024	Red	In progress	
Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	6.1 - The recipients of the monthly INNU reports should be reviewed to ensure that the distribution list is appropriate and complete. 6.2 - All recipients should appropriately review their INNU cases, identify any issues and take appropriate action so that they do not re-occur. 6.3 - An appropriate escalation process should be put in place. In the first instance, this should be to the relevant Clinical Board's Clinical Director with any unresolved cases being escalated to the Health Board's Medical Director. 6.4 - Regular and appropriate INNU monitoring updates should be provided to an appropriate Committee.	6.4 - Any updates/amendments to the INNU Policy will be processed through the QSE Committee. A process for monitoring of INNU policy compliance and quarterly reporting of this will be developed to ensure the most appropriate forum receives the update and supports management of INNU's. Management of INNUs sits within the clinical service remit. Assurance is within the role of the QSE committee.	31/03/2025	10/12/2024	Amber	In progress	

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Internal Audit - LIMITED Alcohol Standards	Management should consider extending the alcohol screening training sessions across the wider Health Board on signs to look out for when a patient is admitted. This would help raise the profile and identify patients who attend the Health Board outside of the Emergency Department who drink in a harmful way and ensure that they are treated in the most appropriate way.	Alcohol screening training (electronic) extended across wider Health Board staff. Information on alcohol, it's impact on health and screening and treatment services to be made available and promoted to all staff and departments, waiting rooms etc.	31/03/2025	05/12/2024	Amber	In progress	July 2024 IA tracker update: 1. Online Alcohol Brief Intervention content being developed via Public Health Wales. C&V Public Health Team are inputting. Alcohol Programme Manager will work to embed training once in post. 2. No change to implementation date. 3. None.
Internal Audit - Mortality Reviews	The Health Board should develop an overarching policy and procedure following completion and approval of the All-Wales Learning for Mortality Review Model Framework which sets out the respective roles and responsibilities and the procedures which should be followed.	Development of a learning from morality framework.	01/04/2025	10/07/2024	Amber	In progress	
Internal Audit - LIMITED Follow Up: Implementation of Health Roster System	Rosters need to be published on time in line with the roster timetable and also approved.	In response to many rosters not being published 6 weeks before they commence, a new monthly report has been developed to identify both the number and percentage of wards/departments who are not issuing their rosters on time for each Clinical Board. This is presented at the Nursing and Productivity Group each month to ensure this is being performance managed by the Clinical Board Directors of Nursing. However, due to the current way that theatre lists are configured, this means that the same target for peri-operative staff cannot be included at this time but will however aim to achieve this same objective but over a longer period.	01/04/2025	09/01/2025	Red	In progress	

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Internal Audit - LIMITED Follow Up: Implementation of Health Roster System	The E-Roster Team should continue to liaise with the Roster Managers and ensure that the rules and parameters within the HealthRoster system are up to date and working effectively to improve the effectiveness and uptake/utilisation of the "auto-roster" functionality.	Although the auto rostering feature has been made available for all areas, take up has been limited due to individual work life balance agreements not being up to date in the Health Roster system. CB Directors of Nursing will request all areas who are not using the auto roster feature to contact the E-Rostering team to ensure all WLB agreements are current and can therefore improve the capability of publishing usable rosters.	01/04/2025	09/01/2025	Amber	In progress	
Internal Audit - LIMITED Follow Up: Implementation of Health Roster System	Roster Managers should ensure that they are finalising shifts in a timely manner. Clinical Board Director of Nurses need to emphasise the importance to the Roster Managers of finalising the shifts.	Although the verification of bank and agency shifts is no longer an issue, the verification of substantive shifts within the Clinical Boards requires improvement. A report is now presented monthly at NPG to identify the number of shifts that are not approved by the payroll deadline and then have to be cancelled. The report will enable the Executive Director of Nursing to performance manage this issue on an ongoing basis. A further communication will be developed and sent to all Ward Sisters and Charge Nurses explaining that the deadlines need to be complied with as it delays the payments to their staff and also results in them having to do additional work by re-entering the shift on health Roster and then verifying.	01/04/2025	09/01/2025	Red	In progress	
Internal Audit - Mortuary Refurbishment at University Hospital Wales	The review of the Capital Projects Manual should be concluded and approved as soon as possible, and brought into use for all projects delivered by Capital, Estates & Facilities as previously agreed.	Agreed. A revised Capital Planning Manual in draft has been developed and is being reviewed internally. Upon completion of internal review, it will be shared with colleagues in NWSSP A&A SSu to comment and advise on any suggested amendments etc. The document will then be updated as necessary prior to it being considered within the UHB governance framework for approval, with the intention to implement from 1st June 2025.	31/05/2025	23/01/2025	Amber	In progress	

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Internal Audit - Smoking Cessation	Appropriate Resourcing of Hospital Smoking Cessation Service	Ahead of the decision on future funding via the business case, the Hospital Smoking Cessation Service and Public Health Team will review collaborative working arrangements to ensure referral and treatment pathways are efficient, appropriate, meet the needs of patients/clients and ensure smooth transition from inpatients to outpatient/community services. Once future funding is established, the two teams will work collaboratively to assess what action is required to optimise resourcing to the Hospital Smoking Cessation Service to enable it to effectively deliver its formally documented mandate and role in full.	30/06/2025	20/12/2024	Red	In progress	
Internal Audit - Medical Equipment	The Clinical Engineering Department should liaise with Directorate and Ward Management on a planned and scheduled basis to confirm the ongoing existence and location of medical equipment items, to ensure the accuracy of the Medusa medical equipment database.	Initially, Clinical Engineering will perform an audit of items not seen for over 10 years. Confirmation of accuracy will be sought from Directorates and Ward Management. Depending on the results of this initial audit follow up audits will be scheduled on a regular basis.	30/06/2025	20/01/2025	Amber	Partially complete	Nov 2023 Audit Committee update: No, a further extension to the implementation date is required. Feb 2024. [EC aDoTH 10/23] Please extend to May 2024 . The member of staff tasked with this (and other actions) has left since the July update and we are recruiting a replacement. Some preparatory work has begun on the audit, but operational pressures and lack of staff resource have delayed further progress. Implementation date changed to May 2023 to allow time to train staff and carry out work. [Jan 25] PowerBI software enviroment now working correctly, new target date of 30/06/25

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Internal Audit - LIMITED - Interventions Not Normally Undertaken (INNU)	1.1 - A complete set of Hospital Health Pathways should be developed and added to the Hospital Health Pathways Portal to aid consistent application of the INNU policy. 1.2 - Following completion of the Health Technology Wales Review, the Health Board should incorporate the Welsh Government (WG) INNU guidance dated 25 August 2023 into its policy or engage with WG if clinicians have concerns. 1.3 - Clinical codes (where available) should be put in place for all interventions to enable identification, categorisation and monitoring to be undertaken.	1.1 - Community HealthPathways is in place and actions from the review following the notification from WG is due for completion Q4 24/25. There is an ambition to upload guidance onto the Hospital HealthPathways platform to support secondary care clinicians with patient management in line with the INNU policy. This is due for completion ~Q3 25/26 depending on other project priorities. As Community HealthPathways is the most impactful platform to support patient management we feel these timelines are appropriate to respond to the matter arising.	31/10/2025	06/01/2025	Red	In progress	Maria Dyban is now the named contact regarding the outstanding actions for the Community HealthPathways. Contacted 16th December to receive an update. Hospital HealthPathways has a project board meeting monthly. The INNU working group will aim to offer a shortlist of procedures that should be written onto the HealthPathways system, to put forward to the project team.
Internal Audit - Smoking Cessation	Absence of effective promotion of the Hospital Smoking Cessation Service within the Health Board	Work will be undertaken collaboratively between the Hospital Smoking Cessation Service and Public Health Team to increase and improve the level of awareness of smoking cessation support available via electronic media across the UHB for patients, staff and visitors. In addition, more Smoking Cessation promotional resources will be placed on display within public, clinical and Ward based settings.	31/10/2025	20/12/2024	Red	In progress	

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AMAT Guide for Internal Audit

Why do we get audited?

- Audits are a key element of good corporate governance – ensures gaps / deficiencies identified by audit are acted upon
- It embeds accountability for addressing those gaps & assists committees in assurance, oversight and management of risk
- It ensures important issues do not “fall off the radar”
- Helps to secure value and impact from audit work
- They are an important part of an organisation’s overall approach to service improvement
- They can help to identify consistent or recurring themes or issues and support organisational learning
- Limited assurance – any audits that are classed as limited assurance will be monitored by the Audit Committee. **It is imperative that any actions from a limited assurance audit are prioritised as a matter of urgency, as the Executive lead will be required to attend the next audit committee to update on the progress.**

What is AMAT and why are we using it?

- Corporate Governance is undertaking work to digitise how we manage our audit trackers (Internal Audit and Audit Wales). We are moving from an Excel spreadsheet that is normally presented at the Audit Committee and instead putting this on to AMAT, which is an electronic innovative system designed to make auditing easier, faster and more effective.
- AMAT is designed around a dashboard system which means the results audit data can be seen at a glance in an easy-to-read format. The dashboard gives clear visuals which makes it easy to see if departments are compliant, how well the UHB is performing and if improvements need to be implemented. We have also received good feedback from Clinical Boards regarding how easy they find the system to use for their clinical audit work.
- AMAT automatically generates notifications via email for individuals who have recommendations and/or actions assigned to them to remind them of the due dates and to act.

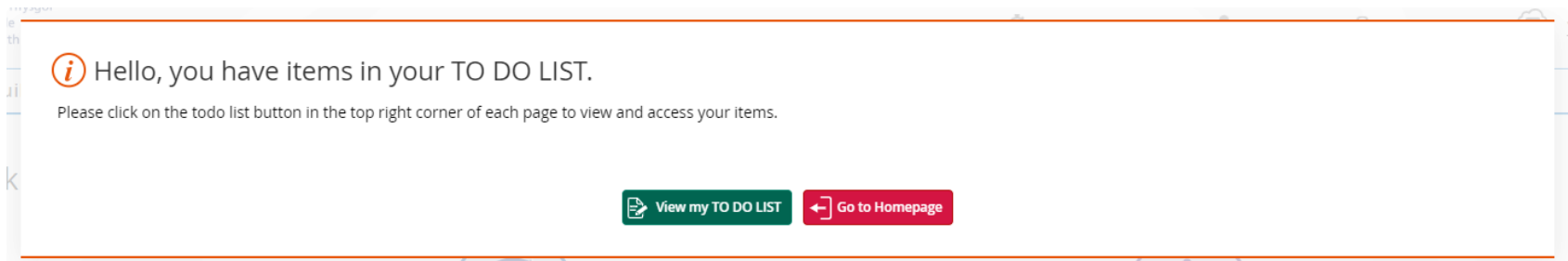
How do I create an AMAT account and log in?

- 1. You will be sent an email asking you to log into AMAT once an administrator has added you to the platform. Emails from AMAT will include links to the website.
- 2. Alternatively, please use the link here: [Audit Management and Tracking - Log in](#)

I have been assigned an action - how do I manage them?

AMAT automatically generates an email notification for individuals who have been assigned to any recommendations or actions. These emails contain links which will take you straight through to the action.

Alternatively, you can click on the ‘To Do List’ that pops up once you log in which will provide you with a list of your assigned actions which you can select to view.



To manage the action, hover over the ‘Manage’ button (highlighted below) and click ‘View & Edit’.

Actions									
We have found 1 action that match your search criteria.									
Export to Excel Generate PDF									
Reference	Action	Site	Service	Responsibility	Date raised	Due date	Approval board	Progress status	Manage
Risk and Regulation/2024/925/MD1/1	MD XXXXX	Trust wide	Trust wide	Ms Rachel Chilcott	05/12/2024	05/12/2024	Audit and Assurance Committee	Overdue	MANAGE

The below page should show.

I am responsible for approving an action – what do I do?

Not everybody with an AMAT account will be able to approve completion requests. It will need to be discussed amongst your teams who will oversee the inspection, who will then be granted access by the Corporate Governance team.

The approval of actions will be decided locally, and progress of the action will need to be discussed within your relevant teams and updated on AMAT accordingly.

If you have been given approval access, once the relevant action has been marked as ‘Fully Complete (Awaiting Approval)’, you will receive an email like the below. The link in the email will take you straight through to the action.

Inspection action awaiting approval

Hi Rachel,

The status of the inspection action detailed below has been set to awaiting approval. Please follow the link below to approve or reject this action.

Inspection title: XXXXXXXX

Inspection origin: Corporate Governance

Recommendation reference number: Corporate Governance/ XXXXXXXX

Action reference number: Corporate Governance/ XXXXXXXX

Comments/Updates: N/A

Updated by: XXXXXXXX

Your role in this inspection action: Internal inspection team member

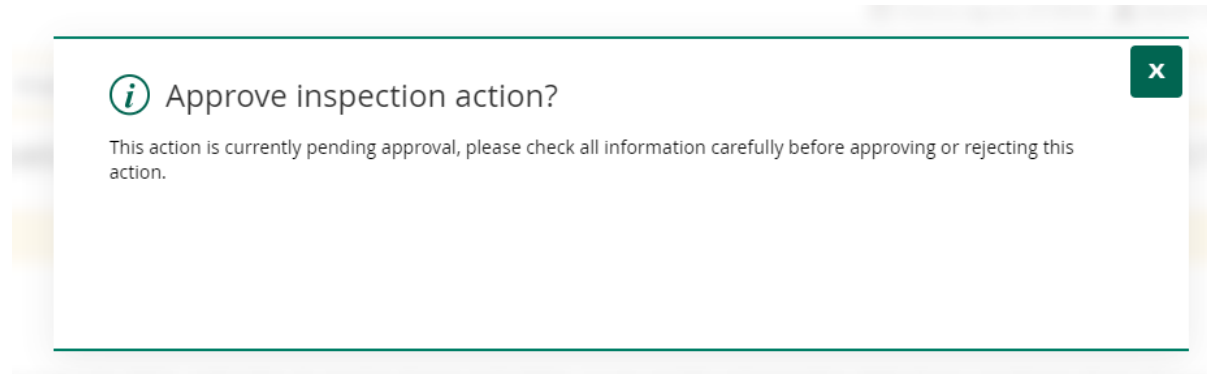
Please follow this link to view this inspection action:
[Click here to view this inspection action](#)

Best regards,
AMaT

Please login to AMaT via the icon on your Trust desktop.

1. This pop-up box will appear – please ensure that you read through and check all of the information provided within the action.

Saunders, Nathan
08/05/2025 15:28:30



2. On the right-hand side, there are two buttons to either 'Approve' or 'Reject' an action.

📋✔ Approve action - xxxxxxxx

Action

Recommendation: *

✔ Approve

✖ Reject

3. If you click 'Approve', the below page will show. Please ensure that you **click the box** (despite it not going to a Committee) as it will not let you move onto the next page without it. You can also upload evidence to support the approval of the action.

📋✔ Approve action - Internal Audit - Development of Genomics Partnership Wales - Risk and Regulation/2022/269/MD1/1

Action approval

Please check this box to confirm that this action was approved by the relevant approving committee/board: * ☐

Upload evidence from the meeting with the relevant approving committee/board?:

Upload new file

No files currently uploaded.

⬅ Back

✔ Approve

4. If you click 'Reject', you will need to cite a reason as to why the action is not deemed complete (as shown below). An email will be sent to the recipient to state that the approval request has been rejected and will outline the reason given. They will then have the opportunity to go back and review the action with further updates.

Reject action

Please provide the reason for rejecting this action and click 'Reject' to confirm.

Reason: *

Reject

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 Rachel Chilcott

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Update inspection - Audit Wales - xxxxxxxxx

|

Inspection details

Recommendations

Actions

Documents

Notes

Reports

1. Select the 'Documents' tab along the top of the page (highlighted above).
2. Click 'Upload new file' on the right-hand side.

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08/05/2025 15:28:30

×

Upload file

Fields marked * are mandatory

Use this form to upload files related to your inspection.

The following file types can be uploaded here:

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- Excel Spreadsheet (.xlsx)
- DOC (2003) (.doc)
- PowerPoint Presentation (2003) (.ppt)
- Message files (.msg)

- Excel Spreadsheet (2003) (.xls)
- PDF (.pdf)
- DOCX (.docx)
- PowerPoint Presentation (.pptx)

Choose File

No file chosen

Information Governance *

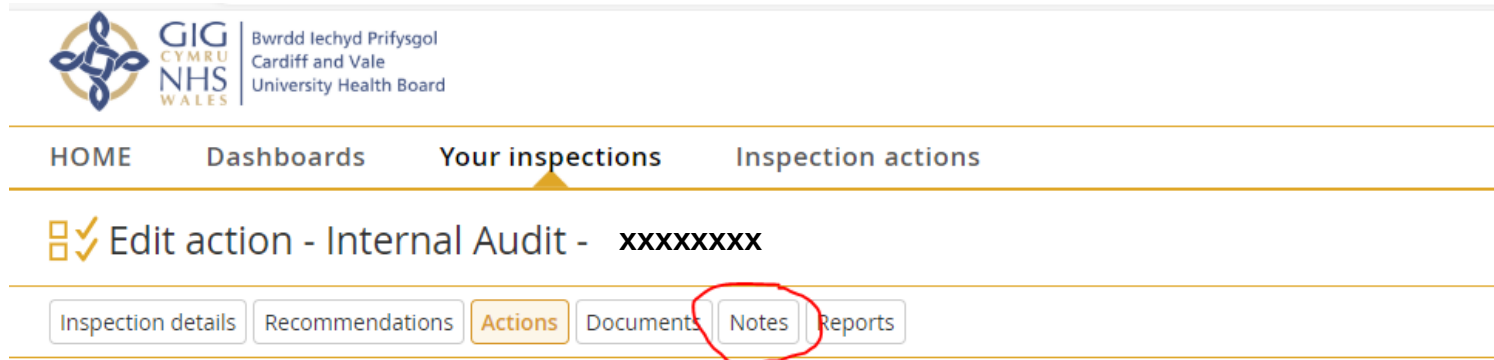
☐ THIS DOCUMENT MUST NOT CONTAIN PATIENT IDENTIFIABLE DATA
I confirm that the file I am uploading DOES NOT contain any patient identifiable information. (Patient identifiable information includes, hospital/NHS ID, patient name, date of birth and address including post code).

Upload

3. Choose the file you wish to upload.
4. Tick the box to confirm that the document does not contain any patient identifiable data.
5. Select 'Upload'.
6. Any evidence uploaded within the action will also appear here.

How do I add notes? –

Saunders Nathan
08/05/2025 15:28:30



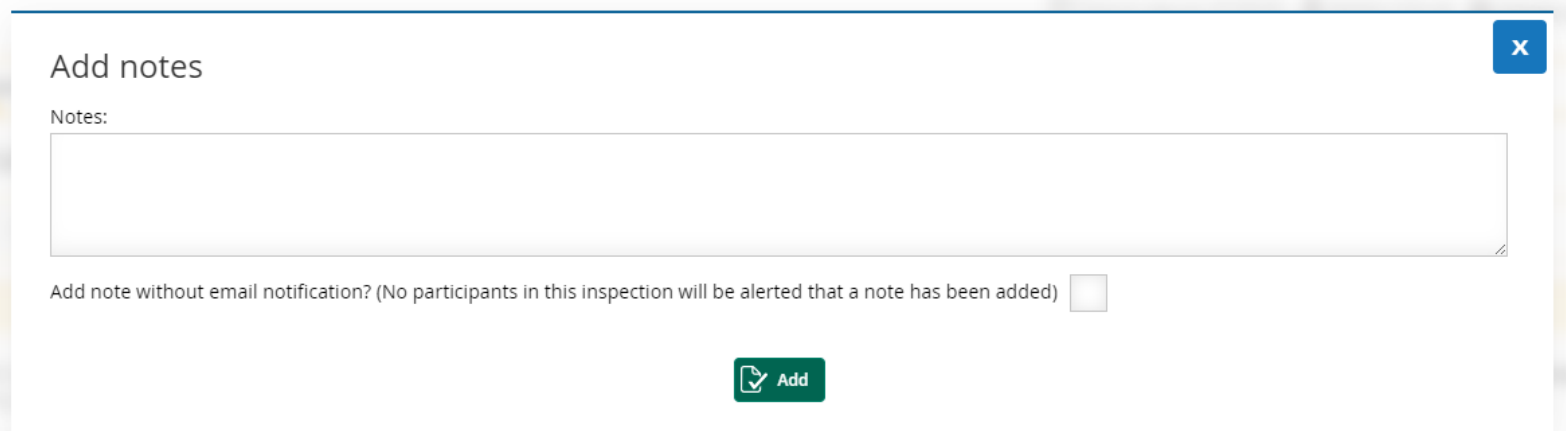
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📁 Edit action - Internal Audit - xxxxxxxx

Inspection details Recommendations **Actions** Documents **Notes** Reports

1. Select the 'Notes' tab along the top of the page.
2. Click 'Add Notes' on the right-hand side.



Add notes ✕

Notes:

Add note without email notification? (No participants in this inspection will be alerted that a note has been added) ☐

 Add

3. The above pop-up box should appear. Type in your note.
4. Select the box if you do not wish to send an email notification of your note to be sent to all individuals within the Inspection Team.
5. Click 'Add'.

Queries

If you have any queries or feedback on the use of AMAT, please email @corporate.meetingcav@wales.nhs.uk where one of the team will respond to your message.

Report Title:	Report of the Losses and Special Payments Panel			Agenda Item no.	3.1
Meeting:	Audit and Assurance Committee	Public	X	Meeting Date:	4 th February 2025
		Private			
Status <i>(please tick one only):</i>	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Finance				
Report Author (Title):	Head of Financial Accounting and Services				

Main Report
Background and current situation:

As defined in the Standing Financial Instructions, the Audit and Assurance Committee is required to approve the write off of all losses and special payments within the delegated limits determined by the Welsh Government. To assist the Audit and Assurance Committee with this task, the UHB has established a Losses and Special Payments Panel, under the chairmanship of the Executive Director of Finance (delegated to the Deputy Director of Finance). This panel meets twice yearly and is tasked with considering the circumstances around all such cases and to make appropriate recommendations to the Committee.

The work of the panel supports the UHB’s sustainability and ensures that we make the best use of the resources that we have.

The Losses and Special Payments Panel met on 26th November 2024 to consider the 6 month period 1st April 2024 to 30th September 2024. This report informs the Audit and Assurance Committee of the items considered at this meeting and the recommendations made for formal Audit and Assurance Committee approval.

The minutes of the Panel meeting are attached as Appendix 1 providing greater detail about the issues discussed at the meeting.

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

The losses and special payments discussed at the 26th November 2024 Losses & Special Payments Panel require consideration and approval by the Audit and Assurance Committee.

The following losses have been identified for write off:

- Clinical Negligence claims of £4.983m and Personal Injury claims of £0.043m for the period 1st April 2024 to 30th September 2024;
- Bad Debt write-offs of £17,269 for the period 1st April 2024 to 30th September 2024;
- Ex gratia and other losses of £3,821 for the period 1st April 2024 to 30th September 2024;
- Small Claims losses of £17,044 for the period 1st April 2024 to 30th September 2024;
- Employment Tribunal losses of £263,840 for the period 1st April 2024 to 30th September 2024.

Recommendation:

The Board / Committee are requested to:

- **APPROVE** the write offs for the period outlined in the Opinion and Key Issues Section of this report as recommended by the Losses and Special Payments Panel held on 26th November 2024.

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Impact Assessment:

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

Risk: No

Safety: No

Financial: Yes - This completes the summarized record of the losses incurred by the UHB in the first 6 months of 2024-25

Workforce: No

Legal: No

Reputational: Yes - This completes the summarized record of the losses incurred by the UHB in the first 6 months of 2024-25

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

MINUTES OF THE MEETING OF THE LOSSES AND SPECIAL PAYMENTS
PANEL HELD ON 26th November 2024

PRESENT: Robert Mahoney (RM) – Deputy Director of Finance (Chair)
Andrew Crook (AC) – Head of People Assurance & Experience
Helen Lawrence (HL) – Head of Financial Accounting & Services
Steve Monk (SM) – Losses & Taxation Accountant
Karen Lewis (KL) – Head of Personal Injury Claims

APOLOGIES: Henry Bales (HB) – Counter Fraud Manager
Rebecca Holliday (RH) – Head of Financial Services
Suzanne Wicks (SW) – Head of Clinical Negligence Claims

1. Minutes of Last Meeting

The minutes of the last meeting were reviewed for accuracy and the group endorsed the minutes as an accurate record. There were no matters arising which were not covered elsewhere on the agenda.

2. Clinical Negligence and Personal Injury Losses

SM presented the financial report on Clinical Negligence and Personal Injury losses for the period 1st April 2024 to 30th September 2024. He stated that the **first part** of the report was to note the Income & Expenditure (I&E) impact and the **second part** was to report the finalised claims for write off.

First Part - Summary of Losses

	2024/2025 £'000	2023/2024 £'000
Clinical Negligence	6,661	36,974
Personal Injury	19	118
Total Loss	6,680	37,092
Less WRP Receipts Due	-5,649	-36,069
Total Net Cost to the UHB	1,031	1,023

SM advised that the gross cost for all new and ongoing Clinical Negligence claims was £6.661m. The number of new claims that the UHB is receiving is broadly level with the previous year as was the number of claims – 25 – which were reclassified by L&R from Possible to Certain to settle.

The value of individual claims continues to increase significantly which is a trend reflected across Wales. C&V currently have 14 open claims valued above £5m, as recently as 2017 there were none.

SM advised that the impact of all new and ongoing Personal Injury claims was a gross cost of £0.019m. He advised that there was a modest reduction in the number of cases that moved from Possible to Certain to settle compared to the same period in 2023/2024. The UHB continues to use our in house Alternative Compensation Scheme which provides redress to injured individuals without the need for costly litigation. Improvements in working practice, safety at work and investigative process has resulted in individuals being dissuaded from seeking legal advice to pursue potential claims.

Recommendation

The Panel recommended that the Audit and Assurance Committee note that the gross cost of Clinical Negligence & Personal Injury claims for the full year was £6.680m and following expected reimbursement from the Welsh Risk Pool of £5.649m, the net cost to the UHB on these claims was £1.031m.

Second Part - Finalised Claims

Clinical Negligence

During the six month period ending 30th September 2024, there were **39** claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of **£4.983m** (which is treated as a loss for write off). The UHB had also incurred £0.269m in defence fees and was successful in recovering £4.612m from the Welsh Risk Pool for these claims, resulting in a net cost to the UHB of £0.640m.

Personal Injury

During the six month period ending 30th September 2024, there were **5** claims (where liability had been conceded and settlements paid) which had concluded at a total settlement cost of **£0.043m** (which is treated as a loss for write off).

The UHB had also incurred £0.008m in respect of defence costs on these claims, resulting in a net cost to the UHB of £0.051m.

The panel were advised that expenditure on defence fees on Clinical Negligence and Personal Injury cases was not treated as a loss and also that all costs are accrued over the lifetime of a claim which can span many years.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 39 Clinical Negligence claims totalling £4.983m and 5 Personal Injury claims totalling £0.043m for the period 1st April 2024 to 30th September 2024.

3. Debt Write Offs

HL presented a report on proposed invoice write offs for the period 1st April 2024 to 30th September 2024.

These were as follows;

months 1-6	2024/25	
	Value	No
Payroll	£ 6,087.93	28
Private Patients	£ 859.00	3
O/Seas Patients	£ 9,259.39	6
Misc	£ 1,063.42	26
	£ 17,269.74	63

As in previous years, recovering overpaid salaries for terminated employees remains a challenge. We continue to send overdue invoices to CCI Credit Management for collection. As noted in previous meeting, most of these overpayments are caused by late submission of employment termination forms and managers being unaware of the relevant payroll cut-off dates.

For overseas cases, there is one invoice for £4,000 that relates to a deceased patient. All other outstanding bills were sent to CCI; however, due to

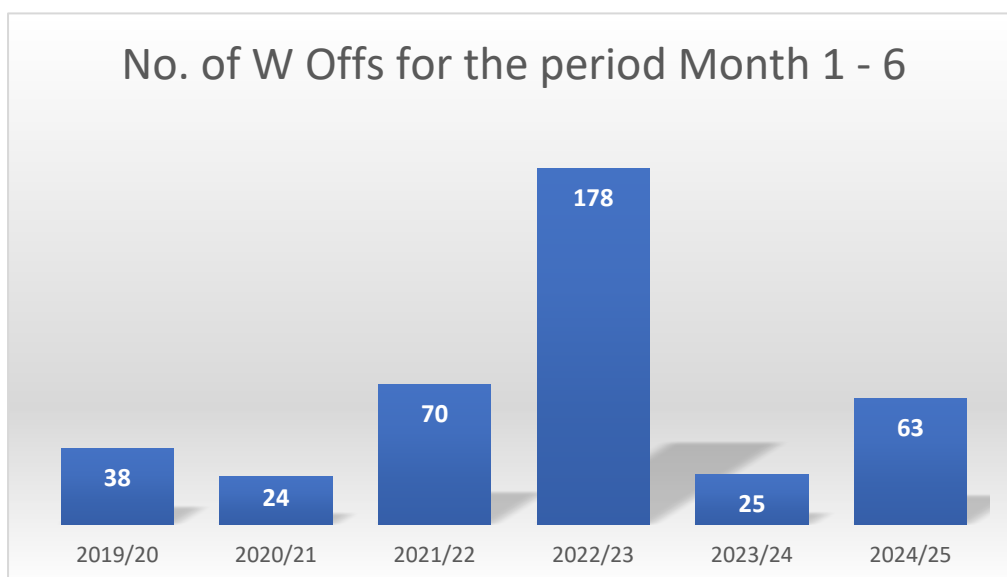
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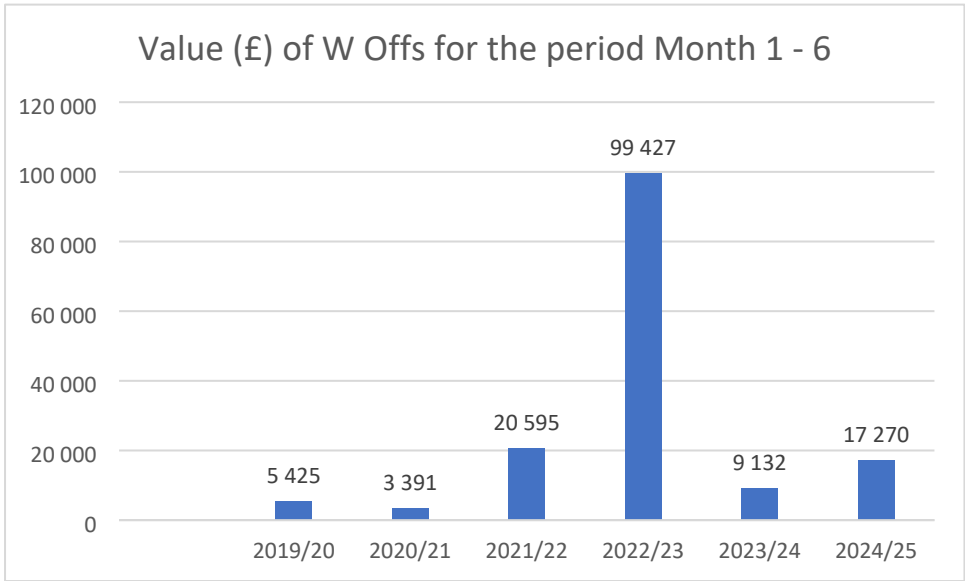
insufficient contact information, CCI has exhausted all collection efforts. Debts exceeding £500 overseas are referred to UKBA.

Most invoices in the miscellaneous category are under £100. All, except those related to exchange rate differences, have been sent to CCI for collection and they have exhausted all collection efforts.

HL presented a table and graphical analysis to highlight the number and value of write offs actioned in the previous 4 years;

months 1-6	2019/20		2020/21		2021/22		2022/23		2023/24		2024/25	
	Value	No	Value	No	Value	No	Value	No	Value	No	Value	No
Accommodation	£ -	0	£ 297.00	1	£ -	0	£ 4,117.65	13	£ -	0	£ -	0
Dental	£ 70.00	5	£ -	0	£ -	0	£ -	0	£ -	0	£ -	0
Payroll	£ 2,034.60	7	£ 1,579.27	6	£ 15,457.71	43	£ 59,461.10	79	£ 8,317.00	9	£ 6,087.93	28
Private Patients	£ 776.00	8	£ -	0	£ -	0	£ 167.50	2	£ -	0	£ 859.00	3
O/Seas Patients	£ 66.00	1	£ 184.13	2	£ 3,829.00	2	£ 28,241.30	15	£ -	0	£ 9,259.39	6
Misc	£ 2,478.03	17	£ 1,331.00	15	£ 1,308.37	25	£ 7,439.69	69	£ 814.97	16	£ 1,063.42	26
	£ 5,424.63	38	£ 3,391.40	24	£ 20,595.08	70	£ 99,427.24	178	£ 9,131.97	25	£ 17,269.74	63





Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 63 bad debts totalling £17,269.74 for the period 1st April 2024 to 30th September 2024.

4. Ex Gratia and Other Losses

SM presented a report on the ex-gratia losses for the period 1st April 2024 to 30th September 2024. There had been **5** payments totalling **£2,472.00** made as a result of complaints made against Cardiff & Vale UHB where, following investigations, the Public Services Ombudsman for Wales made recommendation to the UHB to compensate the claimants. There were **2** cases totalling **£492.07** related to administration and interest levied by the NHS Pension’s Agency in respect of the late payment of Pension contribution invoices. Finally, there were **3** instances totalling **£120.00** where forged £20 notes passed through the UHB’s catering outlets.

HL presented a report on the UHB’s petty cash floats. As part of a post-year-end review of the petty cash procedures and balances, it had been identified that there were a number of small historical discrepancies totalling **£737.18**. These discrepancies date back many years and require writing off in order to

maintain the accuracy and integrity of the UHB's financial records for Petty Cash.

HL advised that a review of all petty cash activities is ongoing as part of the modernisation group, to ensure that cash transactions are kept to a minimum. Going forward independent checks will form part of the Financial Control Procedures which also aligns to the *Standing Financial Instructions*. 8.2.3 - *Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.*

HL advised that to strengthen the petty cash financial controls, the UHB was currently reviewing its year-end process and the Financial Control Procedure will be updated accordingly. This shall ensure accuracy and accountability; all main floats and sub floats will be required to submit signed documentation by the 31st of March and have cash balances verified by the Cashier's office.

The Treasury Manager will have responsibility to verify and highlight any variances to Head of Financial Services. This will provide clear audit trails and ensure that all petty cash holdings are accurately recorded and reconciled.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 11 ex-gratia & other losses totalling £3,821.25 for the period 1st April 2024 to 30th September 2024.

5. Small Claims Losses

KL presented a report on the small claims for the period 1st April 2024 to 30th September 2024. During the period **33** claims had been settled at a total cost of **£17,044.09**. A breakdown of the cases were as follows;

Breakdown of 33 cases:

- ❖ Loss/Damage Clothing – 2 claims = £273.26
- ❖ Loss of Money – 2 claims = £154.95
- ❖ Loss of Spectacles – 3 claims = £786.75
- ❖ Loss of Dentures – 3 claims = £1,827.00

- ❖ Loss of Hearing Aids – 4 claims = £6,577.00
- ❖ Damage to Vehicles – 3 claims = £3,462.64
- ❖ Loss of Personal Possessions – 10 claims = £1,712.27
- ❖ Loss of Jewellery – 4 claims = £1801.12
- ❖ Travel Expenses – 1 claim = £25.00
- ❖ Miscellaneous Lost Item – 1 claim = £424.10

KL advised that since the last period, there has been a slight decrease in the reimbursement of small claims submitted for reimbursements despite settling an additional number of small claims in the period. 33 compared to the 29 in the last reporting period. All Small claims are challenged to ensure evidence of a receipt or proof of purchase to ensure any compensation is in order of correct full value for the items damaged or lost.

The highest value claim this period was for loss of a hearing aid on the Emergency Unit which was for £2,832, the patient had his bag with him containing his hearing aids and clothing when admitted to Emergency Unit, but on transfer to Ward A6 his bag went missing. This was fully investigated following the loss of the aid. A receipt was provided and this was fully compensated.

The second highest value claim was also for a loss of hearing aids for £2,700 on a Medicine Ward at UHW the patient went from Ward C7 for an X Ray and he was wearing the Hearing Aids, they were removed in Radiology Department and he did not receive them back on his return to the Ward. They could not be located and a receipt was provided without dispute, and patient was fully compensated.

Hearing aids are an expensive item, on presentation of receipts it is difficult to argue the value, as well as the inconvenience of the loss of these to the patient. All property including hearing aids are recording on the property list. On these two cases they had both been recorded on property lists. The Ward are mindful of the value of these items and ensure items are recorded on property lists on admission.

For this report the highest number of claims have been from Medicine Wards and relate to loss of patient personal property including hearings aids, dentures and glasses.

The UHB advises patients to hand over any personal items to relatives / friends. This is difficult with items such as spectacles, hearing aids and dentures, as these need to remain with the patient.

Posters around the hospital remain, to highlight and remind staff, patients and visitors, of the procedures they should all follow to avoid missing property and claims being submitted.

Also there have been a few Claims where property has gone missing on the Emergency Unit where no Property Lists have been completed, we have made the Senior Nurses aware of the importance of Property Lists being completed and they will highlight this at their next Staff Meeting.

We have received three small claims relating to car damage, one from damage by a absconding patient, the other related to building maintenance issues.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 33 small claims totalling £17,044.09 for the period 1st April 2024 to 30th September 2024.

6. Employment Tribunal Costs

AC presented a report outlining the claims and costs for the period 1st April 2024 to 30th September 2024. During the period, Cardiff and Vale UHB had been involved with 13 Employment Tribunal claims. **3** of these cases had settled at a cost of **£263,840** and 2 cases had been dismissed. There were 8 claims that remained open.

Recommendation

The Panel recommended that the Audit and Assurance Committee approve the write off of 3 Employment Tribunal cases totalling £263,840 for the period 1st April 2024 to 30th September 2024.

7. Counter Fraud

HB was unable to attend the meeting but had presented SM with a report for the period 1st April 2024 to 30th September 2024 advising that no claims had concluded and there were no proven unrecovered losses to write off for the period.

The next meeting of the panel would be in May 2025.

Report Title:	Counter Fraud Progress Report			Agenda Item no.	4.1				
Meeting:	Audit & Assurance Committee	Public	☒	Meeting Date:	04/02/2025				
Status <i>(please tick one only):</i>	Assurance	☒	Approval	☐	Information	☒			
Lead Executive:	Catherine Phillips								
Report Author (Title):	Henry Bales								
Main Report									
Background and current situation:									
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. The report provides information around key areas of work including, fraud awareness and learning, proactive, investigation and reactive work, and promotional activity									
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 Salary Overpayments									
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	☒	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									
<i>Please tick as relevant</i>									
Prevention	☒	Long term	☒	Integration	☒	Collaboration	☒	Involvement	☒
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	
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.	
Socio Economic: Yes/No	
Equality and Health: Yes/No	
Decarbonisation: Yes/No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Catherine Phillips	

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Counter Fraud Progress Report

19/10/2024 – 22/01/2025

Public

HENRY BALES
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Saunders
08/01/2025 11:30

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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 19/10/2024 – 22/01/2025.

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 and Assurance Committee are encouraged to visit the site at the link/QR code here**

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



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08/05/2025 15:28:30

Promotion and Awareness and Educational Activity

Newsletter – One further Newsletter has been produced. This has been published to Counter Fraud Share point pages and shared with the communications team for wider distribution.

E-Learning – The total number of staff who have completed Counter fraud E-Learning is now 1187, with 6 member of staff completing training during quarter 3. In the financial year 2024-25 21 members have staff have completed e-learning to date.

International Fraud Awareness Week – Fraud awareness week ran between 17th November and 23rd November 2024. In addition to the specific IFAW newsletter a SharePoint page was created with information, videos and links which has been circulated. Members of the counter fraud team also attended sites across the health board during the week to drop off promotional material and speak with staff.

Prevention

Local Bulletins/Alerts – (1)

Alert circulated to all Primary Care Contractors and internally to CAVUHB regarding intelligence received surrounding card payment terminal frauds.

IBURN (intelligence bulletin) – (2)

- 1- Intelligence regarding an individual alleged to be falsifying accreditation and applying for positions within NHS finance departments. – Enquiries made, no applications from individual to organisation, recruitment and finance teams made aware for any future applications.
- 2- Report of an email spoofing payroll related fraud in a different NHS region. Details shared with cyber security for preventative action. No issues identified for CAVUHB.

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Local Proactive Exercise / Risk Work

A National Proactive Exercise was set out by the Counter Fraud Authority earlier this year to look into 'Procurement Fraud Risks' focussing on 'Due Diligence' and 'Contract Management'. The end date for this exercise was November 8th 2024. The exercise has been completed for CAVUHB for both areas, this involved completing internal control evaluations and dip samples of contracts. During this no concerns were raised. When the compiled national report is returned a more detailed review will be provided to the committee.

National Fraud Initiative

The first release of data matches in the 2024-25 NFI programme have now been received (20th December 2024). At this time there are 456 matches for CAVUHB across the various reports.

The counter fraud department will initially focus on the high-risk scoring matches.

Referrals

During this reporting period there have been a total of 32 referrals made to the team. 11 of these referrals have been promoted to investigations (detailed in next section). The remaining referrals have all been closed.

Investigations

During this period there have been 11 new investigations commenced by the counter fraud team. There have been 9 investigations that have been concluded and closed on the system. This means that there are currently 10 investigations open with the at the time of this report. Summaries of the opened, closed and currently open cases are shown below.

Investigations of note will be subject to update in private session.

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Investigations opened in the period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/24/02725	Working elsewhere during contracted hours	28/10/2024	30/10/2024	No fraud issues identified - professional/competence matters passed on to directorate
INV/24/02795	False Sick Notes	04/11/2024		
INV/24/02796	Theft of Medication	04/11/2024	06/12/2024	No offence/offender identified. Actions taken to improve security.
INV/24/02863	Working elsewhere whilst sick	12/11/2024	25/11/2024	No evidence of overlapping shifts. DOI now completed.
INV/24/02923	Working elsewhere during contracted hours	15/11/2024	11/12/2024	No intent to defraud, steps taken to address, there is no loss.
INV/24/02926	Immigration/DWP Related Allegations	18/11/2024	25/11/2024	Potential offences fall outside of remit, Intelligence shared.
INV/24/03059	Theft of Medication	29/11/2024		
INV/24/03132	Diabetic / Weight loss Medication	06/12/2024		
INV/24/03145	Theft of Controlled Drugs	09/12/2024	21/01/2025	No offences identified
INV/25/00121	Accessing records	15/01/2025		
INV/25/00135	Concern surrounding activities outside of work	17/01/2025	21/01/2025	People services / directorate matter, no issues for counter fraud

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Investigations Closed in this period

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/02421	Money missing suspected stolen	CARRIED OVER - 26/10/2023	20/01/2025	Subject convicted at crown court
INV/24/00102	Working Elsewhere whilst sick	CARRIED OVER - 16/01/2024	23/12/2024	Verbal warning given and overpayment being repaid
INV/24/02725	Working elsewhere during contracted hours	28/10/2024	30/10/2024	No fraud issues identified - professional/competence matters passed on to directorate
INV/24/02796	Theft of Medication	04/11/2024	06/12/2024	No offence/offender identified. Actions taken to improve security.
INV/24/02863	Working elsewhere whilst sick	12/11/2024	25/11/2024	No evidence of overlapping shifts. DOI now completed.
INV/24/02923	Working elsewhere during contracted hours	15/11/2024	11/12/2024	No intent to defraud, steps taken to address, there is no loss.
INV/24/02926	Immigration/DWP Related Allegations	18/11/2024	25/11/2024	Potential offences fall outside of remit, Intelligence shared.
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Investigations that remain open

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/00825	Salary Overpayment for Sick Pay	CARRIED OVER - 02/05/2023		
INV/23/01634	Salary Sacrifice Vehicle - Payments not made	CARRIED OVER - 03/08/2023		
INV/23/02002	Theft of Controlled Drugs	CARRIED OVER - 15/09/2023		
INV/24/00336	Overpayment	CARRIED OVER - 09/02/2024		
INV/24/00462	Working elsewhere whilst sick	CARRIED OVER - 21/02/2024		
INV/24/01972	Inflated travel expenses claims	02/08/2024		
INV/24/02795	False Sick Notes	04/11/2024		
INV/24/03059	Theft of Medication	29/11/2024		
INV/24/03132	Diabetic / Weight loss Medication	06/12/2024		
INV/25/00121	Accessing records	15/01/2025		

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3. Significant Salary Overpayments

There have been 8 significant salary overpayments reported for this period. All of these have been reviewed by the counter fraud team and none have required escalation to formal criminal investigations.

NB. 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.

A digital dashboard has been developed and implemented to assist with the monitoring of salary overpayments, their causes and the departments where they occur. This dashboard is accessible to the Finance and Counter Fraud teams and should assist in providing timely and accurate data in relation to any problem areas.

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