Public Audit & Assurance Committee

Tue 06 July 2021, 09:00 - 12:30

MS Teams

Agenda

1. Welcome and Introductions

John Union

2. Apologies for Absence

John Union

3. Declarations of Interest

John Union

4. Minutes of the Committee meeting held on 13th May & 10th June 2021

John Union

4 - Draft Unconfirmed Audit Committee Public Minutes 13.05.21 v2 - JU.pdf (6 pages)
4 - Draft Unconfirmed Special Audit Committee Public Minutes 10.06.21 v3 JU.pdf (6 pages)

5. Action log following meeting held on 13th May 2021

John Union

5 - Public Action Log following 13.05.21.pdf (2 pages)

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

John Union

7. Items for Review and Assurance

7.1. Internal Audit Progress and Tracking Reports

Ian Virgill

7.1 - A&A Progress Report cover July 21.pdf (2 pages)
7.1.1 - A&A Progress Report July 21.pdf (14 pages)

7.2. Audit Wales Update

Wales Audit

7.2 - Audit Committee update.pdf (10 pages)

7.3. Structured Assessment 2021 (Phase One) – Operational Planning Arrangements

Wales Audit

7.3 - Structured Assessment 2021 (Phase One) – Operational Planning Arrangements.pdf (10 pages)

7.4. Rollout of the COVID-19 vaccination programme in Wales

Wales Audit

7.4 - Rollout of the COVID-19 vaccination programme in Wales.pdf (30 pages)

7.5. Procuring and Supplying PPE for the COVID-19 Pandemic

Wales Audit

7.5 - Procuring and Supplying PPE for the COVID-19 Pandemic.pdf (64 pages)

7.6. Welsh Health Specialised Services Committee Governance Arrangements

Wales Audit

7.6 - Welsh Health Specialised Services Committee Governance Arrangements.pdf (32 pages)

8. Items for Approval / Ratification

8.1. Declarations of Interest and Gifts and Hospitality Tracking Report

Nicola Foreman

8.1 DOI Tracking Report (July 2021).pdf (3 pages)

8.2. Regulatory Compliance Tracking Report

Nicola Foreman

8.2 Regulatory Compliance Covering Report.pdf (4 pages)
8.2aRegulatory Heat Map - July 21 - Final.pdf (5 pages)

8.3. Internal Audit Tracking Report

Nicola Foreman

8.3 Internal Audit Tracker Covering Report July 2021.pdf (3 pages)
8.3 Internal Audit Summary Tables - Appendix 1 July 2021.pdf (3 pages)
8.3a Internal Audit Tracker July 2021 - Final (2).pdf (8 pages)

8.4. Audit Wales Tracking Report

Nicola Foreman

8.4 External Audit Recommendation Tracking report covering report.NF.pdf (2 pages)
8.4a External Audit Summary Table - Appendix 1.pdf (1 pages)
8.4b WAO July 21 Final.pdf (2 pages)

8.5. Risk Management Strategy & Action Plan

Nicola Foreman

8.5 - Risk Management Strategy and Action Plan Cover Paper.NF.pdf (2 pages)
8.5.1 - Risk Management and BAF Strategy_Draft.pdf (38 pages)
8.5.2 UHB 024_Ver3-Risk Management Procedures_Final.pdf (21 pages)
8.5.2a UHB 024_Ver3-Risk Assessment Template_Final.pdf (2 pages)
8.5.2b UHB 024_Appendix 2_Risk Register Template.pdf (3 pages)

8.5.3 Roll Out Plan.pdf (1 pages)

8.6. Self-assessment of effectiveness

Nicola Foreman

8.6 - Self-assessment of effectiveness.pdf (20 pages)
8.6.1 - Appendix 1 Committee Effectivness Action Plan.pdf (1 pages)

8.7. Outstanding Audit Recommendations Update:

Nicola Foreman

1. **2018/19**
2. **2019/20**

8.7 Outstanding Audity Recommendations 2018-19 and 2019-20.pdf (4 pages)
8.7a Internal Audit Tracker 18-19 and 19-20 entries.pdf (4 pages)

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgill

1. Annual Planning Process 21/22 Report
2. Engagement Around Service Planning Report
3. Data Quality Performance Reporting (Single Cancer Pathway) Report
4. Infrastructure / Network Management Report
5. C&W CB – Rostering in Community Children's Nursing Report
6. Staff Recruitment Report
7. Wellbeing Hub at Maelfa Report

9.1.1 - Annual Planning Process 2021 - 2022.pdf (12 pages)
9.1.2 - Engagement around Service Planning.pdf (17 pages)
9.1.3 - Data Quality Performance Reporting (SCP).pdf (17 pages)
9.1.4 - Infrastructure Network Management.pdf (19 pages)
9.1.5 - C&W-CB Rostering in Community Children's Nursing Service.pdf (21 pages)
9.1.6 - Staff Recruitment.pdf (16 pages)
9.1.7 - Wellbeing Hub at Maelfa.pdf (37 pages)

9.2. NHS Counter Fraud Services in Wales - Q4 Report

Catherine Phillips

9.2 - NHS Wales Counter Fraud Services Q4 Performance Report final.pdf (28 pages)

10. Review and Final Closure

10.1. Items to be deferred to Board / Committee

John Union

10.2. To note the date, time and venue of the next Committee meeting: Tuesday 7th September 2021 at 9.00am

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Thursday 13 May 2021 9am – 10.30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Ceri Phillips	CP	Vice Chair
Mike Jones	MJ	Independent Member – Trade Union
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Jacqueline Evans	JE	Interim Head of Corporate Governance
Mark Jones	MJ	Audit Wales Financial Manager
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Rachel Gidman	RG	Executive Director of People and Culture
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Anthony Veale	AV	Audit Wales
Darren Griffiths	DG	Audit Wales Manager
David Edwards	DE	Independent Member – ICT

AAC 21/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 21/05/002	**Apologies for Absence** Members noted that apologies for absence had been received from David Edwards, the Independent Member – ICT, Darren Griffiths, the Audit Wales Manager and Anthony Veale from Audit Wales.	
AAC 21/05/003	**Declarations of Interest** No declarations of interest were noted.	
AAC 21/05/004	**Minutes of the Committee meeting held on 6 April 2021** The minutes of the Committee meeting held on 6 April 2021 were received. **The Committee resolved that:** (a) The minutes of the meeting held on 6 April 2021 be approved as a true and accurate record of the meeting.	

AAC 21/05/005	**Action log following meeting held on 6 April 2021** The action log was received and the CC advised the Committee that all of the actions were in hand, had been completed, were on the agenda for today's meeting or scheduled for a future meeting.	
AAC 21/05/006	**Any other urgent business: To agree any additional items of urgent business that may need to be considered during the meeting** No additional urgent items of business were raised.	

AAC 21/05/007	**Internal Audit Progress Reports**
	
	The Internal Audit Progress Reports were received and the Head of Internal Audit (HIA) provided the Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/2021 Internal Audit plan. The HIA advised that the report was brought to each meeting for assurance and noted:
	
	• 8 audits had not been completed in time to submit to the Committee, however they were anticipated to be finalised to feed into the final annual report and Head of Internal Audit Opinion for 2021,
	• The 8 unfinished audits were:
	  ○ Engagement Around Service Planning,
	  ○ C&W CB – Rostering in Community Children's Nursing,
	  ○ Recruitment & Retention of Staff,
	  ○ Annual Planning Process 2021/2022,
	  ○ Data Quality Performance Reporting,
	  ○ Infrastructure / Network Management,
	  ○ Cyber Security System Follow-up,
	  ○ Shaping Future Wellbeing in the Community Scheme,
	• at the time of producing the report, 3 of the outstanding audits had been issued in draft format with a positive audit assessment rating of "reasonable assurance",
	• a further piece of work had been issued in draft on quality data performance reporting which had also received a positive audit assessment rating of "reasonable assurance",
	
	The Vice Chair (VC) advised that when he had read the information provided on the Consultant Job Planning follow up, he had been surprised to see that it had been given a reasonable assurance given the information contained in the report.
	
	The HIA responded that the Consultant Job Planning Audit had started in May 2018 and it had been given a limited assurance rating. A follow up audit was undertaken in January 2020 and the current "reasonable assurance" assessment rating reflected the latest follow up and the scope focused on the agreed actions that had been implemented and progressed.
	
	The CC noted that a further update would be given in 6 months.	

	The Executive Director of People and Culture (EDPC) advised that the medical workforce work was progressing at pace, they had a CD in place and had increased compliance to 22% and there was confidence this would increase rapidly over the next 6 months. The HIA concluded that there was one remaining outstanding action concerning the Consultant Job Planning Follow Up report which would feed into the CVUHB recommendation tracker to monitor progress in managing the outstanding action. The Committee noted that: • the Health and Care Standards assessment report had been finalised which was a high level review to look at the plans and processes in place, • the internal audit team had also undertaken work on the IM&T control risk assessment, which had been a detailed advisory piece of work that had looked at the overall assurance actions in place concerning IT and Information Governance. Whilst no formal audit assessment rating had been given, information had been provided to managers for them to consider, • there had been one additional report within the CD&T Clinical Board which was being deferred to the 2021/2022 plan and had been agreed with the Clinical Board. The CC queried if the items that did not have a formal assurance rating would be recorded as actions and tracked in the usual way, and the HIA confirmed they would still be included in the formal tracking process. **The Committee resolved that:** a) The Audit & Assurance Committee internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports be noted. b) The proposed amendment to the Internal Audit Plan for 2020/2021 be approved.	
AAC 21/05/008	**Standing Orders, SFI's, Reservation and Delegation of Powers** The Standing Orders, SFI's, Reservation and Delegation of Powers report was received, and the Director of Corporate Governance (DCG) set out the changes that had been made to the Welsh Government model Standing Orders, Standing Financial Instructions (SFI's), and Reservation and Delegation of Powers. The Committee noted: • The Minister of Health and Social Services wrote to the Chair of the Board on the 7 April 2021 advising that the Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own standing orders, • Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in February 2019,	

	• Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in full in February 2019, • temporary amendments were made to the Standing Orders in July 2020 following the publication of a Welsh Health Circular 2020/11 relating to public appointments in Wales due to COVID-19, **The Committee resolved that:** a) The updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions for CVUHB be noted and endorsed for submission to the Board on the 27 May 2021 for final approval.	
AAC 21/05/009	**Compliance with the Corporate Governance Code** The Compliance with the Corporate Governance Code information was received, and the DCG advised that the required annual assessment against the "Corporate Governance Code for Central Government Departments" had been undertaken and that there was a requirement to include the information on CVUHB's accountability report. The Committee noted: • An assessment had been undertaken against the applicable elements of the Corporate Governance Code for Central Government Departments" (the Code) • There were no reported/identified departures from the Code during the reporting period, • The assessment had been informed by the Audit Wales "Doing it Differently, Doing it Right? Governance in the NHS during the COVID-19 crisis – Key themes, lessons and opportunities" report published in January 2021 which focused on how NHS bodies had governed during the COVID-19 crisis, with a particular focus on putting citizens first, decision making and accountability, and gaining assurance. The CC asked if any of the Executive Team had seen the assessment and the DCG responded that they had not but she would take it to the Management Executives (ME) meeting if appropriate. **The Committee resolved that:** a) The assessment of compliance against the UK Code of Corporate Governance for April 2020-March 2021 be noted.	
AAC 21/05/010	**Board effectiveness survey 2020-2021** The Board effectiveness survey 2020-2021 report was received, and the Committee noted: • Section 10.2.2 of CVUHB's Standing Orders stipulates that the Board shall introduce a process of regular and rigorous self-assessment evaluation of its own operations and performance of its Committees, and this is undertaken through an annual Board effectiveness survey,	

- CVUHB had undertaken a review of the Board and its sub-committees, using survey questions derived from best practice guidance, including the NHS Audit Handbook,
- Due to COVID-19 the findings of the 2019-2020 Board and Committee self-assessment for 2019-2020 were provided to the Audit and Assurance Committee on the 17 November 2020,
- The actions completed on the Board Effectiveness Action Plan 2019-2020 following the survey undertaken in 2019-2020,
- The survey questionnaire for the annual Board/Committee effectiveness survey 2020- 2021 was issued in early April 2021 and attained a positive response rate overall,
- For the 2020-2021 self-assessment, the survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees,
- The overall findings were positive which provided an assurance that the governance arrangements and Committee structure in place were effective,
- Out of the questions posed, room for improvement was identified in 5 areas and a Board Effectiveness Action Plan 2020-2021 had been developed to strengthen and develop the areas identified, the action plan would be progressed via Board Development sessions,
- The individual Board/Committee survey findings would be presented to each relevant Committee for assurance,
- For the 2020-2021 self-assessment, a survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The DCG advised that there were 5 questions that had suggested a need for Further Improvement, specifically:

- **Board – Question 8** - We Identify and Share Best Practice and benchmark,
- **Charitable Funds Committee Question – 4 -** Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting,
- **Health & Safety Committee – Question 2 -** The Board is active in its consideration of the Committee's composition,
- **Health & Safety Committee – Question 4** - Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting,
- **Quality, Safety, Experience Committee – Question 11 -** The Committee agenda setting process is thorough and led by the Committee Chair.

The DCG advised that there was a requirement to include the information in CVUHB's accountability report.

	The VC asked if the response rate numbers could be misinterpreted as the survey tool used to collect survey responses used bar charts which only took the responses given into consideration, irrespective of the response rate. He also noted the low response rate and if there was asked if work could be undertaken to attempt to increase the responses received. The DCG responded that in future surveys could be sent out earlier which would allow the Corporate Governance team to chase up the members that had not submitted a response. The VC requested that the use of tables to present the information could be presented instead of the bar charts in future, and the DCG responded that the survey process would be revisited and the whole approach would be refreshed and the suggestions made would be included. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2020-2021, and the action plan for 2020-2021 were noted and will be progressed via Board Development sessions, b) The completed actions within the Board Committee Effectiveness Action plan 2019- 2020 were noted.	
AAC 21/05/11	**Items for Approval & Ratification** There were no items for approval and ratification.	
AAC 21/05/012	**Internal Audit reports for information:** The following Internal audit reports were received: 1. Consultant Job Planning Follow-up: Limited Assurance Report, 2. Health and Care Standards, 3. IM&T Control and Risk Assessment **The Committee resolved that:** (a) The internal audit reports be noted.	
AAC 21/05/013	**Review of the Meeting** The CC asked if attendees were satisfied with the business discussions and format of the meeting, and attendees indicated they were satisfied.	
AAC 21/05/014	**Items to be deferred to Board / Committee** There were no items to be brought to the attention of the Board / Committees.	
AAC 21/05/015	**Date and Time of Next Meeting** The CC thanked everyone for their attendance and contribution to the meeting and confirmed that the next meeting would be held on **Thursday 10 June 2021 (Special Meeting) at 9am.**	

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Thursday 10th June 2021 09:00am – 12:30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Ceri Phillips	CP	UHB Vice Chair
Mike Jones	MJ	Independent Member – Trade Union
In Attendance:		
Aaron Fowler	AF	Head of Legal & Risk
Anthony Veale	AV	Audit Wales
Catherine Phillips	CP	Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Helen Lawrence	HL	Head of Financial Accounts and Services
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Rachel Gidman	RG	Interim Executive Director of Workforce & OD
Rhodri Davies	RD	Audit Wales
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Nigel Price	NP	Local Counter Fraud Specialist

AAC 21/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting and confirmed that the meeting was quorate. The CC advised that the majority of the content was reviewed at the Audit Workshop and the aim of the meeting was to approve all documentation in readiness for the Special Board meeting which would follow later that day.	**ACTION**
AAC 21/06/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 21/06/003	**Declarations of Interest** No Interests were declared.	
AAC 21/06/004	**Report from the Losses and Special Payments Panel** The Deputy Finance Director (DFD) stated that this was the only item of non-accounts business on the agenda and concerned a timing issue regarding losses and special payments approval.	

	The report had been presented because the losses were included within the accounts and would need to be approved before being formally approved in the Annual Report. The report confirmed that the losses and special payments panel met on 18th May 2021 which considered the accounts of the last 6 months of the year. The DFD informed Members that the papers set out recommendations for losses and write offs regarding criminal negligence, personal injury, bad debt, permanent injury, small claims, employment tribunals and stock. The CC queried the net impact loss of the clinical negligence claims of £12.522 million and asked how much was outside the amount that was reclaimed as each claim required the UHB to pay £25,000. The DFD responded that the net costs for clinical negligence and personal injury was £1.2 million. A budget was provided for this at the beginning of the year and was included within financial plans. **The Committee Resolved that:** a) The write offs outlined in the Assessment Section of this report be approved.	
AAC 21/06/005	**Introduction to the Annual Report and Accounts 2020-21** The DFD informed the Committee that the paper introduced the Annual Report which included the Performance Report, Accountability Report, and the Annual Accounts. The DFD added that it supported the key changes made to the draft statements and outlined and confirmed the financial performance of the UHB. The DFD highlighted that the Audit & Assurance Committee had a key role in reviewing the Annual accounts and the ISA 260 report from Audit Wales and that the Annual Report contained the Annual Accounts & Remuneration Report. The DFD stated in reviewing the financial statements and associated documentation the committee needed to consider the work carried out throughout the year by Internal Audit & Counter Fraud with specific reference to the opinion provided by the Head of Internal Audit (HIA). In regards to the Annual Report and Accounts assurance, the accuracy on the statements could be provided by the programme of work undertaken by the Audit & Assurance Committee throughout the year and the process that it had followed to sign off the Annual Report and accounts. This included an Audit Workshop and the Special Audit meeting. Assurance was also provided by the work completed by Audit Wales, which was detailed in the ISA 260 report, the response to the audit enquiries to those charged with governance and management, and the letter of representation that would be sent to Audit Wales.	

The DFD highlighted the changes made in the draft Annual Report and Accounts and how Audit Wales had reviewed the drafts and provided feedback with a number of narrative modifications being included in the final report. He added that:

- The Remuneration Report had been corrected where Audit Wales had detected a number of disclosures which required amendment.
- Where reasonable assurance was required, the HIA Opinion was included in the Accountability Report

The financial position recorded in the draft accounts was still the financial position reflected in the final accounts. The DFD highlighted that there had been a number of changes primarily within the notes regarding the values and disclosures. These changes were set out in appendix 4 of the ISA 260 report.

The DFD highlighted that Audit Wales had queried the accounting treatment of ICF Capital monies which would be worked through and agreed as part of the 2021/22 Audit Plan.

In terms of the financial performance of the UHB the DFD advised that:

- There were no changes to the draft accounts.
- In regards to Revenue Resource Limits, although a plan had been approved it did not achieve a 3 year break even position and there was an aggregated deficit of £9.724 million. Therefore the UHB failed against the financial duty within the Revenue Resource Limit.
- The financial duty related to the Capital Resource limit had been met with an aggregated surplus of £257,000 over a 3 year period.

The DFD highlighted that the key item of assurance was provided by the work from Audit Wales as set out in the ISA 260 report where they had worked through and verified the draft accounts into the final accounts over a period of 5 weeks.

The Committee Resolved to:

a) Note the reported financial performance contained within the Annual Report and Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure.
b) Note the changes made to the Draft Annual Report and Accounts;
c) Review the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Report and Accounts;
d) Recommend to the Board that it agreed and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management;
e) Recommend to the Board approval of the Annual Report and Accounts for 2020/21.

AAC 21/06/006	**Audit Wales ISA 260 Report** Anthony Veale – Audit Wales (AV-AW) gave his thanks to the Director of Finance (DOF), DFD, and the finance teams in the production of the accounts. Mark Jones – Audit Wales (MJ-AW) highlighted that the report discharged their responsibility to report their findings to the Audit & Assurance Committee and to the Board before the Annual Report & Accounts were considered for approval. He stated that Audit Wales intended to issue an unqualified opinion on the accounts and the remuneration report in terms of them being properly prepared, materially true and fair and he added that he intended to qualify the regularity opinion as highlighted by the DFD. He highlighted that this was the fifth year that this had happened and that the following year the qualified regularity opinion may not be required. MJ-AW highlighted the matters that needed to be brought to the attention of the Audit Committee: - There were no uncorrected misstatements - Tax issues around senior clinicians pensions He informed the Committee that the one area not highlighted within the report was the inventory which had been queried at the Audit Workshop. He advised that it was not mentioned within the report as Audit Wales were not qualifying the opinion on the inventory as they did last year. The inventory was marginally below materiality and had been subject to enhanced audit work on the inventory to provide assurance that it was not understated and Audit Wales were satisfied with the figure within the balance sheet. MJ-AW made the Committee aware of deadlines stating that Audit Wales had to submit Audited documents to Welsh Government by the 11/06/2021 and were on schedule, subject to Board approval, to do so. All Health Bodies accounts were scheduled to be certified on 15/06/2021and soon after the certification would be laid before the Senedd publicly and Welsh Government would issue a press release alongside it. The DFD commented that the final letter of representation had been slightly modified but was in the standard recommended format as set by Audit Wales. The draft had been reviewed at the Audit Workshop and stated that it was not contentious so it was presented for agreement and recommendation. The DOF agreed with the points made. The DFD highlighted that on the last page under appendix 1 the date was incorrect and read 09/06/2021 but should say 10/06/2021. This had been corrected in the actual letter of representation to be signed. **The Committee Resolved to:** - Note the Audit Wales ISA 260 Report	

AAC 21/06/007	**The Head of Internal Audit Opinion & Annual Report for 2020-21** The HIA advised that the majority of the content within the report remained the same as per the draft reviewed at the Audit Workshop. The HIA highlighted the key messages from his opinion within section 1.2 which clarified the final Head of Internal Audit Opinion which confirmed that the Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively. The HIA thanked the Corporate Governance team, Executives, Management within the HB and others for their ongoing engagement throughout the pandemic which had enabled his team to complete enough internal audit work to provide his opinion for the year. He highlighted figure 1 within the report which provided the final outcome for all internal audit work completed throughout the year: The HIA added that there were 2 audits within the reasonable assurance area on Infrastructure Network Management and another on the Maelfa Well-Being Hub. He stated these items were in draft at the time of the HIA producing his final opinion for the year and those outputs had been included within his opinion for the year. The HIA reminded members that since producing the draft report at the Audit workshop,5 pieces of work were still ongoing and had not progressed to a stage where they could provide an assurance rating but wanted to clarify that all 5 had been progressed to either a final or draft stage. **The Committee Resolved to:** - Note the Head of Internal Audit Opinion.	
AAC 21/06/008 Khan Raj 06/29/2021 10:34:24	**To receive and consider the following for 2020-21:** **a. The Letter of Representation included within the ISA 260 report (see item 4.3)** The DDF stated that this was reviewed earlier in the meeting as part of the ISA 260 report. **b. The response to the audit enquiries to those charged with governance and management** The DDF stated that this was previously endorsed by the CEO, UHB Chair, DCG, DOF, & Chair of the Audit & Assurance committee. This had been reviewed at the Audit workshop and there had been no changes since and was shared at the meeting to be recorded.	

	c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements The DCG commented that this was the first time that the Health Board had received the full Annual report and Accounts as one document as previously it had received the Accountability report and accounts separately. The DCG stated that the final published document would have minor changes in terms of corrected typographical errors and title changes of Executives. **The Committee Resolved that:** The following documents were noted and approved: a. The Letter of Representation included within the ISA 260 report (see item 4.3) b. The response to the audit enquiries to those charged with governance and management c. The CVUHB Annual Report 2020-2021 including the Annual Accountability Report, Performance report and the Financial Statements	
AAC 21/06/009	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 6th July 2021 at 9.00am**	

Public Action Log
Following Audit & Assurance Committee Meeting
13 May 2021
(For the Meeting 06 July 2021)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
		Completed Actions			
AAC 21/04/020	Self-assessment of effectiveness - Verbal	The DCG advised that the results of the surveys should be available by the next committee meeting	Nicola Foreman	13.05.21	COMPLETE Report on the agenda for 13 May 2021 meeting.
AAC 20/04/005 **AAC 20/11/023**	Consultant Job Planning Follow-up: Limited Assurance Report	Follow up Internal Audit Report to be carried out at an appropriate time to be agreed with EMD & to be included in the 2021 Internal Audit plan.	Ian Virgil / Stuart Walker	13.05.21	COMPLETE HIA confirms his meeting with the MD and the progression of this with an expectation of this to be brought to the committee by May. - Item 9.2
AAC 21/04/019	Counter Fraud Annual Plan 2021-2022	The EDF advised the Committee that she would let the CC know when the plan was signed off	Catherine Phillips	06.07.21	COMPLETE Self-review tool was signed off by Executive Director and Chair of Audit committee in early June.
AAC 21/04/013	Draft Accountability Report 2020-2021	Work to develop the Annual report was in progress and the updated document would be presented to the Audit Committee Workshop on the 13 May 2021 & the final report would be considered at the Special Audit Committee Meeting	Nicola Foreman	10.06.21	COMPLETE Final report would be considered at the Special Audit Committee meeting on the 10 June 2021.
		Actions in Progress			
AAC 20/11/023	Job Planning Update	To provide a further update in 6 months' time.	Stuart Walker	07.09.21	Update to the meeting on 7 September 2021.
AAC 21/04/007	Internal Audit Progress and Tracking Reports	The Director of Corporate Governance (DCG) asked the HIA if the Mental Health aspects had been identified elsewhere, and the HIA responded that it was not in the plan currently, however discussions would	Ian Virgil	06.07.21	Update to the meeting on 6 July 2021.

		be held with the END and the DCG to incorporate it into the plan for next year.			
AAC 21/04/009	Report of the Auditor General on Test, Trace, and Protect (TTP) in Wales	The Report on Personal protective Equipment (PPE) would be published mid-April and would be brought to the next Audit Committee meeting for consideration.	Nicola Foreman / Wales Audit	06.07.21	Update to the meeting on 6 July 2021.
AAC 21/04/012	Review the system of assurance	DCG would work with the Management Executives (ME) to develop an assurance strategy	Nicola Foreman	06.07.21	Update to the meeting on 6 July 2021.
AAC 21/04/017	Outstanding Audit Recommendations Update – 2017/18	The EDF asked the DCG if the outstanding audit recommendations for 2018/2019 and 2019/2020 would be completed over the next period, the DCG advised that she would review them and agree timescales for completion	Nicola Foreman	06.07.21	Update to the meeting on 6 July 2021.
AAC 21/06/006	Audit Wales ISA 260 Report	Following audit certification by the Auditor General Audit Wales will issue a separate report setting recommendations and management's responses.	Audit Wales	TBC	Report will be considered at a future meeting of the Audit and Assurance Committee
Actions referred to Board / Committees					
AAC 20/11/011	10 Opportunities for Planned Care	To take report to a future Strategy and Delivery Committee to ensure that the 10 opportunities are considered as part of the Health Board's planning arrangements	Nicola Foreman	13.07.21	Update to the meeting on 13 July 2021

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	06/07/21	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**	**X**	**For Information**		
Lead Executive:	Director of Governance								
Report Author (Title):	Head of Internal Audit								

Background and current situation:

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

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

The 2021/22 plan was formally approved by the Audit Committee at its April 21 meeting.

The progress report provides the Audit Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details of proposed amendments to the plan.

Appendix A of the progress report sets out the Internal Audit plan as agreed by the committee, including details of proposed postponed / removed audits and commentary as to progress with the delivery of assignments.

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

The progress report highlights the conclusion and assurance ratings for the outstanding audits from the 2020/21 plan that were not finalised in time for submission to the May 21 meeting.

Reports that are given Reasonable or Substantial assurance are summarised in the progress report with the reports given Limited or No Assurance included in full. There are no reports that have been given a Limited or No Assurance rating during the current period.

The report also includes details of a small number of proposed adjustments to the content of the plan and changes to the planned timings for delivery of a number of audits.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

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.

Recommendation:

The Audit & Assurance Committee is asked to:

- **Consider** the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports.
- **Approve** the proposed amendments to the Internal Audit Plan for 2021/22.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

Equality and Health Impact Assessment Completed:	~~Yes~~ / ~~No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board

Internal Audit Progress Report

Audit & Assurance Committee July 2021

NWSSP Audit and Assurance Services

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

1. Introduction

This progress report provides the Audit & Assurance Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2021/22 Internal Audit plan.

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

The plan for 2021/22 was agreed by the Audit & Assurance Committee in April 2021 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. Outcomes from Completed Audit Reviews

A number of audits from the 2020/21 plan were not finalised in time for submission to the Audit Committee in May, although the outcomes were included within the Head of Internal Audit Opinion and Annual Report for 2020/21.

All of the audits have now been finalised, as detailed in the table below. A summary of the key points from the finalised assignments are reported in Section five. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS (2020/21 Opinion)	ASSURANCE RATING	
Annual Planning process 21/22	Substantial	
Engagement Around Service Planning	Reasonable	
Data Quality Performance Reporting (Single Cancer Pathway)		
Infrastructure / Network Management		
C&W CB – Rostering in Community Children's Nursing		
Staff Recruitment		
Wellbeing Hub at Maelfa		

3. Delivery of the 2021/22 Internal Audit Plan

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

During the first quarter of 21/22, work has commenced on delivery of the following audits from the plan:

Audit	Outline Scope	Current Position
Legislative / Regulatory Compliance	Review the corporate arrangements for monitoring and managing compliance requirements.	Work in Progress
UHB Healthy Eating Standards	Review the processes in place for developing and implementing the standards and reporting performance against them.	Work in Progress
Surgery CB – Theatres Utilisation	Review the processes in place to ensure the efficient and effective use of theatre resources.	Work in Progress
CD&T CB – Ultrasound Governance	Review the design and implementation of ultrasound governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure	Work in Progress
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	Follow-up of 20/21 Limited Assurance report.	Work in Progress
Five Steps to Safer Surgery Checklist	Review the processes in place to ensure effective completion of the Checklist for all surgical procedures.	Planning
Management of staff Sickness Absence	Review compliance with the All Wales Managing Attendance Policy. Focus on poor performing areas.	Planning

4. Proposed Changes to the 2021/22 Plan

The following audits has been proposed for deferral / removal from the 21/22 plan:

- **ALNET Act**

  The Executive Director of Therapies and Health Sciences identified that the lead manager had only recently taken up post and had commenced work to embed processes within the Health Board. It was therefore felt that it would be more appropriate to defer the audit into the 22/23 plan.

- **Consultant Job Planning Follow-up**

  The outcome of the follow-up undertaken in 20/21 confirmed that the assurance rating had increased to Reasonable, a further follow-up in 21/22 is therefore not required. Implementation of the remaining outstanding actions will now be monitored through the Health Board's recommendation tracker.

Adjustments have been proposed to the planned timings for the following audits:

- Five steps to Safer Surgery Checklist – From Q1 to Q2

- Whistle Blowing Policy – From Q2 to Q3
- Post Contract Audit of DHH Costs – From Q1 to Q3
- Clinical Board QS&E Governance – From Q2 to Q4

The proposed changes detailed above have been reflected within the table at Appendix A, subject to approval by the Committee.

5. Final Report Summaries

5.1 Annual Planning Process 21/22

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The planning environment for the NHS has been dynamic during the period that the Health Board has had to develop an Annual Plan for 2021 -2022. A letter from NHS Wales on 11 March 2021 acknowledges the complexities and how these should be addressed at in-committee sessions of the Board as draft plans.

Prior to the submission of the draft Plan to Welsh Government, we were satisfied that the Board had received sufficient opportunity to scrutinise and review. There was less clarity around the role and purpose of the Strategy and Delivery Committee, given updates were provided direct to the Board.

The Strategy Development and Delivery Group was a key management forum for overseeing the development of an integrated plan. The audit identified that the terms of reference for the group required review, management are aware of this and are currently reviewing the group's structure and remit.

The detailed Plan submitted to Welsh Government, aligned with the requirements of the NHS Wales Annual Planning Framework 2021 – 2022 and did not have any obvious gaps or inadequacies. A submission of the Plan was made by 31 March 2021, as required by Welsh Government, following Board consideration in private session on 25 March 2021.

We discussed with management the level of detail contained within the Plan to support the Welsh Government requirement of firm dates and commitments for the first quarter, which is captured within the '2021 – 2022 on a page' section of the Plan. Since submitting the draft Plan, a further Welsh Government letter to all Chief Executives of Health Boards on 20 April 2021 reinforces these expectations, which are to be reflected upon within the finalised Plan, to be submitted by the end of Quarter 1. We will test

the Health Board's compliance with this further as part of our 2021/22 audit of 'Delivery of the 2021/22 Annual Plan'.

5.2 Engagement Around Service Planning

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The Health Board (HB) has developed guidance to support the engagement of service change and development, which aligns to the principles of the Welsh Government (WG) Guidance for engagement and consultation on changes to health services. An important point within the WG guidance notes, "… the emphasis on the need for a new approach to change based on continuous engagement, rather than perfunctory involvement around specific proposals". The HB's guidance supports this approach, "Across the UHB, efforts are being made to strengthen our approach to continuous engagement with citizens and stakeholders based on the principles of coproduction."

It is noted that the WG guidance is over a decade in age. The external environment will evolve in the medium term, with Community Health Councils (CHC) being superseded by a new all-Wales Citizen Voice Body, which will represent the interests of people across health and social care from 2023.

This report makes recommendations to enhance the HB's engagement guidance, but it is acknowledged that external factors are evolving, which will impact on the guidance going forward.

A recommendation has also been raised to ensure compliance with the guidance. One instance was noted, where the form of engagement deviated from the timely use of a service change proforma and engagement plan. The deviation related to the Colcot Clinic and lessons learned have been identified by the HB. In this instance the CHC did make a referral to the Minister in 2019, although the Minister did not support the CHC position and did not require the HB to take any further engagement action.

Three recommendations of a low priority and considered good practice have been made to strengthen current arrangements, associated with oversight of engagement activity through a central repository, the formalisation of lessons learned and the adoption of a standard approach to illustrate stakeholder mapping.

Due to the impact of COVID-19, the HB's engagement with stakeholders for planned service change was put on hold in 2020/21. Focus was redirected to communication of temporary changes and adaptions to service provision made to respond to challenges that emerged due to the pandemic. As a result of this noted impact, the audit sample referred to engagement prior to 2020/21.

5.3 Data Quality Performance Reporting (Single Cancer Pathway)

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

It is important to note that our review did not scrutinise the compliance rates to the Welsh Government 62-day SCP target; rather we reviewed if the data that produced these results was accurate and reliable. However, it is worth noting that for our sample period of January 2021 (reported against the Single Cancer Pathway), the reported percentage of treated pathways achieving this target was 58% (97 from a population of 168), WG has set an initial target of 75%.

Cancer Services has been evolving over the past 18 months and transitioning to a new system for capturing data. The Cancer Services Lead Manager joined the Health Board in March 2020 and is actively recruiting to key posts within the new structure, with the aim of driving service improvements once embedded. Given the changes to establishment structure and substantial process and system changes, the absence of procedures to support the current ways of working is not unexpected, but also known to management as an issue, which is scheduled to be addressed through the calendar year, once the onboarding of vacant posts is complete.

The audit also identified that the Health Board's wider Data Quality Policy and Procedure are out of data and require review, however, it is noted that management have commenced a review of these documents.

We identified that overall, the arrangements in place within the Health Board in relation to the Data Quality Performance Reporting of the SCP are of a reasonable standard. The following identifies the key controls which underpin this area:

- Regular meetings of the Operational Cancer Group* where Cancer performance is a standing agenda item, and the group feeds into the Executive Cancer Board;
- Improved validation controls of SCP data; and
- Consistent reporting of SCP data within the Health Board and to Welsh Government. Specifically, the March 2021 meeting of the Board received the SCP data, contained within the performance report, which highlighted 58% compliance for January 2021. This figure was reconciled to the January 2021 data return to Welsh Government that also highlighted 58% compliance.

* We were advised through 2020/21 that attendance of the Operational Cancer Group was impacted by COVID-19, this was evident from sampled minutes, but April 2021 presented an improved position.

Audit testing identified data accuracy and validation issues, which are further detailed within Appendix A - Finding 4. On discussion with management it was advised that the control environment has since been strengthened, with greater validation processes now in place. In support of the enhancements introduced, we further propose the introduction of an issues log, to identify any negative validation trends.

No high priority findings were noted within this review.

5.4 Infrastructure / Network Management

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Processes are in place to provide server resource and network infrastructure, to monitor the operation of these and ensure problems are identified and resolved. The risks relating to the provision of the infrastructure using older equipment have been articulated and included on risk registers. Increased resource has been provided for replacement equipment, although not to the full identified value, accordingly the replacement program is on a risk-based priority.

Although the processes within the teams responsible for managing the servers and network are operating appropriately, there is no overarching process for configuration management and no overall record of what equipment is held and the status. The teams managing the servers and the network are self-contained with limited reporting outside of the teams and there are a lack of formal policies and procedures that would provide clarity to these functions.

There is work ongoing to increase the capacity of the network in order to resolve performance issues, however, there has been no full assessment of the future requirements for network capacity.

5.5 C&W CB - Rostering in Community Children's Nursing Service

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The audit identified no high priority recommendations, but issues of a low to moderate nature have arisen, which if addressed would enhance the current controls in operation.

Prior to the commencement of the audit there were no formalised, documented procedures in place in respect of rota management processes and those of the duty desk operations. The auditor as part of the review provided advice and facilitation to aid the creation of these so as to provide clear structure, approach and guidance to the new Administrative Operational Manager and the Team Leaders, as well as nursing staff themselves.

Management acknowledged at the commencement of the review the desire to enhance the efficiency and effectiveness of current rostering arrangements, through greater utilisation of electronic rostering. This is currently being explored and no solution yet procured. The rostering of community nurses presents multiple variables, which fall outside the capability of RosterPro, although this is utilised to capture hours worked. The newly documented procedures will support and inform the process of acquiring an electronic rostering system, fully cognisant of current end to end processes.

Currently in draft, the service intends to roll out a 'Memorandum of Understanding' with families as a means of clarifying the partnership and support offered, to strengthen relationships.

It is noted that the COVID-19 pandemic has impacted on training and this is currently being addressed by management.

5.6 Staff Recruitment

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Overall, the arrangements in place for staff recruitment for the areas reviewed were of a good standard.

Our review of the arrangements in place for International Nurse Recruitment confirmed that they were of a very high standard.

We have identified a few minor weaknesses in respect of recruitment plans and reporting arrangements.

We were however unable to provide any assurance on the objective 'appropriate governance arrangements are in place for the appointment of temporary and bank staff to support the Covid response' as we were unable to undertake any fieldwork in this area. This has impacted on the overall assurance rating that we are able to provide at the current time. We would recommend that this area is covered in a future audit review.

5.7 Wellbeing Hub at Maelfa

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The review was undertaken to determine the performance of the project against its key delivery objectives i.e. time, cost and quality and ensure the adequacy of, and operational compliance with, the UHB's systems and procedures.

Whilst recommendations have been made to improve the systems of control, generally these were positively assessed.

In the context of the timing of this review (shortly after commencement of construction), it is recognised that the recommended improvements were in some cases already in hand, with wider project control arrangements generally robust.

Reasonable control arrangements were found to have operated in a number of key areas, including:

- application of appropriate project management tools;
- robust cost control and review mechanisms, including scrutiny of the target cost and subsequent changes; and
- management of Covid-19 implications, including contractual arrangements and site operating practices.

The audit identified the following control weaknesses:

- Contractual documentation for the current stage had not been finalised and executed; and
- Delays in the timeliness of payments to the Supply Chain Partner and in the authorisation of project changes.

ASSIGNMENT STATUS SCHEDULE

Planned output.	**No**	**Exec Director Lead**	**Plnd Qtr**	**Adj Qtr**	**Current progress**	**Planned Audit Committee**
Legislative / Regulatory Compliance	06	Corporate Governance	Q1		Work in progress	Sept
UHB Healthy Eating Standards	11	Public Health	Q1		Work in progress	Sept
Surgery CB – Theatres Utilisation	25	COO	Q1		Work in progress	Sept
CD&T CB – Ultrasound Governance	27	COO	Q1		Work in progress	Sept
Mental Health CB – Cancellation of Outpatient Clinics Follow-up	29	COO	Q2		Work in progress	Sept
Five Steps to Safer Surgery Checklist	16	Medical	~~Q1~~	Q2	Planning	Nov
Management of staff Sickness Absence	07	Workforce	Q2		Planning	Nov
Retention of Staff	09	Workforce	Q2			Nov
Clinical Audit	15	Medical	Q2			Nov
Health & Safety	18	CEO	Q2			Nov
IT Service Management (ITIL)	19	Digital & Health Intelligence	Q2			Nov
Medicine CB – QS&E Governance Framework	23	COO	Q2			Nov
Medical Equipment and Devices	35	Therapies & Health Sciences	Q2			Nov
Capital Scheme - Genomics	*SSU*	*Strategic Planning*	*Q2*			*Nov*
IM&T Control & Risk Assessment	02	Digital & Health Intelligence	Q3			Feb

Planned output.	No	Exec Director Lead	Plnd Qtr	Adj Qtr	Current progress	Planned Audit Committee
UHB Core Financial Systems	03	Finance	Q3			Feb
Claims Reimbursement	04	Nursing	Q3			Feb
Whistle Blowing Policy	05	Corporate Governance	~~Q2~~	Q3		Feb
Compliance with Welsh Language Act	08	Workforce & OD	Q3			Feb
Nurse Bank	13	Nursing	Q3			Feb
Medical & Dental Staff Bank	14	Medical	Q3			Feb
Chemocare IT System	21	Digital & Health Intelligence	Q3			Feb
Security of Network and Information Systems (NIS) Directive Implementation	22	Digital & Health Intelligence	Q3			April
Specialist Services CB	26	COO	Q3			Feb
Financial Plan / Reporting	33	Finance	Q3			April
Post Contract Audit of DHH Costs	34	Finance	~~Q1~~	Q3		Feb
Delivery of 21/22 Annual Plan	37	Strategic Planning	Q3			April
Estates Assurance – Waste Management	*SSU*	*Finance*	*Q3*			*Feb*
Estates Assurance - Decarbonisation	*SSU*	*Finance*	*Q3*			*April*
Clinical Board's QS&E Governance	12	Nursing	Q2	Q4		April
Risk Management	01	Corporate Governance	Q4			April
Vaccination Programme (Flu / Covid)	10	Public Health	Q4			April

Planned output.	**No**	**Exec Director Lead**	**Plnd Qtr**	**Adj Qtr**	**Current progress**	**Planned Audit Committee**
IT Strategy	20	Digital & Health Intelligence	Q4			April
Mental Health CB	28	COO	Q4			April
Children & Women CB	30	COO	Q4			April
PCIC CB - GP Access	24	COO	~~Q2~~	Q4		April
Recovery of Non-COVID services / Delivery of Planned Care	31	COO	Q3/4			May
Performance Reporting	32	COO	Q3/4			May
Shaping Future Wellbeing in the Community Scheme	*SSU*	*Strategic Planning*	*Q4*			*May*
Capital Systems Management	*SSU*	*Strategic Planning*	*Q4*			*May*
Major Capital Scheme – UHW II	*SSU*	*Strategic Planning*	*Q1-4*		*On-going observer role, proactive input, and overview of the progression through the period.*	*n/a*
Development of Integrated Audit Plans	*SSU*	*Strategic Planning*	*Q1-4*		*Plans will be developed for inclusion within the respective business case submissions for relevant major projects/ programmes.*	*n/a*
Reviews Deferred / Removed from the plan						
ALNET Act	36		Q2		Director of Therapies and Health Sciences requested Deferral to 22/23 plan as work currently on-going to embed processes within the Health Board. To be agreed by June AC.	
Consultant Job Planning Follow-up	17	Medical	Q4		Removed as assurance level increased to Reasonable after 20/21 follow-up – To be agreed by June AC	

Archwilio Cymru
Audit Wales

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

Date issued: June 2021

Document reference: 2457A2021-22

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

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

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Contents

Audit Committee Update

About this document

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

Financial audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2020-21 Performance Report, Accountability Report, and Financial Statements	The Auditor General certified the Health Board's Performance Report, Accountability Report, and Financial Statements on 15 June. The certified document was laid by the Senedd on 16 June. We are currently preparing the Audit of Accounts Addendum Report, which will contain findings and recommendations that we wish to raise, and management's responses. We will present the report at the next meeting.

Performance audit update

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

- completed work since the last Audit Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Structured Assessment 2021 (Phase One) – Operational Planning Arrangements	July 2021
Rollout of the COVID-19 vaccination programme in Wales	July 2021
Welsh Health Specialised Services Committee Governance Arrangements	July 2021

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020 - Supplementary Outputs Executive Leads – Director of Governance and Executive Director of Workforce & Organisational Development	To support our annual structured assessment work, we are undertaking further work to pull together two all-Wales outputs. The first output was published in January and focusses on how NHS bodies have governed differently during the COVID-19 crisis. The second output will focus on arrangements to support staff well-being during the pandemic and will be published in July.	All-Wales output on staff well-being being drafted September 2021*
Orthopaedic Services – Follow-up	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform	Report being drafted

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Chief Operating Officer	the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges. Our findings will be summarised into a single national report with supplementary outputs setting out the local position for each health board.	September 2021*
Quality Governance Executive Lead – Executive Nurse Director and Executive Medical Director	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Fieldwork underway September 2021*
Structured Assessment 2021 Executive Lead – Director of Governance	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness, and economy in the use of their resources. Our work in 2021 will be undertaken in two phases, as follows:	Phase 1 - completed Phase 2 – Fieldwork underway November 2021*

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
	• Phase 1 will examine the operational planning arrangements of each NHS body. • Phase 2 will look at the governance and financial management arrangements of each NHS body.	
Follow-up of radiology services Executive Lead – Chief Operating Officer	In 2016, we undertook a review of radiology services. The work examined the actions the health board was taking to address the growing demand for radiology services, and the extent to which those actions were providing sustainable and cost-effective solutions to the various challenges that existed at the time. We made a number of recommendations to the health board. This work will follow-up progress against these recommendations.	Fieldwork underway September 2021*

***** *These dates are subject to change given the current challenges and pressures associated with the ongoing pandemic*

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care	This work will examine different aspects of the unscheduled care system and will include analysis of	Data analysis currently being completed with

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Chief Operating Officer	national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	a national commentary due for publication in June / July. TBC

Good Practice events and products

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

5 In response to the COVID-19 pandemic, we have established a **COVID-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to prompt some thinking and support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here. Material from our COVID-19 Learning Week held in March 2021.

6 Details of future events are available on the GPX website.

NHS-related national studies and related products

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

8 **Exhibit 5** provides information on the NHS-related or relevant national studies published since our last Committee Update. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 5 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021
NHS Wales Finances Data Tool - Up to March 2021	June 2021

The Auditor General has also recently published his Fee Scheme and Annual Plan for 2021-22.

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

Archwilio Cymru
Audit Wales

Structured Assessment 2021 (Phase One) – Operational Planning Arrangements: Cardiff & Vale University Health Board

Audit year: 2021

Date issued: April 2021

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

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

Contents

Summary report

About this report

1 This report sets out the findings from phase one of the Auditor General's 2021 Structured Assessment on the operational planning arrangements at Cardiff & Vale University Health Board (the Health Board). Our Structured Assessment is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2014.

2 Health bodies are required to submit a three-year Integrated Medium-Term Plan (IMTP) to the Welsh Government on an annual basis. In January 2020, health bodies submitted IMTPs, covering the period 2020-2023, for approval. However, the Welsh Government suspended the process for approving IMTPs to allow health bodies to focus on responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic.

3 The Minister for Health, Social Services and Sport set out shorter planning cycles for health bodies covering 2020-21. Guidance set out key considerations for planning, with the requirement for health bodies to produce a quarter one plan by 18 May 2020, a quarter two plan by 3 July 2020, and a combined plan covering quarters three and four by 19 October 2020.

4 The planning framework for quarters three and four 2020-21 covers the maintenance of effective and efficient operational planning arrangements in health bodies to guide their continuing response to the pandemic as well as responding to winter pressures and the implications of EU transition. Health bodies also need to continue to lay the foundations for effective recovery beyond 2020-21.

5 In our 2020 Structured Assessment report we considered the Health Board's planning arrangements for developing the quarters one and two plans. This report considers the planning arrangements underpinning the development of the operational plan for quarters three and four of 2020-21.

Key messages

6 Overall, we found that the Health Board's **arrangements for developing operational plans are effective, but opportunities to strengthen arrangements for monitoring and reporting on delivery of operational plans remain.**

7 The Health Board's 2020-21 Quarters Three-Four Plan (the Quarters 3-4 Plan) satisfied Welsh Government planning guidance and was submitted within the required timeframe following engagement with Independent Members and the Community Health Council.

8 The Quarters 3-4 Plan is a progression of the previous two quarterly plans and is underpinned by robust modelling and high-quality operational, financial, and workforce data. The Health Board ensured effective engagement with Clinical Boards, enabler services (such as finance), and relevant external partners as part of the planning process. The Health Board's planning arrangements are sufficiently flexible and agile to respond to changing circumstances.

9 Whilst reporting to the Board on key areas within the Quarters 3-4 Plan has increased, there remains a need for the Health Board to strengthen its overall arrangements for monitoring and reporting on operational plan delivery.

10 We have not made any new recommendations based on our 2021 Structured Assessment phase one work.

Detailed report

Scope and coverage of the 2020-21 Quarters Three-Four Plan

11 Our work considered the scope and coverage of the Health Board's 2020-21 Quarters Three-Four Plan (the Quarters 3-4 Plan) in line with Welsh Government planning guidance.

12 We found that **the Quarters 3-4 Plan satisfied Welsh Government planning guidance and was submitted within the required timeframe following engagement with Independent Members and the Community Health Council.**

13 The Quarters 3-4 Plan and accompanying Minimum Data Set ('MDS') were submitted to Welsh Government by 19 October 2020. It was shared with Independent Members at a Board Development Session on 29 October 2020 and retrospectively approved by the Board on 26 November 2020.

14 The Health Board ensured greater Independent Member involvement in the development of the Quarters 3-4 Plan than the previous two quarterly plans. For example, the Health Board used Board Development Sessions to give Independent Members the opportunity to discuss and shape the Quarters 3-4 Plan prior to submission. The Health Board also continued to strengthen stakeholder engagement as part of the development of the Quarters 3-4 Plan. For example, the draft plan was shared with the Community Health Council for comment, and regular updates were provided to the Local Partnership Forum and Stakeholder Reference Group.

15 The Quarters 3-4 Plan is detailed, comprehensive, and satisfies the requirements of the operating framework set by Welsh Government. However, as was the case with the previous quarterly plans, it does not include a clear summary of key actions, timescales, and measures against which progress can be monitored and reported. Whilst the MDS contains some gaps, the Health Board has provided an explanation for the absence of these data. For example, the Health Board does not hold the data for the 'Screening Programmes' tab as screening services are provided by Public Health Wales.

Arrangements for developing operational plans

16 Our work considered the Health Board's arrangements for developing the Quarters 3-4 Plan to support its ongoing response to COVID-19, maintain essential services, and resume more routine services.

17 We found that **the Health Board's operational planning arrangements are robust and sufficiently flexible and agile to respond to changing circumstances.**

18 The Health Board's plan for 2020-21, which was developed in quarter 1 and refined in quarter 2, describes its response to the pandemic through a series of phases underpinned by a gearing approach (**Exhibit 1**). The Quarters 3-4 Plan, which focusses on phases 4 and 5, therefore, is a clear progression of the previous

quarterly plans, which concentrated on delivering phases 1 to 3. In developing the Quarters 3-4 Plan, the Health Board reflected and acted upon feedback received from Welsh Government on previous quarterly plans, such as providing greater clarity on mitigating actions for key identified risks. However, the Quarters 3-4 Plan does not provide an overview of Health Board's performance in delivering the previous quarterly plans. Nor does it include an overview of the key learning captured by the Health Board as part of its wider programme of evaluating new ways of working introduced during the pandemic.

Exhibit 1: Cardiff & Vale University Health Board's phased approach for responding to COVID-19

Phase 1	Repurposing capacity and zoning within UHB hospitals
Phase 2	Commissioning new infrastructure and additional capacity within UHB facilities
Phase 3	Commissioning short-term surge capacity outside UHB Facilities
Phase 4	Ongoing response to the pandemic
Phase 5	System renewal

19 The Health Board's approach to quarterly planning remained unchanged. The process was co-ordinated by the Strategic Planning Team with strong input from the Clinical Boards and enabler services including workforce and organisational development, and finance. The Head of Strategic Planning meets with the Director of Operations, Deputy Director of Workforce and Organisational Development, and the Assistant Director of Finance on a fortnightly basis to facilitate collaboration and integration. All four senior managers reported that this arrangement works well. It enables them to share timely information and ensure an aligned and rapid response to any significant changes to the Health Board's operating environment.

20 The Health Board also has a Strategy Development and Delivery Group (SDDG), which is a senior management forum to oversee the development of integrated strategic business plans and monitor plan delivery. The Health Board continued to make effective use of the SDDG to oversee the preparation of the Quarters 3-4

Plan and to provide formal scrutiny and advice on planning matters that had cross Clinical Board and corporate function implications.

21 Clinical Boards have continued to be actively involved in the planning process. The process was simplified to allow Clinical Boards to engage appropriately in planning whilst not impeding their ability to respond effectively to the pandemic. A streamlined and pre-populated template was introduced, setting out the planning assumptions and parameters within which they were expected to operate during the period. Clinical Boards were asked to review and update the templates as necessary, and the information provided formed the basis of the Quarters 3-4 Plan. Clinical Boards have responded positively to this simplified approach.

22 Partnership working is generally effective, and the Health Board has engaged with its partners as part of the planning the process. The Quarters 3-4 Plan sets out the Health Board's approach to working with local, regional, and national partners to deliver aspects of the plan, such as Test, Trace, and Protect. The Winter Protection Plan, which was developed through the Regional Partnership Board, provides more detail on the Health Board's approach to collaborative planning and delivery.

23 The Quarters 3-4 Plan, like the previous quarterly plans, has been informed by robust modelling and high-quality operational, financial, and workforce data. The Health Board developed three broad, high-level scenarios for quarters 3 and 4 to support its planning and response: COVID-19 'worst-case', 'best-case', and 'central' scenarios. Detailed modelling was undertaken to understand the likely impact of anticipated demand in each scenario covering a range of factors, such as bed capacity. The 'central' scenario was adopted as the Health Board's triangulation point for the purpose of writing the Quarters 3-4 Plan in the context of the four harms associated with COVID-19 and clinical prioritisation.

24 The Health Board's planning approach and operating model have remained flexible, agile, and dynamic throughout the pandemic. The Health Board's gearing approach (see **paragraph 18**) reflects the need for its operating model to be adaptable and to respond differently depending on the prevalence of COVID-19 and the resulting impact on service provision. Consequently, the Health Board operates within rolling six-week planning cycles, informed by data and modelling, which allows it to 'gear' service provision appropriately to changing levels of demand.

25 The Health Board has continued to maintain a focus on its 10-year strategy - Shaping Our Future Well-being. The Management Executive has completed a mid-strategy review and is in the process of setting out the work needed to deliver the next key milestones though the Annual Plan 2021-22 and other strategic programmes. The Health Board has also progressed work on strategic programmes during the pandemic, such as Shaping Our Future Clinical Services. However, there has been minimal alignment between longer-term strategic plans and quarterly operational plans during 2020-21. This is because, in developing the quarterly operational plans, the Health Board has focussed largely on satisfying the

requirements of the Welsh Government operating framework. Going forward, the Annual Plan 2021-22 will be used as a vehicle for progressing the Health Board's medium to longer-term priorities and implementing the learning captured during the pandemic.

Arrangements for monitoring delivery of operational plans

26 Our work considered the Health Board's arrangements for monitoring and reporting on the delivery of the Quarters 3-4 Plan.

27 We found that **reporting to the Board on key areas within the Quarters 3-4 Plan has increased, but opportunities to strengthen arrangements for monitoring and reporting on overall delivery of operational plans remain.**

28 There is frequent reporting to the Board on key areas within the Quarters 3-4 Plan via the monthly Coronavirus Update Report. However, these updates provide a general description of activity rather than progress against delivery of Quarters 3-4 Plan commitments. Reports on the Health Board's financial position and performance against key indicators have continued to be presented to the Management Executive and to the Board and its relevant committees on a frequent basis.

29 Whilst these reporting arrangements are generally effective, there has been no monitoring or reporting of the Health Board's overall performance in delivering the Quarters 3-4 Plan. This is partly due to the lack of a clear summary of key actions, timescales, and measures against which progress can be monitored and reported. As a result, there has been limited scrutiny and assurance by the Board and its committees on delivery against the Quarters 3-4 Plan in its entirety. This was also the case during quarters 1 and 2 as highlighted in our 2020 Structured Assessment report.

30 The Health Board is currently in the process of enhancing its monitoring and reporting arrangements. Planned developments include introducing an Integrated Board Assurance Report, and a Strategy & Delivery Dashboard which will allow the Board and its committees to monitor, scrutinise, and challenge performance on delivery of the Health Board's plans and strategies. There are also plans to review the arrangements to monitor and report operational plan delivery at other health bodies, with a view to identifying positive practice that could potentially be adopted by the Health Board.

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Archwilio Cymru
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Rollout of the COVID-19 vaccination programme in Wales

Report of the Auditor General for Wales

June 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Key messages

Context

1 The COVID-19 pandemic has affected everyone. The vaccination programme is a key strategic tool to fight the virus and help reopen the economy and wider society.

2 The purchase and supply of the vaccines is the responsibility of the UK Government. The vaccination programme in Wales is the responsibility of the Welsh Government and NHS Wales.

3 This report considers the rollout of the vaccination programme in Wales. In it, we discuss the shape of the programme, how it is performing, the factors that have affected rollout to date, and future challenges and opportunities. **Appendix 1** describes our audit approach and methods.

4 There are many vaccines in development globally, and the UK government has signed contracts for vaccine supply with eight major pharmaceutical providers (**Appendix 2**). At the time of our fieldwork, three vaccines were approved by the Medicines and Healthcare products Regulatory Agency (MHRA): Pfizer-BioNTech, Oxford-AstraZeneca and Moderna. All three vaccines require two doses to maximise effectiveness.

Key findings

5 Overall, the programme has delivered at significant pace, with local, national and UK partners working together to vaccinate a considerable proportion of the population who are at greatest risk. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy have provided a strong impetus to drive the programme. To date, the Welsh Government's milestones have been met.

6 The Welsh Government has adopted UK prioritisation guidance from the Joint Committee on Vaccination and Immunisation (JCVI). A national group in Wales provides additional guidance where further clarity on prioritisation is required. The guidance has generally been followed, but the process of identifying people within some of the nine priority groups (**Appendix 3**) has been complex.

7 The organisations involved in the rollout have worked well to set up a range of vaccination models which make best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

8 Overall vaccine uptake to date is high, but there is lower uptake for some ethnic groups and in the most deprived communities. There are also increasing concerns about non-attendance at booked appointments, although health boards to date have been able to minimise vaccine waste.

9 The dependency on the international supply chain is the most significant factor affecting the rollout. Limited stock is held in Wales, primarily to allow for second doses and short-term supply to sites. This means that shortfalls in supply can seriously impact the pace of rollout. However, increasing awareness of future supply levels is allowing health boards to manage the calling of individuals effectively.

10 In the short-term, the workforce supporting the vaccination programme has been meeting the demands placed on it and many staff have been working 'above and beyond'. The current programme is unlikely to complete all second doses until September 2021, and an autumn booster programme is being discussed. This will offer little respite for key vaccination staff in an environment where workforce resilience is vital.

11 Early observations from military partners identified some sites were more efficient than others. Some vaccination sites may become unavailable in coming months as partner organisations look to reopen venues over the summer.

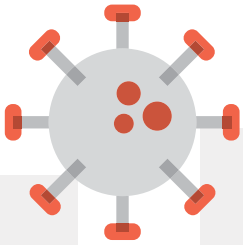
12 As Wales maintains its focus on delivering against existing milestones, there is a need now for the Welsh Government and NHS Wales to develop a longer-term plan for vaccine rollout. This needs to include sustainable workforce models which can respond to supply, whilst also responding to demands as other services are restarted.

13 Consideration also needs to be given to the longer-term estate requirements to support autumn boosters, with a focus on ensuring that vaccination models are cost effective. Strategies to minimise waste need to be maintained and increased action taken to encourage uptake as the programme moves to the remaining population.

14 More broadly, there is much to be learnt from the positive way in which the vaccine programme has been rolled out to date. The Welsh Government and NHS Wales should be looking to apply that learning to wider immunisation strategies and the delivery of other programmes.

> Wales has made great strides with its COVID-19 vaccination programme. Key milestones for priority groups have been met and the programme is continuing at pace with a significant proportion of the Welsh population now vaccinated. This is a phenomenal achievement and testament to the hard work and commitment of all the individuals and organisations that have been involved in the vaccine rollout to date.
>
> However, the job is far from over. A longer-term plan is needed that moves beyond the existing milestones and considers key issues such as resilience of the vaccine workforce, evolving knowledge of vaccine safety, the need for booster doses, and maintaining good uptake rates - especially in those groups that have shown some hesitancy in coming forward for their vaccinations.
>
> **Adrian Crompton**
> Auditor General for Wales

Key facts



3.3 million

Vaccinations given in Wales

0.4%

Percentage of all vaccines considered unsuitable for use

91.5%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a first dose

£29.4 million

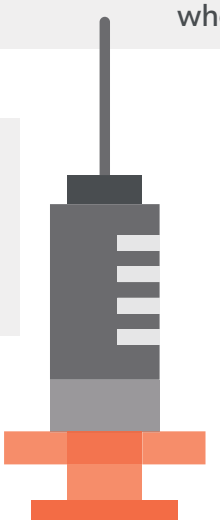
Costs for 2020-21 (excludes redeployed staff and the cost of vaccines)

84.4%

Percentage of the 2.52 million eligible adults who have received a first dose

66.1%

Percentage of the 1.68 million in the 'at risk' priority groups who have received a second dose



Vaccinations being delivered in:

54 mass vaccination centres

346 general practice locations

30 hospital locations

11 pharmacies

18 mobile team units

As of the end of May 2021

Source: Public Health Wales and the Welsh Government

Main report

How the programme is set up

15 Public sector partners across the UK have worked together since the beginning of the pandemic to explore the potential for a COVID-19 vaccination. The programme in Wales was first established in June 2020 to enable an appropriate infrastructure to be put in place before any vaccinations came online.

16 The programme is based around the principle of local autonomy for vaccine deployment through health boards. Supply policy and guidance is nationally coordinated:

a the UK government's Department for Business, Energy & Industrial Strategy (BEIS) led on UK-wide arrangements for research, purchase, and coordination of the national vaccine supply[1] working with the UK Vaccine Taskforce. Responsibility for the Vaccine Taskforce is now shared between BEIS and the UK Department of Health and Social Care. Welsh Government officials engage with the Vaccine Taskforce to streamline vaccine supply and anticipate upcoming issues.

b the Welsh Government is leading on vaccine deployment in Wales. It developed the national Vaccination Strategy for Wales[2] and formed a national programme structure (including Stakeholder and Deployment Boards, and an operational delivery group). The Vaccine Clinical Advisory and Prioritising Group (VCAP) considers clinical developments in vaccination against COVID-19 infection. The group advises the programme and partners on the implementation of the national vaccination programme, interpreting the priorities as outlined by the JCVI for the Welsh context. Collectively, these national groups provide policy and guidance, support financial resourcing, and have facilitated the Primary Care COVID-19 Immunisation Scheme[3] for commissioning primary care.

1 The UK Government Vaccine Taskforce (VTF): 2020 achievements and future strategy report provides an overview of UK level progress

2 The Vaccination Strategy for Wales was first published in January 2021 and formally updated in February, March and June 2021.

3 The Primary Care COVID-19 Immunisation Scheme sets out requirements and reimbursement for Primary Care providers that have signed up to the scheme.

c health boards are responsible for local vaccination plans, set up of mass-vaccination sites through collaborative working with local partners, and aspects of training and staffing. They are also responsible for securing vaccination centres in primary care and outreach/mobile services, with the Welsh Immunisation System (WIS) working to identify those in the priority groups using information on GP and hospital-based IT systems.

d Public Health Wales provides expert advice, surveillance data, vaccine effectiveness and safety monitoring, and public and patient information and reporting. It also assists in the development of training policy, patient group directions (PGDs) and tools.

e other partners are responsible for logistics:

- NHS Wales Shared Services Partnership and the Welsh Blood Service are responsible for supporting the pharmaceutical co-ordination team for consumable and storage logistics.
- Digital Health and Care Wales has led the design, test and rollout of the WIS that enables identification and coordination of priority groups and related appointment booking, vaccination recording and clinical quality assurance such as vaccine batch control. The system also provides performance data.

17 The Vaccination Strategy for Wales provides a high-level framework setting out the expectations for prioritisation and delivery of the COVID-19 vaccine. The Welsh Government has adopted the Joint Committee on Vaccination and Immunisation: advice on priority groups (**Appendix 3**). The national strategy focusses on developing the infrastructure for vaccine deployment, and communication about progress.

18 The first version of the strategy provided a clear milestone for the first four priority groups. In February 2021, the updated strategy provided target dates for the remaining milestones (**Exhibit 1**), with the aim of achieving 75% uptake for priority groups 5-9. This approach has continued to focus all partners on the time-critical aims of the vaccination programme as it continues to roll out.

Exhibit 1: Current key milestones for the vaccination programme

Milestone 1	**By mid-February 2021**: Priority groups 1 – 4 Subject to supply, the aim is to offer first dose vaccination to all care home residents and staff; frontline health and social care staff; those 70 years of age and over; and clinically extremely vulnerable individuals.
Milestone 2	**By mid-April 2021:** Priority groups 5 – 9 Subject to supply, the Welsh Government's aim is to offer first dose vaccination to all remaining priority groups.
Milestone 3	**By July 2021:** Offer first dose vaccination to the rest of the eligible adult population according to the JCVI guidance.

Source: Welsh Government

19 Programme oversight and monitoring take place at national and local levels receiving significant and regular officer level scrutiny as well as ministerial oversight. Public Health Wales and the Welsh Government publish regular updates[4]. Public Health Wales also undertakes enhanced surveillance, including analysis on vaccination uptake by deprivation, age, ethnic background and gender.

20 Vaccination delivery models vary by health board, predominantly based on geography and population density. Mass vaccination sites are being used in areas of higher population density, but in rural and hard to reach areas some health boards have adopted smaller local site models which enable vaccines to be delivered closer to the communities that they serve. Some health boards also depend more on primary care than others. Irrespective of geography, health boards are using outreach models to vaccinate in care homes and have set up temporary and mobile hubs (such as the Swansea Bay UHB Immbulance service).

21 Workforce planning is largely a delegated responsibility for health boards. A national workforce group has created policy and guidance providing high-level productivity modelling and has developed role descriptors for recruitment.

4 Public Health Wales vaccination updates are available on their interactive dashboard. Welsh Government updates are published each week.

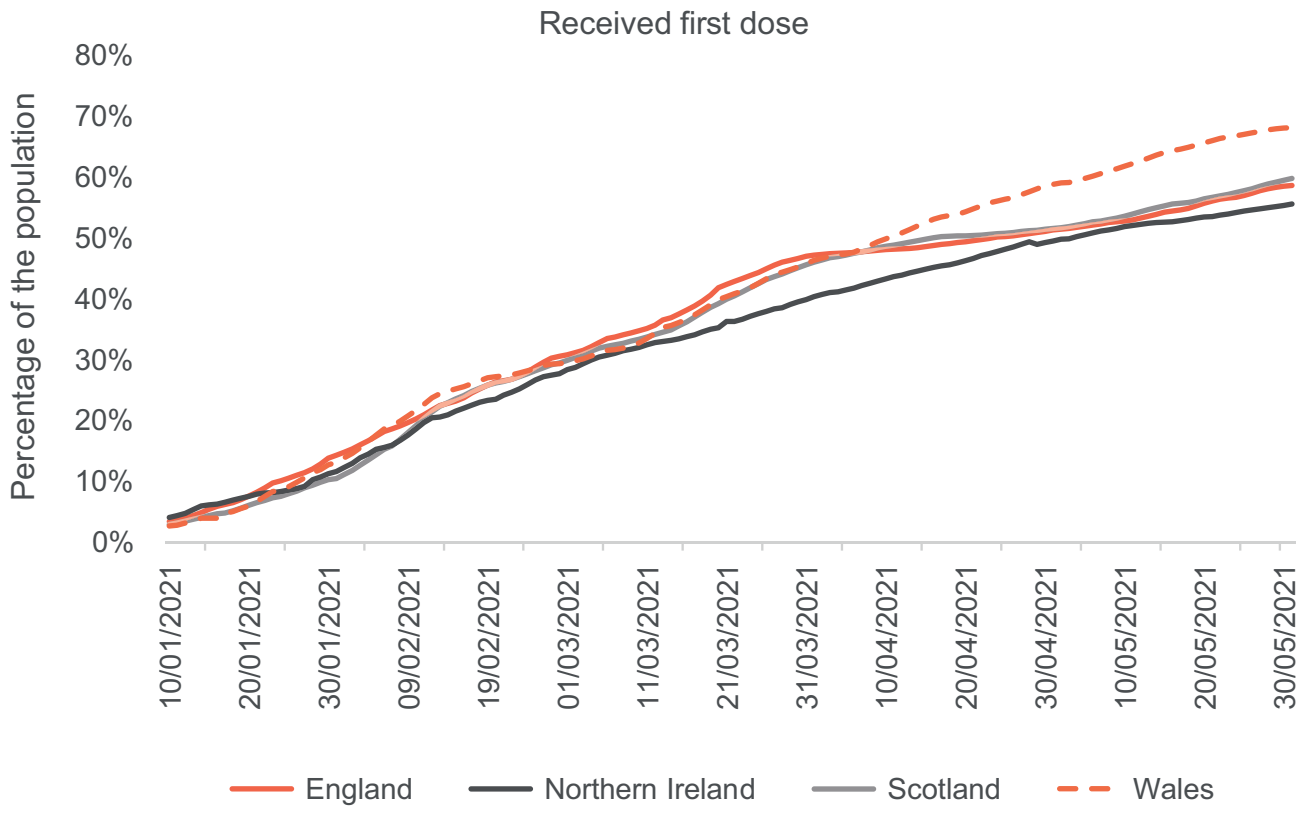
22 To date, vaccine procurement costs have been met by the UK Government in full. The Welsh Government funds the transport, storage, and additional local deployment costs in Wales. It provisionally estimated these costs at £34.9 million for 2020-21, including an estimated cost of £7.8 million for personal protective equipment (PPE). At the end of March, the actual costs for 2020-21 were reported as £29.4 million, as a result of costs associated with PPE largely being funded through existing PPE budget allocation. . Of the £29.4 million, £10.8 million has been spent on additional staffing, £9.54 million on the Primary Care COVID-19 Immunisation Scheme and £0.2 million on capital costs. Some staff are redeployed from within their organisations at no additional cost, although this has potential workforce implications for the part of the business where they originally worked.

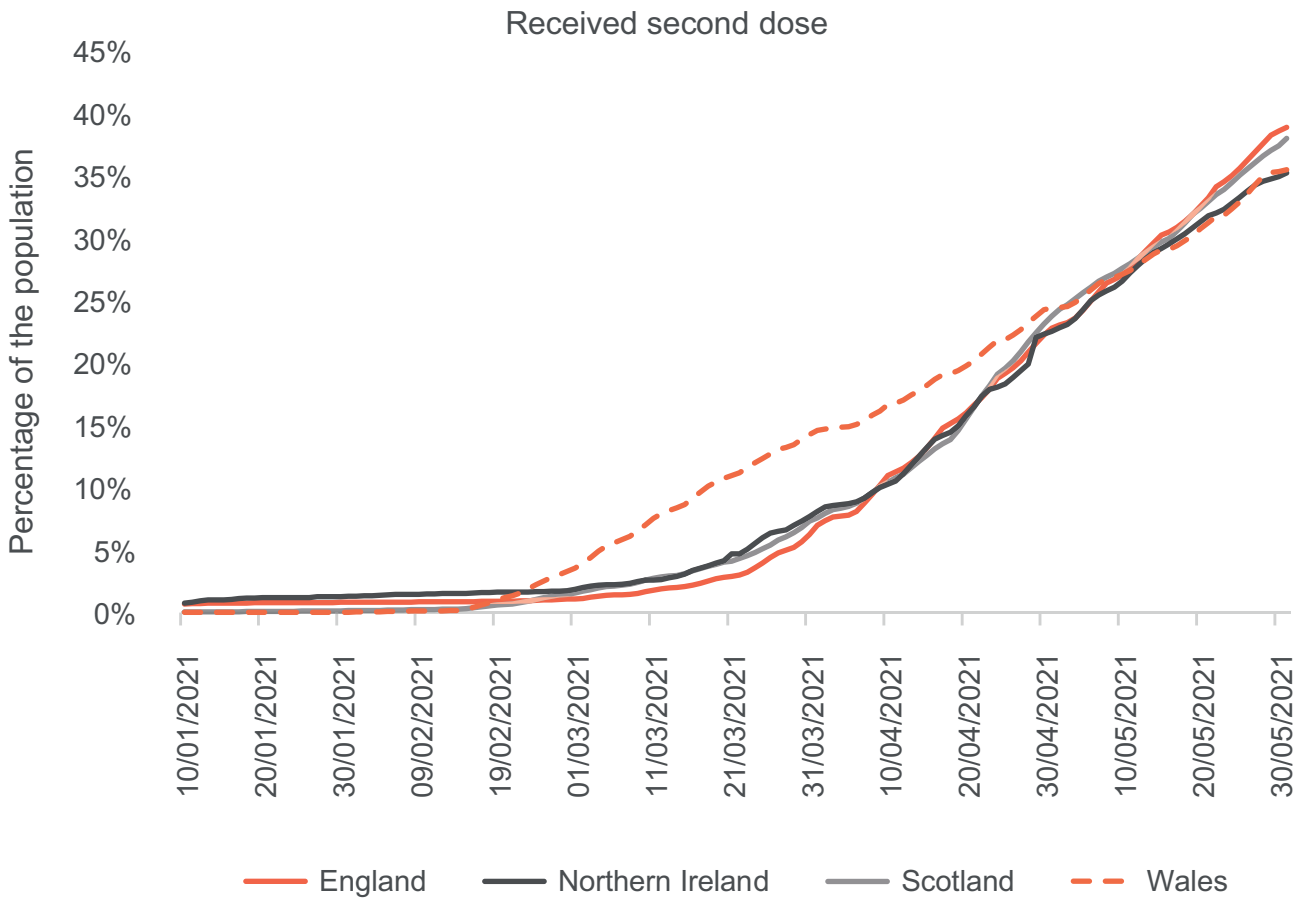
23 Other non-pay costs include transportation, site venue hire, personal protective equipment and syringe packs, security, and communications material. We understand that some vaccination sites are provided to the programme at no additional revenue cost. This is likely to change if local authority or other partners require the return of their facilities and health boards need to relocate to alternative accommodation which may come at a cost. The forecast costs of the programme for the first three months of 2021-22 (April to June 2021) are £31.5 million.

How is the programme performing?

24 Overall, as of 31 May 2021, the percentage of the adult population to have received the vaccine in Wales is higher than in the other UK nations (**Exhibit 2**). Wales made particularly good progress delivering second doses in March, although England and Scotland have now accelerated the delivery of second doses.

Exhibit 2: Percentage of the adult population to have received first and second doses of COVID-19 vaccination by country, as at 31 May 2021

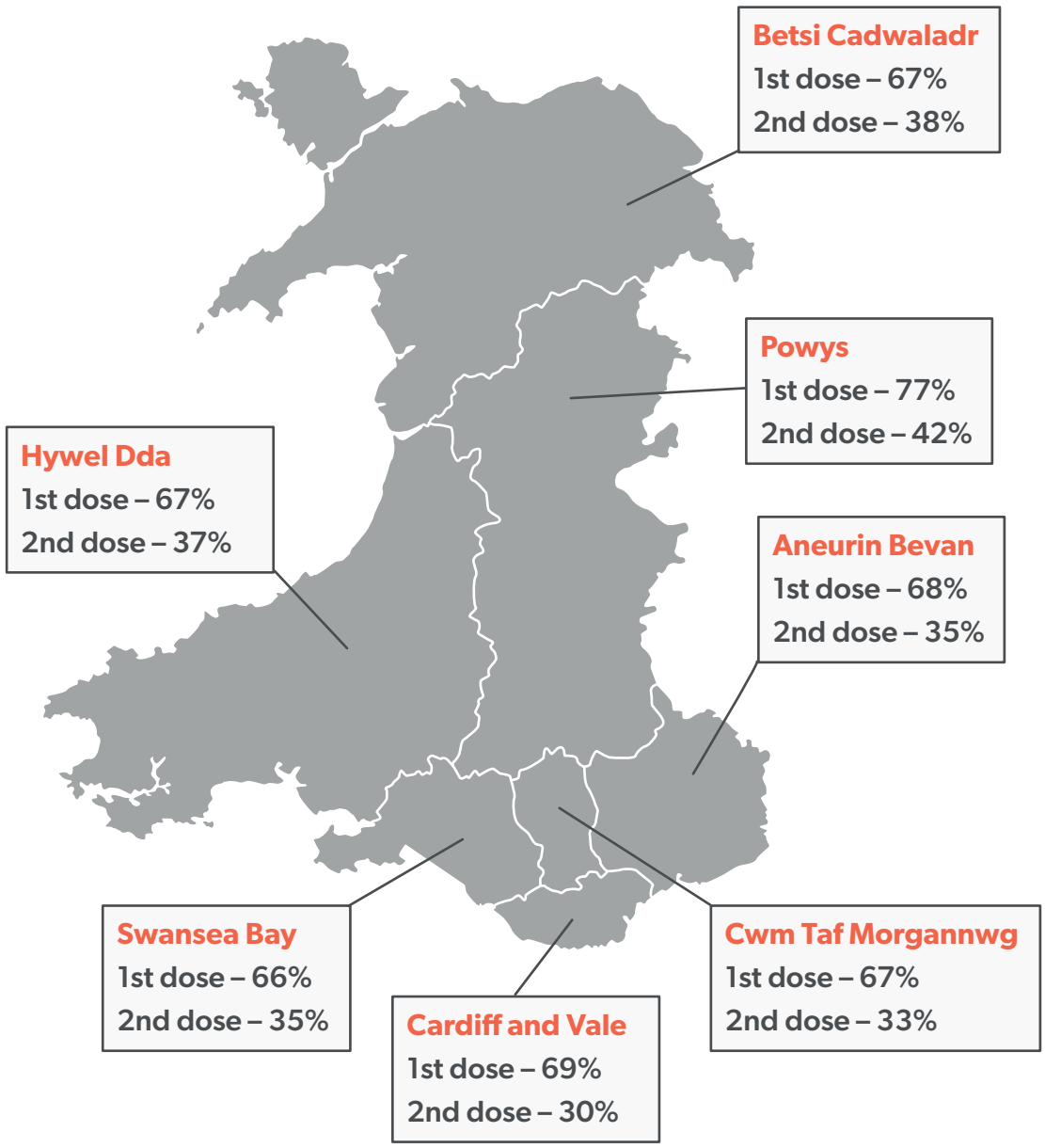




Source: UK Coronavirus Dashboard

25 There is some variation in the progress across health boards, most notably for Powys Teaching Health Board which is making the greatest progress (**Exhibit 3**). This is due to a combination of factors in Powys including a greater proportion of an older population and a higher level of supply per population as a result of batch sizes.

Exhibit 3: Vaccine doses given by health board as a percentage of the adult population as at 31 May 2021



Source: COVID-19 Vaccination Enhanced Surveillance Report, Public Health Wales

26 On 12 February 2021, the Minister for Health and Social Services announced that Milestone 1 of the vaccination strategy had been met. The Minister also announced on 4 April, that Milestone 2 had been met. Both milestones focus on the offering of an appointment for a vaccine. It is not possible to know if everyone eligible within the priority groups 1-9 were identified in the booking process. However, Welsh Government and health board officials took steps to help verify the position, such as contacting care homes to ensure all staff and residents had been offered a vaccination. At 31 May, around 95.5% of those in Milestone 1, and 87.9% of those in Milestone 2 had received their first dose.

27 While the programme has moved ahead to focus on Milestone 3, the Welsh Government and health boards are operating a 'no one left behind' policy. This means that anyone eligible in previous groups who has not yet had a vaccine for any reason can inform the relevant health board and make an appointment.

28 Public Health Wales surveillance reports show that influenza vaccine uptake is typically around 70% for those aged 65 and older. So far, the overall COVID-19 vaccine uptake for priority groups 1-9 is 91.5% which reflects positively in comparison. Reasons for not achieving 100% uptake include for example, people that are too unwell to receive the vaccine and the minority, to date, that have chosen not to have the vaccine. At the time of reporting, 66.1% of the priority groups 1-9 had received their second dose, and good progress was being made with vaccine rollout to younger age groups.

29 **Exhibit 4** shows some variation on uptake of first doses against the prioritisation groups by health board, particularly for priority group 6. We have observed extensive national-level discussion to respond to the challenges of identifying relevant population datasets. This included identifying all those aged 16-64 years clinically at risk where definitions of clinical conditions have needed to be clarified, and information about individuals is contained on different systems. There have also been challenges identifying unpaid carers who have previously not been recorded on any system. This indicates some of the difficulty in using a complex vaccination prioritisation model in the environment where no single centrally maintained population dataset exists for this purpose.

Exhibit 4: Percentage of first doses given by priority (P) group, at 30 May 2021

Priority Group		Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
P1.	Residents of care homes	97.5	98.6	98.0	96.4	98.2	96.8	98.8
P2.	80 years +	96.3	96.0	94.3	95.9	96.1	97.2	96.2
P3.	75-79 years	97.0	96.5	95.9	97.1	96.6	97.2	97.3
P4.	16-69 years clinically extremely vulnerable	94.2	93.8	93.2	94.7	93.9	95.7	94.4
P4.	70 – 74 years	96.6	95.6	95.4	96.5	95.7	96.2	96.6
P5.	65-69 years	94.9	94.5	93.5	95.4	94.3	95.0	95.5
P6.	16-64 years clinically at risk	88.6	86.5	88.1	88.2	86.7	90.4	87.8
P7.	60-64 years	93.6	91.6	91.5	93.7	92.2	91.6	93.3
P8.	55-59 years	91.6	89.4	89.3	91.9	90.0	89.4	91.1
P9.	50-54 years	89.7	87.7	86.5	90.1	87.5	88.1	89.0

Note: P2, P3 and P4 also includes data for those in the respective age groups who are also residents of care homes. Frontline health and care staff, as well as unpaid carers are not explicitly identified at health board level but instead included within the relevant age groups.

Source: Weekly COVID-19 coverage report, Public Health Wales

30 Equality considerations are a growing concern. Public Health Wales data shows clear variation in uptake among different ethnic groups with uptake lower particularly within the Black community (**Exhibit 5**).

Exhibit 5: Percentage uptake of first dose of COVID-19 vaccine by age and ethnic group as at 5 May 2021

Ethnic group	White	Black	Asian	Mixed	Other
80+ years	97.2	80.7	87.3	93.1	82.5
70-79 years	96.6	79.9	87.3	88.0	83.4
60-69 years	94.4	76.8	86.6	84.5	78.9
50-59 years	91.3	71.9	84.3	79.4	71.7

Source: Monthly enhanced surveillance report, including analysis on equality of coverage, Public Health Wales

31 As part of their analysis, Public Health Wales also found lower uptake in deprived communities. Although the differences are not as great as for ethnic groups, uptake between the least and most deprived areas for some age groups varies by up to 5.3%. Analysis of COVID-19 positive cases over the last 12 months has indicated that case prevalence and severity have been higher in Black, Asian and Minority Ethnic groups as well as in some of Wales' most deprived areas, with Merthyr Tydfil experiencing the highest number of cases per head of population. In March 2021, the Welsh Government published its Vaccination Equity Strategy for Wales. The Vaccine Equity Committee met for the first time in April 2021 and is preparing a vaccine equity plan.

32 Vaccine wastage (known as vaccines unsuitable for use) to date is around 0.4% of all vaccines supplied. As of 31 May, this equated to around 14,400 doses. Wastage is more prevalent for Pfizer-BioNTech with 0.8% of doses unsuitable for use. Only 0.2% of Oxford-AstraZeneca doses have been deemed unsuitable, with 0.04% reported for Moderna. In comparison, NHS Scotland has estimated that around 1.8% of COVID-19 vaccines are wasted[5]. The other UK nations do not publicly report vaccine wastage.

5 Scotland's COVID-19 Vaccine Deployment Plan – Update March 2021

33 Reasons for vaccines being unsuitable for use include doses that fail quality assurance on initial inspection, doses that fail quality assurance following preparation and vials/doses which expire during the vaccination session. Specific requirements for storage, transportation, and shelf-life of Pfizer-BioNTech once thawed have presented challenges.

34 Arrangements to minimise wastage include:

a systematic recording of temperatures during the different stages of transportation to ensure storage requirements are met from source to site storage, and then on to vaccine centres.

b using reserve lists so that people can attend at short notice at the end of the day to use any vaccine left because of people not attending booked appointments. Approaches to reserve lists vary across health boards with some making reserve lists open to all priority groups while others are targeted to specific priority groups.

c allocation of the Pfizer-BioNTech vaccine mainly to mass vaccination sites. Pfizer-BioNTech shelf-life once defrosted is shorter than the Oxford-AstraZeneca, so the allocation to mass vaccination sites helps to ensure that it is used rather than reaching the end of its shelf-life.

What have been the factors affecting rollout to date?

35 Vaccine supply is the most significant factor affecting the pace of the rollout. UK-wide supply, while agreed through formal contractual obligations, is constrained by commercial pharmaceutical supply and international demand. In general, the Welsh Government and NHS Wales are informed of the expected notional supply around one month ahead. But this can change at short notice both upward and downwards, so reliable projections are difficult beyond two weeks and are in a range, with best, realistic, and worse case scenarios from BEIS.

36 Supply challenges to date include:

a the temporary withholding of a batch of Pfizer-BioNTech vaccines, equating to 25,000 vials, because of quality control issues in January. The MHRA quality control process ensures that vaccines are safe to administer.

b a reduction in February resulting from the refurbishment of both Oxford-AstraZeneca and Pfizer-BioNTech facilities in Europe to accommodate increased production levels.

c a reduction in April owing to the reprioritisation of Indian-produced Oxford-AstraZeneca vaccine resulting in an expected four-week delay.

37 Workforce models have evolved since the beginning of the vaccination programme, with a need to remain flexible to expand or reduce services at relatively short notice in response to supply. All health boards initially used registered health staff immunisers. This was then supplemented through GP practices, which has enabled vaccination activity to be scaled up and offered close to home. Changes to UK legislation has also enabled non-registered staff to be trained to vaccinate under supervision, and over time other partners, such as the military and more recently fire and rescue service personnel, have assisted in the rollout. Plans are also in place to use community pharmacies, with the first pharmacy offering of the COVID-19 vaccine launched in April 2021 in Cardiff.

38 Support staff, clinical staff who have either previously left or retired, and volunteers are also helping at vaccination sites in a variety of roles. The Welsh Government and health boards recognise the goodwill of retired staff who have agreed to come back and assist, as well as volunteers, but we heard mixed views on how easy and beneficial making use of these groups has been in practice. We heard of cumbersome processes to bring back retired or returning staff, some volunteers were only offering to help for short periods, and there were differing views about the need to undertake mandatory training.

39 Prioritisation in line with the Welsh Government policy and guidance has been an essential element of the programme to date. Almost all (99%) of the population at most risk from COVID-19 are in priority groups 1-9. All health boards have adopted prioritisation principles set out within the national vaccination strategy. However, there have been concerns about how the prioritisation approach has varied across Wales and the risk that some (including NHS staff) may have received their vaccine ahead of their allotted priority group. This has arisen because of the desire not to waste unused vaccine and the differing approaches to manage reserve lists. Welsh Government officials have written to health boards in an attempt to standardise the approach for reserve lists. There have also been challenges defining ‘frontline’ for health and social care staff, which may have also resulted in some staff receiving the vaccine earlier than intended.

40 We found that communications relating to prioritisation for the COVID-19 vaccination at a UK, Welsh Government and health board level have been generally consistent, reducing the risk of mixed messaging. In addition, work undertaken by Community Health Councils has found that the public have generally been happy with the communication that they have received from health boards. However, there appeared to be greater concern at earlier stages of the programme from people:

- a wanting to know where and when they will be vaccinated;
- b not understanding why, for example, a couple could not go to the same vaccination centre on the same day; and
- c feeling that some with lower priority had been vaccinated before them.

41 As the programme has gathered pace, many of those initial concerns have eased. A longer lasting issue related to the format of invite letters. These letters are produced automatically by the Welsh Immunisation System for individuals invited to attend a mass vaccination centre, and for the first three months of the programme there was little that could be done to tailor them. We heard of concerns around:

- a identical letters being used for first dose and second doses. An example was given to us where an individual was called back for a second dose at the initial recommended four-week period[6], but they thought they had received a first dose letter again in error and ignored it.
- b the format of the letters, with interchangeable use of English and Welsh language over several pages, affecting the clarity of the letter and how to raise a concern or rearrange the booking.

42 The format of invite letters has since been addressed in relation to the use of English and Welsh language although the need to make clearer that the invitation is for second doses remains.

6 Initial guidance from the JCVI recommended that the second dose of the COVID-19 vaccine should be administered at four weeks after the first dose. This was subsequently changed to up to 12 weeks in January 2021.

What are the future challenges and opportunities?

43 The vaccine programme in Wales has progressed extremely well but there is still some way to go. Around 4.5 million doses are needed to protect 90% of the adult population in Wales with two doses. At the current rate, and with 3.3 million doses completed as at 31 May, this could mean that second doses for the remaining adult population are not completed until September. Alongside this, there is increasing discussion of an autumn booster programme. It is likely that there will be little respite between finishing vaccinating the remaining adult population and planning a possible next phase of the programme. This all points to a need to develop a longer-term plan for vaccine rollout that looks further ahead and moves beyond the here and now.

44 Vaccine supply is likely to remain a significant challenge. While new vaccines are also becoming available, the more that are in use, the greater the challenge to coordinate their deployment. Storage, transportation, preparation, shelf-life, and training requirements differ depending on the vaccine. Changes to JCVI guidance may also present challenges. For example, the recent guidance to offer under 40s an alternative to the Oxford-AstraZeneca vaccine[7] could result in slower rollout if alternative vaccines are not available. As more vaccines come on stream in Wales, complexity will increase further as may waste and operational efficiency. The Welsh Government are aware of this risk and are working to mitigate it.

45 The current workforce model is meeting the needs of the vaccination programme. However, as other services are restarted and as the wider economy reopens, a sustainable and still flexible workforce solution will be needed for the medium to longer term. Key issues include:

a some health board staff supporting the vaccination programme have been redeployed from their normal role. As other services are restarted, there will be competing workforce pressures as staff are called back to their core roles.

b we have heard that the workforce is fatigued, with many having worked above and beyond at many stages of the pandemic. This will not be sustainable in the longer term. We also heard that as the economy reopens and COVID restrictions are eased, the supply of volunteers is reducing.

c consideration is being given to the potential to combine a COVID-19 booster programme with the routine flu immunisation programme, or whether there is a clinical need to keep them separate. Either way, there are implications for the development of the workforce to meet demand.

7 JCVI statement on Use of the AstraZeneca COVID-19 vaccine: 7 May 2021

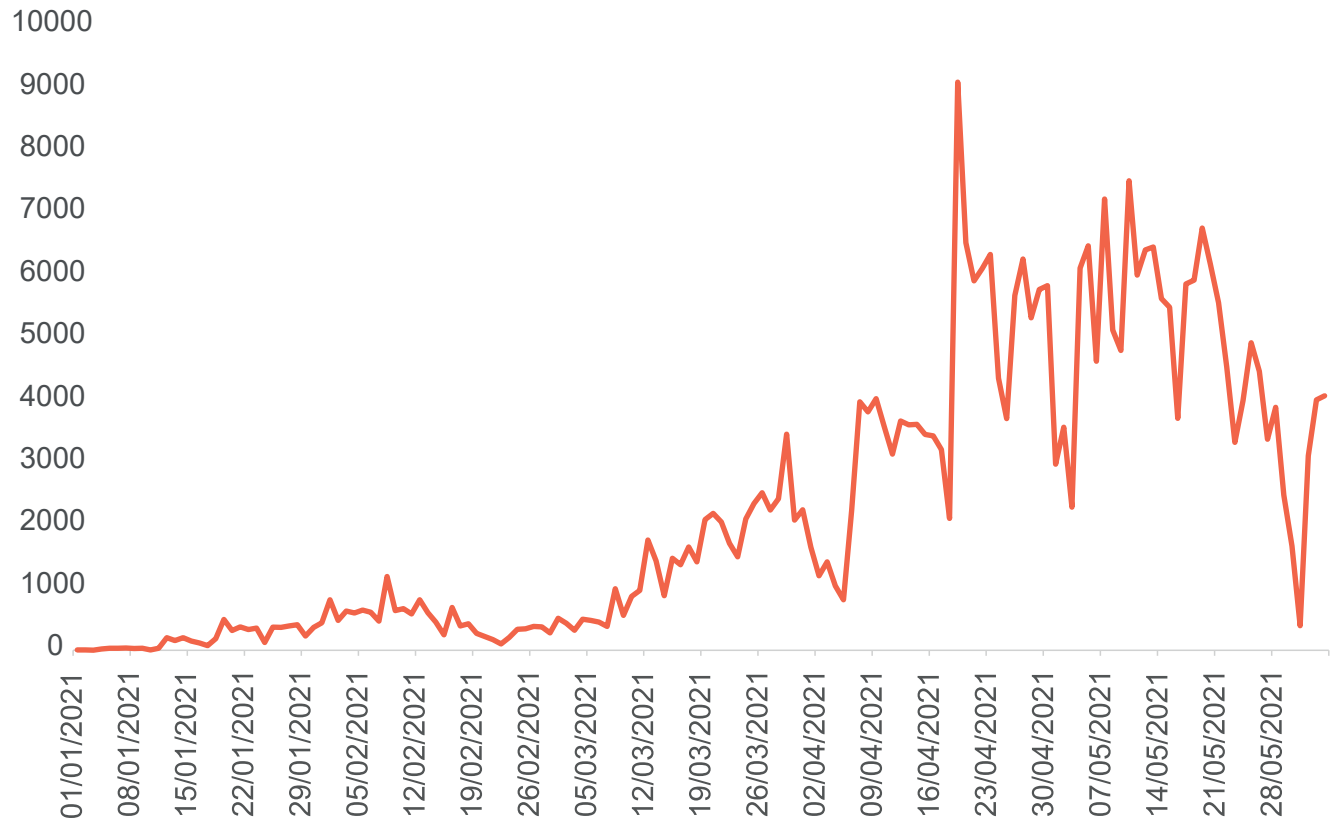
46 Sites used as mass vaccination centres have largely been made available to health boards through the goodwill of partners. Many of these venues were closed due to COVID-19 restrictions. With restrictions easing, organisations will now be looking at the potential to reopen these venues before the anticipated end of the current programme as a way of remaining commercially viable, for example, Venue Cymru in Llandudno. Health boards are likely to need to consider alternative cost-effective options for vaccination centres at relatively short notice to deliver the remainder of the current programme. They will also need to look at how to accommodate the longer-term COVID-19 vaccination programme alongside the wider immunisation programme.

47 There will always be differences in vaccination models to respond to local population needs and geography. Nevertheless, some models will be delivering greater efficiency than others. Early observations from the military partners involved in the vaccination programme identified vaccination sites were not always making the most efficient use of qualified staff and that rates of vaccination per hour per staff varied between 2.6 and 10.2. This variation in vaccination rates merits further investigation by operational officials, but the local variations will be, in part, due to supply and vaccine type. Health boards and the Welsh Government need to maintain a focus on ensuring that service models provide value for money. This will also help inform the shape of future models and programme design.

48 As the programme moves forward, there is a growing concern that the younger population are less likely to accept the offer of a vaccination. Health boards are continually assessing and adapting vaccination models to ensure they are accessible to all and working in partnership with other agencies to understand the reasons for vaccine hesitancy and to put actions in place. This has included some positive actions being taken to engage community leaders in particular ethnic communities, and members of the travelling community. Health boards and partners need to maintain this focus to build trusted relationships and improve the confidence in the vaccine programme. This is likely to be resource intensive if the Welsh Government and NHS wants to maintain its overall positive uptake rate for the remainder of the population and to ensure uptake of second doses is as high as is being achieved for first doses.

49 Having dropped at the end of March and early April, the number of individuals who do not attend for their appointment has since increased again (**Exhibit 6**). It is understood that non-attendance is greater for first dose vaccines, than second dose vaccines. Non-attendance impacts the pace of the programme and represents a cost-inefficiency as staff can end up underutilised. Arrangements to call those on reserve lists in at short notice are helping to fill empty slots, but as the percentage of the population yet to have a vaccine reduces, filling these slots will become more challenging. Non-attendance rates do vary by health board with Aneurin Bevan, Cardiff and Vale, and Swansea Bay University Health Boards experiencing some of the highest levels.

Exhibit 6: Numbers of people invited for vaccination but did not attend by day up to the end of May 2021



Source: Welsh Government

Note: the data used is intended for internal management information purposes and has therefore not been validated

50 Some of the reasons for non-attendance have included delays in invite letters being received, and problems getting through to contact numbers to rearrange appointments, as well as people not turning up because of vaccine safety concerns. Difficulties in getting time off work to attend appointment slots and clashes with holidays as society opens are increasingly likely to result in further non-attendance over the coming months. There is opportunity to reflect on the current approach for booking, with consideration to web-based systems to support self-booking of appointments. This will help provide flexibility and minimise the resource intensive process when people have to re-book or staff must find people to fit in the slots. The programme is actively working on establishing this with Digital Health and Care Wales.

51 Following a recent 'Programme Assessment Review' in March, the Welsh Government has considered future challenges and how it strengthens national programme management arrangements. To date, there has been limited additional central capacity to drive the programme at a national level, and reliance has been placed on a relatively small number of officials both within the Welsh Government and across the NHS to lead the rollout programme. Programme management arrangements during the early part of the vaccine rollout were rather unwieldy, with early oversubscribed Stakeholder Boards due to intense interest. In excess of 60 people from different professional backgrounds attended. Changes have been made to tighten up these arrangements and we understand that more changes are planned to further streamline programme management and governance.

52 Whilst the challenges outlined here need to be carefully considered as the vaccine rollout moves to its next stage, it should be recognised that the programme has moved at a scale and pace not previously seen in Wales. There is much to celebrate in that and there are many positive lessons to learn for the delivery of other programmes and the wider immunisation agenda.

Appendices

1 Audit approach and methods

Our primary focus was on the national vaccination programme and the deployment of vaccines in Wales. We drew on the vaccination deployment of three health boards to obtain an understanding of rural and urban settings. We considered the set-up of the national programme, performance of the programme, and the factors or issues that have affected rollout.

Our work excluded vaccination arrangements administered by the UK government. The National Audit Office has examined the UK government's preparations for potential COVID-19 vaccines[8]. We reviewed that report to help inform our wider understanding of procurement, contracting and vaccine costs, which are administered UK-wide.

Audit methods

We used a range of methods:

- **document review**: we reviewed national strategy, guidance, Welsh Government announcements and update reports, health board vaccination plans, local and national performance reporting. We also reviewed national vaccination stakeholder and deployment board papers and minutes.
- **observations**: we attended several national vaccination stakeholder board and deployment board meetings as observers.
- **semi-structured interviews**: we interviewed Welsh Government officials involved in the vaccination programme, selected members of the national vaccination deployment board, and senior managers from three health boards involved in the set-up of vaccination sites and the deployment of vaccines.
- **data analysis**: we reviewed available data on first and second dose vaccination progress in Wales and the other UK nations. We considered vaccine wastage and deployment costs, in relation to pay costs, non-pay costs and the extent of costs associated with vaccination in primary care settings.

It is not possible for us to present data for the same period throughout this report. Data in this report are taken from differing sources and are published at differing intervals. Detailed information on vaccine availability, stock, and utilisation by manufacturer is not publicly available for reasons of commercial confidentiality.

We completed our fieldwork between February and April 2021.

8 Investigation into preparations for potential COVID-19 vaccines, National Audit Office, December 2020

2 UK COVID-19 vaccines purchased and status as at 1 June 2021

Vaccine	No of doses	Status
Oxford-AstraZeneca	100 million	Approved 30 December 2020 and in deployment across Wales from January 2021
Janssen	20 million	Approved 28 May 2021
Pfizer-BioNTech	100 million	Approved 2 December 2020 and in deployment across Wales from January 2021
Moderna	17 million	Approved 8 January 2021 and in deployment from April 2021 in Aneurin Bevan and Hywel Dda University Health Boards
GlaxoSmithKline/ Sanofi Pasteur	60 million	Phase 3 trials
Novavax	60 million	Encouraging phase 3 safety and efficacy data
Valneva	100 million	Phase 3 trials
CureVac	50 million (initial order)	Phase 3 trials
Total	**507 million**	

Source: Recent GOV.UK announcement, updated based on information from the London School of Hygiene and Tropical Medicine and recent GOV.UK announcement

3 Welsh Government's vaccine prioritisation (based on the JCVI recommendation)

Vaccine prioritisation groups	
1	People living in a care home for older adults and their staff carers
2	All those 80 years of age and older and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and people who are extremely clinically vulnerable (also known as the "shielding" group) – people in this group will previously have received a letter from the Chief Medical Officer advising them to shield
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions*, which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Source: Welsh Government

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Procuring and Supplying PPE for the COVID-19 Pandemic

Report of the Auditor General for Wales

April 2021

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Key messages

Context

1 This report looks at the procurement and supply of Personal Protective Equipment (PPE) during the COVID-19 pandemic. PPE is essential for protecting those who get close to infected people. It can also prevent people spreading the virus amongst each other and to those they are caring for.

2 Our report focuses on the national efforts to supply health and social care in Wales. These efforts have been led by the Welsh Government, working with partners in the NHS Wales Shared Services Partnership (Shared Services) and local government. Shared Services has taken on an expanded role in securing PPE for the whole health and social care sector. **Appendix 1** describes our audit approach and methods.

3 We have not reviewed arrangements for local procurement of PPE by NHS and local government bodies, nor the logistical arrangements in place locally to distribute PPE directly to frontline staff. We have, however, reflected evidence collected by professional bodies about the views of front-line staff. In carrying out this work, we have been mindful of the work by the National Audit Office (NAO) in England on the supply and procurement of PPE. Where possible, we have sought to align our scope, albeit in a devolved context.

Overall conclusion

4 In collaboration with other public services, Shared Services overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. It is now in a far stronger position, with stockpiles of most PPE equipment and orders in train for those that are below 24 weeks. Some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher level of PPE than required by guidance. The Welsh Government and Shared Services put in place good arrangements overall to procure PPE that helped manage risks and avoid some of the issues reported on in England. However, Shared Services did not publish contract award notices for all its PPE contracts within 30 days of them being let.

Key findings

5 The challenge facing the NHS and social care at the start of the pandemic was stark. The stockpile developed for a flu pandemic was inadequate for a coronavirus. Global supply chains had fragmented as countries competed for scarce supplies and some imposed export controls.

6 Public services across Wales responded in an increasingly collaborative way. Shared Services took on an expanded role in supplying PPE to the wider NHS, including independent contractors in primary care (GPs, dentists, pharmacies and optometrists). Shared Services then worked closely with local government to understand demand in social care and then took on an increasing role supplying PPE. Shared Services now supplies almost all social care PPE needs. We recognise the huge individual and collective effort involved in the work to source and supply PPE to frontline staff.

7 Shared Services data shows that, nationally, stocks did not run out although stocks of some items got very low. At times, Wales drew on mutual aid from other countries but ultimately gave out significantly more than it received. The health and care system is now in a much better position, with buffer stocks of most PPE items in place and orders due on key items where stocks are below target.

8 Surveys carried out by the Royal College of Nursing and British Medical Association suggest confidence in the supply of PPE grew shortly after the start of the pandemic, but concerns remain. While we cannot be sure how representative these views are, some frontline staff reported shortages of specific items of PPE, with a small minority saying at times they had none at all. In some cases, staff concerns relate to the fact that they want a higher level of PPE than required under the guidance.

9 A range of bodies were involved in sourcing PPE globally and in responding to, and working with, local manufacturers. In contrast to the position described by the NAO in England, we saw no evidence of a priority being given to potential suppliers depending on who referred them.

10 Overall, Shared Services developed good arrangements to rapidly buy PPE, while balancing the urgent need to get supplies for frontline staff with the need to manage significant financial governance risks in an area of rapidly growing expenditure. These risks included dealing with new suppliers, having to make large advance payments and significant quantities of fraudulent and poor-quality equipment being offered.

11 Time pressure meant due diligence could not always be carried out to the level it would outside of a pandemic in a normal competitive tendering process. But, for each contract we reviewed, we found evidence of key due diligence checks. And while costs were generally higher than before the pandemic, we saw evidence of Shared Services negotiating prices down.

12 However, Shared Services did not meet the requirements under emergency procurement rules to publish contract award notices within 30 days. Shared Services told us that its staff needed to prioritise sourcing PPE and that there were other administrative reasons for delays.

13 Shared Services' plan for PPE ran until March 2021. There are now some key decisions to make about the future strategy for PPE, including the size and nature of the stockpile going forwards and the role of Welsh manufacturers.

Procuring and supplying PPE in these times has been far from business as usual. The challenges, risks and pressures have been higher, and a huge individual and collective response has been needed.

NHS Shared Services, working with others, has responded well to develop and maintain the national stock and to supply health and care bodies. However, despite competing pressures, Shared Services should have moved more quickly to publish details about the contracts it let.

While the overall picture painted by my report is relatively positive given the difficult circumstances, we cannot ignore the views expressed by some of those on the frontline about their own experience. There are also lessons for the Welsh Government and Shared Services to learn – about preparing for a future pandemic as well as addressing some current challenges.

Adrian Crompton
Auditor General for Wales

Key facts

630 million

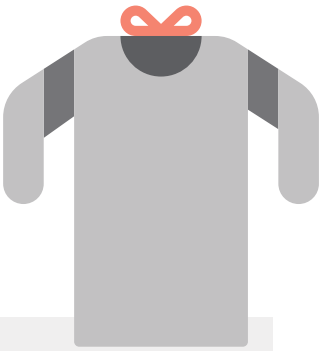
the number of items of PPE issued by Shared Services between 9 March 2020 and 7 February 2021

Less than 2

the lowest number of days' worth of national stock of visors, Type IIR face masks and surgical gowns at points during April 2020

£8 million

the annual amount NHS Wales would typically spend on PPE before the pandemic



Over £300 million

the total amount expected to be spent on PPE for Wales during 2020-21

£880 million

our estimate of how much the Welsh Government has received so far through the Barnett formula as a result of spending on PPE in England

24

the number of weeks' worth of PPE stock Shared Services currently aims to hold

67

the number of suppliers Shared Services has contracted with to supply the NHS and social care with PPE since the start of the pandemic

Key roles and responsibilities

Appendix 2 sets out the main organisations and groups involved in the national supply and procurement of PPE. At a higher-level, the key roles are:

Welsh Government – provides a lead on the pandemic response and policy, including liaison with the UK Government, and funds PPE

Shared Services – responsible for procuring and supplying PPE to hospitals, took on an expanded role for procuring and supplying primary care and social care

Public Health Wales – responsible for developing and issuing, with other UK countries, the infection prevention and control guidance that determines what PPE is needed and in what circumstances

4 Recommendations

Recommendations

Preparedness for future pandemics

R1 As part of a wider lessons learnt approach, the Welsh Government should work with other UK countries where possible to update plans for a pandemic stockpile to ensure that it is sufficiently flexible to meet the demands of a pandemic from different types of viruses.

R2 In updating its own plans for responding to a future pandemic, the Welsh Government should collaborate with other public bodies to articulate a set of pan-public sector governance arrangements for planning, procuring and supplying PPE so that these do not need to be developed from scratch.

R3 Shared Services should work with NHS and social care bodies to maintain an up-to date stock management information system that provides timely data on local and national stocks of PPE that can be quickly drawn upon in a future pandemic to support projections of demand and availability as well as providing a robust source of information for briefing stakeholders.

Recommendations

Procurement strategy for PPE

R4 In updating the strategic approach to PPE, Shared Services and the Welsh Government should work together to develop a clear direction in terms of:

- a return to competitive procurement and an end to emergency exemptions.
- fuller consideration of the wider criteria usually applied to procurement, such as sustainable development and policies on modern slavery.
- the intentions and aspirations in relation to the domestic PPE market, including the balance between the potential benefits of resilience through local production capacity against the potentially increased costs compared to international manufacturers.
- the size and nature of the pandemic stockpile it intends to hold, considering the benefits and costs of holding and maintaining stock and the timing of purchases given the ongoing disruptions to the PPE market.

Recommendations

Transparency

R5 To increase confidence in stocks and supplies at the national level, Shared Services should work with the Welsh Government to publish details of the amount of stock it holds of each item alongside the regular publication of data on the numbers of items issued.

R6 Shared Services should: check that it has published contract award notices for all contracts where it is required to do so; review those that it has published to ensure they are accurate; and ensure that it publishes contract award notices within the required timeframe for future contracts.

R7 The Welsh Government should review whether the Sell2Wales site needs updating to allow bodies to publish retrospective contract award notices more efficiently without relying on suppliers to sign-up.

R8 Given public interest in the awarding of PPE contracts and to promote confidence in the procurement system, the Welsh Government and Shared Services should publish details of the contracts awarded under emergency exemptions in a single place that is easy to access.

The supply of PPE

01

1.1 This part of the report covers the supply of PPE. In particular, it looks at the extended role that Shared Services took on for supplying hospitals, primary care and the whole social care sector. It covers the supply of PPE to those bodies in health and to the local government stores that distribute to social care. We did not look at local processes within hospitals or in local government for getting PPE to frontline staff. We have, however, reflected evidence collected by professional bodies about the views of front-line staff.

UK-wide arrangements for an influenza pandemic proved inadequate for the demands of dealing with the coronavirus and the Welsh Government quickly decided to secure its own PPE supplies through Shared Services

1.2 The Welsh Government and other nations of the UK have long-standing plans for an influenza pandemic. These included a 2011 Influenza Pandemic Preparedness Strategy, agreed by all four UK nations. Following the swine flu outbreak in 2009, the UK Government and Welsh Government developed and maintained a national stockpile in preparation for an influenza pandemic.

1.3 In addition to medicines and other countermeasures, the Pandemic Influenza Preparedness Programme (PIPP) held a stock of PPE, based on estimates of need for an influenza pandemic. The PIPP involved a physical stockpile of items, stored in South Wales, plus UK-wide contracts in place for additional stock to take the PIPP to 15 weeks of supply if required. However, due to a lack of supply in the global market, these 'just-in-time' contracts did not deliver as fully as expected with none of the FFP3 respirators being received. To mitigate some of these issues, equipment that was close to, or past, its expiry date was tested and had its expiry date extended.

1.4 The Welsh Government quickly realised that the PIPP would not be adequate for a coronavirus pandemic. The PPE would need to be used at a faster rate to deal with the specific demands of COVID-19. Some items – notably gloves and aprons – were below the estimated requirement for a flu pandemic and would not last as long as needed for COVID-19. Surgical gowns were not held in the PIPP stockpile.[1] These items proved to be critical for hospital staff treating COVID-19 patients. The NAO's report on the supply of PPE confirms the inadequacy of the UK stockpile for the demands of a coronavirus.

1 As reported by the NAO, the UK Government's scientific advisors had recommended in 2019 that gowns and visors be added to the stockpile, but the UK Government was still deciding which gowns to procure when the pandemic started.

1.5 The Welsh Government initially anticipated there would be a UK Government led approach to find additional supplies. However, this arrangement proved challenging in practice. The global market was fragmented, countries around the world were competing for scarce supply and some imposed export controls. The NAO has set out the challenges the UK Government faced just to secure PPE supplies for England.

1.6 The Welsh Government decided in late March 2020 that it would continue to work with the other UK administrations, where possible, but would procure and supply PPE for itself. We consider the work to procure PPE for Wales in **Part 2**.

The Welsh Government established effective arrangements for coordinating the supply effort although it took time to develop collaboration between health and social care

1.7 A small team of Welsh Government officials coordinated the PPE supply effort, working very closely with Shared Services. Daily meetings during the early stages of the pandemic discussed issues such as stock levels, likely demand, distribution of available stock and procurement of new supplies. Shared Services took day-to-day charge of delivery and collated information for Welsh Government officials to brief senior colleagues and ministers, and to respond to wider scrutiny.

1.8 The Welsh Government established two key groups to oversee PPE arrangements and provide a formal framework for joint working specifically on PPE:

- a ‘health counter-measures group’ started meeting on 12 February 2020 to secure and deploy PPE supplies in line with ministerial policy and public health guidance. The group included Welsh Government officials responsible for health and social care, Shared Services and Public Health Wales. It reported to the Planning and Response Group, which was set up in March to coordinate the overall health and social care response to the pandemic and chaired by a senior Welsh Government official. The Welsh Government suspended the health counter-measures group on 1 June 2020 once it judged the emergency phase had passed.
- an ‘executive leads group’ met from late April 2020 and brought together a senior officer from the Welsh Government, Shared Services, each health board, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust and Public Health Wales to exchange information on local issues and the national response. Before formalising this group, there was already extensive communication between senior NHS executives and Welsh Government officials through other mechanisms.

1.9 During March 2020, joint working was not as developed between Shared Services, local government and the social care sector. Shared Services' core work is to supply services delivered directly by health boards and trusts, and it had not previously been responsible for supplying independent primary care contractors and social care. The Welsh Government wrote to local authorities on 19 March 2020 stating that social care providers could obtain PPE from Shared Services for the treatment of symptomatic residents if they were unable to secure it from other sources.

1.10 The Welsh Local Government Association (WLGA) and the Welsh Government set up a working group on COVID-19 procurement, bringing together local government procurement leads and the Welsh Government's National Procurement Service. This group met daily from 23 March 2020 to the end of June 2020 when the meetings then became less frequent. The Planning and Response Group had a social care sub-group where representatives from the WLGA and social care organisations could raise issues about PPE supply. However, the WLGA told us that local authorities did not feel sufficiently involved in a collective health and social care response until 9 April, when Shared Services joined the procurement group.

1.11 Nonetheless, people we interviewed reported that collaboration and partnership working was much stronger than it had been during normal times. This collaboration was helped by already having a single public body responsible for supplying PPE to much of the NHS and existing networks and relationships between the Welsh Government, NHS bodies and local government. The position in Wales contrasts with the position in England. The NAO reported that prior to the pandemic many more organisations were involved and there was more distance between the government and the agencies responsible for procurement, supply and stock management, much of which was contracted to the private sector.

Public health guidance determined what PPE was needed and formed the basis of efforts to work out how much PPE would be required by health and social care

Guidance

1.12 Before the first UK case, public health authorities across the UK were working out PPE requirements. In January 2020, the four nations agreed that COVID-19 should be classified a High Consequence Infectious Disease (HCID). Guidance issued on 10 January 2020 set out infection controls, including the isolation of COVID-19 patients and use of PPE.

1.13 After reviewing emerging information, including the fatality rate, the virus was declassified from an HCID on 19 March 2020. As a result, the guidance changed from advising that anybody entering the room of an isolating patient wear a gown, long gloves, respirator masks (FFP3) and eye protection to tailoring the guidance to the setting, whether the patient was known or likely to have COVID-19 and what procedures were being undertaken.

1.14 The core infection prevention and control guidance are issued jointly by all four UK nations, although individual nations issue supplementary guidance where there are differences. Those developing the guidance, including representatives from Public Health Wales, have access to expert advice[2]. In its July 2020 report, the Senedd Health, Social Care and Sport Committee reported some early uncertainty among providers about the guidance, notably in social care. It noted that updated guidance issued on 2 April 2020 had provided greater clarity.

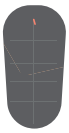
1.15 **Exhibit 1** sets out the PPE requirements at the time of drafting this report. Overall, there have been over 30 changes to the guidance since it was first issued in January 2020. One key change came on 10 April 2020 when the guidance was updated to reflect that non-symptomatic patients could be contagious. The updated guidance provided more detailed information about what PPE should be worn by health and social care staff when treating all patients, not just confirmed or suspected COVID-19 patients. On 21 August 2020, the guidance was updated to include a COVID-19 risk pathway to support returning services.

1.16 On 17 April 2020, Public Health England issued separate guidance to allow for the re-use of PPE in the case of acute shortages until confirmation of adequate re-supply. The same day, Wales' Chief Medical Officer shared the English guidance with NHS and social care bodies in Wales but noted that he did not envisage re-use being needed in Wales. On 27 April, the Public Health England guidance on re-use of PPE was incorporated into the jointly issued UK infection prevention and control guidance.

1.17 By 3 May, the separate Public Health England guidance on re-use included a note from Public Health Wales (and the public health agencies of Scotland and Northern Ireland) stating that single use PPE should not be reused, and that reusable PPE should only be reprocessed in line with manufacturer instructions. This note was never included in the UK infection prevention and control guidance. The re-use section of the UK guidance was removed in August 2020.

2 Including from the Scientific Advisory Group on Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).

Exhibit 1: PPE used to manage COVID-19

	Type of PPE	Further detail
	Aprons	A single-use apron is used when providing direct care within two metres.
	Body bags	Used by those managing the human remains of COVID-19-related deaths.
	Clinical waste bags	Used across all health and care settings, at all times and for all patients or individuals, for the safe disposal of used PPE.
	Eye or face protectors	These visors or safety spectacles are used during aerosol generating procedures and otherwise if blood and/or body fluid contamination to the eyes or face is likely.
	Face masks	Non-fluid-resistant face masks (Type II masks) are used by health and care workers when entering a hospital or care setting. Fluid-resistant face masks (Type IIR masks), are used when delivering direct care within two metres of a suspected or confirmed COVID-19 case
	Gloves	Worn during patient contact where there is a risk of exposure to body fluid.

	Type of PPE	Further detail
	Gowns or coveralls	Used (during aerosol generating procedures and otherwise) to withstand penetration by blood and/or body fluids when an apron provides inadequate cover for the task.
	Hand hygiene	The use of alcohol-based hand rub is part of hand hygiene in all health and care settings, at all times and for all patients or individuals.
	Respirator masks	Respirator masks are used to prevent inhalation of smallv airborne particles during an aerosol generating procedure. Respirator masks are known as a filtering face piece (FFP) mask. There are three categories of FFP mask (FFP1, FFP2, FFP3). FFP3 masks should be worn when performing an AGP. Workers should first be fit-tested for an FFP3 mask to ensure an adequate seal. In some circumstances FFP2 masks can be used as a safe alternative to FFP3 masks.

Note: An aerosol generating procedure is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract.

Source: Based on NAO analysis of official guidance reported on page 15 in The supply of personal protective equipment (PPE) during the COVID-19 pandemic, November 2020

Modelling

1.18 Initially, Shared Services worked with NHS bodies to obtain information on local stocks and estimate short-term demand. Each health board had its own systems for projecting demand and managing stocks. Local authorities came together to try to work out the demand for care homes and domiciliary care, but this proved difficult and early estimates of demand quickly grew as guidance on the use of PPE changed.

1.19 The Welsh Government secured support from a military logistics team. The team reported on 2 April 2020 recommending central modelling of demand. With help from the NHS Wales Finance Delivery Unit, Shared Services started to develop its working model, drawing on the rate of items being issued. This proved challenging as guidance and policy were changing during the first few weeks, for example to expand the scope of provision to optometrists and dentists. The analysts found it difficult to obtain reliable information on the number of primary care providers, staff and treatment sessions, the principal drivers of demand. Information on social care was also incomplete, especially for the large number of independent providers commissioned by local authorities. Shared Services obtained feedback and tested assumptions with NHS bodies. The WLGA and local authorities were involved in developing the demand model for social care.

1.20 Shared Services hired Deloitte in late April 2020 to review the modelling and suggest further improvements. Deloitte helped to develop a more detailed and formal supply and demand model, adding reporting functionality that Shared Services did not have the capacity to deliver and helping Shared Services staff develop their modelling skills. The model developed iteratively, with the final model (model 1) largely ready by late May with some further refinement in June. Shared Services, working with Deloitte, developed a second version (model 2) to incorporate the planned return of routine health services from August 2020. This resulted in an increase in projected demand that informed the PPE Winter Plan (**paragraph 1.36**) and stockpiling to carry health and social care through the winter.

1.21 The models were an important planning tool. Actual PPE distribution by Shared Services differed considerably from the projections for some items. In general, Shared Services issued to the NHS more stock than projected by model 1, but less stock than projected by model 2. However, this varied considerably by product. For example, Shared Services has issued more aprons than anticipated but fewer FFP3 respirators. In social care, the number of items issued was well below those projected under both models through to the end of 2020.

1.22 Shared Services highlighted a number of reasons for the variations in healthcare. The models are based on assumptions about the scale of activity and interaction with patients or residents, based on a reasonable worst-case scenario. Many routine face-to-face services that had been expected to resume from August 2020 did not do so as the second wave took hold, or they were replaced by remote consultations using video technology. Shared Services also identified increased staff sickness levels in health boards, and staff not using PPE in accordance with guidance, as factors.

1.23 In social care, the WLGA told us that some providers continued to use their established PPE suppliers to maintain contractual relationships, even after PPE funded by the Welsh Government was available. It is also possible that demand is less than expected due to staff re-using PPE that was intended for single use or using items for longer than recommended. In addition, we are aware of differences in policy between local authority areas. Some go beyond the guidance, for example requiring social care staff to wear visors where the client is not a confirmed or suspected COVID-19 case. Such departures from guidance impact on the amount of PPE required.

Shared Services responded quickly to meet increased demand for PPE, though stocks of some items were very low at times before the position stabilised from late April 2020

1.24 From mid-March 2020, Shared Services took on new staff to meet the operational and logistical challenges. At the time of drafting, it had hired 94 new members of staff and expanded its vehicle fleet, hiring 44 extra vehicles, to support deliveries. It expanded its use of existing warehouses, including a large warehouse that it had procured in January 2019 to store equipment in the event of a no-deal Brexit. Shared Services also secured additional logistical capacity by contracting with Welsh hauliers and securing around 10,000 cubic metres of storage space from the private sector, paying only for the space actually used.

1.25 The military logistics team supporting the Welsh Government (**paragraph 1.19**) identified in its 2 April 2020 report that national and regional storage distribution capacity was fit for purpose and there was sufficient capacity to meet demand. The military would not need to replace existing supply chain provision but could usefully support local stores to manage supplies effectively and step in if workforce resilience failed. The military did subsequently assist local stores, but Shared Services were able to handle logistics nationally, with the military assisting on occasions with urgent requirements, such as unloading gowns from a plane at Cardiff Airport.

1.26 Shared Services initially distributed stock from the PIPP stockpile on a 'push' basis, issuing standard packs of available stock to providers based on a broad estimate of their needs. The PIPP stockpile made a substantial contribution to PPE provision during March and April 2020, but this varied by product (**Exhibit 2**). As noted in **paragraph 1.4** the PIPP stockpile did not contain all of the items needed for a coronavirus pandemic.

Exhibit 2: quantity of Items in the PIPP stockpile in March 2020 and how long it lasted

Product category	Units in stock at the outset (1 March 2020)	How long it lasted (weeks from 9 March 2020)[1]
Aprons	9,129,800	6.0
Eye protectors	3,144,000	10.0[2]
Type IIR masks	4,906,000	5.5
FFP3 respirators	870,000	10.9
Gloves (singles)	4,814,000	1.5
Hand sanitiser	37,326	4.3

Notes:

1 The length of time the stock lasted is based on actual distribution of stock by Shared Services to health and social care providers. Actual consumption by users may be different.

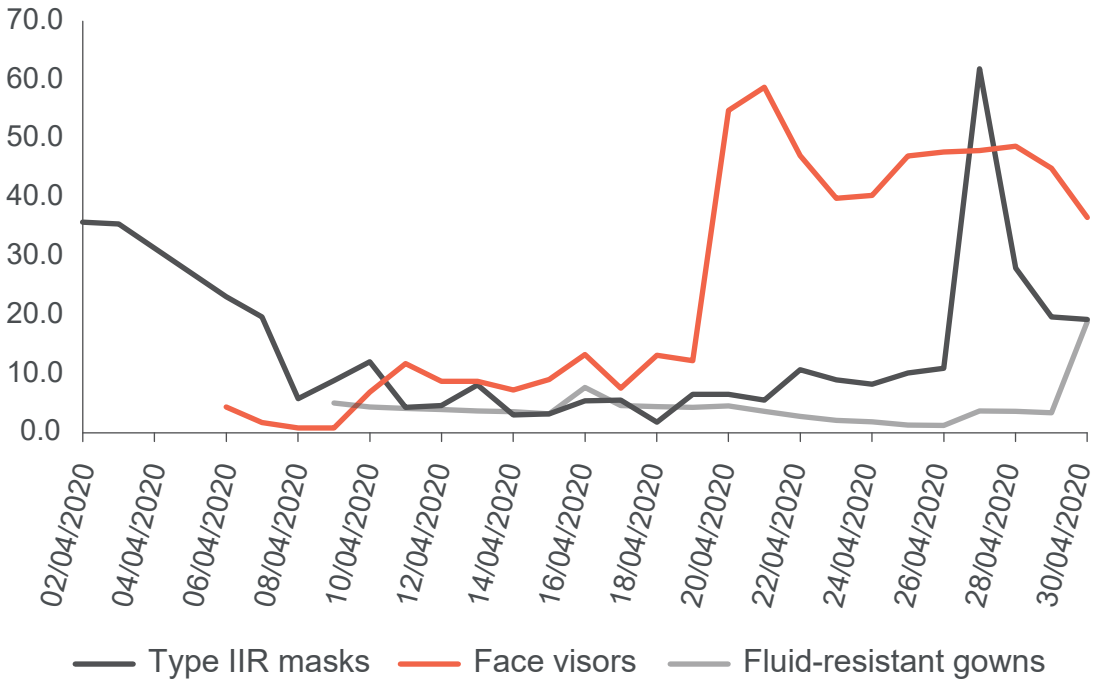
2 The PIPP stockpile included a type of safety glasses, procured by the UK Government, that were found by the Health and Safety Executive to not meet the required standards for splash protection. The Medicines and Healthcare products Regulatory Agency issued a safety alert for these products in May and around 25,000 glasses were subsequently destroyed by Shared Services.

Source: Audit Wales analysis of Shared Services data

1.27 PIPP stock levels declined as items were drawn down and deliveries from other sources were limited by supply shortages. Meanwhile, demand increased rapidly as Shared Services started to supply the independent primary health care and social care sectors as well as hospitals.

1.28 Pressures were particularly acute in April (**Exhibit 3**). There was less than a week's supply of Type IIR masks, face visors and fluid-resistant gowns in Shared Services' stock for much of the month. Type IIR masks almost ran out on 16 April, with stocks coming through on the day as part of mutual aid from Scotland and then as an order from China arrived. Supplies of fluid-resistant gowns were in perilously low supply, with less than two days of stock available at some points. Shared Services relied on an emergency delivery of fluid-resistant gowns around 20 April 2020 from England, and urgent action was taken to identify stocks held in local stores and hospitals. Shared Services did not have a comprehensive view of stocks held at local stores until the StockWatch system was established (**paragraph 1.41**).

Exhibit 3: days of Shared Services stock available for Type IIR Masks, face visors and fluid-resistant gowns, April 2020

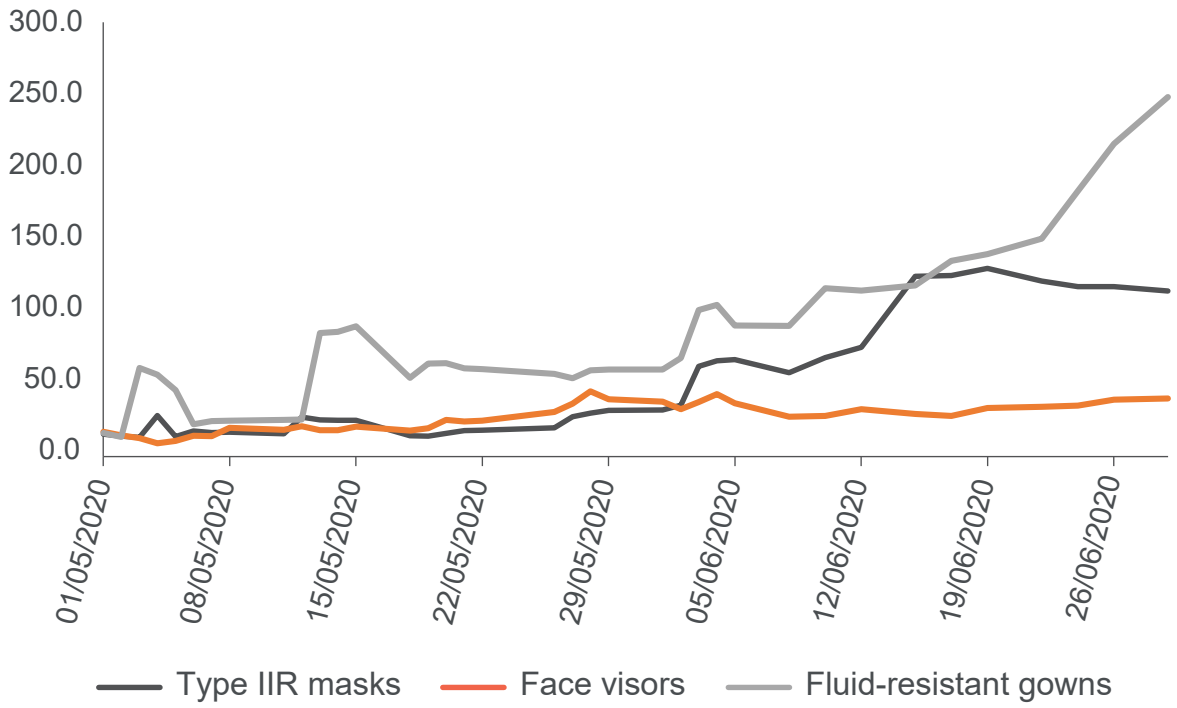


Note: days of Shared Services' stock remaining calculated using an average of previous 28-day issues. Lowest point for Type IIR Masks was 1.8 days on 18 April, for Face Visors was 0.8 days on 8 April, and for Fluid-Resistant Gowns was 1.2 on 26 April.

Source: Audit Wales analysis of Shared Services data

1.29 The situation gradually improved in late April 2020 and through May and June as stock from new suppliers started to be delivered (**Exhibit 4**). A delivery of 200,000 fluid-resistant gowns from Cambodia on 27 April (see case study in **Exhibit 10, page 39**), followed by larger deliveries from China in early May, enabled the Welsh Government to provide mutual aid to the other UK nations. Wales has ultimately provided more PPE items than it received[3]. The position on most items was stable by the end of May, with more than 14 days' worth of supply in central stocks for all items except gloves. By 20 July, following a delivery of gloves, there were more than 14 days' of supply for each item and all categories were classified as 'green' on Shared Services' risk rating system.

Exhibit 4: days of Shared Services stock available for Type IIR masks, face visors and fluid-resistant gowns, May to June 2020



Note: days of Shared Services stock remaining calculated using an average of previous 28-day issues.

Source: Audit Wales analysis of Shared Services data

3 Shared Services reports that, since the start of April 2020, it has issued 13.8 million items of mutual aid to other UK nations and received 1.4 million items on request from Scotland and Northern Ireland. In addition, it has received around 3.3 million items from the UK Government to replenish the PIPP stocks. Shared Services also entered into contracts to provide £37.5 million of PPE for other UK nations (**paragraph 2.42**).

1.30 Shared Services has gradually shifted to a ‘pull’ system of supply. Rather than standard packages or deliveries based on available stock, providers can specify what they need. This shift happened relatively quickly for NHS providers, in August for local government and in September for primary care. The ‘pull system’ means Shared Services has a better understanding of demand and providers are better able to get what they need and avoid having an oversupply that they need to store locally.

1.31 Shared Services’ stock data shows that it did not run out of stock for any item of PPE during the pandemic. We have not sought to check the levels of local stocks nor whether PPE was reused locally. Shared Services told us that NHS bodies were always kept supplied with sufficient stock to meet the requirements of the guidance. The minutes of the executive leads group (**paragraph 1.8**) showed that no NHS body reported that it had run out of PPE. The minutes reflect the concerns about low stocks detailed above and that at times there was mutual aid between health boards.

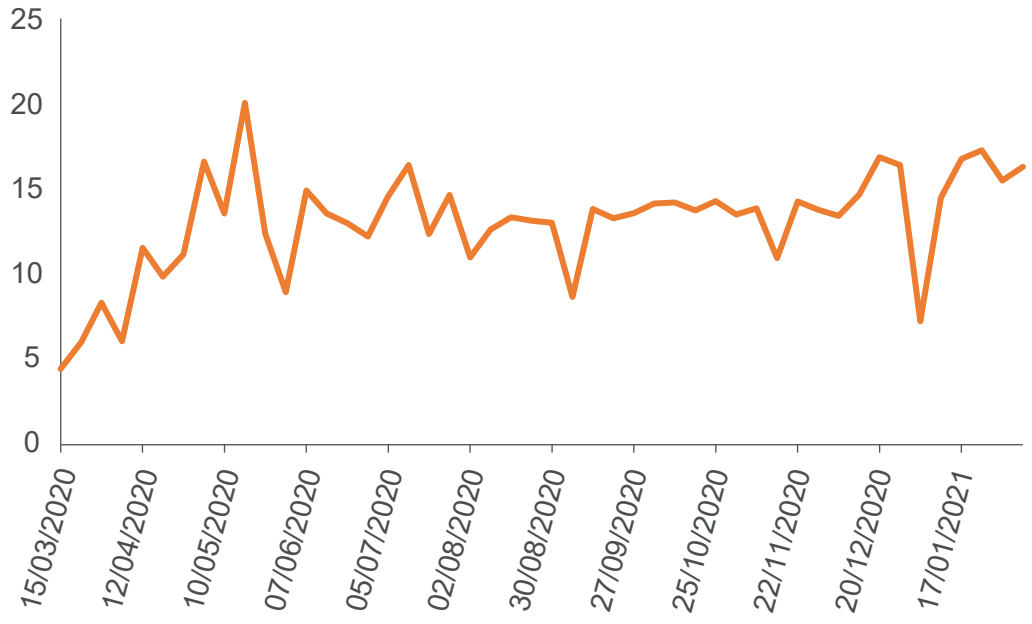
1.32 The Senedd Health, Social Care and Sport Committee highlighted the significant difficulties that the social care sector faced in meeting PPE requirements in the early stages. Notes from the local government working group on procurement (**paragraph 1.10**) confirm this picture. The group expressed serious concerns about the developing situation in late March 2020 and early April, including concerns about a lack of information on the availability of stock, the clarity of guidance and very low stocks of key items including hand sanitiser and masks.

1.33 By 6 April 2020, the group felt that the sector was in a crisis. At this stage, Shared Services was only responsible for supplying social care providers with PPE where they were unable to secure their own. Councils and private care homes were primarily securing PPE for themselves individually or as part of regional arrangements. However, the Welsh Government tasked Shared Services with supplying social care more widely and supplies started to increase. These were essential in maintaining a basic level of supply.

1.34 The situation improved, with the group reporting that by 7 May 2020 around two-thirds of the social care sector's needs were being met by Shared Services. The WLGA and Shared Services adopted a service level agreement on 1 September 2020 under which Shared Services would make weekly deliveries to local stores based on councils' estimated requirements. The change from Shared Services acting as a supplier of last resort to supplying most of social care's needs was not formally communicated to social care until 12 October. However, a shift in policy towards supplying social care providers' needs on demand occurred much earlier, in April 2020, and was communicated informally to providers through the WLGA and local authorities. While some independent providers preferred to maintain contracts with existing PPE suppliers, it appears that most needs are now being met by Shared Services.

1.35 Between 9 March 2020 and 2 February 2021, Shared Services distributed around 630 million items of PPE to health and social care. **Exhibit 5** shows that the amount distributed ramped up between March and June before becoming more stable. Over the period April 2020 to January 2021 around half of the PPE issued by Shared Services was for social care.

Exhibit 5: weekly distribution of PPE items by Shared Services, 9 March 2020 to 7 February 2021 (millions of items)



Source: Welsh Government, Weekly Personal Protective Equipment issues: up to 7 February 2021, released 11 February 2021

Shared Services has built up a buffer of PPE stock but the goal of 24-weeks' worth has not been met for all items

1.36 In July 2020, the Senedd Health, Social Care and Sport Committee recommended that the Welsh Government publish a strategy for securing a resilient PPE supply, including a plan for stockpiling. The Welsh Government accepted the recommendation. Shared Services' Winter Plan for PPE, agreed by the Welsh Government, involved building up a 24-week buffer of key items. Shared Services and the Welsh Government are in the process of reviewing the Plan and the 24-week target (**paragraph 2.46**).

1.37 For most items Shared Services was able to build up a 24-week buffer. For some items Shared Services' data shows several years of stock, although this may reflect the way that future demand is calculated[4]. **Appendix 3** sets out in detail the position on levels of stock issued and held nationally (excluding local stocks).

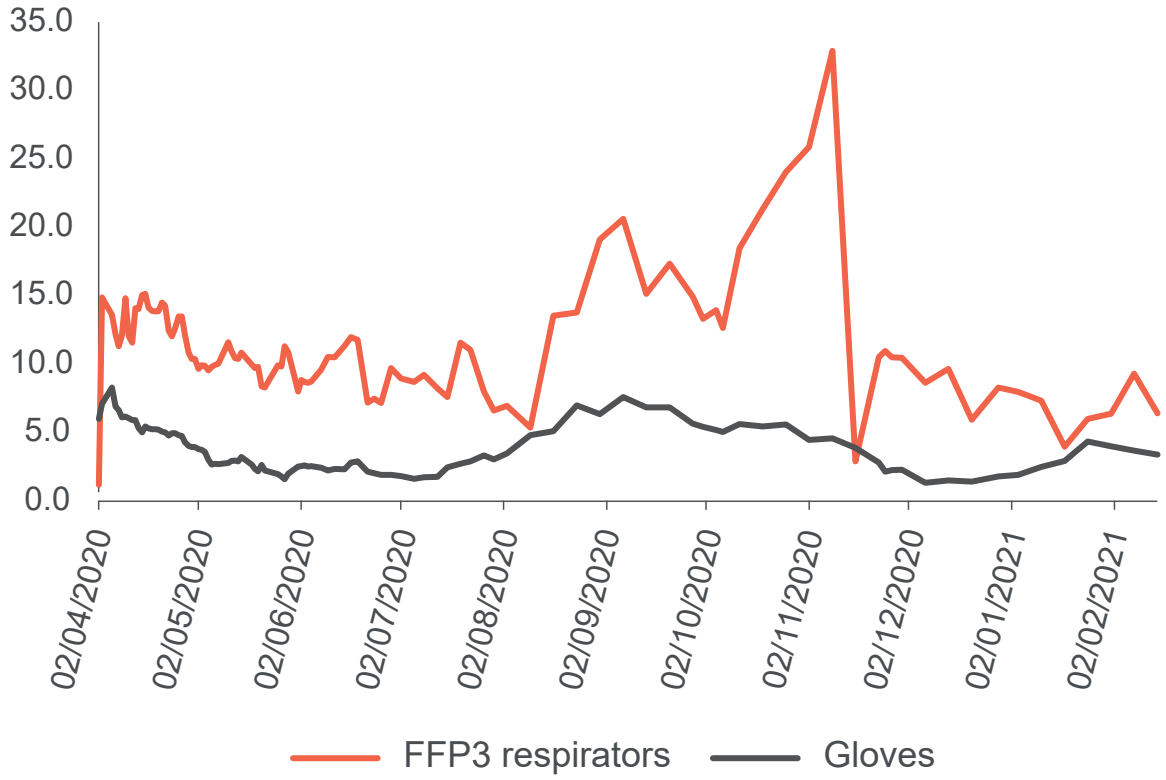
1.38 However, for some items there has never been a 24-week buffer. Through the second wave of the pandemic some stocks have declined significantly – in particular, FFP3 respirators and nitrile gloves (**Exhibit 6**). These two items have proved difficult to source.

1.39 In the case of nitrile gloves there are very few manufacturers, mostly located in Malaysia where the rubber needed to make them is grown. Shared Services reported that the state of emergency declared in Malaysia in January 2021 due to COVID-19 has hampered recent supplies. For FFP3 respirators, the issue is with a particular brand of mask which clinicians' favour. Shared Services told us that the manufacturer had refocused its efforts on FFP2 respirators, which had contributed to a global shortage and slippage in expected delivery dates.

1.40 At the time of drafting, Shared Services was awaiting delivery of large orders of FFP3 respirators and gloves. Shared Services calculates that these deliveries will take stock levels of these items to over 24 weeks. In the meantime, Shared Services has procured small amounts of these items to keep supply stable. However, the WLGA told us that while gloves are available, there is a shortage of specific sizes.

4 We have projected how long stock will last based on a combination of modelled and actual draw down over the previous 28 days. For some items, such as body bags, stock is sent out in a batch that lasts for several weeks. By basing the projections on recent supply, it can look like the stock will last longer than is the case and these projections then change when the next batch is sent out.

Exhibit 6: weeks of Shared Services' stocks of FFP3 respirators and nitrile gloves held, 2 April 2020 to 8 February 2021



Note: weeks of Shared Services' stock remaining calculated using an average of previous 28-day issues. The lowest point for FFP3 respirators was 1.2 weeks on 2 April and for gloves was 1.3 weeks on 7 December.

Source: Audit Wales analysis of Shared Services data

1.41 Systems for monitoring stock have improved over time. Shared Services' systems came under strain as stocks arrived from the PIPP stockpile, new purchases and as mutual aid, sometimes unexpectedly. The volume of stock and activity was far higher than before the pandemic. In response to the report of the military logistics team (**paragraph 1.25**), Shared Services introduced a StockWatch system for local stores to report weekly on their stock holdings for each item. However, Shared Services told us that local authorities do not always report information on a timely basis.

1.42 The WLGA told us that some councils question the value of StockWatch for social care. Local authorities' joint equipment stores hold minimal stocks of PPE, with most of it being sent to providers as soon as it arrives. StockWatch does not record stocks held by social care providers and is not integrated with local authorities' stock management systems. Notwithstanding these issues, Shared Services considers the information from StockWatch is valuable in helping it supply PPE to social care.

Confidence in the supply of PPE seemed to increase following the initial response but there remain concerns about specific items and some equality issues

Staff and social care providers' views

1.43 The Senedd Health, Social Care and Sport Committee heard evidence from representative groups and noted 'the fears and concerns of frontline staff about the availability of appropriate PPE' during the initial response. We invited organisations that gave evidence to the Committee to provide any updates for us to consider. We received further Wales-only survey evidence from the Royal College of Nursing (RCN), who surveyed nurses working in health and social care, and the British Medical Association (BMA). As the participants were self-selecting, rather than a random sample, we cannot know how representative these experiences are of the whole NHS and social care workforce.

1.44 While the overall number of respondents fell significantly, the RCN data suggested some improvement between April and May 2020 in the percentage who said they had sufficient supplies of different types of PPE. However, a significant minority of respondents still identified concerns, particularly in response to questions about FFP3 respirators and gowns in the context of high-risk procedures, such as aerosol generating procedures (**Exhibit 7**). Staff perceptions of PPE may have reflected their experiences of distribution within local sites rather than the national picture on stock levels.

Exhibit 7: RCN survey respondents who said they had sufficient supplies of each type of PPE, April and May 2020

PPE Type	April	May
Eye protection	52%	85%
Type IIR masks	46%	80%
Apron	90%	96%
Gloves	94%	96%
FFP3 respirators	63%	79%
Long-sleeved gowns	57%	67%

Note: the RCN received 875 and 292 responses from Wales in April and May respectively. The RCN only asked respondents about FFP3 respirators and gowns within the context of high-risk procedures, such as aerosol generating procedures.

Source: RCN member surveys

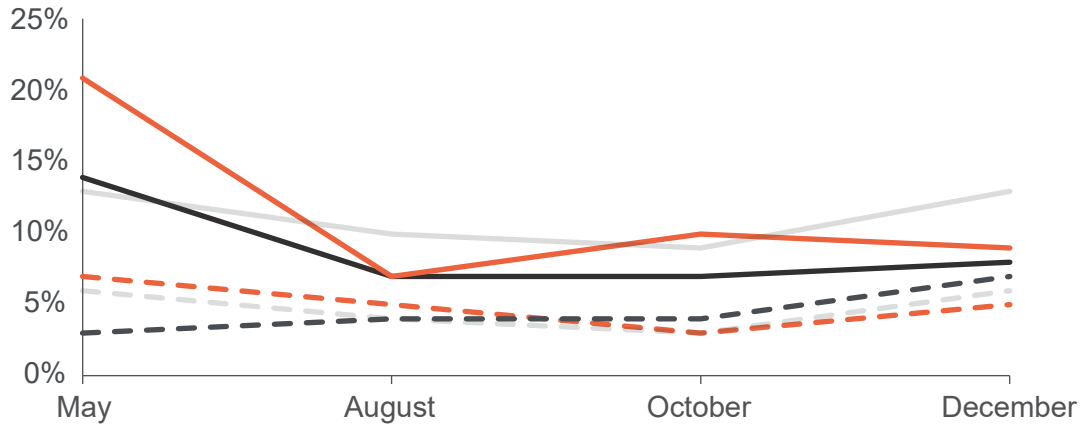
1.45 The BMA asked its survey respondents to identify areas of concern from a list of different issues. Those identifying PPE shortages as a concern dropped from 38% to 13% between May and December 2020[5]. However, when asked about specific types of PPE, BMA respondents' perceptions of PPE levels is mixed.

1.46 For several items, very few or no respondents said there was no supply at all (**Exhibit 8**). However, the proportion highlighting shortages increased for most items in December 2020. Concerns about shortages of gloves in December 2020 may reflect the fact that these have been challenging to source (**paragraph 1.38**). However, it is unclear why there would be an increase in concerns about supply of fluid-repellent (Type IIR) masks, eye protection and aprons given the levels of national stock of these items at the time. In its report (**paragraph 1.25**), the military said that some perceptions of supply could be due to a lack of sight of available stocks.

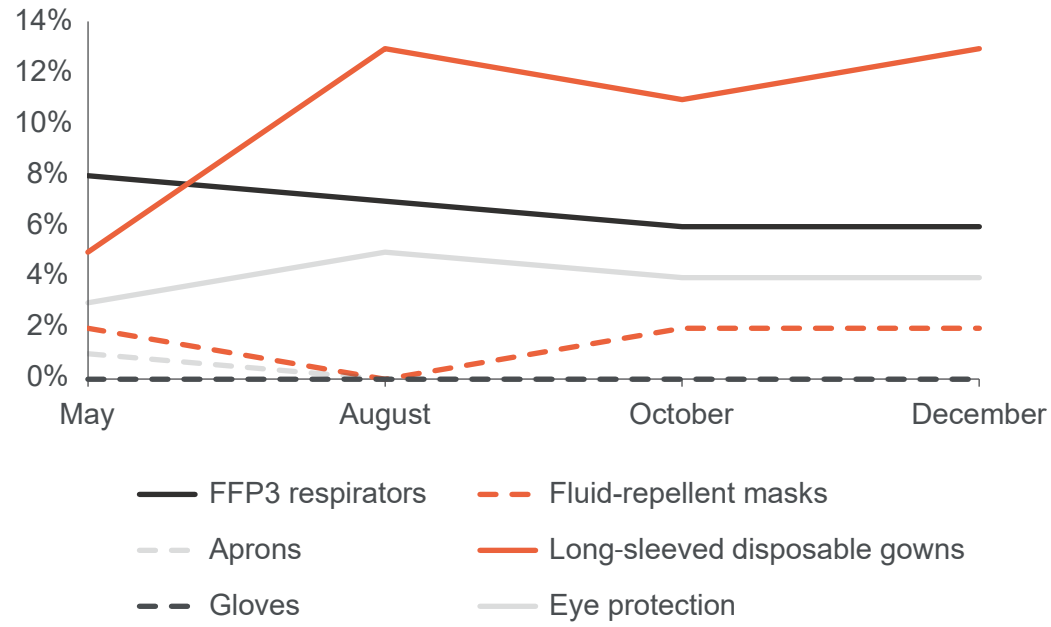
5 The question asked respondents to choose from a list of possible concerns over the next few months. They were able to choose as many options as they wanted, including 'PPE shortages'.

Exhibit 8: BMA survey respondents who said they had shortages or no supply of each type of PPE, May to December 2020

Shortages



No supply at all



Note: response numbers varied between 463 in May, 258 in August, 492 in October, and 505 in December. The survey asked: 'Over the last two weeks, have you had adequate NHS supplies or shortages of the following PPE?'. Respondents could answer 'adequate', 'shortages', 'no supply at all', 'don't know', or 'not relevant'. In some cases, the 'not relevant' response was as high as 27% and was consistently around 25% for those responding to the questions on FFP3 respirators and long-sleeved gowns.

Source: BMA COVID-19 PPE surveys

1.47 A key concern of staff reflected in the BMA survey has been the availability of FFP3 respirators and long-sleeved disposable gowns. These items are required by the guidance for higher risk aerosol generating procedures. It is hard to be sure to what extent staff concerns are about a lack of supply of required PPE or the guidance itself. The RCN and BMA survey findings in relation to FFP3 respirators and gowns also reflect wider concerns with the level of PPE required by the guidance. The BMA has expressed concern about revisions to guidance around gowns and FFP3 respirators when COVID-19 was downgraded from a High Consequence Infectious Disease in March 2020 (**paragraphs 1.12-1.13**).

1.48 In its February 2021 survey[6], the BMA found that just 37% (166 of 488) of respondents in Wales said they are currently provided with adequate PPE for non-aerosol generating procedures, while 44% said they did not feel it was adequate. In response to a question about what PPE would help them to feel safe in non-aerosol generating procedures, 88% said FFP3 respirators would help, while 45% said that long-sleeved disposable gowns would help. Neither of these items are required by guidance for non-aerosol generating procedures.

1.49 Evidence provided by the WLGA records some deep concerns that social care workers felt their PPE was inadequate. The contemporaneous notes of meetings of heads of procurement (**paragraph 1.10**) in the middle of May 2020 record that social care staff felt unprotected with 'just a flimsy apron over street clothes'. Again, these concerns seem to reflect concerns with the nature of PPE required by guidance rather than the level of supply. Care Inspectorate Wales' surveys show social care providers' views improving during April 2020. In the first two weeks 11% of care home providers and 18% of domiciliary care providers said they had insufficient PPE. By the second half of April those figures fell to 5% and 8% respectively.

1.50 We are also aware that some health and care staff had concerns about the quality of some certified PPE. These were few in number relative to the overall volume of PPE supplied by Shared Services. The safety glasses that were held in the PIPP stockpile were unpopular, in part because they needed to be manually assembled, and were subsequently withdrawn for other reasons (see note to **Exhibit 2**). There were also complaints from staff about skin irritation caused by face masks, but these did not indicate non-compliance with product safety standards. There was also an isolated issue with a batch of nitrile gloves that were prone to tearing when putting on. These were mislabelled as nitrile gloves and were a vinyl mix that had not been ordered. Shared Services reported the issue to the Medical and Healthcare products Regulation Authority, and the contractor replaced the batch of 16 million gloves with the correct specification.

6 The BMA provided us with early sight of part of its February 2021 survey, but we had not seen the full dataset at the time of drafting.

Equality

1.51 Staff and representative groups have raised the issue of feeling inadequately protected due to PPE generally being designed for generic male physiques. This issue has been identified as a concern long before the start of the pandemic. Early in the pandemic, an issue was identified with the fit of a particular type of mask. Cardiff and Vale University Health Board identified a method to improve the fit and reduce fit-test failures. It shared a video across NHS Wales to help improve the fit of the masks for a wider range of healthcare staff. The use of fit test machines also lowered failure rates.

1.52 The Welsh Government and Shared Services are aware of these concerns about the fit of PPE for certain groups. They told us that there are several manufacturers, including a manufacturer in Wales, developing products with potential to offer a more bespoke fit for different face and body types. However, as far as they are aware these items are yet to secure full certification.

1.53 Equality concerns have also been raised by groups who have identified that being unable to see a carer's face is to the detriment of some care. The use of clear face masks has been suggested. However, the leading design purchased by the UK Government, on behalf of all UK nations, is not yet certified as PPE so can only be used where a user has undertaken a risk assessment and in line with Health Safety Executive guidance.

Cases and deaths

1.54 There have been several COVID-19 outbreaks in Welsh hospitals[7], but we do not have evidence to establish a casual link between these outbreaks and PPE. Some health boards have reviewed the factors contributing to individual outbreaks, including potential links to staff compliance with PPE. Further work would be needed to fully understand any role that PPE, as part of overall infection prevention and control measures, may have played.

7 Public Health Wales publishes data on the number of 'probably' and 'definite' cases of hospital transmission on its COVID-19 data website.

1.55 Many health and care staff have contracted COVID-19, and sadly some of those people have died. There is published Office for National Statistics data[8] on cases and deaths generally and the Health and Safety Executive has provided us with data on notifications it has received[9]. However, there are various limitations noted with the data in both cases and care needs to be taken when interpreting the findings. We do not have hard evidence that any of these cases or deaths were caused by occupational exposure, or more specifically by a shortage of suitable PPE.

1.56 We did not examine these issues and any possible root causes in more detail as part of our work. The Welsh Government has emphasised to us that NHS Wales has well-established processes to ensure that staff and patient deaths are appropriately reported, fully investigated and where appropriate referred to the coroner. It is from these processes that it and NHS Wales will gain evidence on any potential systemic failures, including in the supply or use of PPE, that have resulted in work-related deaths from COVID-19. In its February 2021 report, the UK Public Accounts Committee recommended that the UK Government carry out a review into whether there are any links between PPE shortages and staff infections and deaths.

8 Office for National Statistics data shows that 23 social care workers and 34 NHS workers died of COVID-19 in Wales between 9 March and 28 December 2020. The analysis does not prove conclusively that rates of death involving COVID-19 are necessarily caused by differences in occupational exposure. Office for National Statistics, Deaths involving the coronavirus (COVID-19) among health and social care workers in England and Wales, deaths registered between 9 March and 28 December 2020, released 28 January 2021.

9 Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), employers have a duty to report to the Health and Safety Executive (HSE) cases where a worker has been diagnosed as having COVID-19 and there is reasonable evidence to suggest that it was caused by occupational exposure for whatever reason. Of 1,696 notifications for Wales between 10 April 2020 and 9 January 2021, 1,156 related to human health and social work activities. Among the 1,696 were 11 fatal notifications, of which seven related to human health and social work. The HSE has made clear in its Technical summary of data on Coronavirus (COVID-19) disease reports that there are a number of limitations that should be kept in mind when considering this data and its accuracy.

Procurement of PPE

02

2.1 This part of the report examines the work led by Shared Services to procure PPE. In March 2020, the Welsh Government chose to adopt the UK Cabinet Office's Procurement Policy Note 01/20[10]. The Policy Note permits, under regulation 32(2)(c) of the Public Contract Regulations 2015, procurement of goods, services and works without competition or advertising so long as there are genuine reasons for extreme urgency. This meant Welsh public services were able to procure PPE without going through the usual competitive processes. The Welsh Government also adopted Procurement Policy Note 02/20[11], allowing advance payments where a value for money case is made. Any payments up front exceeding 25% of the contract value require Welsh Government approval.

2.2 During March 2020 and through April, Shared Services undertook its own procurement of PPE as did local government bodies for social care. At this point, the procurement was 'at risk' with no guarantee of any UK Government funding cover. In mid-June 2020, the UK Government confirmed to the Welsh Government that it would get funding to procure PPE via the Barnett formula[12].

Public services worked together in an increasingly collaborative way to identify and respond to potential PPE suppliers

2.3 In the early days of the pandemic, many local organisations came forwards with offers to supply PPE. The Welsh Government appointed Life Sciences Hub Wales (LSHW) in a facilitation role to collate all offers of support to health and social care and identify appropriate businesses who could potentially supply items on NHS Wales' critical products list.

2.4 LSHW established an online portal for industry to upload offers of support. Using guidance provided by Shared Services' Surgical Materials Testing Laboratory (SMTL) and the National Procurement Service (NPS), LSHW reviewed submissions from suppliers wanting to sell PPE and other products and services. These reviews included ensuring conformity with quality requirements and some standard business checks. Qualified offers of products were forwarded to Shared Services to progress offers into the procurement process.

2.5 LSHW also received, and directed to NHS Wales organisations, enquiries relating to donations of other products and services. Enquiries relating to field hospitals, the production of wearable products, and volunteering by healthcare workers and the general public were referred by LSHW to the appropriate bodies.

10 UK Government Cabinet Office, Procurement Policy Note - Responding to COVID-19, Information Note PPN 01/20, March 2020

11 UK Government Cabinet Office, Procurement Policy Note - Supplier relief due to coronavirus (COVID-19), Action Note PPN 02/20, March 2020

12 The Barnett Formula determines how decisions to increase or reduce spending in England result in changes to the budgets of the devolved administrations.

2.6 As at 26 October 2020, LSHW had managed 2,285 enquiries, referring 556 to the NHS, Welsh Government and other relevant organisations (**Exhibit 9**). Three-quarters of enquiries triaged but not progressed by LSHW were for reasons such as incomplete documentation received, failure to pass initial due diligence, and products and processes falling out of scope and not on the critical products list.

Exhibit 9: offers of products and services in response to COVID-19 referred by Life Sciences Hub Wales

Product type	Organisation receiving referral	Number of referrals
Infection control (including PPE) and medical devices	Shared Services	226
Digital solutions	Welsh Government Digital Health Cell	165
Point of care and testing	Public Health Wales	22
Other	Industry Wales, Welsh Government and others	143
Total		**556**

Source: Life Sciences Hub Wales

2.7 The Critical Equipment Requirement Engineering Team (CERET), established by the Welsh Government in March 2020, works closely with Welsh manufacturers who indicated that they could potentially expand into manufacturing PPE with some support. CERET worked with Business Wales to invite expressions of interest, with Business Wales reporting the following results:

- over 30 companies have repurposed their production lines to provide hand sanitiser
- 25 companies have repurposed their production lines to make face visors
- there are now 9 companies who have invested in machinery to produce clinical grade face masks and face coverings, five of these companies can now mass produce although they are yet to win contracts to supply the NHS (**paragraph 2.48**)

2.8 Shared Services faced the challenge of fragmented global supply chains, due to countries imposing export restrictions and huge demand as the pandemic took hold across the world. Many existing suppliers were unable to supply PPE in the volume and at the pace required. Shared Services therefore had to source PPE using their network of contacts, through suppliers getting in touch themselves and through other referrals. In some cases, Shared Services told us they had to work with agents who had the right contacts with the key manufacturers. In at least one case, this meant sourcing products directly from a factory that was supplying the global companies that Shared Services had been unable to source PPE from.

2.9 Shared Services and the Welsh Government report that they have never had an equivalent to the twin-track 'high priority lane' approach to identifying potential suppliers described by the NAO in its report on government procurement in England during the COVID-19 pandemic. In our review of procurement documentation, we found no evidence of such an approach or of suppliers getting preferential treatment because of the person referring them.

2.10 Shared Services and LSHW told us that referrals from politicians were subject to the same process, scrutiny and prioritisation as any other contacts. In our sample testing we did not see reference to any referrals being from politicians. We found one example where one of the directors of a supplier was known to a member of the group set up by Shared Services to scrutinise requests for orders to be raised. This was appropriately declared in the advice for decision makers.

Overall, the Welsh Government and Shared Services developed good arrangements to manage the risks involved in procuring PPE in a fragmented market but did not publish details of all contracts on time

Timeliness risks

2.11 The challenging situation with stocks, especially in the early weeks of the pandemic (**paragraphs 1.27 to 1.29**), meant that Shared Services was under significant pressure to procure PPE very quickly. While recognising the importance of timely decision making, the Welsh Government set out in a 30 March 2020 letter to NHS bodies that it still expected good governance around spending decisions. The letter recognised the need to adapt arrangements on an interim basis and included guidance on financial management and reporting, including expectations related to being clear on delegating authority for decision making and recording decisions and the supporting rationale.

2.12 To speed up decision making, the Board of Velindre University NHS Trust agreed changes to its own and Shared Services' schemes of delegation. On 18 March 2020, these were amended to allow the Chair and Managing Director of Shared Services to authorise expenditure up-to £2 million (up from £100,000), with the limit increased to £5 million on 30 March 2020. All approvals over these limits needed to go through the Board of Velindre University NHS Trust. In addition, the requirement for Welsh Government approval for expenditure over £1 million has stayed in place throughout.

2.13 Overall, the arrangements enabled Shared Services to make swift decisions and supply PPE quickly. We understand this was achieved within the pre-existing staff capacity. We recognise that this placed significant pressure on individuals involved, who have been working late at night and in the early hours of the morning to deal with suppliers overseas and to take calls from worried frontline staff. We saw evidence of the Board of Velindre University NHS Trust and the Welsh Government responding promptly to turn around approvals and avoid delays. **Exhibit 10** provides a case study showing the rapid timescales and collaboration involved in procuring PPE.

Exhibit 10: timeline of procurement and supply of surgical gowns from Cambodia, April 2020

April 21

Minister for Health and Social Services tells press conference Wales has just days of full PPE.

April 22

19:50 lead comes into Shared Services from a company in Northern Ireland on potential supply of gowns from Cambodia. Within an hour, Shared Services has sought in principle approval from the Welsh Government, subject to due diligence which was underway.

April 23

Before 08:00 Welsh Government gives in-principal approval.

11:30 FGG meets to scrutinise documentation and requests further checks on company and to negotiate on advance payment and price.

13:30 Shared Services meets virtually with the company directors to discuss issues, including price, and understand company structure and background.

15:00 FGG provided with updated position, including reduced price and advance payment.

16:00 Surgical Materials Testing Laboratory confirms the products have the correct certification.

April 24

Shared Services charters a plane from Cambodia to Cardiff Airport.

April 25

Shared Services receives confirmation that the gowns have been manufactured and are on trucks in Cambodia.
Shared Services becomes aware that freight-handling staff at Cardiff Airport are on furlough.

April 26

Shared Services agrees with Cardiff Airport a payment mechanism for freight handling staff to come off furlough and requests military support to unload the plane.

April 27

Gowns arrive at Cardiff Airport. The military, Shared Services and Cardiff Airport staff and others are involved in unloading. Some go to the central stores; some are distributed directly to Welsh hospitals and some are sent as mutual aid to other parts of the UK.

Source: Audit Wales review

Financial risks

2.14 Seeking to urgently procure scarce PPE in a fragmented and highly competitive global market posed significant financial risks. Many of the companies offering PPE were either new or had recently expanded into PPE and had limited track records. There were significant risks of fraudulent activity. And there were novel financial requirements, most notably a requirement from many companies for payment in advance.

2.15 Shared Services set up a new cross-profession Finance Governance Group (FGG) in early April 2020 to manage risks while enabling rapid decision making related to COVID-19 procurement. **Appendix 2** sets out the membership of the FGG which also included members of the Board of Velindre University NHS Trust. FGG meetings consider potential contracts for PPE that either or both:

a need Welsh Government support for the advance payment because it is 25% or more of the value of the contract (**paragraph 2.1**).

b need formal approval from the Board of Velindre University NHS Trust.

The group's role is to ensure appropriate scrutiny and checks before requests for orders to be raised are sent for approval (**Exhibit 11**).

Exhibit 11: role of the Finance Governance Group in the contract approval process

Procurement Services submit checklist to the FGG

Checklist covers:

- the need for the product
- pricing and costs
- supplier details and due dilligence carried out
- compliance with quality standards
- delivery timescales
- procurement rules being applied
- approvals needed
- payment methods

FGG scrutinises the checklist

FGG completes a decision sheet setting out its key considerations and its decision / recommendation

FGG sends checklist and decision sheet to order approver(s)

Source: Audit Wales review

2.16 We reviewed the checks put in place on a sample of 16 contracts let by Shared Services. Our sample included the larger/more risky contracts reviewed by the FGG as well as some smaller contracts not covered (**Appendix 1**). We found that in all cases there was a documented evidence trail, picking out the key issues and risks and how they would be managed. All the decisions we reviewed had been made in line with the required processes, and the subsequent approvals of the orders were in line with Shared Services' scheme of delegation and Welsh Government requirements.

2.17 The pressure of securing PPE meant due diligence could not always be carried out to the level it would outside of a pandemic in a normal competitive tendering process. However, for each contract we reviewed, we found evidence of key due diligence checks being carried out. These included background checks on the companies involved. In some cases, the companies looked like they were entirely new to the PPE market. However, further exploration showed that they had a sister company or were part of a group with experience in the PPE market. In other cases, the companies were new, but the Directors involved had credible direct access to PPE manufacturers.

2.18 Our findings on approvals confirm those of an internal audit review of Shared Services' financial governance, including PPE and other COVID-19 related expenditure, reported in October 2020. It found that the procedures around background checks, approvals and recording of decisions that the Welsh Government and NHS had put in place were complied with in all cases. It also noted that there were improvements to the financial governance arrangements and quality of documentation over the period.

2.19 The FGG monitors orders that involve advance payments to ensure the products are received. Nine orders reviewed by the FGG had advance payments made through an 'escrow' account. Shared Services and Welsh Government told us that this approach was used for large volume contracts or with new higher risk suppliers. The arrangements meant that the suppliers could see that the funding was in place but could not draw down the money until the goods were received and checked.

2.20 Shared Services cancelled four orders involving advance payments that had been reviewed by the FGG. Two of these advance payments had been made through an 'escrow' account. Refunds were received in full for three orders and for one order the advance payment was transferred to another order with the same supplier.

2.21 Despite the urgency, there was not a blanket approach of buying PPE whatever the cost. Inevitably, in what was in effect a seller's market, prices were higher (**paragraph 2.44**). We saw an example where Shared Services recorded that it had prioritised a slightly more expensive provider over a cheaper one, because it could supply more quickly. Nonetheless, we saw examples where Shared Services negotiated down the price. For one order, a unit glove cost negotiated to two-thirds of a unit cost offered by a different supplier avoided expenditure of £6.5 million. Shared Services also avoided costs by negotiating transport of PPE freight by sea and not air for some orders.

2.22 Benchmarking data presented to the FGG, including historic data and data from other parts of the UK, set parameters for what Shared Services was willing to pay. Shared Services did not proceed with one contract where it had later been able to source the same PPE at a lower price.

2.23 As at the end of December 2020 the FGG had reviewed 43 proposed contracts, nearly all of which related to PPE. There were a further four contracts which were entered into in late March and very early April 2020 before the FGG was established. There were also a further four contracts that should have been, but were not, subject to review by the FGG. Shared Services Internal Audit reported that appropriate authorisation was in place for each contract order. Some of the contracts considered did not proceed or were subsequently cancelled.

2.24 As of January 2021, a total of 37 orders related to PPE that had either been through FGG or should have been[13], had been delivered, or were expected to be delivered. Of those 37 orders, 16 were with existing suppliers and 21 with companies new to Shared Services. Around half of the orders with new suppliers came from companies new to the PPE market, six of which were with the same new supplier.

Quality risks

2.25 There were widespread concerns, particularly at the start of the pandemic, that there were unscrupulous traders offering bogus PPE. PPE must meet strict certification standards. Shared Services Procurement Services worked closely with the SMTL, based in Bridgend, to test the quality of PPE. For some orders, this meant verifying that the certification provided was authentic. We understand that SMTL identified 37 fraudulent certificates being offered by potential suppliers. In some cases, SMTL carried out tests on a sample of the product. SMTL also worked closely with domestic manufacturers to help them secure certification.

2.26 As noted in **paragraph 2.19,** Shared Services had protection from losing advance payment where the PPE was not certified as described. There were two examples where proposed orders presented to the FGG were not proceeded with because the PPE did not meet the quality requirements. Other than the isolated example of mislabelled gloves (**paragraph 1.50**), we saw no evidence of examples, like those described by the NAO in England, where PPE was purchased centrally that was not deemed fit for purpose.

13 These 37 include the four orders let before the FGG started to meet. We chose to analyse this sub-set of 37 orders rather than all orders as they comprise most of the expenditure on PPE and exclude many smaller, lower risk contracts.

2.27 Contemporaneous notes kept by the WLGA record that local government bodies had purchased some PPE with fraudulent certificates in the early stages of the pandemic and that some of this had probably been used by frontline staff. These purchases were outside of the quality checking process put in place by Shared Services. We have not sought to verify the volume and nature of these purchases nor how local government bodies managed the risks.

Transparency risks

2.28 In the absence of transparent competition, public bodies can maintain public confidence by openly reporting details of contracts let under emergency powers. The Cabinet Office's Procurement Policy Note (**paragraph 2.1**) sets out that a contract award notice should be published within 30 days of a direct contract being awarded. In Wales, contract awards above the relevant thresholds set out in the UK Public Contracts Regulations 2015 are published on the Welsh Government's Sell2Wales website. Before the end of the Brexit Transition Period, Sell2Wales automatically published award notices to the online version of the Official Journal of the European Union (Tenders Electronic Daily). Sell2Wales now publishes them on the Find a Tender Service, the new UK e-notification service.

2.29 All 16 of the contracts covered in our sample testing of expenditure were direct awards due to extreme urgency. Shared Services has published full contract award notices for nine. Of the remaining seven:

- five contracts involved the same intermediary. For four of these, Shared Services published contract award notices covering the fees of the agents for a range of services but not the separate contract for the PPE items. Shared Services told us the contracts were with non-EU manufacturers and therefore it did not need to publish a contract award notice. We could find no such exemption in the relevant regulations or guidance. For one of the contracts, Shared Services published a contract award notice, but it was drafted as though the intermediary had provided the PPE and did not refer to the separate contract Shared Services had agreed with the manufacturer.
- for one contract, Shared Services published a different type of notification - a Voluntary Ex-Ante Transparency Notice (VEAT)[14] - but not a full contract award notification. Shared Services told us that because it published a VEAT, it did not need to publish a full contract award notice. We could find no such exemption in the relevant regulations or guidance.
- the final contract involved air travel sourced through the military and English NHS. Shared Services told us it did not need to publish a notification for this contract.

2.30 Of the nine full contract award notices published in our sample, none were published within 30 days of awarding the contract. On reviewing them, we found several had incorrect dates for the date the contract was awarded. Shared Services is rectifying these errors. For two contracts in our sample, Shared Services published VEATs within 30-days of letting the contract, although this is not a requirement for VEATs which are normally published in advance of letting a contract.

2.31 Shared Services told us that its staff have been stretched and needed to focus on the priority of securing PPE for frontline staff. Shared Services told us it was therefore not able to prioritise publishing contract award notices. Shared Services also told us that publication of contract award notices was delayed for some orders because of difficulties getting suppliers to register on Sell2Wales.

14 This was a Voluntary Ex-Ante Transparency Notice (VEAT), which is used to give advance notice of the intention to let a contract. However, the VEAT in this case was published after the contract was let.

2.32 There has been regular reporting and scrutiny of COVID-19 expenditure within Shared Services' governance framework. Shared Services published the Internal Audit report on its website as part of audit committee papers. However, in our view it could build public trust in the procurement process in Wales by making the details of its contracts for PPE easy to access. We think there is merit in maximum transparency and collating information that is not commercially confidential into a single place. It would be very difficult for the public or those interested to get an overview of PPE contracts from the Sell2Wales website without already having in-depth knowledge.

Ethical risks

2.33 All public bodies are expected to observe Welsh Government guidance on ethical supply chains in procurement. The guidance includes reference to ensuring that supply chains do not involve modern human slavery. No change was made to this guidance during the pandemic. The Welsh Government told us that the expectation remained, while recognising that the context of a pandemic may limit what was practically possible.

2.34 The WLGA's notes of the meetings with Welsh Government and Shared Services show that on multiple occasions, local government representatives raised concerns and queries about how to manage the risks of there being slavery and unethical employment practices in the manufacturing of PPE for Wales.

2.35 In our review of Shared Services documentation for PPE to the NHS, we saw no specific references to ethical employment practices in the consideration of risks. The Internal Audit review of Shared Services' financial governance arrangements (**paragraph 2.18**) considered ethical supply. It found that 'there were no issues/ concerns identified with the companies at the time of purchasing, but due to the urgency of the pandemic and the need to secure equipment; this was not a primary consideration when determining which supplier to use'.

The Welsh Government expects to spend over £300 million on PPE for health and social care in 2020-21

2.36 Normally, NHS Wales would expect to spend around £8 million a year on PPE. We do not have figures for social care as much of the spend would have been by private care homes. The arrangements for funding PPE expenditure, especially in social care, have changed during the pandemic (**Box 1**).

Box 1: arrangements for funding PPE

The Welsh Government currently funds the provision of COVID-related PPE required by national guidance for healthcare and social care settings. This commitment extends to all secondary care and primary care settings including GP surgeries, dentists, optometrists and pharmacies. NHS bodies continue to fund their 'business-as-usual' PPE requirements on the basis that these are broadly in line with previous expenditure.

Initially, Shared Services would only supply social care for staff working with suspected or confirmed cases of COVID-19. Local authorities could claim the additional costs of PPE back from the Welsh Government through the Hardship Fund, set up to support local government during the COVID-19 pandemic. Since mid-April 2020, Shared Services has increasingly been meeting the needs of social care (residential care and domiciliary care) in both the public and independent sectors. Shared Services agreed a service level agreement with the WLGA, which runs from September 2020 to August 2021.

2.37 Shared Services expects to spend an additional £286 million on PPE, primarily for health and social care, in 2020-21. Shared Services placed orders of PPE with 18 suppliers in 2019. During the period March 2020 to February 2021, Shared Services has bought PPE from 67 suppliers, of which 51 are new suppliers. The £286 million projected spend on PPE by Shared Services, which is funded by the Welsh Government, includes:

- £186 million for PPE distributed to health and social care bodies; and
- £99 million for PPE which is held in stock or expected for delivery by the end of March 2021.

2.38 At the end of January 2021, Shared Services was expecting to spend an additional £7.8 million on COVID-related operational expenditure in the 2020-21 financial year, with £5.6 million (72%) of this related to PPE. **Exhibit 12** shows that almost £3.2 million of the additional PPE-related spend is on staff costs, and £1.6 million is on transportation costs.

Exhibit 12: forecast additional PPE-related operational costs being incurred by Shared Services in 2020-21

	£ million
Staff costs	3.2
Transportation costs	1.6
Storage and security costs	0.6
Other PPE related costs	0.2
Total	**5.6**

Source: Shared Services

2.39 The Welsh Government agreed initially to fund local government expenditure on PPE as part of the wider Hardship Fund, set up to support local government through the pandemic. It is difficult to identify exactly how much PPE the Welsh Government has funded through this mechanism. The Welsh Government has provided data for Hardship Fund claims submitted up to October 2020.

2.40 Councils have received around £10 million for PPE claims although that may include some non-PPE items such as cleaning product, and around £0.5 million for associated costs such as transporting and storing PPE. The Welsh Government has also provided around £39 million[15] to cover the general increased costs of social care for providers, including the costs of PPE. The Welsh Government is unable to separate out the PPE elements of the general cost pressure expenditure.

2.41 Combining the Shared Services spending on PPE for health and care, operational costs and the funding for social care through the Hardship Fund takes the total funded by Welsh Government to over £300 million. We estimate that the Welsh Government has received around £880 million so far through the Barnett formula due to spending on PPE in England, although the Welsh Government is yet to confirm the final figure with HM Treasury.

2.42 In addition to the spend on PPE for Wales set out above, as of the end of January 2021 Shared Services had spent £37.5 million on PPE procured on behalf of other parts of the UK (**Exhibit 13**). Shared Services recoup the expenditure by invoicing the relevant administration.

15 This is in addition to other Hardship Fund support for social care, such as funding additional staff costs.

Exhibit 13: procurement of PPE on behalf of other UK nations for which expenditure is recouped, to the end of January 2021

	£ million
England	28.3
Scotland	4.8
Northern Ireland	4.4
Total	**37.5**

Note: this expenditure is separate from mutual aid that was provided on request to other UK nations to meet urgent requirements (**paragraph 1.29**).

Source: Shared Services

The cost of PPE items has been significantly higher than before the pandemic but has fallen since the first wave

2.43 Intense global competition for scare PPE resources drove up prices significantly, to a peak in April 2020. As the market adjusted, the prices paid by Shared Services fell over time. Procurement Services have shared an analysis of prices they paid for Type IIR masks, FFP3 respirators and nitrile gloves at the start of the pandemic and how they fell over time.

2.44 **Exhibit 14** shows how the unit cost of Type IIR masks, FFP3 respirators, nitrile gloves and fluid-resistant gowns rose sharply at the beginning of the pandemic before falling back to more normal levels towards the end of 2020. The largest increase was for gloves, which cost 800% of the average pre-pandemic price at the peak. Generally, across the period of the pandemic, Shared Services has procured higher volumes of PPE items at the lower prices. In the case of Type IIR masks, Shared Services' most recent contracts are for a cheaper unit price than before the pandemic.

Exhibit 14: examples of unit costs paid by Shared Services for Type IIR masks, FFP3 respirators, nitrile gloves and fluid-resistant gowns in November 2019 and during the pandemic in 2020

Type of PPE	Date	Unit price, £[1]	Volume purchased (for orders during the pandemic)[2]
Type IIR masks	Nov 2019	Range: 0.14 – 0.24 Average: 0.24	-
	Apr 2020	0.73	1,200,000
	Apr 2020	0.60	750,000
	Apr 2020	0.47	40,000,000
	Apr 2020	0.40	44,000,000
	May 2020	0.35	65,000,000
	June 2020	0.20	65,000,000
	Oct 2020	0.05	76,000,000
FFP3 respirators	Nov 2019	Range: 2.42 – 5.38 Average: 4.80	-
	Apr 2020	6.49	500,000
	June 2020	4.76	1,800,000
	Oct 2020	5.50	2,000,000
Nitrile gloves	Nov 2019	Range: 0.02 – 0.19 Average: 0.03	-
	Apr 2020	0.25	100,000,000
	Apr 2020	0.15	10,000,000
	May 2020	0.135	144,000,000
	Oct 2020	0.095	100,000,000
	Nov 2020	0.08	182,000,000

Type of PPE	Date	Unit price, £[1]	Volume purchased (for orders during the pandemic)[2]
Fluid-resistant gowns	Nov 2019	Range: 0.42 – 2.23 Average: 1.41	-
	Apr 2020	4.50	400,000
	May 2020	2.50	3,000,000

Notes:

1 Pre-pandemic prices are a weighted average of multiple different types of products which fall under the category. For example, there were 17 different lines under 'nitrile gloves' in November 2019. It is likely that the mix of products purchased during the pandemic differs from the position pre-pandemic.

2 The volume of items procured may not reconcile to the data on stocks and issues because some items were due to be delivered in batches, with some batches yet to be received. Also, for some orders, Shared Services was procuring additional items for other UK governments.

3 The unit prices and volumes of nitrile gloves are per individual glove.

Source: Shared Services

2.45 There has been significant media attention on the fees associated with intermediaries and agents involved in the procurement of PPE in England. We understand that where Shared Services engaged with agents, the agent's fee was absorbed into the unit price for the items, under an arrangement between the agent and the manufacturer. As such Shared Services does not know how much profit was made by the agent. In one case, the fees for the agents were capped at a specific percentage of the unit price. These fees covered overheads, administration, staffing costs, land transport, due diligence checks, in-country inspections, escrow account fees and profit.

There are some key decisions to make as part of the future procurement strategy for PPE, including on the involvement of domestic manufacturers

2.46 Shared Services' Winter Plan for PPE ran to the end of March 2021. There are some significant issues for the Welsh Government to consider for future procurement, including the size and nature of any future stockpile and the involvement of Welsh manufacturers. Shared Services is working with the Welsh Government to extend the key principles of the Winter PPE Plan (**paragraph 1.36**) into 2021-22. An interim position is being developed which is likely to reduce the 24-week target stock holding for most PPE items to reflect the reducing risk from the end of the EU transition period. A longer-term strategic plan will be developed during summer 2021.

2.47 Of the 67 suppliers that we referred to in **paragraph 2.37**, 13 were Welsh manufacturers and there were also several Welsh-based distributors involved in securing PPE. Other Welsh manufacturers have supplied local bodies with donations of PPE, for example of hand sanitiser and visors.

2.48 Welsh Government officials involved in the CERET worked closely with manufacturers to help them build capacity and get certification for some of the more complex PPE items. However, the time taken in preparations meant that the potential suppliers could not capitalise on relatively high prices in spring and summer 2020 when Shared Services was ramping up orders for its Winter Plan, and when the Welsh suppliers would have been reasonably price-competitive. In its report, the NAO highlighted the challenge of developing the domestic PPE market given the large amount of PPE stockpiled in England, which limits the potential size of the market for some items.

2.49 The Senedd Health, Social Care and Sport Committee's report encouraged the Welsh Government to consider the options for supporting local businesses that wish to continue making PPE. The Welsh Government is re-shaping its overall approach to procurement, with a view to having a greater focus on the local economic benefits and the foundational economy. In our view, the Welsh Government now needs to give a clear steer to public services and manufacturers as to its intentions for the domestic PPE market.

2.50 Under the normal approach to procurement, public services can compare the merits of different bidders using a range of criteria to demonstrate 'value' in the round. The more expensive option may offer additional benefits in terms of innovation or and wider policy goals, such as sustainable development in line with the Well-being of Future Generations (Wales) Act 2015. The issues highlighted in **paragraphs 2.33 to 2.35** around ethical supply chains are also relevant in this context.

2.51 There are also some decisions to make about the size and nature of the stockpile that will be held in case of a future pandemic. The current goal of a 24-week buffer is significantly larger than the stockpile previously held for a flu pandemic. Holding a stockpile involves costs in warehousing, staff to manage the stock and possible waste as some items may go past their useable date. If there is to be a significant stockpile, there will be questions to resolve about the timing of procurement and whether it can be built up when prices are back to normal rather than at a time of still high international demand.

Appendices

1 Audit approach and methods

Audit approach

The scope of our work took in the procurement and supply of PPE for all public services. However, in practice, our primary focus was on the NHS and social care and the national procurement led by the Welsh Government and NHS Wales Shared Services Partnership (Shared Services). While recognising that there has been local procurement and distribution of PPE, this was not a significant focus of our work.

To inform our work, we reviewed evidence submitted to the Senedd Health, Social Care and Sport Committee in spring/summer 2020. The Committee covered PPE in its July 2020 report, Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales: Report 1.

We also reviewed two reports by the NAO that covered the procurement and supply of PPE in England.

- Investigation into government procurement during the COVID-19 pandemic, November 2020,
- The supply of personal protective equipment (PPE) during the COVID-19 pandemic, November 2020.

Building on these reports, the UK Parliament's Public Accounts Committee published its own report in February 2021, COVID-19: Government procurement and supply of Personal Protective Equipment.

We have explored similar issues in our work. We have discussed PPE procurement and supply with the NAO and with counterparts at Audit Scotland and the Northern Ireland Audit Office.

Audit methods

We used a range of methods:

- **Document review:** we reviewed pre-pandemic planning documents, strategic plans, papers considered by NHS boards and committees, guidance documents including on PPE use in different settings and on procurement, and relevant Internal Audit reports including:
  - in October 2020, the NHS Wales Audit and Assurance Services (part of Shared Services) reported on Shared Services' financial governance arrangements during the COVID-19 pandemic. The review covered COVID-19 related expenditure, including but not limited to PPE, between March and July 2020. Part 2 of our report covers some similar issues for PPE specifically.
  - in December 2020, the Welsh Government's Internal Audit Services reported on Welsh Government strategy and governance arrangements for PPE. The auditors recorded a 'reasonable assurance' rating, noting their view that the arrangements were operating effectively for oversight of PPE. The report recommended that officials conduct a 'lessons learned' exercise, collate a timeline of key events and make some minor administrative changes.
- **Semi-structured interviews:** we interviewed officials involved in the planning and procurement of PPE across Shared Services, the Welsh Government, and the Welsh Local Government Association.
- **Data analysis:** we reviewed available data on the distribution of PPE items in Wales, NHS Wales expenditure, the price of items of PPE and the levels of stock held and distributed. The more centralised approach to monitoring and reporting for the NHS means data on healthcare has been more readily available than data on social care.
- **Staff surveys:** we analysed survey data provided by bodies representing medical, and nursing staff (Royal College of Nursing and British Medical Association). As the participants were self-selecting, rather than a random sample, we cannot know how representative these experiences are of the whole NHS and social care workforce.
- **Procurement testing:** we reviewed a sample of 16 PPE-related contracts, checking for compliance against expected procedures and looking for broader consideration of risks to value for money. We selected a mix of larger value and smaller value contracts that were not part of the normal supply chain (**Exhibit 15**). Our sample covered 71% of the value of these contracts let at the end of November 2020, which included purchases on behalf of other UK countries.

- **Site visit:** in November 2020, we visited the warehouse where a significant proportion of the PPE buffer stock is held. We carried out a health and safety risk assessment in advance. Audit Wales and NHS Wales staff wore face coverings and maintained social distancing.
- **Wider engagement:** we wrote to organisations that supplied evidence related to PPE as part of the Senedd Health, Social Care and Sport Committee inquiry in spring/summer 2020. We invited them to share any new evidence or issues of concern. We wrote to 21 organisations and received 6 responses. In some cases, we followed up those responses through further dialogue.

Exhibit 15: details of contracts covered in our procurement sample testing

Sample number	PPE item procured	Anticipated contract value at end of November 2020
1	Type IIR masks	£23,400,000
2	Type IIR masks	£21,150,000
3	Nitrile gloves	£19,440,000
4	Type IIR masks	£18,000,000
5	Nitrile gloves	£14,497,960
6	Type IIR masks	£14,483,220
7	Type IIR masks	£12,432,205
8	FFP3 respirators	£11,143,934
9	FFP3 respirators	£9,500,000
10	FFP3 respirators	£12,100,000
11	Fluid-resistant gowns	£6,019,355
12	Fluid-resistant gowns	£1,720,000
13	Fluid-resistant gowns	£1,008,000
14	Type IIR masks	£890,000
15	Air freight charges	£655,000
16	Air freight charges	£248,259

2 Organisations and groups involved in the procurement and supply of PPE

Beyond the Welsh Government as a whole, we refer in this report to various organisations or groups involved in the national procurement and supply of PPE. **Exhibit 16** provides an overview but is not exhaustive. Other organisations or groups have had input at different times for specific purposes.

Exhibit 16: organisations and other key groups involved in the national procurement and supply of PPE for health and social care

Organisation	Description
NHS Wales Shared Services Partnership (Shared Services)	Shared Services provides professional, technical and administrative services on behalf of other NHS bodies, which include procurement services and the Surgical Materials Testing Laboratory. The Shared Services Partnership Committee sets the Shared Services policy for NHS Wales, monitors the performance and supports the strategic development of Shared Services and its services.
Public Health Wales	Public Health Wales NHS Trust aims to protect and improve health and well-being and reduce health inequalities. It has worked alongside the public health agencies of the other UK nations to develop and issue infection prevention and control guidance, which includes the use of PPE.
Velindre University NHS Trust	Shared Services is hosted by Velindre University NHS Trust via a formal agreement, signed by each statutory organisation in NHS Wales. As a hosted organisation, Shared Services operates under the legal framework of Velindre University NHS Trust.
Finance Governance Group (FGG)	Shared Services set up the FGG to scrutinise and manage risks related to COVID-19 procurement. The FGG involves different parts of Shared Services along with members of the Velindre University NHS Trust Board. Shared Services representatives are from procurement, audit and assurance, finance and corporate services, legal and risk services and counter fraud.

Organisation	Description
Surgical Materials Testing Laboratory (SMTL)	The Surgical Materials Testing Laboratory is part of Shared Services and provides testing and technical services in support of NHS Wales procurement.
Life Sciences Hub Wales (LSHW)	An organisation formed in 2014 that brings together members in the Life Sciences sector to collaborate on solutions. A framework document between the Welsh Government and LSHW sets out the governance and accountability arrangements, and LSHW receive an annual remit from the Welsh Government.
National Procurement Service (NPS)	Part of the Welsh Government, promoting Welsh public sector procurement collaboration and managing a number of collaborative procurement frameworks for a range of goods and services.
Critical Equipment Requirement Engineering Team (CERET)	Established by the Welsh Government in March 2020, bringing together colleagues from across Welsh Government, the NHS, SMTL, LSHW and Industry Wales to support the procurement of PPE for healthcare settings.
Welsh Local Government Association (WLGA)	The WLGA coordinated social care responses and procurement between the 22 local authorities and liaised with Shared Services, the National Procurement Service and the wider Welsh Government.

3 Shared Services PPE stocks during the pandemic

Exhibit 17: volume and number of weeks of items held in stock at 7 February 2021, highest and lowest points

PPE item		Weeks of stock at 7 February 2021	Highest number of weeks	Lowest number of weeks
Aprons	Weeks	37.8	47.8	2.4
	Date		30 Nov 2020	5 May 2020
Body bags	Weeks	384.8	5,733.8	2.2
	Date		30 Jul 2020	14 Apr 2020
Eye protector	Weeks	601.9	205.557.3	0.1
	Date		9 Jul 2020	11 May 2020
Face visor	Weeks	19.3	55.6	0.1
	Date		7 Sept 2020	8 Apr 2020
FFP2 respirator	Weeks	97.0	1,496.6	12.3
	Date		12 May 2020	27 Jul 2020
FFP3 respirator	Weeks	9.3	32.9	1.4
	Date		9 Nov 2020	2 Apr 2020
Fit test kits & spares	Weeks	667.6	2,729.4	0.2
	Date		4 Jan 2021	6 Apr 2020
Gloves	Weeks	3.7	7.6	1.3
	Date		7 Sept 2020	7 Dec 2020
Gloves (cuffed)	Weeks	26.8	71.5	0.8
	Date		18 Jan 2021	7 Apr 2020
Gowns (fluid-resistant)	Weeks	116.3	145.9	0.2
	Date		17 Aug 2020	25 Apr 2020

PPE item		Weeks of stock at 7 February 2021	Highest number of weeks	Lowest number of weeks
Gowns (other)	Weeks	3.3	44.8	0.6
	Date		22 Jun 2020	26 Apr 2020
Hand sanitiser	Weeks	79.1	127.1	1.6
	Date		18 Jan 2021	15 Apr 2020
Hand wipes	Weeks	11.4	83.2	5.7
	Date		4 Jan 2021	31 Aug 2020
Type I & type II masks	Weeks	85.3	147.2	0.3
	Date		30 Nov 2020	7 Apr 2020
Type IIR masks	Weeks	50.5	116.0	0.2
	Date		18 Jan 2021	7 Apr 2020
Respirator hoods	Weeks	Analysis not possible due to limited issuing		
	Date			
Respirator filters	Weeks	Analysis not possible due to limited issuing		
	Date			

Note: one unit of gloves are reported as pack, which vary in size, and hand sanitiser as a bottle, varying in volume.

Source: Audit Wales analysis of Shared Services data

Exhibit 18: total units of PPE issued up to 7 February 2021

PPE Item	Units
Aprons	113,770,625
Body bags	11,316
Eye protector	1,627,000
Face visor	5,167,736
FFP2 respirator	126,036
FFP3 respirator	2,823,373
Fit test kits and spares	5,965
Gloves	337,469,340
Gloves (cuffed)	1,306,900
Gowns (fluid-resistant)	2,000,584
Gowns (other)	643,990
Hand sanitiser	391,514
Hand wipes	20,135,400
Type I & type II masks	1,174,150
Type IIR masks	143,238,551
Respirator hoods	102
Respirator filters	22,176
Total	**629,914,758**

Note: one unit of gloves are reported as pack, which vary in size, and hand sanitiser as a bottle, varying in volume.

Source: Welsh Government, Weekly Personal Protective Equipment issues: up to 7 February 2021, released 11 February 2021

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Welsh Health Specialised Services Committee Governance Arrangements

Report of the Auditor General for Wales

May 2021

This report has been prepared for presentation to the Senedd under the Public Audit (Wales) Act 2004 and the Government of Wales Act 1998

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within **A Healthier Wales**.

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Summary report

Background

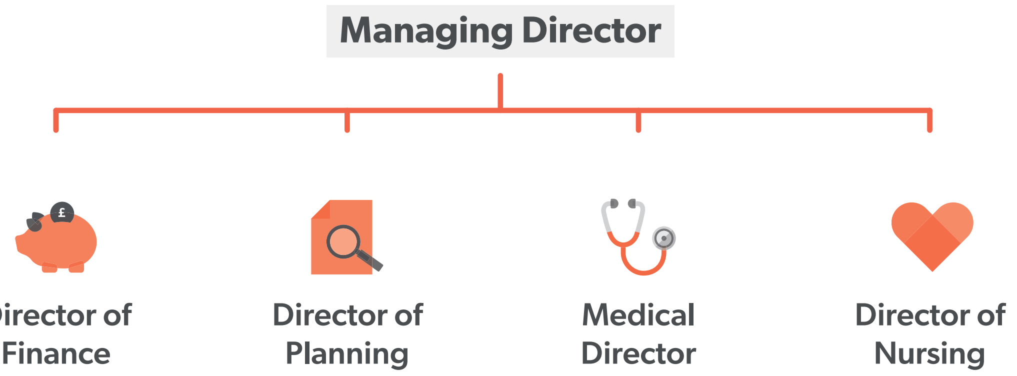
1 The Welsh Health Specialised Services Committee (WHSSC) is a joint committee of each local health board in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The remit of the Joint Committee is to enable the seven health boards in Wales to make collective decisions on the review, planning, procurement, and performance monitoring of agreed specialised and tertiary services.

2 The Joint Committee is hosted by Cwm Taf Morgannwg University Health Board and is responsible for the joint planning and commissioning of specialised services on behalf of local health boards in Wales. WHSSC is made up of, and funded by, the seven local health boards with an overall annual budget of £680 million with the financial contributions determined by population need. Some health boards in Wales provide specialised services. In particular, Cardiff and Vale and Swansea Bay University Health Boards receive significant funding for the services that they provide.

3 On a day-to-day basis, the Joint Committee delegates operational responsibility for commissioning to Welsh Health Specialised Services (WHSS) Officers, through the management team (**Exhibit 1**) and supported by six multidisciplinary commissioning teams. These teams commission specialised services, including:

- Cancer and Blood
- Cardiac
- Mental Health and Vulnerable Groups
- Neurosciences and long-term conditions
- Renal
- Women's and children's

Exhibit 1: WHSS management structure



Source: Welsh Health Specialised Services Standing Orders

4 In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. The Good Governance Institute highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. In the same year, Healthcare Inspectorate Wales (HIW) conducted a review of clinical governance at WHSSC. That review found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

5 Time has now passed since these reviews. Considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in A Healthier Wales, the Auditor General felt it was timely to review WHSSC's governance arrangements. This report considers the extent to which there are effective governance arrangements and whether the planning approach effectively supports the commissioning of specialised services for the population of Wales. Given the impact of COVID-19 on the capacity and productivity of services, we have also highlighted some specific challenges which relate to recovery.

6 Much of our review was carried out between March and June 2020, but as a result of the pandemic, we paused aspects of the review, restarting in July with a survey to all health boards and concluding the fieldwork in October. The delivery of our work included interviews with WHSS officers and WHSSC independent members, observations of Joint Committee and sub-committee meetings, questionnaires of health board chief executives and chairs and a review of documentation.

Key findings

7 Overall, we found **since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales**.

Governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19

8 Our work has found improvements in the overall governance arrangements in WHSSC since 2015. WHSSC is formed of a mix of independent members, health board chief executives, and WHSS officers who work in collaboration to lead specialised services commissioning on behalf of the population of Wales. There are benefits to this system of governance which provides partners with the opportunity to collaborate on service developments. In general, we found that the Joint Committee operates well and there is normally a healthy working relationship between Joint Committee members. There are, however, occasions when this has become more challenging, such as discussions around new service models for major trauma and thoracic surgery. This tends to occur when new services are commissioned from providers who are Joint Committee members. This can present a risk of conflict of interest but the negative impact of this has been reduced through the introduction of a new majority voting system. These conflict-of-interest issues will remain a live risk, particularly when considering post-pandemic service recovery.

9 The agenda of the Joint Committee meetings appears appropriate and proportionate. However, our observations highlighted opportunities to increase the attention given to finance, performance, and quality reporting at Joint Committee. We also identified a need to review the independent member recruitment arrangements and the level of remuneration that they receive to help deal with the challenges of independent member turnover.

10 The Joint Committee's sub-committees and groups are well-chaired and administered, although there is a need to strengthen the Integrated Governance Committee to ensure it discharges its terms of reference. WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities, and Communications. WHSSC also forms part of the governance and accountability framework of the Health Board via the Audit and Risk Committee and requirement for financial disclosure in annual reports and accounts. Work is ongoing to strengthen the role and function of the Health Board's Audit and Risk Committee in respect of its hosted statutory joint committees.

11 WHSSC has developed good risk management processes using a corporate risk assurance framework. The risks are regularly scrutinised at corporate and Joint Committee levels with a specific arrangement to capture COVID-19 risks since the onset of the pandemic. Likewise, performance management arrangements provide a good foundation, adopting a tiered model for service escalation and appropriate operational monitoring. WHSSC has adapted these arrangements as a result of the pandemic but may need to become more robust in future to ensure specialised services minimise the risk of harm as a result of delays in treatment.

12 After an initially slow response, WHSSC has responded to the recommendations made in 2015 relating to the need to strengthen quality assurance arrangements. In 2019, WHSSC established a Quality Assurance Team, which is embedding well and is now taking steps to update its quality assurance framework.

Planning arrangements provide a good foundation but there is a need for a clear strategy to respond to the challenges presented by COVID-19

13 Annual planning arrangements are generally effective. Year on year, development and approval of the Integrated Commissioning Plan has become timelier and there are clear formal arrangements for the identification and prioritisation of emerging specialised care services and treatments. Welsh Government officials told us of the additional capacity and capability they received from WHSSC planning officers to help drive through review of health board and trust quarterly plans during the first wave of the pandemic. This provides a good indication of the expertise within the team. Information to support planning and commissioning is improving and this is supported by a performance information system which continues to develop. Delivery of existing commissioned service plans is well managed, but elapsed time for the introduction of new services such as new service models for major trauma and thoracic surgery in South Wales has been slow. This is not within the sole remit of WHSSC but indicates the need for wider 'end to end' programme management at regional levels.

14 Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan. COVID-19 has significantly reduced access to some specialised services, and recovery will have some significant financial consequences. There is a need to understand the financial consequences resulting from the pandemic in terms of service recovery. Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs to become more ambitious and more strongly linked to patient outcomes, prioritisation, and decommissioning (where there isn't good evidence that services/interventions are leading to improved outcomes).

15 COVID-19 has delayed specialised services strategy development and will no doubt continue to impact on the timeline for the development of the strategy. Specialised service officers can start to shape a strategy that focusses on the impacts of COVID-19 alongside advances in technological, therapeutic and policy developments. Strategy renewal is more crucial than ever and will need to be shaped around the changing risks and opportunities for specialised services taking consideration of the issues and opportunities identified in this report.

Future arrangements for commissioning specialised services

16 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales, signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability. Whilst the governance arrangements for WHSSC have continued to evolve positively in the main, there would still be benefits in the Welsh Government including WHSSC in the planned review of national hosted functions. In looking at potential future governance and accountability arrangements for specialised services, it should be recognised that the current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that see individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

The Welsh Health Specialised Services Committee (WHSSC) commissions around £680 million of specialised services on behalf of the population of Wales and is a vital component of the Welsh healthcare system. Given this level of responsibility and investment, I'm encouraged by the progress WHSCC has made to improve its governance, management, and planning arrangements over recent years.

An immediate challenge for WHSSC is to develop a clear strategy to address the challenges associated with recovering specialised services following the Covid-19 pandemic. My report also shows that there is still a need to take a more fundamental look at the model for commissioning specialised services, in line with the commitment set out in the Welsh Government's NHS Plan 'A Healthier Wales'. It is important that this commitment is taken forward and I hope that the findings set out in this report can helpfully inform that debate.

Adrian Crompton
Auditor General for Wales

Recommendations

17 Recommendations arising from this audit are detailed in **Exhibits 2 and 3**.

Exhibit 2: recommendations for the Welsh Health Specialised Services Committee

Recommendations

Quality governance and management

R1 **Increase the focus on quality at the Joint Committee.** This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.

Programme management

R2 **Implement clear programme management arrangements for the introduction of new commissioned services.** This should include clear and explicit milestones which are set from concept through to completion (ie early in the development through to post-implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the joint committee.

Recommendations

Recovery planning

R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:

a the backlog of waits for specialised services, how these will be managed whilst reducing patient harm.

b potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening.

c the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.

Recommendations

Specialised services strategy

R4 The current specialised services strategy was approved in 2012. WHSSC should **develop and approve a new strategy during 2021**. This should:

a embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post-pandemic recovery.

b be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services:

- which do not demonstrate clinical efficacy or patient outcome (stop);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer);
- where alternative interventions provide better outcome for the investment (change);
- currently commissioned, which should continue (continue).

Exhibit 3: Recommendations for the Welsh Government

Recommendations

Independent member recruitment

R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role.

Sub-regional and regional programme management

R6 This is linked to **Recommendation 2** made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi-partner programme management arrangements are in place from concept through to completion (ie early in the development through to post-implementation benefits analysis).

Future governance and accountability arrangements for specialised services

R7 **A Healthier Wales** included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.

Main report

Governance and assurance

18 Our review has examined WHSSC's governance and assurance arrangements, such as the way the Joint Committee and its sub-committees conduct business, systems for managing performance and risk, and arrangements to ensure probity and propriety. We found that **governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19**.

Conducting business effectively

19 We looked at the clarity of governance structures, decision-making arrangements and conduct at the Joint Committee and its sub-committees. We found that **committee arrangements have improved, although challenges around conflicts of interest remain and there is a need for stronger focus on quality, finance, and performance at Joint Committee meetings**.

The Joint Committee is well administered with a healthy relationship between members. However, there is scope for greater scrutiny of service quality and routine finance and performance reports, and an opportunity to look afresh at independent member recruitment arrangements

20 The Joint Committee is made up of 15 voting members and three associate members. The voting members include the chief executives of the seven health boards, four independent members (three of whom are drawn from health boards), including the Chair (a Ministerial appointment) and Vice Chair, and four WHSS officers. In October 2020, a new Chair was appointed, taking over from the Interim Chair who had been in post for a little over three years. WHSSC is expecting turnover of independent members in the coming months which will present both capacity and recruitment challenges. It was reported that recruiting independent members is difficult, especially since the pool from which they can be recruited is limited to health boards only. Consideration should be given to widening the recruitment pool to include all NHS Wales organisations, not just health boards. In addition, there is no additional remuneration for independent members of WHSSC, which makes the position less attractive. Thought, therefore, should be given to whether the current remuneration arrangements reflect the commitment expected of independent members of WHSSC.

21 We observed the Joint Committee both before and during the pandemic. Meetings were well attended and the relationship between members was respectful with a healthy level of challenge. Due to the pandemic, WHSSC moved to holding virtual meetings from March 2020. At this time, the Joint Committee's agenda had a COVID-19 focus with updates on commissioning independent hospitals, which the WHSS team was responsible for, risk management and delivering specialised services during the pandemic. WHSS officers fed back that the revised arrangements improved meeting efficiency and engagement and created better approaches for responding to questions. Moving forward, we would encourage WHSSC to review and consider the advantages of retaining these arrangements.

22 Those we interviewed were positive about the Joint Committee, indicating that it had matured in the past one to two years. Generally, it was felt the Joint Committee works effectively, is open and transparent, that chief executives are supportive of each other, and that roles and responsibilities are clear. Our observations at Joint Committee indicated a tendency to focus on new service modelling which resulted in a south Wales focus in meetings. We also saw limited discussion about the performance of commissioned services. Despite good systems for quality assurance at an operational level within WHSSC, there is a lack of sufficient oversight at Joint Committee. These need to be strengthened as part of a focus on service recovery.

Decision making arrangements have improved, but conflicts of interest remain a risk

23 WHSSC commissions specialised health services for Wales as a whole. Whilst membership of the Joint Committee is drawn from existing health boards, the members are supposed to be independent. However, decision-making for some members poses a potential conflict of interest. This is because the larger Welsh health boards are substantial providers of specialised services, especially in south Wales. Those we spoke to reported that there can be some tensions around negotiations, citing the major trauma centre and thoracic surgery, and potential to draw attention on these specific issues at committee meetings at the expense of wider aspects of the agenda.

24 As a result of previous challenges in decision making, WHSSC's voting arrangements changed from 100% agreement required to a two-thirds majority vote in accordance with a Ministerial direction dated 12 November 2018. This was subsequently reflected in an amendment to WHSSC's standing orders. The new voting system is more pragmatic and ensures quicker decision-making, but this was introduced relatively recently, so WHSSC should keep this new arrangement under review. The governance arrangements mean that chief executives and independent members take part in votes on commissioning services from their own health board. As a result, the previous interim Chair of WHSSC reinforced the need to act on behalf of the all-Wales position when making decisions. Moving forward, the difficulties presented by the pandemic are likely to be challenging. When acting on behalf of 'all-Wales' and to minimise patient harm as a result of delays in receiving specialised care, shifts in investment may be necessary. This again may increase the risk of conflicts of interest if chief executive members are required to vote on diverting investments from their own health boards.

Flows of assurance between the Joint Committee and individual health boards are variable

25 As the Joint Committee commissions specialised services on behalf of the seven health boards, we would expect to see clear lines of assurance from the Joint Committee to individual Boards. On reviewing health board papers[1] we found that as a minimum all seven health boards had approved their own standing orders, which set out their responsibilities regarding WHSSC, and WHSSC's standing orders. All health boards report WHSSC's assurance reports and minutes of the Joint Committee meetings (or provide a link to the minutes).

26 However, health board minutes show some variability in the extent of discussions of WHSSC services. For example, the programme business case approval for major trauma and thoracic surgery prompted extensive papers and good discussion at health boards. But at other times WHSSC papers were just noted with limited discussion. We found that Board level oversight of quality and escalated specialised services appears limited, but we note that this is something WHSS officers are working to improve through their engagement work with health boards across Wales.

1 For each health board, we reviewed its Board papers and papers for its quality and safety, finance and performance meetings.

WHSSC's hosting arrangements function largely as intended, albeit there are occasional operational challenges and an opportunity to strengthen the governance role of the host health board's Audit and Risk Committee

27 WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities and Communications. WHSSC employees have a contract of employment with Cwm Taf Morgannwg University Health Board and WHSSC's Managing Director has a line of accountability to its Chief Executive. Interviewees indicated that in general these arrangements operated sufficiently, but there were some concerns expressed about Cwm Taf Morgannwg University Health Board's capacity to support WHSSC, particularly in relation to HR and ICT support services. In addition, it was noted that Cwm Taf Morgannwg University Health Board is a provider of specialised services commissioned by WHSSC, which could provide further conflicts of interest over and above the inherent provider/commissioner tension at Joint Committee.

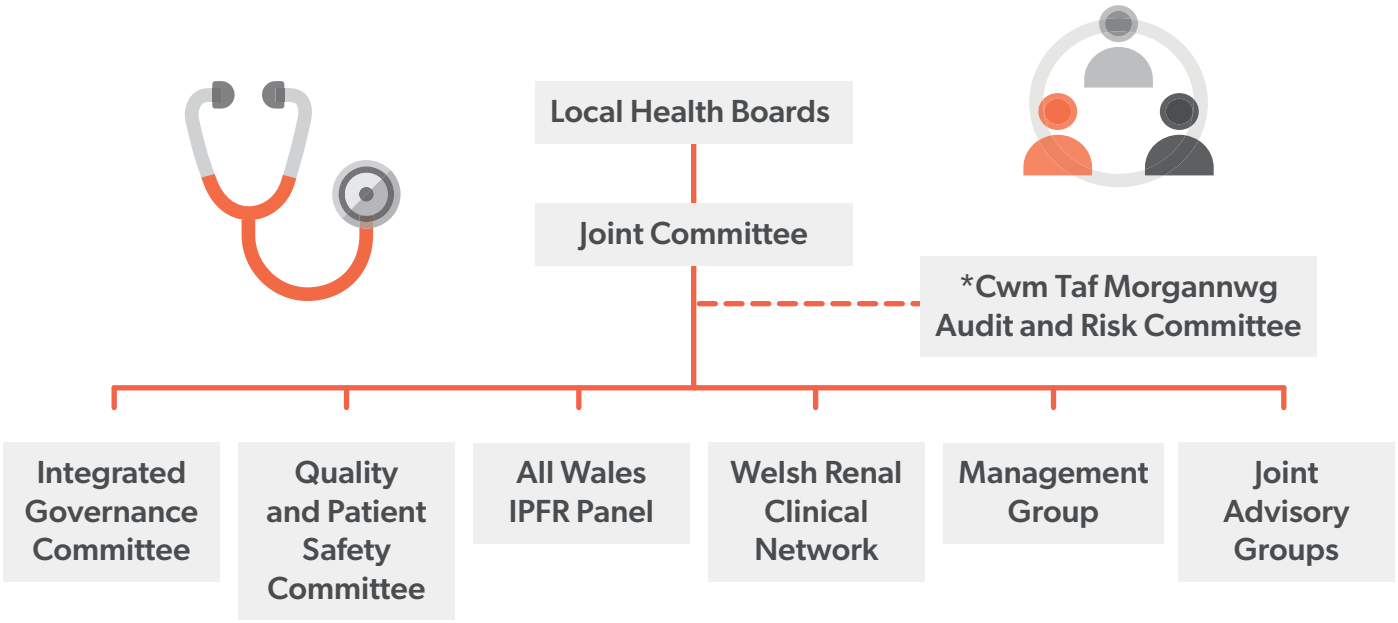
28 A hosting agreement exists between WHSSC and the seven Welsh health boards which includes provision for Cwm Taf Morgannwg University Health Board's Audit and Risk Committee to assist in the discharge of WHSSC's governance and assurance responsibilities. However, the existing hosting agreement has limited detail on how these arrangements should work, and the degree of scrutiny of WHSSC business at the committee can be fairly limited. Hosted organisations are considered at Part 2 of Audit and Risk Committee meetings. Cwm Taf Morgannwg University Health Board is working to clarify the assurance requirements of the hosted bodies[2] through developing an assurance framework. The new framework aims to define the role, function, responsibilities and accountabilities of the Audit and Risk Committee, the host, the all-Wales statutory joint committees and the directors involved. We understand that this work is ongoing and will require further engagement across all bodies affected.

2 Cwm Taf Morgannwg University Health Board is also the host for the Emergency Ambulance Services Committee (EASC) and the NHS National Imaging Academy.

WHSSC's sub-committees and groups generally operate well, although there is a need to ensure that all aspects within terms of reference are appropriately covered

29 WHSSC is required through its standing orders to have committees responsible for quality and safety, and audit. As identified earlier, the Audit and Risk Committee is facilitated through hosting arrangements. However, the Joint Committee is also supported by a range of its own sub-committees and groups (**Exhibit 4**). Some provide scrutiny and receive assurances, while others are more focussed on delivery and decision making. The Quality and Patient Safety Committee, forms part of WHSSC's own committee and group structure. The Joint Committee also has three advisory groups, which at the time of our fieldwork were under review.

Exhibit 4: WHSSC Governance Structure[3]



* Functions as both the Health Board's Audit and Risk Committee and WHSSC's Audit Committee.

Source: WHSSC

3 See section 2.3 of the 2019/20 WHSSC Annual Governance Statement for more information on the arrangements for Cwm Taf Morgannwg's Audit and Risk Committee and Quality and Patient Safety Committee in relation to WHSCC governance.

30 Most of our observations took place prior to the pandemic. Generally, we found that the meetings had a clear agenda, were well administered with formal procedures observed as expected, such as declarations of interest and review of previous minutes. Meeting papers were clearly written with a templated cover report detailing the purpose of the paper such as for approval, noting and assurance. The sub-committees have an up-to-date work programme and terms of reference.

31 WHSSC's Quality and Patient Safety Committee effectively scrutinises assurance reports from all of its commissioning teams on escalated services, service risks, quality visits, inspections and any incidents or concerns. The committee also receives reports on concerns, serious incidents, ombudsman reports, clinical policy review and COVID-19. WHSS officers are also aiming to improve the flow of information between WHSSC and the quality and safety committees of health boards.

32 During 2019-20, the Integrated Governance Committee met infrequently, leaving a six-month gap between the October 2019 and April 2020 meetings. However, the number of meetings was still in line with the committee's terms of reference and, since April 2020, the frequency of meetings has increased. Our work indicates that there needs to be greater clarity on the role and function of this committee. At present, part of the Integrated Governance Committee's remit is to maintain oversight of the work of the Quality and Patient Safety Committee, Audit and Risk Committee, and the Welsh Renal Network. The Integrated Governance Committee is also responsible for scrutinising delivery and performance of the Integrated Commissioning Plan. Whilst there was good oversight of the plan's development by the committee, we found that with the exception of a routine report on escalated services, there was no evidence of wider scrutiny of delivery against the plan.

33 Our observations found that Management Group, an officer-level group which makes recommendations to the Joint Committee, is well chaired, and in general papers are well discussed. But, as with Joint Committee, we saw a need for better discussion of performance, finance, and service quality and patient safety.

Systems of assurance

34 We examined whether the Joint Committee has an effective system of internal controls to support assurance systems. We found that **in recent years there has been notable strengthening of systems of assurance, but there is scope to strengthen them further**.

Arrangements to promote probity and propriety are in place

35 WHSSC's governance and accountability framework was last fully reviewed in September 2019. This version reflects the amended voting arrangements and includes:

- Standing Orders
- Memorandum of Agreement
- Hosting Agreement
- Joint Committee Business Framework

36 To help ensure probity and propriety, WHSSC maintains registers for declarations of interest and gifts, hospitality, and sponsorship. The registers are appropriately updated, with records available on the WHSSC website and declared within the Annual Governance Statement.

37 WHSSC keeps an internal audit recommendation tracker, which is clearly formatted and reviewed at each Audit and Risk Committee meeting. There were no external audit recommendations on the tracker when we conducted our review, but we are told that historically recommendations have been listed on the tracker and they were scrutinised in the same way as they were for the host. We would particularly expect the recommendations made in this review to appear on the tracker and be subjected to scrutiny.

38 WHSSC also monitored progress against the 2015 Good Governance Institute and HIW reviews. WHSSC developed a governance action plan and most actions are closed. The Integrated Governance Committee received six-monthly updates on the outstanding actions, the last of which was in March 2019.

Good risk management processes are in place, with risks regularly scrutinised at corporate and Joint Committee level, and systems in place to capture risks arising from COVID-19

39 WHSSC has a Corporate Risk Assurance Framework (CRAF) which identifies high-level risks to commissioned services. Each of the commissioning teams has a risk register. Risks rated 15 or above after controls are put in place are escalated to the CRAF. The Joint Committee has sight of the CRAF twice a year and it is reviewed regularly by the sub-committees and the Corporate Directors Group Board. The CRAF is clearly presented and includes the information we would expect to see on a corporate risk register including a lead director and assuring committee for each risk.

40 WHSSC has recently updated its integrated risk management framework including reviewing existing risk registers, developing a new risk register template, and training staff. The framework sets out accountabilities, responsibilities, and the organisation's risk appetite. WHSSC is seeking further improvements to tighten escalation and de-escalation processes and by introducing an electronic risk management system. It hopes to roll out new risk processes in spring 2021.

41 During the pandemic, a separate risk assessment and register was completed to assess how essential specialised services were impacted by COVID-19. The assessment is a live document which is updated as providers supplied more information. The Joint Committee continues to review both the COVID-19 risk register and the CRAF.

WHSSC is taking necessary action to strengthen its performance management arrangements but will need to consider how these are adapted to monitor and manage the post-pandemic recovery of services

42 WHSSC predominantly monitors a service's performance through national key performance indicators. The measures are set out in contracts and service specifications. Underperformance is managed through WHSSC's escalation framework, which has four levels of escalation, with level four being the highest. The WHSS team holds regular Service Level Agreement (SLA) meetings with Welsh providers, and at least an annual contract meeting with English providers. Escalated services are subject to enhanced performance management arrangements until significant improvement can be demonstrated to allow de-escalation.

43 During the height of the pandemic, WHSSC stood down SLA monitoring in line with the Welsh Government's practice. At this point only essential specialised services were being delivered. During this time, the WHSS team found it difficult to engage with both Welsh and English providers who were heavily focussed on the pandemic. Pragmatically, to overcome this they adopted a direct monitoring system, reviewing available performance data and challenging providers on the findings. WHSSC is still 'direct monitoring' services and is sharing information with the Welsh Government. Where the WHSS team has been able to proactively engage with providers they have been able to negotiate the continuation of some services. WHSSC reported that despite the pandemic, escalation arrangements continued to work well, and it has helped to highlight differences in activity and productivity between different providers.

44 The pandemic has also highlighted the need to review performance management arrangements and metrics. For example, performance against referral to treatment (RTT) waiting times was often used to determine escalation levels[4]. But in the current climate where RTT waiting times have risen across the NHS, it is difficult to differentiate risk of harm or patient outcome when so many patients are delayed and waiting. As a result, WHSSC is currently in the process of reviewing each service in escalation to see if it is still relevant. WHSSC does not currently have an overarching Performance Management Framework, although it has developed a performance analysis system called 'MAIR' (My Analytics and Information Reports). However, the team is developing a Commissioning Assurance Framework. The framework will set out a new performance assurance process alongside more outcome focussed performance measures. It also proposes an annual meeting between WHSSC executives and health board executives to understand commissioner priorities to feed into the Integrated Commissioning Plan development process. It is hoped the new framework will be launched alongside the refreshed Integrated Commissioning Plan. This is a positive development as monitoring services as they recover from the pandemic will need a different approach. Reviewing data on patient outcomes and harm will need to be an important part of these developing arrangements.

45 WHSSC's integrated performance dashboard is presented to the Corporate Directors Group Board and Management Group monthly, and to the Joint Committee bi-monthly. While there is discussion and challenge at commissioning team meetings, as stated earlier, we observed little scrutiny of this report at Joint Committee. The existing reports do not have a breadth of measures, reporting mainly on waiting times and RTT performance and there is opportunity to refresh these as part of post-pandemic recovery and the new Commissioner Performance Assurance Framework.

4 The escalation framework works on a four-tier basis with level four being the highest level of escalation. Services can be escalated for performance and/or quality issues.

WHSSC is driving quality improvement through its Quality Assurance Team and quality assurance framework

46 In 2015, the Good Governance Institute and HIW made several recommendations related to quality governance. Since these reviews, WHSSC has made good progress in improving quality governance. The Joint Committee has senior clinical representation, the Director of Nursing and Quality Assurance is a member of the Joint Committee and the Medical Director attends the meeting. At an operational level, each of the six multidisciplinary commissioning teams has an associate medical director for clinical advice and guidance.

47 A Quality Assurance team, led by the Director of Nursing and Quality Assurance, was established in 2019. The team is responsible for monitoring and learning from quality and patient experience to help improve commissioned services. Specifically, this includes managing and responding to complaints, near misses, serious incidents and never events. The team is also part of the multidisciplinary commissioning teams and is involved in planning and quality assuring commissioned services. In addition, WHSSC has updated its Quality Assurance Framework which was agreed in 2014 and will form part of the new Commissioning Assurance Framework.

48 To share intelligence and reduce duplication, the Quality Assurance team maintains good relationships with providers and regulators. For example, the team holds quarterly meetings with the quality leads at provider health boards to review a range of quality measures and information. They also use intelligence from regulators, clinical audit, and the National Collaborative Commissioning Unit (mental health services) to feed into planning and monitoring of services. There is a different system for English providers. NHS England has a quality assurance portal, which WHSSC accesses. Information on the portal is detailed and benchmarked against similar NHS England providers. WHSSC plans to replicate this approach for Swansea and Cardiff and Vale University Health Boards.

Strategic planning

49 Our work examined whether WHSSC has a clear and robust approach to strategic and financial planning. As a result of the pandemic, the specialised services environment has changed, with some services, particularly surgical, stopping or significantly curtailed. Our review found that **planning arrangements provide a good foundation but there is need for a clear strategy to respond to the challenges presented by COVID-19**.

Annual planning arrangements are generally effective, but recovery of services will be challenging

50 WHSSC currently undertakes planning each year culminating in a rolling three-year Integrated Commissioning Plan. This plan is agreed annually and has become increasingly timely and mature in recent years. There are clear stages of development and engagement with health boards as part of the approval process, prior to formal ratification/approval at the WHSSC Joint Committee. There is also a clear process and accountability for different stages of preparation and approval and, if necessary, consultation with relevant stakeholders.

51 WHSSC consults key stakeholders and the public on new commissioning policies, service specifications and revised commissioning policies where there are material changes to the service. There are good examples of this in relation to major trauma and thoracic surgery with the relevant community health councils actively engaging in stakeholder feedback and analysis. Community health council feedback informs both WHSSC planning and the relevant health boards whose population may be affected by proposed service changes.

52 The extent that health boards incorporate specialised services within their own integrated medium-term plans is variable across Wales. For example, Powys Teaching Health Board and Hywel Dda University Health Board rely more significantly on externally commissioned specialised services and we see these featuring in their plans more so than in the plans of the health boards that are specialised service providers.

53 Our work indicates that WHSSC has sufficient capacity and capability to support planning. That capacity and capability was drawn upon in 2020 to help support the Welsh Government's NHS Planning Team's review of health boards' quarterly plans, using their knowledge and experience of complex service planning. WHSSC's planning arrangements include significant contribution from each of the specialised services commissioning teams, clinical impact advisory group and WHSSC Management Group. Clinical advice helps to shape specialised services and WHSSC intends to increase the level of internal 'consultant-level' expertise further.

54 WHSSC has adopted a continuous approach for identifying and evaluating new research, treatments and using NICE[5] guidance to shape commissioned services. This 'horizon scanning' is supported by a consistent and transparent prioritisation process (**Exhibit 5**) to help ensure that investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. The robustness of the approach helps to secure agreement of new proposals at the Joint Committee.

Exhibit 5 – key principles of the prioritisation process adopted by WHSSC

- Scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out using formal and agreed methodology
- The prioritisation process is intended not to duplicate work already completed (for example by NICE)
- There must be appropriate and timely engagement with NHS Wales as part of the process
- There are clear and agreed scoring criteria and voting technology is utilised during assessment. The criteria include:
  - Strength of clinical evidence
  - Patient benefit
  - Economic assessment
  - Burden of disease (severity of condition and also impact on the population)
  - Reducing inequalities of access

Source: Audit Wales fieldwork

5 National Institute for Health and Care Excellence https://www.nice.org.uk/

55 COVID-19 has significantly affected the delivery of specialised services across Wales and England. After the first wave of the pandemic, we understand that variation in service productivity between providers was increasing, with some providers able to restart specialised services earlier and with greater degrees of success than others. This creates a commissioning challenge as WHSSC looks to develop post-pandemic recovery plans on behalf of the population of Wales.

Information to support planning and commissioning is improving and will need to adapt to the challenges brought about by the pandemic

56 WHSSC's development of My Analytics and Information Reports (MAIR) in 2018-19 was a notable improvement on previous arrangements. WHSSC has worked closely with health board teams to ensure that health boards now have access to the comprehensive information sets now available. Reports can be tailored by health board or provider, by specialty and point of delivery. Results can also be made available using a variety of visualisation tools including maps, charts, tables, and pathways. This has enabled health boards to gain a deeper understanding of their demand patterns for specialised services and compare their own access rates to other health boards and inform areas for targeted review.

57 Plans for further development of MAIR include:

- Producing performance management dashboards and heat mapping
- Improving the timeliness of performance reporting
- Exploring how quality and outcomes data can be incorporated
- Improving the familiarisation of health boards with the variety of WHSSC's contracts by the production of deep dive reports.

58 Commissioning and contracting services can only be effective if there is robust information to inform operational and strategic decisions. Our work has identified that prior to the COVID-19 pandemic, there was a good track record of analysis of demand and capacity of services both in Wales and England. This will become even more important post-pandemic, to help provide options for recovering service performance and reducing risk of harm as a result of delays in access to care.

Delivery of Integrated Commissioning Plans is effective, but development and implementation of new services can be slow

59 For services that are already commissioned and being delivered, the necessary arrangements are in place to ensure they are resourced and being delivered as intended, with arrangements to escalate matters should there be any concerns.

60 Commissioning of new services from first consideration through to the launch of new services can, however, be a lengthy process, particularly for services provided in Wales. For example, the major trauma network in south Wales was launched in September 2020, after having been originally identified as necessary back in 2013, although WHSSC's involvement only commenced in 2018-19. Similarly, the improvements to thoracic surgery services, identified as necessary by the Royal College of Surgeon's report in 2016, are not expected to go live until 2024, and this is subject to a capital business case requiring Welsh Government funding.

61 Whilst introduction of new services is by no means simple, there has been protracted debate on where the new developments mentioned above should be housed, although the statutory engagement and consultation process, which is integral to this, can consume considerable time. The roll out of such schemes is not the sole domain of WHSSC and depends upon the wider architecture that supports regional service development within the NHS in Wales. There is scope, however, to strengthen end-to-end programme management of such schemes to improve timeliness of service development. The pandemic has created a common sense of urgency amongst providers. This momentum needs to be maintained to identify and rapidly develop or reshape services to accelerate recovery.

Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan but will need to ensure value for money as services restart and aim to recover

62 Financial planning is an integral element of the Integrated Commissioning Plan. Health boards are fully engaged in discussions on costs and projected cost growth for the coming financial year during planning and agreement stages, prior to ratification of the plan. Cost growth is explicitly defined in the plan and justified through the agreed process for horizon scanning and prioritisation. Financial planning has two distinct elements:

- determining overall specialised services costs and the apportionment of these costs to health boards; and
- contracting and commissioning health boards and trusts in relation to provision of specialised services.

63 These are managed through financial risk-sharing agreements. These agreements set out who pays for what in relation to the provision and receipt of services. The risk sharing agreements are based on a financial formula and this is used both as part of planning and at the year-end to look at variance in activity against plan and determine distribution of under and overspends. There are different models for risk sharing designed to suit different types of commissioned services. For most services, planning is based on actual utilisation and a two-year average of activity. This is designed to smooth some peaks and troughs but also create incentive for efficiency. Highly specialised services which are not utilised often are funded using a population-based formula which is designed to provide continuity of income. This is to ensure services are sustainable, but also to protect against peaks of extreme costs when services are required.

64 Our review of health board expenditure on specialised services for the period 2014-15 to 2020-21[6] indicates the overall costs have increased above inflation. We understand that this is typical when new specialised therapies and treatments are developed and adopted into commissioning agreements.

65 In the short to medium term, however, the impact of COVID-19 on finances presents a number of challenges, including:

- payments to providers have continued in Wales and England albeit recent negotiations have resulted in rebates/reductions where there is under-delivery by providers;
- lack of service delivery during the pandemic has created a backlog of waits for some specialised services; and
- lack of patients presenting to primary and secondary care with symptoms during the pandemic may mean that there is greater hidden demand, and that conditions may have exacerbated, requiring more costly intervention downstream.

66 The Joint Committee should seek to understand the short and medium term financial impacts of COVID-19 to determine what this means for service recovery plans.

6 2019-20 data is taken from the Month 12 Health Board expenditure on Welsh Health Specialised Services. 2020-21 costs are based on forecast expenditure budgeted within the 2020-21 integrated commissioning plan. We acknowledge that 2019-20 data is currently unaudited, and 2020-21 data is subject to significant variation as a result of the COVID-19 outbreak.

Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs more strongly to link to patient outcomes, prioritisation, and de-commissioning

67 Prudent and value-based care is a core aspect of the 2020-2023 Integrated Commissioning Plan. This focussed on increasing the value achieved through improvement, innovation, use of best practice and eliminating waste. The value-based commissioning approach adopted by WHSSC is logical and methodical. This includes identifying commissioning opportunities, refining these, and engaging the WHSSC Management Group members and wider teams. WHSSC has developed thematic areas for value-based commissioning. Some of these will be easier to achieve than others and some may need to be pursued over a multi-year period. The areas include procurement, efficiency, service rationalisation, disinvestment, and assessing access criteria.

68 While COVID-19 has changed the position significantly, the extent of the original value-based commissioning savings for 2020-21 was around £2.75 million. Overall, our review has identified that WHSSC's value-based approach is developing and there is opportunity to exploit this further. In doing so, we expect there will need to be a clear and strong focus on collecting patient outcome information to inform the development of opportunities to reduce waste and maximise the benefit of investment in specialised care. For example, there remains greater opportunity to assess services:

- which do not demonstrate clinical efficacy or patient outcome (**stop**);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (**transfer**);
- where alternative interventions provide better outcome for the investment (**change**);
- currently commissioned, which should continue (**continue**).

COVID-19 has delayed the development of a new specialised services strategy, but this now provides the opportunity to shape the direction to focus on recovery, value and to exploit new technology and ways of working

69 A key function of commissioning relates to planning of services to meet population need. The specialised services strategy provides a framework for commissioning services, but the current version is dated 2012. Senior specialised services officers had intended to refresh the strategy in 2020, but this has been delayed by the pandemic. However, this gives specialised service officers the opportunity to shape the strategy to focus on COVID-19 recovery arrangements alongside routine technological, therapeutic and policy developments.

Future arrangements for commissioning specialised services

70 Our review, in examining both WHSSC's governance and planning arrangements indicates that **there would still be merit in reviewing the future arrangements for commissioning specialised services in line with the commitments of A Healthier Wales.**

71 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales signalled an intention to create a national executive to strengthen national leadership and strategic direction across a range of areas. Linked to this, **A Healthier Wales** signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability.

72 Whilst the findings in this report show that the governance arrangements for WHSSC have continued to evolve positively in the main, they do also point to a need still to undertake the wider review signalled within **A Healthier Wales**. The current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that sees individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

73 The Good Governance Institute's report in 2015 questioned the hosting arrangements for WHSSC, suggesting that a more national model might be appropriate. WHSSC's hosting arrangements have remained unchanged since that report and our work has shown that in respect of WHSSC's governance, the use of the hosting health board's Audit and Risk Committee needs to be reviewed to ensure there is sufficient depth of debate and scrutiny (see **paragraphs 27** and **28 above**).

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Report Title:	**Declarations of Interest, Gifts, Hospitality & Sponsorship**								
Meeting:	**Audit & Assurance Committee**					**Meeting Date:**	**6th April 2021**		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

As previously agreed by the Audit & Assurance Committee an update on Declarations of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee for information. This report provides an update for the financial year to date.

The Risk and Regulation team have continued to work with colleagues from Betsi Cadwaladr University Health Board to put in place Declarations of Interest software for the current year. The use of this software will modernise how the Risk and Regulation Team record and report on Declarations of Interest, Gifts, Hospitality and Sponsorship with the intention that a more comprehensive register of interests is collated and maintained year on year.

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

Following a significant increase in declarations for the financial year 2020/21 (in comparison to previous years) it is predicted that the Risk and Regulation team will see further increases for the present year now that a wider percentage of the Health Board staff pool are aware of the teams presence and the Standards of Behaviour Policy generally.

It was hoped that the software to be provided by colleagues at Betsi Cadwaladr would be in place prior to this committee meeting, however delays in hand-over have prevented this from happening.

Whilst the new software is finalised the Risk and Regulation team have continued to receive and record declarations of interest, gifts and hospitality alongside maintaining the CAV Declarations inbox and Health Board wide physical communications.

As of 24th June 2021 18 Declarations of Interest have been received which have not presented any notifiable conflicts. Of those interests declared 6 have declared secondary employment.

Three declarations of gifts have been declared which present no cause for concern.

Should the software requested from Betsi Cadwaladr fail to be in place prior to the 12th July 2021. Alternative arrangements will be made to record Health Board declarations utilizing existing systems in place, including ESR functionality.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The management of the Standards of Behaviour Policy by the Corporate Governance Team should provide the Audit and Assurance Committee with assurance that adequate systems are in place for the ongoing monitoring of conflicts of interest and the declaration of gifts and hospitality.

Further assurance should be taken from the Corporate Governance Team's ongoing work with the Health Board's Countefraud Department for the investigation of specific cases and also following recent developments that will allow Declarations to be lodged and recorded through soon to be acquired specialist software which will allow a more efficient and all encompassing approach to be taken to the recording of declarations.

Recommendation:

The Audit & Assurance Committee is asked to:

- **NOTE** the ongoing work being undertaken within Standards of Behaviour.
- **NOTE** the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	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, click here for more information*									
Prevention	X	Long term	X	Integration		Collaboration		Involvement	X

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Legislative and Regulatory Tracker Report**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	6th July 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

In April 2019 the organisation received a report on Legislative and Regulatory Compliance which provided a 'limited' assurance rating and made seven recommendations. These recommendations were all accepted by the Director of Corporate Governance. Four of the ratings were classed as high priority and three were rated as medium priority.

Good progress has been made on the development of the Legislative and Regulatory Tracker but there is still some work to be done to ensure that the tracker is fit for purpose in providing assurance to the Audit Committee and the Board.

An Internal Audit review of the Health Board's Legislative and Regulatory Compliance will be undertaken during July 2021 and it is anticipated that further improvements to the Regulatory Tracker will be made following the outcome of that review.

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

Following the height of the pandemic the Risk and Regulation Team have been able to devote additional time to the preparation and management of the Regulatory and Legislative Compliance Tracker. The additional support has allowed greater communication to be made with executive leads and accountable individuals and whilst this has not resulted in any significant changes to the Tracker for this meeting, it is predicted that noticeable improvements to the content of the Tracker and management of recommendations contained therein will be reported moving forward

This in turn will provide further assurance to the Audit and Assurance Committee and the Board and ensure that any outstanding actions from the Internal Audit on this piece of work are implemented.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The tracker now provides the following details:

- All Regulatory Bodies which inspect Cardiff and Vale UHB are listed and include the bodies detailed at Appendix 1;
- The Regulatory Standard which is being inspected is listed
- The Lead Executive in each case is detailed

- The Assurance Committee where any inspection reports will be presented along with any action plans as a result of inspection is detailed
- The accountable individual is detailed and where there is a gap this will be the lead Executive
- Where we have been informed what the inspection cycle is we have detailed it where we have not been informed or simply don't know we have put 'ad hoc'.
- The last inspection date is detailed and also detailed is where Cardiff and Vale have not been inspected in the last 10 years.
- Where we know the inspection date it is detailed. Where we know the inspection cycle and the last time it was inspected we have put in a predicted date so we don't completely lose sight of it. Where the cycle time is ad hoc we have stated that no inspection has been notified and when we are notified via the central inbox, which has been set up, this will be added to the tracker. Hence we have called this column 'expected date of inspection'. Where there is an * it means an inspection was expected but never took place.
- Where we know the outcome of the inspection we have included it. Where there were no issues picked up we have put this column to 'action complete' this links to the final column which is a binary complete or not complete. The reason for this is that it will link to the dials in due course.

The tracker will continue to be updated throughout the organisation and reported to the Audit Committee on a bi-monthly basis as well as being reported to Management Executive and HSMB meetings.

A further two entries have been noted on the register since April 2021's committee meeting. The additional were undertaken by Health Inspectorate Wales, the details of which are as follows:

1) An aged British Standards Institute inspection of Clinical Engineering within the CD&T Clinical Board dating back to the 1st June 2020.

   Feedback is awaited from the BSI following a further inspection on the 1st March 2021.

2) A Cardiff and Vale of Glamorgan Food Hygiene inspection was undertaken at the Aroma Coffee Outlet, Barry Hospital on the 27th May 2021 which produced a Level 5 Food Rating.

Detailed below are inspections which are due to take place during the next quarter. As this would in many instances involve individuals coming onto site we do not believe that these inspections will take place.

1. All Wales Quality Assurance Pharmacy inspections at Pharmacy SMPU and UHL on the 27th July 2021 and 6th August 2021 respectively.
2. A Health Inspectorate Wales follow up inspection of Radiology, Medical Physics and Clinical Engineering on the 17th August 2021.
3. Welsh Scientific Advisory Committee are Scheduled to undertake inspections of Auiology in November 2021 (Paedeatrics and Newborn Hearing screening) and June 2022 (Adults).

Recommendation:

For Members of the Audit Committee to:

(a) Note the inspections which have taken place since the last meeting of the Audit Committee in April 2020 and their respective outcomes.

(b) To note the continuing development of the Legislative and Regulatory Compliance Tracker.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Appendix 1 – Regulatory Bodies

- All Wales Quality Pharmacist;
- British Standard's Institute;
- Cardiff and Vale of Glamorgan Food Hygiene Ratings;
- Community Health Council;
- Fire and Rescue Services;
- Health Education and Improvement Wales;
- Health Inspectorate Wales;
- Health and Safety Executive;
- Human Tissue Authority;
- Information Commissioners Office;
- Joint Education Accreditation Committee
- Medicines and Health Products Regulatory Agency;
- Natural Resources Wales;
- Office for Nuclear Regulation;
- Quality in Primary Immunodeficiency Services;
- United Kingdom Accreditation Service;
- Welsh Water;
- West Midlands Quality Review Service.

Clinical Board	Directorate	Regulatory body/inspector	Service area	Regulation/Standards	Lead Executive	Assurance Committee	Accountable individual	Inspection Cycle Time	Last Inspection Date	Next Inspection Date	Recommendation Narrative / Inspection outcome	Inspection Closure Due by	Management Response / Update	RAG Rating	Please Confirm if completed (c), partially completed (pc), no action taken (na)
ALL WALES QUALITY ASSURANCE PHARMACY															
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy SMPU	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	183	27/01/2020	27/07/2020	166 actions update 21/5/21 - 16 overdue actions remain	15/07/2021	Pharmacy Quality System recovery action plan developed and under weekly review by the Clinical Board. 5 oldest incidents, non-conformances and change controls now closed.		**PC**
CD&T	Pharmacy	Regional Quality Assurance Specialist	Pharmacy UHL	Quality Assurance of Aseptic Preparation Services	Stuart Walker	QSE Committee	Darrel Baker	365	06/08/2020	06/08/2021	91 actions update 21/5/21 - 4 overdue actions remain	15/07/2021			**PC**
BRITISH STANDARDS INSTITUTE															
CD&T	MPCE	BSI	Clinical Engineering, CEDAR	ISO9001:2015	Fiona Jenkins	QSE Committee	Edward Chapman/Kathy Ikin/Rhys Morris	180	01/06/2020	01/03/2021	CE: 2 Non-conformities 1. No clear professional leadership in place 2. lack of space to operate efficiently and safely.	01/06/2020	Directorate Management Team seeking resolution of these issues		**C**
CARDIFF AND VALE OF GLAMORGAN FOOD HYGIENE RATINGS															
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Coffee Outlet, Barry Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			27/05/2021		Food Rating 5				**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		22/05/2020		Food rating 4		EHO had suspended all inspections until recently. Limited inspections have recently recommenced. The recently appointed UHB EHO Officer is undertaking inspections to ensure compliance.		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Kelly Lovell, Ruth Hutchinson		20/02/2020		Food rating 5		EHO had suspended all inspections until recently. Limited inspections have recently recommenced. The recently appointed UHB EHO Officer is undertaking inspections to ensure compliance.		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Ward Based Catering, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Keith Prosser		02/12/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 4	02/12/2020	EHO have suspended inspections of Ward Based kitchens due to COVID19 restrictions		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Bwyd Blasus	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Ranjith Akkaladevi		28/11/2019		Food rating 4		EHO had suspended all inspections until recently. Limited inspections have recently recommenced. The recently appointed UHB EHO Officer is undertaking inspections to ensure compliance.		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Aroma Express, Brecknock House	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Stepfanie Burgess		28/11/2019		Food rating 3		EHO had suspended all inspections until recently. Limited inspections have recently recommenced. The recently appointed UHB EHO Officer is undertaking inspections to ensure compliance.		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Rookwood Hospital	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety	Andrew Wood		25/11/2019	Planned for 02/12/20 but due to Covid-19 awaiting confirmation from EHO	Food rating 5	25/11/2020	Patients have been relocated to UHL, no further catering will be required at Rookwood		**NA**
Estates	Facilities	Cardiff and Vale of Glamorgan Food Hygiene Ratings	Teddy Bear Nursery	Food Safety Act 1990 (the Act),	Abigail Harris	Health and Safety			04/09/2019		Food rating 4		EHO had suspended all inspections until recently. Limited inspections have recently recommenced. The recently appointed UHB EHO Officer is undertaking inspections to ensure compliance.		**NA**
COMMUNITY HEALTH COUNCIL															
Estates		Community Health Council	CRI Car Park		Abigail Harris	Audit and Assurance	Geoff Walsh		03-Dec-21		6 recommendations				**NA**
Estates		Community Health Council	Disabled Car Park		Abigail Harris	Audit and Assurance	Geoff Walsh		21 and 25 November 2021		10 recommendations				**NA**
FIRE AND RESCUE SERVICES															
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Lansdowne Ward, St David's Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	21/01/2020	20/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 1 x management 1 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year		**PC**
Clinical Gerontology	Capital and Asset Management	Fire and Rescue Services	Sam Davies Ward, Barry Hospital	Health and Safety at Work Act 1974	Abigail Harris	Health and Safety	Director of Strategic Planning	365	27/01/2020	26/01/2021	Failed to comply with requirements of safety order. Schedule of works required included: 2 x estates	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year		**PC**
Medicine	Capital and Asset Management	Fire and Rescue Services	Ward A6	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	19/02/2020	18/02/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises. Aritcle 17: Maintenance - Fire resisting doors are not adequately maintained	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year		**PC**
Specialist Services	Capital and Asset Management	Fire and Rescue Services	Rookwood Hospital, Artificial Limb Centre	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	10/02/2020	09/02/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year		**PC**

Mental Health	Capital and Asset Management	Fire and Rescue Services	Vale Mental Health Services, Barry Hospital	Health and Safety at Work Act 1974	Len Richards	Health and Safety		365	27/01/2020	26/01/2021	Duty of Works: Article 8: The provision in respect of fire resisting doors is not Adequate The standard of fire separation is not adequate Article 13: Fire fighting and fire detection: The fire detection is not adequate for the type and use of the premises.	IN01: non-compliance but insufficient for enforcement notice. May return to check works have been completed.	Due to Covid access has been restricted to these areas to complete these works. In addition the fire service has suspended their audit inspections until the National emergency is stood down. Therefore all outstanding works will be completed this financial year		**PC**
HEALTH EDUCATION AND IMPROVEMENT WALES															
HEALTH INSPECTORATE WALES															
PCIC	PCIC	HIW	MVC (Splott)	**HIW**	Ruth Walker	QSE	Director of Nursing, PCIC				**1/3/21 Focused inspection undertaken.Immediate action plan with completed actions submitted 12/3/21. Awaiting feedback**		**Immediate improvement plan submitted and accepted. Reported April QSE**		**c**
Mental Health	Hafan Y Coed	HIW	Hazel Ward	**HIW**	Ruth Walker	QSE	Director of Nursing, MH				**Virtual Interivew on 18/3/21** Omprovment Actions • Ligature Assessment - completed • Proivde cleanignf audit - completed • Monitor staff up to date with mandatory training- - Study day allocated to all staff.		**Improvement Plan Accepted . Reported June QSE**		**C**
Mental Health	MHSOP	HIW	E12	**HIW**	Ruth Walker	QSE	Director of Nursing, MH				Virtual Interivew on 10/3/21. 15th Draft report received. Action plan being developed * undertake environemntal risk assessment/audit (completed)		**Improvement plan Accepted. Evidence Sent. Reported April QSE**		**C**
Children's & Women	Acute Child Health	HIW	Paediatric Surgical Ward (OWL ward)		Ruth Walker	QSE	Director of Nursing for C&W				Quality Checks put on hold by HIW. Awaiting date Vitual inspection held on OWL ward 18th march 2021. Improvement plan submitted and accepted * Remind doctros re: bare belw the elbow - (completed) * Ensure outstandign PADR's completed -Apraisal appointments given to all outstanding PADR's		**Improvement plan Accepted. To Be reported September QSE**		**C**
PCIC	GP Practice	HIW	Radyr Medical centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC				Quaity Check cancelled. Awaiting further date New Date 25th May 2021		**No Improvments identified. To be reported to September QSE**		**C**
Specialist	Haematology	HIW	Teenage Cancer Trust	HIW	Ruth Walker	QSE	Director of Nursing, Specialist				Virtual Inspection Interview 6/1/21 CNCELLED DUE TO COVID - AWAITNG NEW DATE : **New Date 31/3/21**		**No Improvments identified. Reported June QSE**		**C**
Medicine	Medicine	HIW	MEAU, UHL	HIW	Ruth Walker	QSE	Director of Nursing, Medicine				Quality check to take place in MEAU , UHL on 08.12.20. via video call. Action plan and completed actions and Factual Accuracy submitted 7/1/20 and accepted. Evidence of actions completed sent on the 30th of April and 10th of June		**Improvement plan accepted.** **Reported February QSE**		**C**
Children & Women	Maternity	HIW	Maternity Services	HIW	Ruth Walker	QSE	Head of Midwifery				HIW are undertaking a national review of maternity services across Wales (Phase 2). **Letter recevied 13/1/21 from HIW Phase 2 on hold.**	Details of community maternity sites sent to HIW 17.07.20 and self assessement sent 24.07.20.	**On hold.**		**PC**
Mental health	Community Mental health	HIW	Cardiff North West Gabalfa Clinic CMHT	HIW	Ruth Walker	QSE	Director of Nursing, Mental Health		Due on 17th & 18th March 2020- postponed due to Covid		Pre inspection information to be submitted by March 9th. 29.01.20 HIW informed of two liaison members of staff to work with HIW team. **Inspection was cancelled due to Covid 19.**		**Gabalafa clinic. Not on current planned inspections programme. Can be removed**		**N/A**
CD&T	Radiology, Medical Physics and Clinical Engineering	HIW	Diagnostic Radiology	Ionising Radiation (Medical Exposure) Regulation 2017 - IR(ME)R	Fiona Jenkins	QSE Committee	Andrew Gordon/Kathy Ikin	730	17/11/2020	17-18th August 2021	Notification of inspection received IM(ME)R Inspection. Contact details provided to HIW 15.05.21				**NA**
Mental Health	Community Mental health	HIW	Community Mental Health	HIW	Ruth Walker	QSE	Director of Nursing for Mental health Services				National Review of Mental Health Crisis prevetnion in the Community List of contacts sent 5th May 2021. Aiming for interviews July 2021				**NA**
PCIC	GP Practice	HIW (GP Announced visit)	Waterfront Medical Centre	HIW	Ruth Walker	QSE	Director of Nursing, PCIC		Inspection due on March 23rd 2020		Cancelled no further date received		Awaiting update from HIW		**NA**
Medicine	EU/WAST	HIW	EU/WAST	HIW	Ruth Walker	QSE	Director of Nursing Medicine				Themaitc revew.The focus of the review is to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience				**N/A**
HEALTH AND SAFETY EXECUTIVE															
HUMAN TISSUE AUTHORITY															
CD&T	Haematology	HTA	South Wales BMT Programme	Human Tissue Act	Fiona Jenkins	QSE Committee	Xiujie Zhao	730	expected Jan/Feb 23				WBS Audit January - no major deficiencies, some minor actions to complete. HTA confirmed that after a risk-based assessment that the service was low risk for non-compliance and that inspection was not necessary on this cycle.		**C**
CD&T	Haematology	HTA	Stem Cell processing Unit (HTA)	Human Tissue Act	Fiona Jenkins	QSE Committee	Alun Roderick/Sarah Phillips	730	expected Jan/Feb 23				WBS Audit January - no major deficiencies, some minor actions to complete. HTA confirmed that after a risk-based assessment that the service was low risk for non-compliance and that inspection was not necessary on this cycle.		**C**
INFORMATION COMMISSIONERS OFFICE															

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff are fully aware of the responsibilities regarding IG, the organisation should consider means by which assurance can be given that staff have read appropriate policies and therefore are aware of organisational requirements and their responsibilites		IG Manager to investigate the feasibility of implementing a process that provides this assurance. A review of potential digital solutions will be carried out in early 2021/22		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff receive the appropriate level of IG training for their role, regular training needs analysis should be undertaken in order to inform the IG training programme		There currently is a national piece of work looking at the different training requirements across NHS staff in Wales. This is being considered at the Information Governance Management Advisory Group (IGMAG)		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				In order to ensure that specialised roles with IG responsibility have received appropriate training to carry out their role effectively, a training needs analysis for these roles should be undertaken. To ensure that training requirements for staff with specialised DP roles are recognised and formalised, these should be included in all job descriptions of roles with IG responsibilities. This should ensure that staff can carry out their roles effectively		For the following staff, a TNA shall be undertaken separate to the piece of work referenced in A4: Caldicott Guardian, SIRO, Data Protection Officer, Information Asset Owners, Information Asset Administrators. HR input requested to ensure that specific JDs are updated apprpriately to include formal recognition of IG responsibilities wihtin those roles.		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that management have a complete picture of performance and compliance, and provide assurance that the organisation is complying with the relevant legislation, the reporting of KPIs relating to records management should be reinstated		The reporting of such measures, as outlined, may be more appropriately, and may already be, reported at a Medical Records Group. If this isn't the case, the IG Manager will work with the Medical Records management to ensure that these KPIs are reported. Discussions taking place with the Directorate Manager, CD&T who is responisble for med records, to asgree set of KPIs to be put in place by Q1 21/22		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all areas have carried out comprehensive data mapping exercises to ensure that the there is a clear understanding and documentation of information processing.in line with the requirements of the organisation's IG policy and national legislation.		All IAR are currently being centrally collated. A review will be conducted to ensure that IAO are correctly capturing lawful basis,		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that it has a complete ROPA which includes all the information required by the legislation, so they are aware of all information held and the flows of information within the organisation, and have assurance that the record is an accurate and complete account of that processing.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR. IARs relating to 3rd parties/contracts have been completed. This has been completed.		**C**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that there is an internal record which documents all processing activities in line with the legislation. This will provide assurance that all information processed is recorded as required by the appropriate legislation.		Ensure that a ROPA is undertaken in line with Art 30 of the GDPR. This has been completed for 3rd parties but needs to also include al internal processing functions.		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should review the purposes of processing activities to ensure that they identify and document a lawful basis for general processing and an additional condition for processing criminal offence data, and therefore obtain assurance that they meet their obligations under the current legislation. The organisation should ensure that it documents the reasons for determining the lawful bases for each processing activity. Otherwise they risk failing to correctly identify the lawfull basis for processing and not meeting their obligations under the relevant legislation. The organisation should ensure that there are clear procedures in place to ensure that the t lawful basis is identified before starting any new processing of personal data or special category data. This will provide assurance that the organisation is relying on the correct lawful bases as required by the legislation.		Review Privacy Notice and IG Policy to ensure lawful basis for processing criminal data is clearly documented. 5.2.5.1 of the IG Policy (Data Protection Impact Assessment) states that 'All new projects or major new flows of information must consider information governance practices from the outset' and 'In order to identify information risks, a DPIA must be completed'. This is the point at which the lawful basis will be determined by theIG dept. The UHB's Privacy Notice does not document the lawful basis for each processing activity. We would be unable to document within the scope of the Privacy Notice the lawful basis for each of the UHB's numerous processing activities.		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				PC		In the context of referrals into the UHB and out of the UHB, the patient is likely to already be aware of this dataflow. This represents an exemption under Article 14 (5)(a) of the GDPR. In all other cases, we believe that manually informing individuals of this information would represent a 'disproportionate effort' given that we are unable to determine what a referring organisation has made their patients aware of and the volume of referrals received by the UHB -- therefore being exempt under Art 14(5)(b).		**PC**

IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should consider additional means in which privacy information can be promoted or made available to individuals, to ensure that it does not rely on passive communication which risks individuals not being made aware of how their data is processed. This would help ensure that the a organisation is not in breach of legislation.		This has been raised at the national Information Governance Group to investigate how other UHBs/Trusts are achieving this requirement. Examples of how others have achieved this are being reviewed with the intention of communicating out to all staff in Q2 2021/22		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				Retained data should be reviewed on regular basis to identify any opportunities for minimisation or pseudonymisation of data to provide assurance for the organisation that they process the least information possible in line with the legislation.		This should be achieved by regular review of IAR. Linked to A23.		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that the IAO function is effective, the organisation should formalise the appropriate level of access which IAOs have to the SIRO and DPO, and ensure that designated IAO responsibility is included in job descriptions. This will provide assurance to the organisation that the IAOs are able to effectively carry out their role in the risk management process as required in legislation.		The IG dept suggests that the role of IAO is assigned to a designated level of management across the organisation (e.g. Directorate Manager/General Manager) and that this role is incorporated into Job descriptions. A list of IAOs exists however there remain some gaps. a review is to be completed in early 2021/22		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				The organisation should ensure that all staff with specific information risk roles receive regular training to provide assurance that they are able to carry out their roles effectively with regard to information risk.		TNA to be performed. National piece of work currently being undertaken, which the local IG team are linked into.		**PC**
IT	Information Governance Dept	ICO			David Thomas	Digital and Health Intelligence	James Webb				To ensure that staff with specific risk management roles are fulfilling those roles effectively, the organisation should formalise means by which IAOs are routinely consulted on project and change management processes s and attend or are able to feed into IG meetings. This will provide assurance that they are carrying out their roles in relation to risk management effectively and thereby reduce the risk of a breach of legislation through information risk not being handled properly.		This is being considered by the IG group which will feed into Digital Management Board. This will be addressed by making the IAOs aware of the remit of the IG Group (April 2021)		**PC**
JOINT EDUCATION ACCREDIATION COMMITTEE															
Specialist Services	Haematology	JACIE	South Wales BMT Programme	6th edition of JACIE standards	Stuart Walker	QSE Committee	Keith Wilson	1460	4-5/02/2019	01/02/2023	Minor deficiencies noted	01/10/2019	Programme received formal re-accredition notice - There are ongoing discussions with the executive board regarding a new facility for BMT/Haematology as the service will not achieve re-accredition post the next inspection cycle.		**PC**
MEDICAL GENETICS															
	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019			**NA**
	Institute of Medical Genetics	UKAS	Institute of Medical Genetics, UHW	ISO 15189	Fiona Jenkins	QSE Committee	Lisa Grffiths		29/05/2020	no date set	No findings/non-conformances were raised, so there is no improvement action report				**NA**
	Medical Genetics	UKAS	Institute of Medical Genetics, UHW	ISO 15189	Fiona Jenkins	QSE Committee	Lisa Grffiths		05/11/2020 - 10/11/2020	TBC	Mandatory findings x 49 Observations x 5 Extension to Scope (for new services) x 13	01/05/2021	Mandatory fingings 45 closed by UKAS. Evidence submitted to UKAS for further 4 but UKAS delayed in assessing evidence. Observation 5 closed Extension to Scope - 6 findings closed by UKAS. 2 findings on second cycle of evidence submitted. Evidence submitted to UKAS for further 5 but UKAS delayed in assessing evidence.		**PC**
MHRA															
CD&T	Pharmacy	MHRA	Pharmacy SMPU	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	18/02/2020		1 major 10 others	31/03/2021	Pharmacy Quality System recovery action plan developed and under weekly review by the Clinical Board. 5 oldest incidents, non-conformances and change controls now closed.		**PC**
CD&T	Pharmacy	MHRA	Pharmacy UHL	Good manufacturing practice (GMP) and good distribution practice (GDP)	Stuart Walker	QSE Committee	Darrel Baker	365	23/07/2019		3 majors 2 others	31/03/2020	Descalated from MHRA Inspection Action Group 1st July 2020 Outstanding Estates issues to resolve to meet requirements of the regulator		**PC**
NATURAL RESOURCES WALES															
OFFICE FOR NUCLEAR REGULATION															
QUALITY IN PRIMARY IMMUNODEFICIENCY SERVICES															
RESEARCH AND DEVELOPMENT															

	Haematology	Research and Development			Stuart Walker	QSE Committee									
UKAS															
Specialist Services	ALAS	SGS/UKAS	ALAS (CAV)	ISO 9001:2015	Fiona Jenkins	QSE Committee	Paul Rogers	185 (Twice Yearly)	15-17/01/2020		2 x Minor Corrective Actions: Patient satisfaction/ feedback - we collect this but could do more to analyse the data Staff Competency and Awareness - Improve recording of non-CPD role competencies	01/10/2021	Positive Audit with 2 minor corrective actions that we were aware of. Have plans in motion to address both staff engagement/ recording of competencies and better analysis of patient feedback. Confident of completion of these before next audit review in 01/10/2021		**PC**
Surgery	Perioperative	SGS/UKAS	SSSU	ISO 13485:2016	Fiona Jenkins	QSE Committee	Clare Jacobs	365	01/01/2019		3 minors	01/01/2020			**NA**
Surgery	Perioperative	SGS/UKAS	HSDU	ISO 13485:2017	Fiona Jenkins	QSE Committee	Mark Campbell	365	07/08/2019		2 minors	07/08/2020			NA
CD&T	Haematology	SGS/UKAS	Haematology/Blood Transfusion	ISO 15189:2012	Fiona Jenkins	QSE Committee	Alun Roderick	n/a	06/11/2019		Accreditation extra visit: Action Mandatory x 2 Require Evidence to UKAS x 1 Action Recommended x 1	06/12/2019			NA
Institute of Medical Genetics	Medical Genetics	SGS/UKAS		ISO 15189:2012	Fiona Jenkins	QSE Committee	Peter Thompson		2 and 5/11/19		Action Mandatory x 14 Require Evidence to UKAS x 14 Action Recommended x 5	05/12/2019			NA
WELSH WATER															
WSAC															
Surgery	Audiology	WSAC	audiology - adults	audiology quality standards	Fiona Jenkins	QSE Committee	Lorraine Lewis	1095	01/06/2019	01/06/2022	compliant with 8 of 9 standards and meeting 85% target	01/01/2020	The one standard that was out of compliance around review appointments and individual management plans is now in compliance ready for next audit in 2022.		**C**
Surgery	Audiology	WSAC	Newborn hearing screeing wales	audiology quality standards	Fiona Jenkins	QSE Committee	Ellen Thomas/Razun Miah	730	01/06/2018	01/11/2021	80% target met in all standards and 85% overall target met	01/01/2019	Audit delayed by 18 months due to covid		**NA**
Surgery	Audiology	WSAC	audiology - paediatrics	audiology quality standards	Fiona Jenkins	QSE Committee	Rhian Hughes/Ellen Thomas/Razun Miah	730	01/06/2018	01/11/2021	80% target met in all standards and 85% overall target met	01/01/2019	Audit delayed by 18 months due to covid		**NA**
WEST MIDLANDS QRS															

Report Title:	**Internal Audit Recommendation Tracker Report**								
Meeting:	Audit Committee						**Meeting Date:**	6th July 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

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

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

The tracker shows progress made against recommendations from 18/19, 19/20 and 2020/21.

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

As can be seen from the attached summary tables the overall number of outstanding recommendations has increased from 106 individual recommendations to 126 during the period April 2021 to June 2021. The increase in recommendations can be attributed Whilst the reduction is modest, this is reflective of the fact that a further 10 internal audit reports were added to the tracker. The audits reports added on this occasion were:

1) UHW Surge Hospital (6 recommendations, all of which have been completed)
2) Compliance with Nurse Staffing Levels Act (Wales) 2016 (1 recommendation, which has been completed)
3) Claims Reimbursement (2 recommendations, both of which have been completed)
4) Charitable Funds (3 recommendations, all of which have been completed)
5) Tentacle System Follow Up (9 recommendations, 8 of which have been completed)
6) Integrated Health Pathways (6 recommendations, 3 of which have been completed)
7) UHB Core Financial Systems (3 recommendations, 1 of which has been completed)
8) Risk Management (5 recommendations, 1 of which has been completed).
9) Consultant Job Planning (4 recommendations)
10) IM&T Control and Risk Assessment (18 recommendations)

Of the 126 recommendations listed 60 are recorded as completed, 33 are listed as partially complete and 33 are listed as having no action taken.

Of the 33 actions listed as no action being taken, 22 relate to the Consultant Job Planning and IM&T Control and Risk Assessment reviews which were added following May's Audit Committee and comments are yet to be provided by executive leads due to the short turnaround time between meetings.

It should also be noted that the Consultant Job Planning Follow up recommendations at rows 15 to 20 of the attached tracker will be amalgamated with or superseded by the entries added at rows 106 to 109 at the next committee meeting.

A further internal audit review has been undertaken on Health and Care Standards which has not been added to the tracker as no recommendations were made. That review confirmed that a reasonable level of assurance could be given in relation to the effectiveness of the system of internal control in place to manage the risks associated with the Health and Care Standards.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since the last meeting of the Audit Committee where the internal audit tracker was presented (April 2021). Each Executive Lead has been sent the recommendations made by Internal Audit which fall into their remits of work.

The table below shows the number of internal audits which have been undertaken over the last three years and for the financial year 2021/20 (to date) and their overall assurance ratings.

	Substantial Assurance	Reasonable Assurance	Limited Assurance	Rating N/A	Total
Internal Audits 18/19	10	26	7	-	43
Internal Audits 19/20	10	25	2	2	39
Internal Audits 20/21 (to date)	4	9	1	1	14

Attached at Appendix 1 are summary tables which provide an update on the April 2021 position.

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

Recommendation:

The Audit Committee Members are asked to:

(a) Note the tracking report which is now in place for tracking audit recommendations made by Internal Audit.
(b) Note that progress will be seen over coming months in the number of recommendations which are completed/closed.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

INTERNAL AUDIT REPORT RECOMMENDATION FOR 2018/19 (July 2021Update)

	Update April 2021				Update April 2021				Update April 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached	3	2		1	4	4						
Overdue under 3 months												
Overdue by over 3 months under 6 months												
Overdue over 6 months under 12 months												
Overdue more than 12 months	3	1	2		2	2						
Superseded												
Total	**6**	3	2	1	**6**	**6**						

Total number of recommendations outstanding as of 24th June 2021 for financial year 2018/19 is **5** (9 of which are complete) compared to the position in April 20 when a total number of 17 outstanding recommendations were noted.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2019/20 (July 2021 Update)

	Update July 2021				Update July 2021				Update July 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Overdue under 3 months									3			3
Overdue by over 3 months under 6 months	1			1	4	1		3				
Overdue over 6 months under 12 months	5		5		11	3	8		6	2	4	
Overdue more than 12 months					3	2	1					
Superseded												
Total	**6**		5	1	**18**	**6**	**9**	**3**	**9**	**2**	**4**	**3**

Total number of recommendations outstanding as of 24th June 2021 for financial year 2019/20 is 33 compared to the position in April 2021 when a total of 48 outstanding recommendations were noted.

INTERNAL AUDIT REPORT RECOMMENDATIONS FOR 2020/21 (July 2021Update)

	Update July 2021				Update July 2021				Update July 2021			
Recommendation Status	**High**	**C**	**PC**	**NA**	**Medium**	**C**	**PC**	**NA**	**Low**	**C**	**PC**	**NA**
Date not reached												
Overdue under 3 months	3	3							1			1
Overdue by over 3 months under 6 months	2	1	1		27	19	7	1	16	13	2	1
Overdue over 6 months under 12 months	3	3			8	6	1	1	3	1	2	
Overdue more than 12 months												
Superseded												
Total	**8**	7	1		35	25	8	2	20	14	4	2

Total number of recommendations outstanding as of 24th June 2021 is 63 compared to the position in April 2021 when a total of 30 outstanding recommendations were noted.

It should be noted that 18 recommendations from the IM&T Control and Risk Assessment review are not included in the above table as the report was not rated.

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R1/6	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Business Manager, Estates	Closed	Agreed date not reached	C	Kronos has been introduced and evaluated and detrmined that it is only suitable for timekeeping and does not provide adequate benefits with its links with ESR. However, it has proved beneficial for basic functions.
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R4/6	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised on individual timesheets	Business Manager, Estates	Closed	Agreed date not reached	C	Closed - All complete.
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R5/6	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update timesheets with reasons why staff have not clocked in or out of the system prior to authorising them, for example annual leave, special leave, unpaid leave, working off site, system down etc. Supervisors should amend shift start and finish times on Kronos where it has been agreed that staff can work alternative shift patterns. Disciplinary action should be taken against staff that are persistently late and fail to work their assigned shift pattern.	Business Manager, Estates	Closed	Overdue by over 18 months under 24 months	C	Closed - All complete.
C&V 1819 - 11	2018-19	Commissioning	Director of Digital & Health Intelligence	Reasonable	R1/3	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	Eleri Probert / Mel Wilkey	Open	Overdue by over 18 months under 24 months	PC	The ToR for the Strategic Commissioning meeting has been revised and now includes two Clinical Board representatives. The document will be reviewed again to reflect that we have a new Director of Finance following this an updated copy will be provided.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R2/7	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Closed - All complete.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R3/7	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Completed
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R4/7	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of remedial work (O). See also recommendation 2 in relation to assessment and reporting of the backlog of remedial jobs.	Director of Capital, Estates & Facilities	Closed	Overdue by over 12 months but under 18 months	C	Closed - All complete.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R5/7	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	Chair of Water Safety Group	Closed	Overdue by over 12 months but under 18 months	C	IP&C Chair of Water Safety who are rsponsible to Nurse Director not Director of Planning.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R6/7	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Specialist Contractors are routinely appointed to undertake risk assessments and remedial work is actions accordingly
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R7/7	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Regular reports provided to water safety group
C&V-1819-04	2018-19	Legislative/Regulatory Complaince	Director of Planning	Reasonable	R5/7	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Philip Mackay / Mal Perrett	Open	Overdue by over 18 months under 24 months	PC	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of
C&V-1819-04	2018-19	Legislative/Regulatory Complaince	Director of Planning	Limited	R6/7	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Philip Mackay / Mal Perrett	Open	Agreed date not reached	NA	This action if for the Fire Safety Manager to be followed up by end of June
CVU-2019-20	2019-20	Legislative / Regulatory Compliance	Director of Planning	Reasonable	R5/7	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Philip Mackay / Mal Perrett	Open	overdue over 12 months but under 18 months	PC	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of closure a laborious resource intensive task. However CEF intend to develop an alternative electronic system to enable closure of actions to be carried out by the responsible person attributed to each action resulting in evidence that is both current and auditable.

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R1/6	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board Performance Reviews with joint review of improvement trajectorymonitored via the Medical Director /Director of Workforce. Immediate request for improvement plan, documenting improvement trajectory over	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. This has been superceded by the 2nd Follow-up Report
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R2/6	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors/Clinical Directors – one to three months. 2. Medical Director – Immediate.	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. This has been superceded by the 2nd Follow-up Report
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R3/6	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Medical Director and AMD for Workforce and Revalidation - one month. 2. 15th June 2018 Medical Director/Director of Workforce.	Open	Over 6 months under 12 month	**PC**	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes the need to complete the outcome forms This has been superceded by the 2nd Follow-up Report
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R4/6	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Clinical Board Directors action - Issues by Medical Director and AMD for Workforce and Revalidation - one month.	Open	Over 6 months under 12 month	**PC**	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes annualised job plans, with the annual job plan cycle aligned to the financial year. Please see procedure for details This has been superceded by the 2nd Follow-up Report
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R5/6	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/LED/Communications Team / Three months	Open	Over 6 months under 12 month	**C**	24/08/2020: Training has been provided by the AMD for Workforce and implemented. In line with the implementation of the e-JP system, a revised training plan will be developed to update all CDs with how this will work with the new system. This has been superceded by the 2nd Follow-up Report
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R6/6	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director - Workforce - 3 months reviewpilot progress.	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. The system will make use of digital signatures. Within procedure and system, noted that no response will be taken as assumed acceptance of JP. This has been superceded by the 2nd Follow-up Report
CUHB-1920-23	2019-20	Freedom of Information	Director of Digital & Health Intelligence	Reasonable	R7/7	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	Information Governance Manager	Open	Over 6 months under 12 month	**PC**	Training providers have been contacted with delivery expected by Q4 2021/22
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R1/6	M	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: - roles and responsibilities – of Directorates, Managers, Consultants; - funding and budget guidance. - monitoring and compliance arrangements including KPIs; and - reporting arrangements.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R3/6	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R4/6	M	The following arrangements are reviewed and strengthened:- - budget setting, monitoring and reporting; - payment of honorary staff expenses; and - ability to access Trust funds to support study leave budgets.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures. Discussed at LNC, AE, RS, HS to Meet outside LNC, Date to be arranged
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R5/6	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Ejob Planning Live 13% currently on system. Work Ongoing.

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Management Response / Executive Update
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R6/6	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system	Assistant Medical Director (Workforce and Revalidation), Medical Workforce Manager and Medical Education Lead	Open	Over 6 months	**PC**	Ongoing
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R3/11	M	Induction content should be reviewed and updated to reflect current practice (O)	Health & Safety and Asbestos Manager	Closed	Over 6 months	**C**	completed. March 2020
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R8/11	L	A Permit to Work procedure should be developed, ratified and communicated to all relevant officers (D)	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager March 2020	Closed	Over 6 months	**C**	Work remains ongoing to develop the procedure.
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R9/11	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Head of Discretionary Capital & Compliance	Closed	Over 6 months	**C**	Work remains ongoing. Completed reported monthly to the Estates H|&S committee
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R10/11	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Head of Discretionary Capital & Compliance	Closed	Over 6 months under 12 months	**C**	Work remains ongoing. Annual audit completed for 2020
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R1/3	M	Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. (O)	Director of Capital, Estates & Facilities	Closed	Over 3 months under 6 months	**C**	Project complete. Overspend is accountted for within the Discretionary Capital Programme 2021/22 and agreed at Management Execs. Ongoing to end of project
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R2/3	M	The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. (O)	Director of Capital, Estates & Facilities	Closed	Over 12 months under 18 months	**C**	Project now complete.
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R3/3	M	All payments should be made in accordance with the terms of the contract. (O)	Director of Capital, Estates & Facilities	Closed	Over 12 months under 18 months	**C**	Project now complete.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R1/5	H	The UHB should ensure policies are reviewed and updated within appropriate timescales.	Head of Corporate Governance	Open	Over 6 months under 12 months	**PC**	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R2/5	M	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Head of Corporate Governance	Open	Over 6 months under 12 months	**PC**	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R3/5	M	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet.	Head of Corporate Governance	Open	Over 6 months under 12 months	**PC**	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R4/5	L	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Head of Corporate Governance	Open	Over 6 months under 12 months	**PC**	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R5/5	L	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Head of Corporate Governance	Open	Over 6 months under 12 months	**PC**	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R1/10	H	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision: All original Identification, Right to Work and Qualification documents		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R2/10	M	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R3/10	M	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R4/10	M	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R5/10	L	Management to review the Employment Services SLA.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R9/10	L	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.		Open	Over 3 months under 6 months	**NA**	

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C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R10/10	L	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-08	2019-20	Strategic Planning - IMTP	Director of Planning	Reasonable	R4/4	L	Management should ensure the ToR are reviewed and updated as required.	Marie Davies	Open	over 6 months under 12 months	**PC**	BCAG will review ToR periodically going forward to ensure the role and function of group is updated if necessary.
CVU-2021-29	2020-21	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	R1/5	H	Long term sickness within Trauma Theatres, UHW must be monitored, reviewed and documented appropriately and evidence retained on individual personal files in accordance with Section 4 of the NHS Wales Managing Attendance at Work Policy.	Ceri Chinn, Lead Nurse –	Closed	over 6 months under 12 months	**C**	Duty manager in place and supporting the actions agreed
CVU-2021-29	2020-21	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	R2/5	M	Sickness Notification Form must be completed by Clinical Leaders and retained on respective personal files.	Ceri Chinn, Lead Nurse –	Closed	over 6 months under 12 months	**C**	The clinical leaders meeting are now back up and running and this is being picked up
CVU-2021-29	2020-21	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	R3/5	M	All episodes of sickness absence must be supported by accurately completed Self Certification Forms, Return to Work Interview Forms and where applicable GP Fit Notes.	Ceri Chinn, Lead Nurse –	Closed	over 6 months under 12 months	**C**	The clinical leaders meeting are now back up and running and this is being picked up
CVU-2021-29	2020-21	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	R4/5	M	All short term sickness must be monitored, reviewed, documented appropriately and retained on individual personal files in accordance with Section 3 of the NHS Wales Managing Attendance at Work Policy.	Ceri Chinn, Lead Nurse –	Closed	over 6 months under 12 months	**C**	The clinical leaders meeting are now back up and running and this is being pickted up
CVU-2021-29	2020-21	Surgery Clinical Board - Theatres Directorate Sickness Absence Management	Chief Operating Officer	Reasonable	R5/5	M	A formal monitoring and reporting process should be implemented within the Theatres Directorate highlighting sickness absence activity which is then reported up to the Clinical Board.	Ceri Chinn, Lead Nurse –	Closed	over 6 months under 12 months	**C**	The clinical leaders meeting are now back up and running and this is being picked up
CVU-2021-07	2020-21	Regional Partnership Board	Director of Planning	Reasonable	R2/4	M	Management should review the governance of the SLG to ensure appropriateness.	Cath Doman, Director of Health and Social Care Integration	Closed	Over 3 months under 6 months	**C**	RPB governance review complete. SLG remains appropriate. Some changes in membership in place to ensure representation from Mental Health Clinical Board and the COOs office.
CVU-2021-07	2020-21	Regional Partnership Board	Director of Planning	Reasonable	R3/4	M	Management should ensure that governance arrangements are enhanced for the Integrated Care Fund Programme Board.	Meredith Gardiner, Programme Manager	Closed	Over 3 months under 6 months	**C**	RPB governance review complete. Starting Well and Ageing Well Partnerships in place which will oversee respective funding streams.
CVU-2021-07	2020-21	Regional Partnership Board	Director of Planning	Reasonable	R4/4	L	Management should consider formal reporting on outcomes from the RPBs activities into the Health Board, to allow for effective scrutiny.	Abigail Harris, Executive Director of Planning	Open	Over 3 months under 6 months	**NA**	
CVU-2021-38	2020-21	Environmental Sustainability Report	Director of Finance	Reasonable	R1/2	M	Management should ensure a timetable is prepared annually and made available to all relevant staff prior to compiling the SDR. This should include the timeline for the first meeting of the task and finish group, data submission deadlines, the various stages of review and approval and submission to the Communications Team.	Energy Manager/Head of Energy and Performance	Open	Over 3 months under 6 months	**NA**	
CVU-2021-38	2020-21	Environmental Sustainability Report	Director of Finance	Reasonable	R2/2	M	Evidence of the retrospective approval of the sustainability report by the Environmental Steering Group / Health & Safety Group and sign off by the Director of Capital Estates and Facilities should be provided to audit each year. The documented procedural guidance should be also updated to reflect the actual review and approval process currently in place.	Energy Manager/Head of Energy and Performance	Open	Over 6 months under 12 months	**PC**	Collecting data from other sources
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R1/6	H	Management should ensure that appropriate processes are in place for concluding investigations/Root Cause Analysis and the submission of closure forms to the Welsh Government in a timely manner.	Assistant Director Patient Safety and Quality	Closed	Over 6 months under 12 months	**C**	May 2021 - WG/DU have recently issued a revised National Policy on the Reporting of Pateient Safety Incidents. This will be implemented from June 14th. It introduces new timescales for reporting and investigation as well as for closure.
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R2/6	M	Management should remind staff surrounding the requirement for prompt reporting of Serious Incidents and submission of the SI1 form to Welsh Government.	Assistant Director Patient Safety and Quality	Closed	Over 6 months under 12 months	**C**	See above. A revised National Policy has been introduced. The UHB is now required to report the most serious incidents to the DU witihn 7 days.
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R3/6	M	Management should ensure that all outstanding actions are completed.	Assistant Director Patient Safety and Quality	Open	Over 6 months under 12 months	**NA**	
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R4/6	L	Management should consider having key contacts for Quality and Safety issues with each Clinical Board	Assistant Director Patient Safety and Quality	Closed	Over 6 months under 12 months	**C**	There are key contacts within every Clinical Board.
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R5/6	L	Staff should be reminded to keep Datix as up to date as possible to ensure an effective audit trail.	Assistant Director Patient Safety and Quality	Open	Over 6 months under 12 months	**PC**	The UHB is currently in the process of introducing the Once for Wales Concerns Management System and this wil lbe assoicated with the relavant training which wil linclude the requirement to keep the ssytem as up to date as possible.
CVU-2021-18	2020-21	Management of Serious Incidents	Executive Nurse Director	Reasonable	R6/6	L	The review into the consistency of information supplied to Clinical Boards should be completed.	Assistant Director Patient Safety and Quality	Open	Over 6 months under 12 months	**PC**	As above. Once the revised sytem is introduced will introduce a range of standardised reports for each Clincal Board.

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CVU-2021-31	2020-21	Mental Health Outpatient Clinic Cancellations	Chief Operating Officer	Limited	R2/5	M	Management must ensure that sufficient evidence is retained to confirm that all available options have been effectively considered before clinics are cancelled	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones – DM Adult Dr Tracey Tye – Locality Lead North Dr. Rakesh Pankajakshan – Locality Lead Vale Dr. Bhushan Vaidya – Locality Lead - South	Closed	Over 6 months under 12 months	C	New process in place to agree clinic cancellation with either Locality Medical Lead or Clinical Director
CVU-2021-31	2020-21	Mental Health Outpatient Clinic Cancellations	Chief Operating Officer	Limited	R5/5	H	1. Monthly reporting which covers Outpatient Clinic Cancellations should be developed which covers as a minimum the total monthly number and percentage of Mental Health Outpatient Clinic Cancellations and the equivalent results for the year to date. Where poor results are reported, the reasons should also be identified. Consideration should also be given to whether additional drill down of the results should be included. For example Directorate or clinic level. 2. All relevant staff should be reminded of the existence of the cancellation reports in the PARIS reports module including instructions how to locate and use them.	Dr. Neil Jones – Dep CBD Michelle Lewis – Information Lead - MH Jo Wilson – DM MHSOP Dr. Mark Jones	Closed	Over 6 months under 12 months	C	Completed, though the report will need some further development to allow this to be done without manual searching.
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R1/6	L	The Asbestos Risk Register should be reported to, and monitored at, the AMG (O).	Health, Safety & Asbestos Manager At the next AMG meeting	Closed	Over 3 months under 6 months	C	Asbestos report provided to Capital Estates and Facilities monthly Health and Safety Group which has representation from the croporate H&S team and is also included in the Director of CEFs report to Capital Management Group on a monthly basis.
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R2/6	L	a) Compliance auditing should take place in line with the AMP, for surveys and analytical work. b) The achievement of /progress towards compliance audit targets should be reported to the AMG (O).	Health, Safety & Asbestos Manager December 2020	Closed	Over 3 months under 6 months	C	Annual inspections are undertaken in accordance with the AMP and Asbestos regulations
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R3/6	M	a) Management should ensure all expired training is brought up to date as soon as possible. b) The training matrix should be reviewed and enhanced to ensure full training information is presented. c) Monthly asbestos compliance reporting, and reporting to the AMG, should incorporate training compliance data (O).	Health, Safety & Asbestos Manager a) November 2020 (Asbestos Awareness) / December 2020 (Cat B) b) December 2020 c) December 2020	Closed	Over 3 months under 6 months	C	Programme for absestos awareness training and CAT B training is in place
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R4/6	M	a) Contractors should be reminded of the need to complete the community job authorisation sheets. b) Estates staff should also be required to complete the authorisation sheets, to provide an audit trail demonstrating that they have received the required asbestos information via their supervisor (O).	Health, Safety & Asbestos Manager December 2020	Closed	Over 3 months under 6 months	C	Part of control of contractors policy
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R5/6	M	See Control of Contractors report issued February 2020 (recommendation 1)		Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	Asbestos Management	Director of Planning	Reasonable	R6/6	L	Contractors should be reminded of the need to share copies of waste consignment notes with the UHB where relevant (O).	Health & Safety and Asbestos Manager	Closed	Over 3 months under 6 months	C	Regular ISO inspections undertaken to ensure compliance with regulations
CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R1/6	M	**OBSERVATION:** In accordance with standard UHB practice, and Welsh Government requirements (NHS Wales Infrastructure Investment Guidance), revenue costs (or a range of potential costs, based e.g. on bed occupancy) should be presented within business case submissions to appropriate forums to enable a fully informed decision to be taken when granting approvals.		Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R2/6	L	**OBSERVATION:** In accordance with standard UHB practice, appropriate terms of reference setting out project governance arrangements, should be applied at all major capital projects.		Closed	Over 3 months under 6 months	C	

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CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R3/6	M	The future use / case for change for the Lakeside Wing will be subject to the formal business case approval process (O).	Executive Director of Planning ongoing	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R4/6	L	A post project evaluation exercise should consider any innovative project governance / management arrangements applied and their potential application at future UHB capital projects (O)	Executive Director of Planning (Senior Responsible Officer) At the post-project evaluation	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R5/6	M	Recognising the near-completion of this project, the Actions and Decisions Logs should be updated to provide a clear audit trail of project decisions, for retrospective scrutiny where necessary (O)	Project Manager N/A	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	UHW Surge Hospital - Lakeside Wing	Director of Planning	Reasonable	R6/6	M	The UHB's project and construction risk registers should be costed where appropriate (O).	Director of Capital, Estates & Facilities At future schemes	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	Compliance with the Nurse Staffing Levels Act (Wales) 2016	Executive Nurse Director	Substantial	R1	M	It is acknowledged that the Summary of Required Establishments on Ward during Covid-19 Pandemic report has been utilised to inform ward staffing levels during the pandemic. However, management will need to ensure that following the pandemic all reports and systems recording nurse staffing and establishment levels are correct and consistent.	Jason Roberts - Deputy Executive Nurse Director / Dependent on Covid situation	Closed	Over 3 months under 6 months	C	The Nurse staffing levels across all clinical areas were recorded throughout the pandenic on a monthly basis, calculated using professional judgement. However since May 2021 there has been a reconfiguration of the clinical footprint to ensure alignment to the COVID recovery plan. There is a plan through May/June 2021 to undertake a formal calculation of clinical areas (in the absence of a calculation carried out in early 2021) to assure the UHB in regards to compliance with the Staffing Act
CVU-2021-02	2020-21	Claims Reimbursement	Executive Nurse Director	Substantial	R1/2	M	The Claims Team should look into streamlining the current process and fully utilising Datix to retain all documentation submitted to Welsh Risk Pool. This will ensure a full audit trail is retained, and information is readily accessible to all staff involved in the claims reimbursement process.	Redress Manager from 1.04.21	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	Claims Reimbursement	Executive Nurse Director	Substantial	R2/2	L	It is acknowledged that while COVID restraints would have impacted the timeliness in which Case Management Reports were submitted, every effort should be made to ensure claims are submitted within required timeframes. For each claim, all applicable fields within DATIX should be completed, thus allowing monitoring of adherence to timescales to take place.	Head of Concerns and Claims- by 21 May. Dashboard and meetings established.	Closed	Over 3 months under 6 months	C	
CVU-2021-02	2020-21	Charitable Funds	Director of Finance	Substantial	R1/3	L	Management should issue a general communication regarding the completion of application forms reminding staff that estimated costs should be included. In the event that a form is received without any costs it should be returned to the applicant for the information to be added and then resubmitted.	Simone Joselyn April 2021	Closed	Over 3 months under 6 months	C	completed 30.4.21
CVU-2021-02	2020-21	Charitable Funds	Director of Finance	Substantial	R2/3	L	Should a similar situation arise in the future to ensure transparency of donations and associated expenditure management should ensure that a separate fund is set up.	Alun Williams April 2021	Closed	Over 3 months under 6 months	C	completed 1.4.21
CVU-2021-02	2020-21	Charitable Funds	Director of Finance	Substantial	R3/3	L	Management to ensure that the actions approved at the Charitable Funds Trustees meeting are actioned by the end of the financial year.	Alun Williams April 2021	Closed	Over 3 months under 6 months	C	completed
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R1/9	H	The database should be updated to the latest, supported version.	Service Improvement Manager, Cancer Services Completed (Update to version 2013)	Closed	Over 3 months under 6 months	C	Tentacle has been retired. CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R2/9	M	The level of recording of developments and changes to Tentacle should be improved. At a minimum the record should record what change was made, the date of testing, staff involved with UAT and a formal agreement of user acceptance.	Service Improvement Manager, Cancer Services – partially completed with final deadline of 21st February 2020	Open	Over 3 months under 6 months	PC	CTM MVP testing record complete. Development program requests list and subsequent test list available on Cancer Services Teams channel. Release notes supplied to users.Formal process for agreement of user acceptance for changes has been produced.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R3/9	M	The use of generic accounts should be restricted. Staff who have left the UHB should be removed from the system.	Service Improvement Manager, Cancer Services – by 21st February 2020	Closed	Over 3 months under 6 months	C	Tentacle has been retired. CTM has replaced it, which address this audit recommendation. Quarterly user review schedule inplace with Cancer Services Service Improvement Manager.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R4/9	M	Tentacle and its associated databases should held in a secure location on UHB network	Service Improvement Manager, Cancer Services	Closed	Over 3 months under 6 months	C	Tentacle has been retired. CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team. Tentacle associated db stored in secure folder within Cancer Services Management folder accesible only to senior dept members. Plan for storing legacy data is being formulated.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R5/9	M	The future use of office software should be established to ensure Tentacle remains viable until a replacement is developed.	Assistant Director of ICT September 2020	Closed	Over 3 months under 6 months	C	Tentacle has been retired and the CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R6/9	M	The process for loading information into Tentacle on a daily basis should be set out in a procedure, together with the required passwords for access. This should be available to key staff in the event of the Tentacle leads being absent.	Service Improvement Manager, Cancer Services - by **29 Feb 2020**	Closed	Over 3 months under 6 months	C	Tentacle has been retired . CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team.

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CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R7/9	M	The load process should be amended to identify items that have not loaded. E.g. by including a batch check against items to load and loaded items in order to identify instances where items have not successfully loaded.	Service Improvement Manager, Cancer Services - by **29 Feb 2020**	Closed	Over 3 months under 6 months	**C**	Tentacle has been retired. CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R8/9	L	If the system is to be continued to be used, then system documentation should be developed.	Annotation of code - completed	Closed	Over 3 months under 6 months	**C**	Tentacle has been retired. CTM has replaced it, which addresses this audit recommendation. CTM Project close report submitted to Audit Team.
CVU-2021-02	2020-21	Tentacle System Follow-up	Director of Digital & Health Intelligence	Substantial	R9/9	L	Brief user guides should be developed for the system	Service Improvement Manager, Cancer Services - by **17 April 2020**	Closed	Over 3 months under 6 months	**C**	Full user guide available in Cancer Services dept folder and Caner Services Teams channel.
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R1/6	M	Any future such projects must be supported by a fully documented project management structure and approach that includes an effective decision making process to justify the reasons for the adoption of the system through a VFM study and subsequent tender exercises in accordance with All Wales Procurement procedures. Additionally, appropriate support should be put in place for the HealthPathways Project Lead that ensures effective cover for their role should they be away for a period of time or during long term sickness.	Ruth Jordan 28/2/21 Ruth Jordan 31/3/21	Closed	Over 3 months under 6 months	**C** **PC**	14/6/21: All projects from the I&I team that support transformation are processed according to the recommendation and a joint post with procurement is currently being appointed. The HealthPathways team were transferred to the management of the PCIC Clinical Board at the start of the 22/22 financial year to support operational stability. A review of structures and processes is currently under way
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R2/6	M	Future projects must be supported by a formally documented work plan and implementation timescales that outline the development and implementation of any system.	Patricia Osborne / complete	Closed	Over 3 months under 6 months	**C**	Completed
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R3/6	L	Written user guides or online desktop procedures should be provided to GPs/Consultants which will further their understanding and use of Health Pathways.	Patricia Osborne / 10.02.21 Maria Dyban / 10.02.21	Closed	Over 3 months under 6 months	**C**	14/6/21: The HealthPathways site has a 'how to' page within the system that is easy to navigate
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R4/6	M	Consideration should be given to requesting from Streamliners NZ Limited a report written into the system that can identify which clinician has accessed what clinical pathway, thereby enhancing functionality and aiding analysis of trends or frequency of use.	Patricia Osborne / 17.01.21	Closed	Over 3 months under 6 months	**C**	17/1/21: Request submitted to Streamliners in New Zealand. The response advised that this functionality is not possible due to data protection and other factors
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R5/6	M	Whilst there are sound and accessible processes in place that allow GPs and Consultants to feedback issues and HealthPathways reports are in place that can monitor pathways in use, the review was not able to comprehensively establish user perceptions in this respect across Cardiff and the Vale of Glamorgan. UHB management should obtain further opinion and feedback from GPs to establish the level of current usage and current satisfaction with database functionality.	Maria Dyban / ongoing Patricia Osborne / 10.02.21 Patricia Osborne / ongoing	Open	Over 3 months under 6 months	**PC**	The team are planning to solicit further feedback viia SurveyMonkey in order to influence service development, but project lead capacity is required to progress this.
CVU-2021-02	2020-21	Integrated Health Pathways	Executive Medical Director	Reasonable	R6/6	M	Feedback provided by GPs and Consultants as to the effectiveness and worth fullness of the HealthPathways performance data should be reported within the organisation as a means of 'lessons learned' and continuous improvement.	Patricia Osborne / ongoing Maria Dyban & Patricia Osborne / 01.05.21 Maria Dyban & Patricia Osborne / 01.04.21 Maria Dyban / 12.02.21 Maria Dyban / with immediate effect	Open	Over 3 months under 6 months	**PC**	As part of the transition of the team to PCIC it was noted that performance metrics are not available and the team intend to explore suitable metrics further. We have done the following promotional/educations events: 1. regular HP updates via PCIC newsletter throughout the pandemic. 2. webinar for UHB 10/2/21 with over 60 clinicians in attendance (mainly consultants) 3. webinar to Paediatric consultants and trainees 15/6/21 4. webinar at South West cluster 17/6/21 5. webinar to ED consultants and trainees (to be scheduled in the next 6 weeks) 6. we are planning to go into individual GP practices (Cloughmore surgery is the first one to engage, just looking for a date in the next 6 weeks) 7. Maria Dyban has a lot of emails from UHB consultants who initiated new conversations with HP with regards to updating HP site/new pathways creation (neurosurgery, gastro, ENT, Parkinson's specialists, allergy service, paediatrics, paediatric orthopaedics, paediatric physio., surgical specialties via Simon Davies, ED, vulnerable people service) 8. We have been engaging with CAV convention and we are present in all Clinical Working groups
CVU-2021-02	2020-21	UHB Core Financial Systems	Director of Finance	Reasonable	R1/3	M	Management should ensure the FCPs are updated as soon as possible.	Helen Lawrence – Sept 2021 Alun Williams - March 2021	Open	Over 3 months under 6 months	**PC**	
CVU-2021-02	2020-21	UHB Core Financial Systems	Director of Finance	Reasonable	R2/3	H	Management should ensure that the main Asset Register is updated to reflect the accurate position. The required Due process follow up should be commenced as soon as possible specifically for missing assets and all other applicable assets. For future verification exercise, it may be helpful if Finance provides a key with various categories (e.g. D- Disposal, A- Additions, M- Missing, O- others for unique issues: departments specifying on a separate column what O denotes etc). This can be forwarded at the point the initial email is sent out to the departments. This would help ensure standardization across the board, managing the time used in collating the information and help to analyse with ease if required.	Helen Lawrence - March/April 2021	Open	Over 3 months under 6 months	**PC**	We have done the following promotional/educations events:
CVU-2021-02	2020-21	UHB Core Financial Systems	Director of Finance	Reasonable	R3/3	M	Management should ensure that the bank reconciliation statement is reviewed with evidence of signoff from the reviewer retained.	Alun Williams March 2021	Closed	Over 3 months under 6 months	**C**	1. regular HP updates via PCIC newsletter throughout the pandemic.
CVU-2021-02	2020-21	Risk Management	Director of Corporate Governance	Reasonable	R1/5	L	To demonstrate the periodic assessment of risk management maturity, future reviews of the BAF and RM Strategy should incorporate references and alignment to best practice guidance / risk management standards (See Appendix B).	Head of Risk and Regulation / Risk and Regulation Officer May 2021	Open	Over 3 months under 6 months	**PC**	2. webinar for UHB 10/2/21 with over 60 clinicians in attendance (mainly consultants)

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CVU-2021-02	2020-21	Risk Management	Director of Corporate Governance	Reasonable	R2/5	M	Continued efforts should be made to embed current processes for recording risks, which will facilitate the aggregated risk profile of the Health Board. To aid efficiency and effectiveness of current processes, consideration should be given to the means of capturing and recording risks, to facilitate greater aggregation and visibility	Head of Risk and Regulation / Risk and Regulation Officer December 2021 (6 months after go live)	Open	Over 3 months under 6 months	**PC**	3. webinar to Paediatric consultants and trainees 15/6/21
CVU-2021-02	2020-21	Risk Management	Director of Corporate Governance	Reasonable	R3/5	L	Consideration should be given to alternative styles of reporting the corporate risk summary, to highlight the risks with the most extreme score or on an upward trend in the first instance, for Board consideration.	Head of Risk and Regulation May 2021	Closed	Over 3 months under 6 months	**C**	4. webinar at South West cluster 17/6/21
CVU-2021-02	2020-21	Risk Management	Director of Corporate Governance	Reasonable	R4/5	M	To continue as planned to roll out the delivery of effective risk management systems and processes, as detailed in the BAF action plan to the Board on 28th January 2021.	Head of Risk and Regulation December 2021	Open	Over 3 months under 6 months	**PC**	5. webinar to ED consultants and trainees (to be scheduled in the next 6 weeks)
CVU-2021-02	2020-21	Risk Management	Director of Corporate Governance	Reasonable	R5/5	L	Consideration should be given to utilising greater Microsoft Excel functionality, to enhance the maturity of the corporate risk register template. *(For example, data validation and conditional formatting functionality could be applied to the risk rating and assurance committee columns)*	Head of Risk and Regulation May 2021	Open	Over 3 months under 6 months	**PC**	6. we are planning to go into individual GP practices (Cloughmore surgery is the first one to engage, just looking for a date in the next 6 weeks)

Report Title:	**Audit Wales Recommendation Tracking Report**								
Meeting:	Audit Committee						**Meeting Date:**	6th July 2021	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The purpose of the report is to provide Members of the Audit Committee with assurance on the implementation of recommendations which have been made by Audit Wales by means of an external audit recommendation tracking report.

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

21 External Audit Recommendations were brought forward from April's Audit Committee. No additional Audit recommendations have been added.

The External Audit tracker demonstrates that a further 7 recommendations have completed since April, however, there are also 12 (of 21) recommendations that are partially complete. 2 actions of 21, which relate to Clinical Coding, have had no recorded action taken since the last committee meeting albeit meetings are scheduled with the Director of Digital and Health Intelligence to review these entries.

Three recommendations are over 1 year old, six are over 6 months old (of which two are complete) and twelve actions of the 21 are less than three months old (of which five are complete).

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

A review of all outstanding recommendations has been undertaken since April 2021 and this will continue and be reported at each Audit Committee to provide regular updates in the movement of recommendations.

The table at Appendix 1 shows a summary status of each of the recommendations made for external audits undertaken in **18/19, 19/20 and 20/21** as at 24th June 2021. It is hoped that all recommendations for 2018/19 will have been completed by September's Committee meeting.

This report and appendices will also be discussed at Management Executive and HSMB meetings so that the leadership teams of the Health Board have an overview of progress made against External Audit Recommendations.

Recommendation:

The Audit Committee Members are asked to:

(a) Note the progress which has been made in relation to the completion of Audit Wales recommendations.

(b) To note the continuing development of the Audit Wales Recommendation Tracker.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

External Audit (WAO) Recommendations 2018/19 – 2020/21 (July 2021)

External Audit	Complete	No action	Partially complete	< 3 mths	> 3 mths	+6 mths	+ 1 year	Grand Total
Structured Assessment 2018	2	-	1	-	-	3	-	3
Clinical Coding Follow Up	-	2	-	-	-	-	2	2
Audit of Financial Statements	-	-	1	-	-	-	1	1
Implementation of the Wellbeing of Future Generations Act	2	-	5	-	-	7	-	7
Audit of Accounts Report Addendum - Recommendations	-	-	3	3	-	-	-	3
Follow Up of Operating Theatres	3	-	2	5	-	-	-	5
Total	**7**	**2**	**12**	**8**	**-**	**10**	**3**	**21**

From the above table it can be seen that since the last report to Committee in April 2021 4 of the 21 outstanding WAO recommendations from April 2021 7 have been completed. It can also be seen that there are a further 2 of 21 recommendations where there has been no action a further and 12 of 21 where the recommendation is partially completed. 3 actions of 21 are over 1 year old and 10 of 21 are over 6 months old.

Audit Log Ref No.	Financial Year Fieldwork Undertaken	Final Report Issued on	Audit Title	Executive Lead for Report	No. of Recs Made	Rec No.	Recommendation Narrative	Management Response	Operational Lead for Recommendation	Committee Implementation Monitored by	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R1g/11	R7 [2017] The Health Board needs to ensure that the level of information reported to the Resource and Delivery Committee on its performance is sufficient to enable the Committee to scrutinise effectively. This should include: ï ensuring that the Committee receives more detailed performance information than that received by the Board. Consideration should be made to including a summary of the Clinical and Service Board dashboards used in the monthly executive performance management reviews; ï expanding the range of performance metrics to include a broader range of key performance indicators relating to workforce. Consideration should be made to revisiting the previous workforce KPIs reported to the previous People, Planning and Performance Committee.	Overall this recommendation has been partly addressed. ï The S&D Committee continues to receive a high-level performance dashboard, which is less detailed than the performance report received by the Board. ï Since September 2018, the S&D Committee receives six-monthly updates against the workforce plans, including key workforce metrics.	Head of Corporate Governance	Audit and Assurance Committee	Open over 6 months under 12 months	c	A performance management framework has been developed and implemented.
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3b/11	b. Review and update the Standing Orders and Standing Financial Instructions, ensuring these documents are reviewed and approved on an annual basis;	Agreed and timetabled to be undertaken on an annual basis going forward	Head of Corporate Governance	Audit and Assurance Committee	Open over 6 months under 12 months	c	Updated Standing Orders and Standing Financial Ordered were approved at the May 2021 Board meeting
WAO 1	2018-19	Jan-19	Structured Assessment 2018	Chief Executive Officer	11	R3d/11	d. Ensure the governance team manage policy renewals and devise a process to keep policy reviews up to date;	Agreed	Head of Corporate Governance	Audit and Assurance Committee	Open over 6 months under 12 months	**pc**	Delayed due to COVID-19. Policy and process to be complted by June 2021
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Digital and Health Intelligence		R1	**Clinical Coding Resources:** Strengthen the management of the clinical coding team to ensure that good quality clinical coding data is produced. This should include: c) ensuring that there is capacity to allow band 4 coders to undertake mentoring and checking of coding of band 3 staff in line with job descriptions; d) revisiting the allocation of specialities across staff to ensure that there is sufficient flexibility within the existing capacity to cover periods of absence and succession planning is in place for staff who are due to retire in the next five to ten years; g) increasing levels of engagement between the different teams within the Health Board, to provide opportunities to raise issues, develop peer support arrangements and share knowledge; h) updating the clinical coding policy to reflect the current operational management arrangements; and k) increasing the range of validation and audit processes, including the consideration of the appointment of an accredited clinical coding auditor.	The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. The UHB faces on-going challenges on the use of its resources in light of increasing demand for services and inflation surpassing investment. As a consequence the UHB made a difficult decision to reduce non direct clinical expenditure by 12.6% in 2018/19. However recognising the value of coding, there was a marginal increase in expenditure on the staff who do the coding when factoring in pay awards and increments, but this required an ongoing reduction in supervisory expenditure. **k)** Unless affected by the present review which will lead to the restructuring of the Digital team, the intention is that a new Band 5 (Assistant coding manager) appointment will have an element of their time for audit.	James Webb	Digital & Health Intelligence Committee	Open over 12 months under 18 months	na	
WAO 17	2019-20	Jun-19	Clinical Coding Follow-up From 2014 not yet completed	Director of Digital and Health Intelligence		R2	**Medical Records:** R2 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include: a) reinforcing the Royal College of Physician (RCP) standards across the Health Board and developing a programme of audits which monitors compliance with the RCP standards; b) improving compliance with the medical records tracker tool within the Health Board Patient Administration system (PAS); c) putting steps in place to ensure that notes that require coding are clearly identified at ward level and that clinical coding staff have early access to medical records, particularly at UHW; e) reducing the level of temporary medical records in circulation; f) considering the roll out of the digitalisation of health records to the Teenage Cancer Unit to allow easier access to clinical information for clinical coders; and g) revisiting the availability of training on the importance of good quality medical records to all staff.	**a)**Head of Clinical Coding to raise concerns with Patient Safety / Clinical Audit. **b)** The UHB is developing mobile tracking technology which would support an audit programme designed to determine levels of tracking compliance across departments. **g)** Head of Coding to discuss with Medical Directors to establish the most appropriate platform	James Webb	Digital & Health Intelligence Committee	Open over 12 months under 18 months	**na**	
WAO 18	2019-20	Jul-19	Audit of Financial Statements Report Addendum - Recommendations	Director of Finance	9	R4	**4: the Phase 2 and Phase 3 continuing healthcare claims require concluding** The Health Board should establish the reason for the ongoing delay with each of the remaining Phase 2 and Phase 3 claims and it should seek to conclude them promptly	Phase 2 – all cases completed Phase 3 –5 claims remain incomplete. 2 of these are with Finance for reimbursement process, the remaining 3 cases have been reviewed but are not ready for completion yet due to requiring further meetings, negotiation, panels etc.	Deputy Finance Director	Audit and Assurance	Open over 12 months under 18 months	pc	Phase 2 – all cases completed Phase 3 – 9 claims remain incomplete – all claims have been reviewed but these are not ready for completion yet due to requiring further meetings, negotiation, panels etc. Delays in finalising some claims during 20/21 due to the nurse assessors involved being redeployed to other areas during Covid crisis, and the inability to hold face-to-face meetings due to the pandemic.
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R1	**Long-term** Further enhance the profile of primary care by building upon the successes of existing promotional campaigns.	We will continue to build on the Primary Choice campaign to promote Primary Care.	Director of Operations, PCIC	Strategy and Delivery	Open over 6 months under 12 months	pc	The Primary Choice campaign has covered the following primary care roles GP, nurse, dental, optometrist and receptionist. the sceond phase was paused due to Covid but work has now recommenced to include MH practitioner, physio, clinical practioner, pharmacist and roles within the OOHs service. In addition to this there has been significant comms as part of the CAV24/7 work around accessing primary care.

WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R2	2 Develop a campaign to educate the public about what types of services will be available at each of the centres and hubs.	We have an active engagement programme for each of the Wellbeing Hubs and Health and Wellbeing Centres, we will continue to evolve our engagement working with local organisations, public health colleagues and community groups to promote the services in each centre.	Director of Operations, PCIC	Strategy and Delivery	Open over 6 months under 12 months	pc	Programme of business cases in development with engagement on design detail of services required to meet local needs taken forward as part of business case. First scheme (Maelfa) in constuction on track to be completed Dec 2021 and planning for Penarth and Ely hubs well underway.
WAO 20	2019-20	Nov-19	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R5	**Prevention** 5 Undertake needs assessments on an ongoing basis and continually review services to ensure that centres and hubs remain current and fit for purpose.	Primary Care Clusters are required to produce plans to meet the needs of their populations, this will include considerations of Wellbeing Hub services once established. These plans will take into account evidence from wider needs assessments including future updates to the population assessment required under the Social Services and Wellbeing Act and the Wellbeing Assessment required under the WFG Act	Director of Operations, PCIC	Strategy and Delivery	Open over 6 months under 12 months	pc	Clusters plans are required and work is underway to update current plans. Work on Health and Wellbeing Centre had been paused due to Covid but has recently restarted. There will be clinical involvement from the clusters in this work.
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R6	6 Develop a clear plan to agree finances prior to centre and hub services commencing to prevent duplication of resources.	This will form part of the operating model of the Wellbeing Hubs.	Director of Operations, PCIC	Strategy and Delivery	Open under 3 months	pc	Operating model options and revenue consequences form part of each project scope are under active consideration by the SOFW in the community delivery board.
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R7	**Integration** 7 Undertake a community services mapping exercise for each of the localities to identify services it could signpost patients to if they fall outside of the services delivered by centres and hubs.	We will be undertaking this mapping on a locality and cluster basis in partnership with existing tools and services such as Dewis Cymru.	Director of Operations, PCIC	Strategy and Delivery	Open under 3 months	c	The Right Sizing Community Services initiative has mapped out some of the intermediate care services, and where we have service capacity gaps. Third sector has mapped service provision. Work is progressing to look at how cluster, locality and intermediate care service models form single integrated out of hospital model of care. A full programme is now in place to deliver
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R8	**Collaboration** 8 Develop some overarching principles for the centres and hubs operating model which allow for some local variation based on community need.	We will establish an overarching operating model for the Health and Wellbeing Centre and Wellbeing Hubs focussed on operating as single assets and supporting community ownership.	Director of Operations, PCIC	Strategy and Delivery	Open under 3 months	c	Work has commenced on the operating model of the hubs and options are being tested via the Delivery Board. The operating prinicples and model is included in the RPB @home programme. HWB Centres and Hubs will be key locality assets to deliver the new community-based care model.
WAO 20	2019-20	**Nov-19**	Implementing the Wellbeing of Future Generations Act	Director of Planning	10	R9	**Involvement** 9 Explore the best vehicles to engage marginalised citizens both in terms of planning future centres and hubs and in ensuring they are accessible to all when in operation. For example, by finding community leaders to help roll out key messages and engage with these groups on an ongoing basis.	We will ensure this forms part of the engagement plan for each project.	Director of Operations, PCIC	Strategy and Delivery	Open under 3 months	pc	For each scheme, there is an engagement plan with the local community to ensure the detailed plans have been informed by both service views and views of those who will use the services. As part of the @home programme, C3SC has been commissioned by the RPB to develop an engagement framework. This is being prototyped with the CRI HWBC.
WAO21	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R1	Some of the accounting processes and records need to be simplified, with far less use of manual adjustments to financial ledger outputs: The Health Board should reevaluate why so many manual adjustments are currently necessary and, in do so, liaise with us and consider engaging with a health boasrd that has the same finance system and avoids similar level of manual intervention	The Health Board agrees to review its manual adjustments and assistance from Audit Wales in identifying good practice would be very helpful.	Deputy Finance Director	Audit and Assurance	Open under 3 months	pc	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. Action not due
WAO21	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R2	The quality of some of the Health Board's underlying working papers requires further improvement: The Health Board should review and simplufy its supporting records for certain areas of its annual financial statemnets, including the inappropriate use of manual data entry (rather than formulas) within spreadsheets. To aid the review the Health Board should liaise with us to understand hjow some of hte documentation affects our audit.	The Health Board will work with Audit Wales to review its supporting records with the aim of simplication to support the final accounts audit	Deputy Finance Director	Audit and Assurance	Open under 3 months	pc	The UHB has met with Audit Wales on 4th November 2020 in order to progress this. The finance department has redeployed additional resource to support improvements. Action not due
WAO21	2019-20	**Aug-20**	Audit of Accounts Report Addendum - Recommendations	Director of Finance	3	R3	Related party declarations need to be signed and submitted after the end of each financial year: The Health Board shoud update it sannual related party declaration so that it specifies that the IM / SO must consider the whole financial year and therefore sign and submit it after 31 March, or on departure if that is relevant	The Health Board will revert to requesting returns after 31 March 2021. The Health Board will continue to obtain signed declarations from IMs and SOs at the time of departure. In addition,	Deputy Finance Director	Audit and Assurance	Open under 3 months	pc	Please note that this is an end of year action and will not be completed until after the end of year as agreed by the implementation date
WAO22	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R1	Ensure that momentum is maintained to deliver the benefits of the theatre improvement project which relate to process improvement, such as Day of Surgery Admission and pre-operative assessment: • prioritise the expansion of the pre-operative assessment service across specialties where doing so will achieve maximum benefit in improving quality and safety of care.	THE WAO reported reported highlight that RI had been implemented. There is still work to do to expand POAC in order to cover the large increase in patients due to covid, and to provide a richer offer of support including for areas such as diabetes and fraility, but the report highlighted the good work done in this area.	Ceri Chinn	Strategy and Delivery	Open under 3 months	pc	We have bid for additional investment through recovery to increase POAC activity. This has been supported and staff are being appointed. We are also working to relocate this service in conjunction with estates and planning team
WAO22	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R2	Ensure that staff are engaged with the aims and success of the theatre improvement project. Where possible and beneficial, build change management capacity and leadership from within the service to ensure that service changes are properly embedded, and that operational leaders are involved in the design of their services.	The schemes of employee engagement continue and have been enhance through the pandemic. A workforce manager post is being implemented in order to drive staff engagement and workforce redesign. This post will be central to achieving the goals of this recommendation and a full project approach will be implemented to monitor progress during 21/22	Ceri Chinn	Strategy and Delivery	Open under 3 months	c	This has been implemented and there will be on-going review
WAO22	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R3	Ensure sufficient time and resources are given for people management, including appraisals, sickness absence management, development and delivery of training.	A new starter training day have been introduced which has been extremely well received. The workforce programme manager post will support with the development of training days and as the pandemic reduces there will be an increase focus on PADRs.	Ceri Chinn	Strategy and Delivery	Open under 3 months	c	This has been implemented and there will be on-going review
WAO22	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R4	Create standards for professional management and leadership and ensure that team leaders meet that standard.	A development booklet for clinical leaders has been developed which outlines the professional standards for our clinical leaders. A development plan will be developed by the workforce programme manager to supports clinical leaders to achieve these.	Ceri Chinn	Strategy and Delivery	Open under 3 months	pc	Agreed implementation date not yet reached. Good progress being made - Awaiting workforce manager
WAO22	2020-21	**Dec-20**	Follow-up of Operating Theatres	Chief Operating Officer	5	R5	Ensure that quality and safety improvement initiatives are developed and led by service staff. These could focus on areas such as reducing surgical site infection, cleanliness, improving WHO checklist processes, applying lessons from incidents and improving patient experience.	The department has a strong history of incident management and reporting. Additional debriefing initatives are being initiatied post covid to help support staff who are involved in adverse incidents - led by the Lead Nurse and a Consultant Anaesthetist. There is a theatre estates group which is looking at the risk and saefty concerns due to the aging estates.	Ceri Chinn	Strategy and Delivery	Open under 3 months	c	This has been implemented and there will be on-going review

Report Title:	**Risk Management Strategy and Action Plan**								
Meeting:	**Audit and Assurance Committee**						**Meeting Date:**	**6th July 2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

Following an Internal Audit of the Health Board's Risk Management and Board Assurance Strategy and procedures the Risk and Regulation team undertook a review of the strategy and supporting procedures to produce a new suite of documents in response to the recommendations contained in the Internal Audit report (a copy of which was shared at the April 2021 Committee meeting).

The following revised documents are attached as appendices to this report:

- Appendix 1: Risk Management and Board assurance Framework Strategy; and
- Appendix 2: Risk Management Procedure (with supporting Risk Assessment and Risk Register)

Alongside this work an Action Plan has also be developed to fully embed the revised Strategy and Procedure into practice across the Health Board. A copy of that plan is attached as Appendix 3.

The revised Strategy has been through its consultation period and is shared with the Committee for approval prior to ratification at Board.

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

The revised Risk Management and Board Assurance Framework and Strategy and supporting Procedure have been produced in response to an Internal Audit review of the Health Board's Risk Management practices and will replace the existing policy and procedure that were implemented in July 2019.

The variations to the existing policy and procedure do not represent a substantial re-write of the documents. Instead the changes bolster the original documentation and provide evidence of the Health Board's compliance with examples of best practice such as the ISO 31000 standards relating to risk management.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)
The Internal Audit of the Health Board's Risk Management Strategy confirmed that the Board could can take reasonable assurance that arrangements to secure governance, risk management

and internal control, within those areas under review, were suitably designed and applied effectively. The report further confirmed that the areas requiring attention would have a low to moderate impact on residual risk until resolved.

It is suggested that the variations to the Risk Management and Board assurance Framework Strategy and Risk Management Procedure appropriately address the actions/recommendations detailed in the internal audit review.

Recommendation:

The Audit and Assurance Committee is asked to:

- **APPROVE** the updated Risk Management and Board Assurance Framework Strategy and Risk Management Procedure; and
- **NOTE** the Action Plan for the implementation of the revised Strategy and Procedure.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
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, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	x
Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

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

Disclaimer

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

Proprietary Information

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

Engagement has taken place with:

Name	Title	Date Consulted

Version Control Table

Version	Issue Date	Summary of Amendment
1	27.09.2019	New Strategy approved by the Board in July 2019

2	**xxxxx**	1. References added. 2. 3 Lines of Defence added. 3. Revised risk scoring matrix. 4. Revised risk appetite..

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

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

Risk Management and Board Assurance Framework Strategy

TABLE OF CONTENTS

1. Introduction and aims

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

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

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

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

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

It aims to:

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

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

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

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

2. Scope

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

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

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

3. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Target Risk Score** The estimated achievable risk score when all actions are completed.

4. Risk Management Organisational Structure

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

4.1 The Lines of Defence in Effective Risk Management and Control

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

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

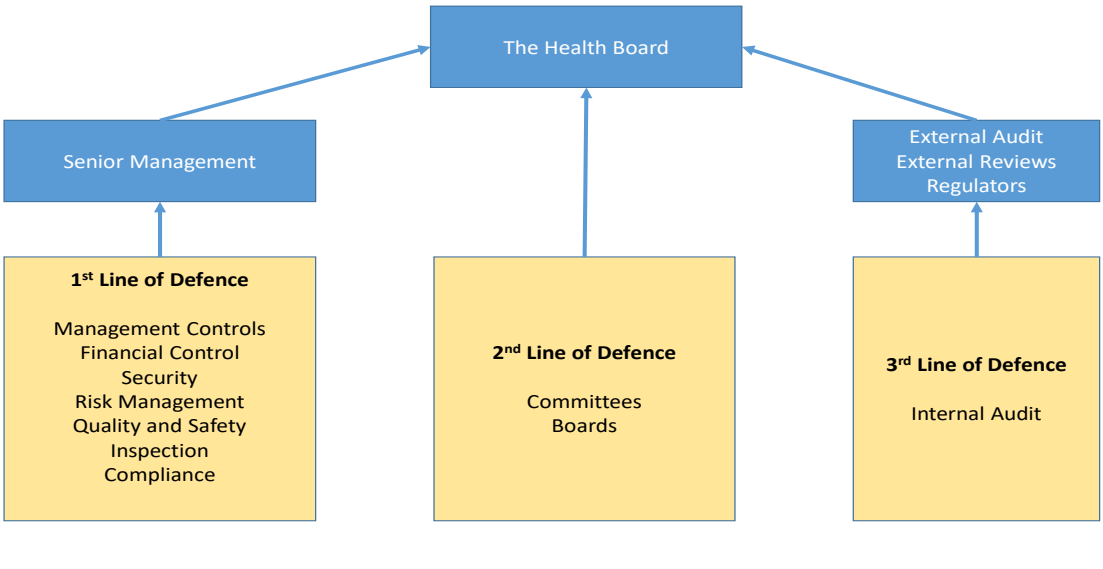

Figure 1: The Three Lines of Defence Model

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

The 1st Line of Defence is the level of operational management where managers own and manage risks. Operational management have responsibility for day to day risk management: identifying, assessing, recording, controlling and (where necessary) reporting risks to senior management. Operational management control of risk is ostensibly through the design, implementation and assurance of controls.

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

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

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

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

4.2 The Board

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

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

4.3 Audit and Assurance Committee

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

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

4.4 Other Committees of the Board

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

4.5 Management Executive and Health Systems Management Board

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

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

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

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

4.6 Clinical Boards and Corporate Directorates

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

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

5. Duties

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

5.1 All staff

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

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

5.2 Line Managers

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

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

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

5.3 Clinical Board Directors

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

Specifically they will:

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

5.4 The Director of Corporate Governance

The Director of Corporate Governance will:

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

5.5 Executive Directors

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

Specifically they will:

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

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

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

5.6 Chief Executive

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

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

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

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

5.7 Internal Auditors

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

5.8 Central Corporate Functions

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

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

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

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

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

6. Risk Management Process

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

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

6.1 Communication and Consultation

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

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

6.2 Types of Risk

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

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

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

6.3 Risk Appetite

Organisations should specify the amount and type of risk that it may, or may not take, relative to objectives. They should define the amount of risk they are willing to take in pursuit of value, or that it is prepared to accept in the pursuit of its strategic objectives (ISO 31000, 2018). This is achieved through the publication of a risk appetite matrix that describes the organisation's willingness or tendency to take risk in specific circumstances, with the purpose of providing managers and stakeholders with guidance that enables a consistent approach to risk-based decision making at all levels of the organisation.

Decisions on accepting risks may be influenced by the following:

- The likely consequences are insignificant and/or the risk has a very low possibility of occurring.
- A higher risk consequence is outweighed by the chance of a much larger benefit if the risk is appropriately managed.
- The potential financial costs of minimising the risk outweigh the costs that would arise if the risk event occurred.
- Treating the risk may lead to further unacceptable risks in other ways.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risks or all other alternatives, including nothing, is even greater (NPSA, 2004).

The Board's assessment of Risk Appetite is based on the Good Governance Institute Matrix for NHS Organisations (GGI, 2019) and is published at Appendix 2. The Board will review its risk appetite on an annual basis.

The C&V UHB risk appetite matrix recognises the key elements described in the GGI matrix (financial, compliance, innovation/quality/outcomes and reputation) but it adds sub-elements to improve the precision of application to UHB activities and consequently greater risk sensitivity in decision making.

The C&V UHB risk appetite matrix retains the 5 risk levels described in the CGI Risk Appetite Maturity Matrix:

Avoid	Avoidance of risk and uncertainty is a Key Organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward

Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
Figure 2: CGI Risk Appetite Levels	

6.4 Risk Assessment

Risk assessment is a collective term for an overall process of risk identification, risk analysis and risk evaluation that is conducted systematically, iteratively and collaboratively across stakeholders (ISO 31000, 2018).

Each Clinical Board or Corporate Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.

Detailed guidance on Risk Assessment is provided in UHB 024 Risk Management Procedure.

6.4.1 Risk Identification. Risk identification is the finding, recognition and description of risks that have the potential to assist or prevent an organisation from achieving it's objectives, or which might cause harm or loss. A range of techniques can be used to identify risk and this might include specific techniques advised or delivered by the risk management and compliance functions operating in the second line of defence. A variety of factors may be considered when identifying risk, either individually or in a co-relationship:

- Risk causes and risk events.
- Threats and opportunities.
- Vulnerabilities and capabilities.
- Changes to the internal or external context.
- The nature and value of assets and resources.
- Limitations of knowledge and the reliability of information.
- Time related factors
- The biases, assumptions and beliefs of those involved in decision making.

6.4.2 Risk Analysis. The purpose of risk analysis is to understand the nature of the risk including the level of risk it might present to the organisation. Risk analysis is an essential prelude to risk evaluation, where decisions are made on whether risks need to be treated, and if they are to be treated then how they are to be treated. Risk analysis requires a detailed consideration of context (including objectives),

uncertainties, risk sources, consequences, likelihood, events, scenarios and the effectiveness of any existing controls.

Risk analysis can involve varying degrees of detail and complexity according to the potential extent of the threat, the available decision-making time and the available resources. It should consider factors such as:

- The likelihood of a risk event and the consequences (impact) on objectives, or the harm/loss, if a risk event occurs.
- The complexity of a risk event and any connectivity with other risks.
- Time related factors (where feasible).
- The effectiveness of existing controls.
- The general level of confidence in the reliability of information and decision making related to the risk.

The approach to quantifying risk is described in Appendix 3. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target (after completion of actions) circumstances.

The score of a particular current risk rating will determine at what level decisions on acceptability of the risk should be made and where it should be reported to. The Board defines as “Extreme” any risk that has the potential to damage the organisation’s objectives. General guidelines are in Figure 3:

Risk Level	Risk Score	Action
Extreme Risk	15 -25	Immediately report the risk to the relevant Executive Director who will inform the Chief Executive. In the event that this might cause delay, the Clinical Board Director should report directly to the Chief Executive.
High Risk	8-12	Report to Clinical Board (or for Corporate Directorates to the Executive Director).
Moderate Risk	4-6	Report to Heads of Service with proposed treatment/action plans, for particular monitoring.
Low Risk	1-3	Report to local manager for local action to reduce risk
Figure 3: Risk Levels		

6.4.3 Risk Evaluation. Risk evaluation supports decisions. The evaluation takes account of the wider context and is a comparison of the results of the risk analysis

with the established risk criteria and risk appetite to determine what subsequent action is required. Potential decisions could be to:

- Do nothing further because the risk likelihood/impact, complexity or connectivity are within established risk criteria and the risk can therefore be tolerated. No active management of the risk is required.
- Decide that existing controls for this risk are effective. Therefore no new risk treatment is required but the risk will require continued active management.
- Decide that the risk is at an intolerable level and it therefore requires treatment.
- Reconsider objectives if the threat from the risk, even after treatment, remains significant.
- Undertake further analysis to better understand the risk.

6.5 Risk Treatment

Risk treatment is an iterative process in which options for the reduction of risks are identified, selected, implemented and monitored.

Identifying and selecting the most appropriate risk treatment option(s) requires the balancing of costs, efforts or disadvantages inherent in their implementation against the benefits derived in the achievement of objectives or minimisation of losses/harms.

ISO 31000 (2018) identifies that options for treating risk may involve one or more of the following:

- Remove the source of the risk i.e. eliminate the hazard(s) that create the risk potential.
- Avoid the risk by deciding not to undertake the activity that provokes the risk i.e. avoid exposure to the hazard(s).
- Accept the risk because it is unavoidable or because it might create opportunity.
- Reduce the likelihood.
- Reduce the impact (consequence).
- Share the risk (for example through contracts or insurance).

Risk treatments may not produce the desired outcomes, may produce unintended consequences, may not take effect within the desired timeframe or may even introduce new risks. Therefore, if there are no treatment options available or if they do not modify the risk in the required timeframe and/or to an acceptable level, then the risk should be recorded on a risk register and be regularly monitored and reviewed.

6.6 Monitoring and Review

Risk management should be continually improved through learning and experience (HM Government, The Orange Book, 2020). The purpose of monitoring and review is to assure and improve the quality and effectiveness of the (risk) process design, implementation and outcomes (ISO 31000, 2018).

Once a risk has been identified, analysed and evaluated a Risk Owner should be appointed. Risk owners should be the individuals best placed through their authority and influence to take responsibility for mitigation of the risk. The identified risk owner is responsible for:

- Ensuring that the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures.
- Reviewing the risk register at appropriate intervals to ensure the descriptor, controls and risk score accurately reflect the level of risk and that progress is being made at sufficient pace to reduce the risk score to the target risk level.
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions.
- Reporting on the overall status of the risk, escalating where appropriate in line with local risk procedure and the risk escalation process detailed in this policy.

Action owners have responsibility for the activities needed to address gaps in control measures and the assurance of the effectiveness of existing controls. Action owners are required to report progress to Risk Owners in a timeframe and manner identified by the Risk Owner. Action owners will normally be identified from within the same Clinical Board or Corporate Directorate as the Risk Owner but specialists from other areas of the organisation, such as HR or H&S may also be required to perform as specialist action owners.

Ongoing and continuous monitoring supports risk owners and the organisation in understanding if and how risks may be changing, and the extent to which risk treatments are operating as intended. The results of monitoring and review provide assurance that risks are managed to a level that is unlikely to threaten the attainment of objectives or create significant loss or harm. Risk owners are responsible for monitoring and reviewing their own elements of the risk management process; this will generally occur through the recording of assurance on risk registers but may also occur through the delivery of assurance reports to committees and boards. Functions within the second line of defence have specific responsibilities for the monitoring of the overall risk process through ongoing, regular, periodic and ad-hoc monitoring and review.

All C&V UHB risk management policies will be reviewed on an annual basis and as and when required in accordance with the following:

- Legislative changes.
- Good practice guidance including 1st and 2nd line audit.
- Case law.
- Significant incidents.
- New vulnerabilities.

- Changes to organisational structures.

Overall accountability for procedural documents across the Health Board lies with the Chief Executive who has overall responsibility for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

Overall responsibility for the Risk Management and Board Assurance Framework Strategy lies with the Director of Corporate Governance who has delegated responsibility for managing the development and implementation of the strategy to the Head of Risk and Regulation.

6.7 Recording and Reporting

The purpose of risk recording and reporting is to communicate risk management activities and outcomes across the organisation, provide information for decision making, meet governance requirements and support the Board and oversight bodies in meeting their responsibilities.

6.7.1 Risk Registers. Risk registers will cover all risk types to create central references to inform the decision making of managers, executives, risk committees and the Board. Four levels of risk register will be maintained as follows:

- Ward/Department/Team Risk Register.
- Directorate Risk Register.
- Clinical Board/Corporate Directorate.
- Corporate Risk Register.

Risks registers will record the Initial Risk Rating, Current Risk Rating, and Target Risk rating. Current controls (and the assurance of their effectiveness) will be listed along with outstanding actions needed to create the control necessary to reach the target risk rating.

6.7.2 The Escalation of Risks. Action should be taken at each level of the organisation to lessen or remove the risk. As may be seen in Figure 4, risks will predominantly be escalated according to the current risk rating score. However, if the appointed Risk Owner feels that the risk can no longer be managed locally and requires more senior input and support, or that the risk event may impact across the wider UHB enterprise, then irrespective of its risk score it may be escalated, if necessary up to the Board. This should not be seen as failure but instead as prudent risk management that seeks to ensure an appropriate response at the most appropriate level within the organisation. The Risk and Regulation team are available for further advice on risks of this type.

Any risks identified and evaluated as having a low/moderate current risk rating (1-6) can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each ward / department; the Clinical Board/Corporate Directorate to which the ward/department belongs are responsible for the oversight and governance of the risk management process.

Risks identified and evaluated as having a high rating current risk rating (8-12) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead who will place the risk onto the Clinical Board/Corporate Directorate risk register and monitor/report the progress of the risk thereafter.

Risks identified and evaluated as having an extreme current risk rating (15-25) should be immediately escalated to the designated Clinical Board/Corporate Directorate Risk Lead. The Risk Lead will immediately report risk greater than 20 to the relevant Executive Director who will inform the Chief Executive. In the event that this will cause delay the Clinical Board Director can report directly to the Chief Executive. Following this urgent notification process, risks greater than 20 should be notified to the Risk and Regulation Team for placement onto the Corporate Risk Register, using the proforma at Appendix 4.

The Corporate Risk Register will map extreme level risks, as well as risks that, whilst having a relatively low current risk rating, are sufficiently complex or wide in their potential impact, to require Executive Level/Board scrutiny. Risks appearing on this register have potential to impact on the achievement of strategic objectives. This information will be used by the Risk and Regulation Team to shape the agenda for Board and Committee meetings, and the BAF, to ensure that the Health Board is actively responding to and considering its key risks.

6.7.3 Review of Risks. Risk Owners should consider the frequency with which they want to review risks, and this decision will usually be influenced by the type of risk, or the strength of current controls. The decision may also be influenced by specific requirements imposed by statute or by regulators/auditors/inspectors. However, as a minimum standard Low risk (1-3) should be reviewed and updated at least biannually, Moderate risks (4-6) should be reviewed and updated at least quarterly, and High (8-12) and Extreme (15-25) risks should be reviewed and updated monthly.

Assurance	Current Risk Rating	Level	Actions
Board Bi-Monthly HMSB Quarterly	20-25	Board Assurance Framework (BAF)	Strategic Risks identified by Committees, Clinical Boards or Corporate Directorates.
		Corporate Risk Register	Extreme Operational Risks or Risks to Strategic Objectives

Board Bi-Monthly			
Clinical Board/QSE Quarterly	15-25	Clinical Board/Corporate Directorate	Risks scoring 20 or > require immediate escalation to Risk and Regulation team who will pass to appropriate Executive and/or committee and consider for placement on the Corporate Risk Register and, if strategic objectives are threatened, for ultimate placement on the BAF. Risks scoring less than 20 should be retained and managed at Clinical Board/Corporate Directorate level unless they require escalation to their complexity or cross health board impact.
Directorate Meeting Monthly	8-12	Directorate	Risk added to Directorate Risk Register. Risks to be reviewed monthly.
Ward Department Risk Review meetings – at least quarterly.	4-6	Ward/Department/Team	Inform Line Manager and risk may be added to the Risk Register. These risks will be managed by the Line Manager/Department Manager. These risks will form part of the departmental risk register that will be reviewed by the department at least every 6 months.
Risk Review meetings – at least 6 monthly	1-3	Ward/Department/Team	If unable to immediately mitigate the risk, add to local risk register. This risk should be managed locally with all staff having authority to manage the risk. These risks form part of the departmental risk register.
Figure 4: Risk Escalation Guide			

6.7.3 Board Assurance Framework (BAF)

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

The BAF is developed through the following key steps:

a. The Board annually agree the Strategic objectives as part of the business planning cycle.

b. The Management Executive, with the support of the Director of Corporate Governance, will draft the principle risks that may threaten the achievement of the strategic objectives; these risks will then be discussed and approved by the Board of Directors.

c. For each principle risk the Executive Lead will:

(1) Give an initial (inherent) risk score, by determining the consequence and likelihood of the risk being realised.

(2) Link the risk to the strategic objectives.

d. Risks from the previous year's BAF will be reviewed and a decision made whether to:

(1) Transfer the risk on to the BAF for the current year.

(2) Move the risk to the Corporate Risk Register and nominate a Risk Owner or Management Group.

(3) Accept or Close the risk.

e. The Executive Lead will then:

(1) Identify the key controls in place to manage the risks and achieve delivery of the strategic objective(s).

(2) Identify the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk.

(3) Evaluating the assurance across all areas of principal risk i.e. identifying sources of assurance the Health Board is managing the risks to an acceptable level of tolerance.

(4) Identify how / where / when those assurances will be reported.

(5) Identify areas where there are gaps in controls (where the Health Board is failing to implement controls or failing to make them effective).

(6) Identify areas where there are gaps in assurances (where the Health Board does not have the evidence to assure that the controls are effective).

(7) Develop an action plan to mitigate the risk.

(8) Agree a current (residual) risk rating for the first quarter of the financial year which is determined by the consequence and likelihood of the risks.

f. The BAF will be presented to the first meeting, in the financial year, of the HSMB. It will moderate the risk scores and ensure there are appropriate controls and assurances. Where gaps in control and assurances exist they will ensure that associated action plans are in place for each risk thus affected.

g. Bi-monthly the Executive lead, supported by the Director for Corporate Governance, will review and monitor the controls and reported assurances and update the risk score and action plans for each of the risks for which they are responsible.

h. The Executive will review and monitor all of the risks on the BAF each month prior to presentation to the Board. In particular the Management Executive will ensure that progress is being made to reduce or eliminate the impact of the risk.

i. Once agreed by Management Executive the completed BAF will be presented to the Board for scrutiny and approval on a monthly basis. At the first meeting of the financial year it will be reviewed in its entirety.

The Audit and Assurance Committee, as a sub-committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

The BAF is an integral part of the system of internal control and defines those extreme risks with potential to impact upon the delivery of Strategic Objectives. It also summarises the controls and assurances that are in place, or the plans to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks, the implementation and progress against the action plan is then monitored by the Board for implementation.

Levels of assurance are applied to each of the controls as follows:

(1) Management Reviewed Assurance.

(2) Board or Committee Reviewed Assurance.

(3) External Reviewed Assurance.

This provides an overall assurance level on each of the strategic risks.

7. Risk Management Training

The following training is designed to complement the risk related elements of the Core Mandatory Training identified in C&V UHB Mandatory/Statutory Training Procedure (UHB 080). The aim of the tiered Risk Management training is to enable UHB personnel to meet their Risk Management responsibilities outlined in this strategy:

Level One – Risk Management Awareness. This will be provided to all staff on induction, as part of Core Mandatory Training, and will be repeated on ESR every 2 years. The intended learning outcomes are to understand what risk is, what risk management is, how a risk is reported and how the organisation's risk appetite and culture operates.

Level Two – Practical Risk Management. This level of training is targeted for any employee undertaking risk management as part of their primary or secondary roles, and for Team Leaders/Managers/Departmental Heads. Line Managers, Clinical Board Directors and Executive Directors have a specific role to play in identifying candidates for this training, ideally in prelude to assuming a risk facing role, but if not then as soon as practicable after assumption of role. Level Two training does not require repetition, though this does not mean that additional risk related training and education should not be identified through PDR. This training will be in two parts:

- **Part 1**. To understand the risk management framework including the risk management strategy, the BAF, the corporate risk register, risk appetite, risk culture, and roles and responsibilities.
- **Part 2**. To understand the risk management process including context, risk versus issue and incidents. Risk assessment, risk tolerance, risk scoring, risk treatments, escalation, communication, monitoring and review.

Level Three – Board Level Risk Management Awareness. This level of training is designed for Board Members and Board Directors. It will be provided on induction and to meet governance requirements it must be repeated every two years thereafter. Level Three training will be facilitated by the Director of Corporate Governance and scheduled within the rhythm of board meetings. The training aim is to provide the audience with an understanding of: the risk management framework, with specific emphasis on the operational risk management approach; the risk management strategy;

'setting the tone' and risk culture; risk appetite; the corporate risk register and the Board Assurance Framework.

Non-Specific Training and Support. It is recognised that, in addition to these three levels of specified training, there may emerge a need for non-specific risk management training and support. Where this is applicable the Risk and Regulation team can discuss the apparent training need and either signpost to external sources of training/education or provide a bespoke training event for individuals or small groups.

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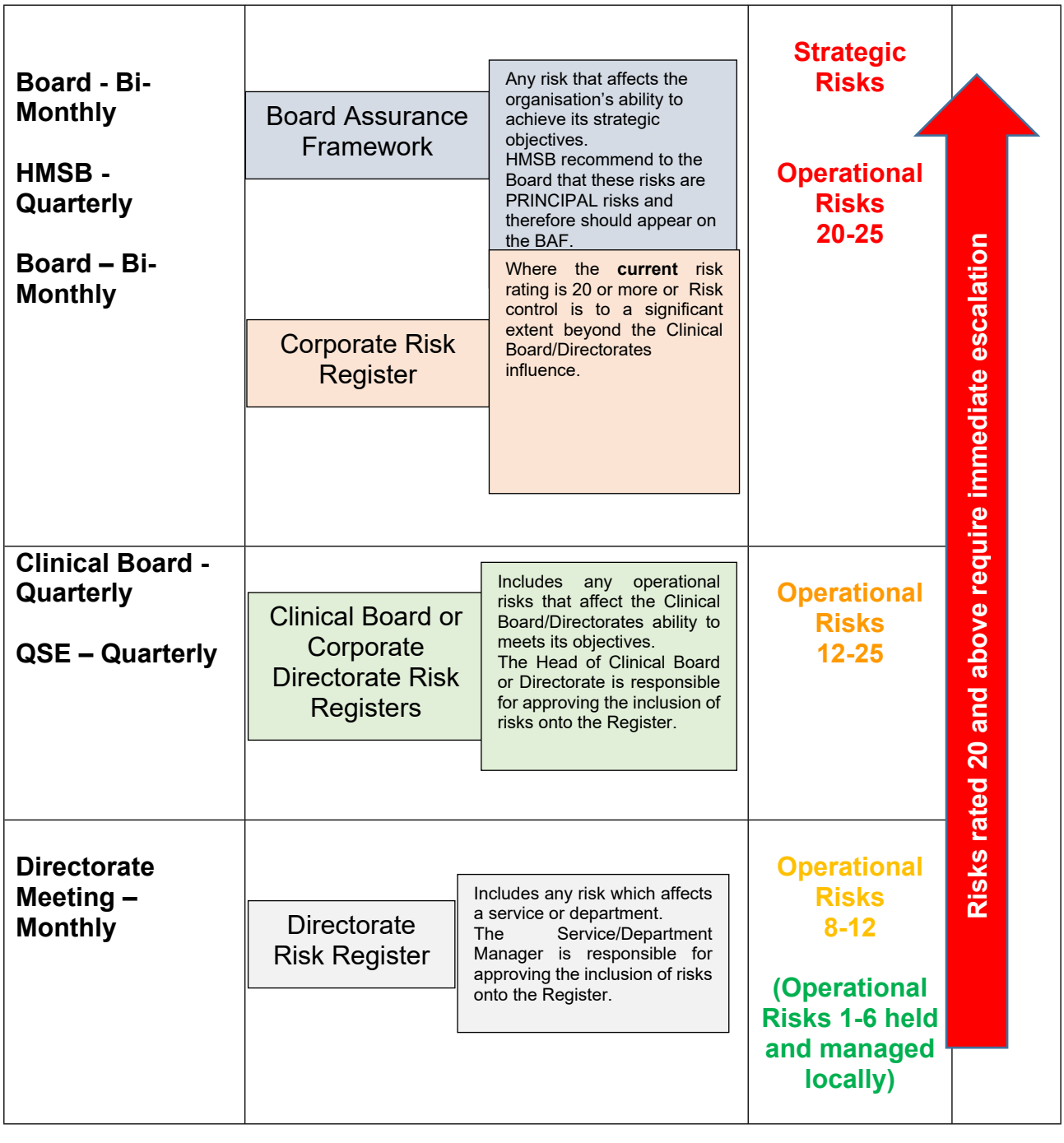
9. Equality impact assessment

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

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

Appendix 1

Risk Registers and Risk Reporting Hierarchy



Appendix 2

Cardiff and Vale UHB – Summary Risk Appetite Matrix

GGI Key Element/Lead	Sub Element	Current Risk Appetite	Target Risk Appetite
1. Financial/Value for Money (VfM) Executive Director of Finance	1a. The availability of Financial Resources and the value derived from their application.	**Cautious:** VfM remains our primary concern but we are prepared to accept limited financial loss or higher cost options where improvements to service delivery standards are possible.	Seek: We invest for the best possible return. We have controls in place but we still accept the possibility of financial loss.
2. Compliance and Regulatory Director of Corporate Governance	2a. The Regulation & Governance of our activity to ensure legal compliance and recognised best practice.	**Cautious**: Challenge of our decisions/actions/omissions *will* occur and we want to be reasonably sure that such challenge is defensible.	Open: Challenge will occur and *could* be problematic. However, the gain will outweigh the adverse impact
3. Quality and Outcomes Executive Nurse Director & Executive Medical Director	3a.The Safety, Quality and Accessibility of Care.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We often challenge current clinical practices and often pursue innovative treatment and care solutions. Confident in our risk control we allow non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We routinely challenge current clinical practices and routinely pursue innovative treatment and care solutions.
	3b. The Accessibility, Quality and Security of Information.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current information management practices and pursue innovative technological solutions. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we seek potential for long term gain. We *routinely* challenge current information management practices and pursue innovative technological solutions.
	3c. An effective, valued and well developed Workforce.	**Open**: Despite short term inherent risks we recognise potential for long term gain. We *usually* challenge current recruitment, retention, training and regulation practices and/or procedures. We are confident that our risk management controls allow for non-critical decisions to be devolved to a low operational level.	Seek: Despite short term inherent risks we recognise potential for long term gain. We *routinely* challenge current recruitment, retention, training and regulation practices and/or procedures.
	3d. The availability of the Materiel, Infrastructure and Sustainability required to meet our objectives, business needs or statutory obligations.	**Open**: There are short term inherent risks to the availability or sustainability of materiel/infrastructure. However, we are willing to manage these risks to a tolerable level because we recognise potential for long term gain.	Seek: Allocation and investment decisions related to sustainability, materiel and infrastructure will seek the best possible return. With rigid controls in place there is an acceptance of the possibility for financial loss, loss of resource availability or failure to meet statutory obligations.
4. Innovation Director of Transformation	4a.The application of Foresight & Innovation to our current and future activities	**Cautious**: Innovations in practice and/or risks arising from technological developments will only be considered if they have a strong potential to improve service quality, financial position or statutory compliance.	Seek: We consider the risks associated with innovation, creativity and research to be an essential component part of C&V UHB activity. We have devolved the authority for risk decisions to an operational level.
5. Reputation Chief Executive	5a.The positive Reputation of C&V UHB and the wider Wales NHS	**Open**: We are willing to take decisions that have potential to expose the organisation to additional scrutiny or interest. The means to manage the organisation's reputation are in place.	Seek: We recognise that the organisation will be subject to additional scrutiny/interest but we feel that the potential benefits outweigh the risks. New ideas are seen as potentially enhancing the reputation of the organisation.

Appendix 3

Approach to assessing Risk

Consequence scores

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work Physical injury to self/others that requires no treatment (including first aid) Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation – requiring no intervention.	Minor injury or illness, requiring minor intervention. Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation managed by local level intervention.	Moderate injury requiring professional intervention. Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Physical injury to self or others requiring medical treatment Psychological distress requiring formal intervention by mental health professionals. Vulnerability to abuse or exploitation requiring increased intervention	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Significant physical harm to self or others Significant psychological distress requiring specialist mental health intervention. Vulnerability to abuse or exploitation requiring significant levels of intervention	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence × likelihood (C × L)

	Likelihood

Consequence	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- 1–3 Low risk
- 4–6 Moderate risk
- 8–12 High risk
- 15–25 Extreme risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated. Where a risk has multiple impacts score the impact with the highest consequence.

Determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score).

Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 4

Corporate Risk on a page Report as at Click or tap to enter a date.

Update: ☐		**New Risk for Corporate Risk Register:** ☐		
Risk Reference: Click or tap here to enter text.	**Director Lead:**	**Date of identification:** Click or tap to enter a date.		
	Assuring Committee Click or tap here to enter text.**:**	**Date Last Reviewed:** Click or tap to enter a date.		
	Risk: Click or tap here to enter text.	**Frequency of Review:** Click or tap here to enter text.		
	Impact: Click or tap here to enter text.			
	Links to Strategic Objectives: Click or tap here to enter text.			

Movement Since Last Update:			Consequence	Likelihood	Score (CxL)
↑	☐	Initial Risk Rating	Choose an item.	Choose an item.	Choose an item.
↓	☐	Current Risk Rating	Choose an item.	Choose an item.	Choose an item.
↔	☐	Target Risk Rating	Choose an item.	Choose an item.	Choose an item.

Controls	**Assurances of Control Effectiveness**
Click or tap here to enter text.	Click or tap here to enter text.
	Additional Risk Treatments Required
	Click or tap here to enter text.

Khan Raj 06/29/2021 10:34:24

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board	**Reference Number:** UHB 024 **Version Number:** 3 **Next Review Date:** August 2022 **Previous Trust/LHB Reference:** N/A

Risk Management Procedure

Introduction and Aim

The University Health Board (the UHB) will face a number of risks which, if unmanaged, will threaten the achievement of its goals and objectives.

The Board describes its commitment to delivering effective risk management in the UHB 470 - Risk Management and Board Assurance Framework Strategy

This Guide is an adjunct to the strategy and has been written to provide risk leads at ward/departmental or clinical board level with detailed guidance on the risk management process, conduct of risk assessment and the purpose and use of risk registers**.**

Objectives

This procedure is intended to define the Risk Management process and:

- Guide users on Risk Assessment purpose and techniques.
- Guide users on Risk Treatment purpose and techniques.
- Provide considerations for monitoring and reviewing the Risk Management Process.

And to define the Risk Assessment and Risk Register procedures to:

- Provide guidance on risk description and risk scoring to enable consistency in the expression of risk by staff from a variety of roles and professions.
- Identify the purpose of initial, current and target risk ratings.
- Clarify who is responsible throughout the process from identification to resolution.
- Specify how risks will be considered, prioritised and managed within the UHB.
- Provide a mechanism to identify if a risk is tolerable taking into account the risk rating, risk appetite and the actions being taken to deal with the risk.

Scope

This procedure applies to all UHB staff in all locations, including those with Honorary Contracts.

Equality Impact Assessment	An Equality Impact Assessment has been written to support implementation of the Risk Management Strategy and Board Assurance Framework Strategy. The Equality Impact Assessment found no impact.
Documents to read alongside this Procedure	UHB 021 - Health and Safety Policy UHB 022- Fire Safety Policy UHB 034 - Lone Worker Policy

	UHB 060 - Maternity Risk Assessment Procedure UHB 088 - Display Screen Equipment Procedure UHB 089 - Control of Substances Hazardous to Health (COSHH) Procedure UHB 119 - Mental Health Clinical Risk Assessment and Management Policy UHB 287 - Information Risk Management Procedure UHB 344 - Ionising Radiation Risk Management Policy UHB 377 - Safety Notices and Important Documents Management Procedure UHB 433 - Incident, Hazard and Near Miss Reporting Procedure UHB 467 - Health and Safety Risk Assessment Procedure UHB 470 - Risk Management and Board Assurance Framework Strategy
Approved by	Director of Corporate Governance
Accountable Executive or Clinical Board Director	Director of Corporate Governance
Author(s)	Risk and Regulation Officer

Disclaimer

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

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

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Introduction

Health services are inherently risky: their core activities involve a response to unpredictable events where the potential for harm or loss (both financial and non-financial) is high. Health services need to be aware of the risks they face and have procedures in place to manage these risks in the interests of both the organisation, their patients, staff, visitors and on occasion the wider public interest.

Risk management is the systematic identification, assessment and evaluation of risk. The UHB is committed to developing and implementing a Risk Management and Board Assurance Framework Strategy that identifies, analyses, evaluates and controls the risks that threaten the delivery of the UHB's strategic objectives and through pre-emption and reaction minimise the harm that clinical or resourcing errors can cause to patients, service users, staff or visitors.

The UHB's Risk Management and Board Assurance Framework Strategy is designed to provide guidance to all staff within the organisation on the management of strategic and operational risks through the completion and maintenance of Clinical Board and Corporate Directorate Risk Registers, the Corporate Risk Register and Board Assurance Framework. This document is subordinate to that strategy and is designed to provide amplifying guidance on the Risk Management Process (Part One) and a more detailed explanation of the Risk Assessment Process (Part Two).

PART 1: THE RISK MANAGEMENT PROCESS

1.1 Definition of Risk

There are many definitions of risk, with some implying that risk is something which should always be avoided. However, without any risk there would be very few opportunities or innovations. Modernising and improving our services requires the UHB to take opportunities whilst managing risk. For the purpose of its overall risk management activities the UHB defines risk as:

"The effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies."

We operate in an uncertain world. Whenever we try to achieve an objective, there's always the chance that things will not go according to plan. Every undertaking has an element of uncertainty and some uncertainties have potential for risk. Risks may have more than one potential impact. Through analysis and targeted action the quantity of uncertainties or their potential impact can usually be reduced.

Risk deals with uncertainties. Once a risk has occurred it is no longer uncertain and therefore becomes an issue to be managed; the management of issues is beyond the remit of this guide.

1.1.1 Risk Types

The types of risk faced by the Health Board occur at two levels:

Strategic Risks: These are those risks that represent major threats to achieving the UHB's strategic objectives, or to its continued existence. Strategic risks can include key operational failures which would be very damaging to the achievement of strategic objectives if they materialised. Being clear about strategic risk enables the Board to be sure that the information it receives is relevant to the achievement of these objectives.

Operational Risks: These concern the day-to-day risks that the UHB faces, which if they occur could adversely impact on operational activity rather than strategic objectives. Operational risks arise from a variety of hazards and threats that may impact on patient safety, health and safety, service quality, financial governance etc. Operational risks have the potential to stop the Health Board achieving nationally or locally agreed targets or may have such an impact on service delivery that the Health Board is in breach of contract. Operational risks may also result in reputational harm. These risks are the responsibility of line management and should generally be identified and managed at the lowest possible level, with escalation to a higher level usually determined by the grading/scoring of the risk in accordance with the UHB's Risk Management and Board Assurance Framework Strategy.

The risks faced by the UHB can have a variety of causes and may exist across a variety of domains such as risks to patient safety, health and safety, financial governance, reputation etc. All risks, irrespective of cause/type, will be recorded and managed in a consistent way as described in the Risk Management and Board Assurance Framework Strategy.

Risk is the effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies.

Once a risk has occurred it is no longer uncertain and it therefore becomes an issue.

The types of risk faced by the UHB fall into two categories; strategic and operational. The risks may occur in a variety of domains.

1.2 The Risk Management Process

The risk management process is depicted at figure 1. It is an iterative process that requires communication, consultation and regular monitoring and review to achieve optimal efficiency. The first 'step' in the process is establishing the context for the risk assessment. The risk assessment then involves the identification, analysis and evaluation of risk. Once a risk has been identified and understood through this process, decisions can be made with regard to how to treat the risk. At all stages of risk management there is a consistent need for monitoring and review of the process, with communication and consultation across all stakeholders.

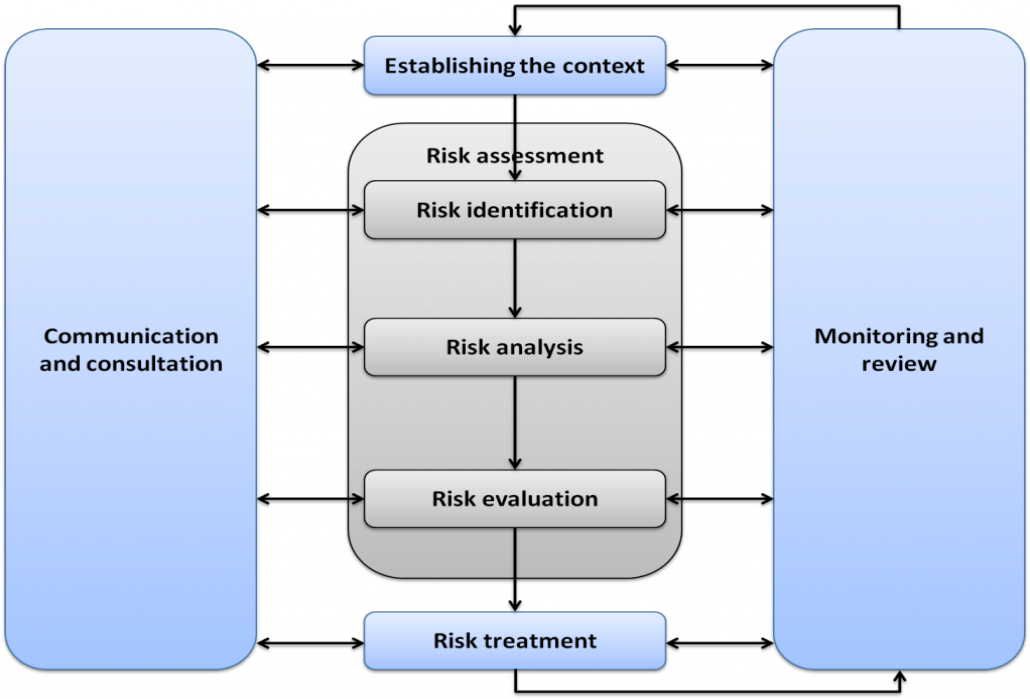

Figure1: ISO 31000 Risk Management Process.

1.2.1 Establishing the Context. To better enable risk assessment, communication and monitoring it is good practice to consider the overall context in which the other elements of the risk management process will occur. The context can be broken down into external and internal factors. Some examples of external factors are:

- National Health and Well-being initiatives.
- Service user expectations of high quality and safe services.
- Service user advocacy groups.
- Professional bodies.
- Legislation e.g. The Health and Safety Act 1974, The Mental Health Act 2007.

Some example of internal factors are:

- Results of internal audits and assurance processes.
- UHB policies and procedures.
- Project requirements or terms of reference.

It is useful to identify stakeholders at this stage. This is not just the people or groups potentially affected by the risk but also those who might be in a position to reduce or eliminate the risk and whose support might need to be sought. Since risks are linked to objectives it is also important, when appreciating context, to understand the UHB's strategic objectives as well as the objectives and issues relevant at a more local level within a department, speciality or clinical board.

Risk management is an iterative process.

Good risk management is about more than good risk assessment – communication and monitoring are essential.

It is important to understand the context for a potential risk event before assessing a risk.

Understanding context can be improved by focussing on external and internal factors.

1.2.2 Risk Identification

This is the process of identifying the type and nature of risk. Focus on this step is critical as without a sound understanding of the risk the remainder of the assessment process is flawed. A formal risk identification process is needed to identify:

- The extent and nature of risks.
- The circumstances under which risks may arise.
- The causes and potential contributing factors.

The aim is to identify the risks that patients, staff, volunteers or visitors may be exposed to, and/or, the risks that may prevent the UHB from achieving its objectives. Risks can generally be categorised as:

- Risks to the safety of patients, staff and the public.
- Risks to the quality of service provided by the UHB.
- Risks to the availability, competence or organisational development of human resources.
- Risks to compliance with statutory duties or standards.
- Risks to objectives and projects.
- Risks to business continuity.
- Risks to reputation.
- Risks to finances.

- Risks to the environment.

It is important to note that if a risk event occurs it may impact on more than one of these categories and this may need to be considered when assessing risk. For example a safety incident may result in injury to a patient but could also breach health and safety law resulting in a fine (financial) and result in press coverage which harms the UHB's reputation.

Proactive risk identification. Proactive risk assessment enables the UHB to identify actual or potential hazards and ensure that adequate control measures are in place to mitigate the risk. Proactive risk assessment is often a requirement to meet statutory duty e.g. Health and Safety risk assessments.

Reactive risk identification. The aim of effective risk management is to be proactive i.e. to identify risk early and either prevent its occurrence, reduce the likelihood of its occurrence or reduce the impact if it does occur. However, it is recognised that this is not always feasible and therefore reactive risk assessment has a role. Reactive risk assessments should take place after adverse events or near misses. This recognises the possibility that, with appropriate action, the likelihood of a similar incident occurring again can be reduced and/or the impact of any repeat event can be minimised. For example, post incident root-cause analysis, audit or a service review may identify new risks.

There are a variety of sources and methods for identifying risk. Quite often people focus on incident reporting, and although this is important, there are other, often equally important, sources of risk information, some of which are outlined in Figure 2.

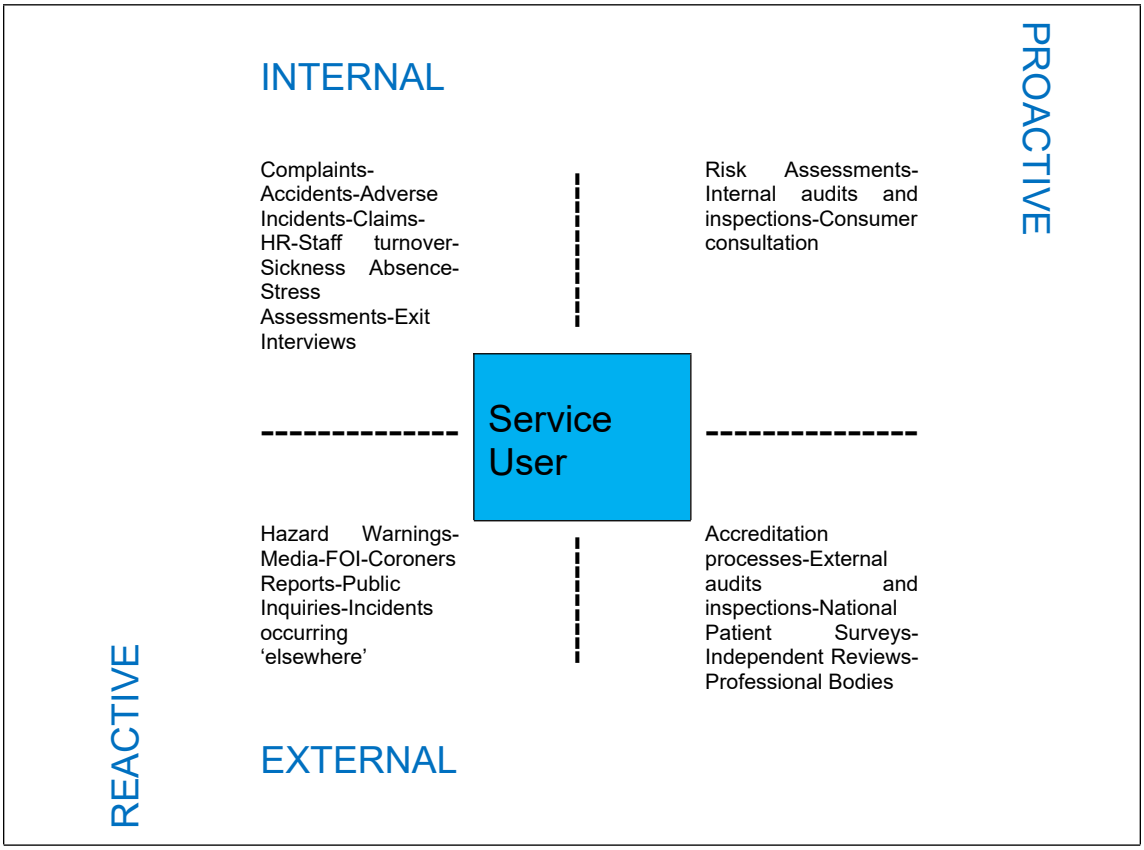

Figure 2: Potential Sources of Risk Information

Some areas of risk may be perceived as being 'entirely clinical' or 'entirely management'. While it is certainly useful for local clinical and management teams to conduct initial work in identifying risks specific to their area of expertise it is essential for an integrated system that at some point clinical and management teams work together to develop a comprehensive, organisational risk register.

Risk identification determines the nature of risks, the circumstances under which they may arise and the causes and potential contributing factors.

Risks can generally be categorised according to which aspects of operational activity may be impacted if the risk occurs.

Risk identification can be both proactive and reactive.

1.2.3 Risk Analysis

The purpose of risk analysis is to understand the nature of risk and where appropriate the level of threat that it poses. A risk event can have multiple causes and consequences, and can affect multiple objectives. Risk analysis involves a detailed consideration of uncertainties, risk sources, consequences, likelihood, events, scenarios, controls and their effectiveness.

Risk analysis should consider factors such as:

- The likelihood of risk events occurring.
- The magnitude (or consequences) that a risk will have on objectives if the risk event occurs.
- The complexity of the risk and any connectivity it may have to other risks or objectives.
- Any time-related factors that may influence likelihood or consequence.
- The confidence (i.e. assurance) held in the effectiveness of existing controls.

Risk analysis can be undertaken with varying degrees of detail and complexity, depending on the purpose of the analysis, the availability and reliability of information and the resources available. Analysis techniques can be qualitative, quantitative or a combination of these, depending on the circumstances and intended use. The risk analysis may be influenced by any divergence of opinions, biases, perceptions of risk and judgements. Additional influences are the quality of the information used, the assumptions and exclusions made, any limitations of the techniques and how they are executed. These influences should be considered, and where relevant documented and communicated.

Highly uncertain events can be difficult to quantify. This can be an issue when analysing events with severe consequences. In such cases, using a combination of techniques generally provides greater insight.

Risk analysis provides an input to risk evaluation, to decisions on whether risk needs to be treated and, if to be treated, the most appropriate risk treatment strategy and methods.

Risk analysis considers:

- The likelihood of risks occurring.
- The impact that a risk will have on objectives if the risk occurs.
- The complexity of the risk and any connection it may have to other objectives or known risks.
- Any time related factors that may influence likelihood, consequence or later risk treatment options.
- The level of confidence held in the effectiveness of existing controls.

1.2.4 Risk Evaluation

Risk evaluation involves comparing the results of the risk analysis with the established risk criteria and *Risk Appetite* to determine what action is required.

Cardiff and Vale University Health Board's Risk Appetite is published in the Risk Management and Board Assurance Framework Strategy. Risk Appetite describes the "Amount and type of risk that an organisation is prepared to pursue, retain or take" (ISO 31000). As such it helps us set an appropriate balance between uncontrolled innovation and excessive caution. It guides on

the level of risk permitted, encourages consistency of approach across the Health Board, and prevents the expenditure of time/resources on further reducing risks that are already at an acceptable level to the organisation.

Where possible risk evaluation might also include consideration of when a risk event might occur. This measure aims to identify *Risk Proximity*. Risk proximity is a consideration of the time period in which risk events may occur. It could be that risks will be more likely to manifest themselves at particular times, and awareness of these times will enable focused pre-emptive risk treatments. Awareness of 'risk time' can also enable a balanced focus on risks, allowing a greater emphasis on those risks that are likely to occur in the short term. Finally, risk proximity also allows identification of the potential for simultaneous risk events. This may be important because simultaneously occurring risk events might require similar (and scarce) risk treatments and thus pre-emptive planning may be required to mitigate the impact of these simultaneous events.

The output from risk evaluation is a decision to either:

- Undertake further analysis to better understand the risk before making a final decision.
- **Terminate** the risk i.e. avoiding the activity, process or practice that may give rise to the risk. Or adjusting the activity, process or practice to remove the risk.
- **Tolerate** the risk i.e. accept the risk as it is without taking any action to mitigate or reduce the risk. This would occur because the cost/effort of risk reduction or mitigation activity are not cost effective or the risk impact is acceptable (i.e. *within* the current risk appetite).
- **Treat** the risk. This will occur when the risk cannot be terminated, is intolerable (i.e. *beyond* the current risk appetite) and cannot be transferred. Options for reducing the likelihood of occurrence or minimising the impact are identified.
- **Transfer** the risk**.** This can be achieved through various forms of insurance or the payment to third parties who are prepared to take the risk on behalf of the organisation. This will usually only be an option for risks related to financial management or commercial activities.

1.2.5 Risk Treatment

The purpose of risk treatment is to select and implement options likely to reduce the negative effects of the risk or enable the opportunities that may result from a risk being realised. Risk treatment is a process that requires:

- The planning and implementing of risk treatment(s).
- Assessing the effectiveness of the treatment(s).
- Deciding whether the remaining risk (sometimes described as residual risk) is acceptable.
- And if not acceptable, deciding what further treatment is required.

Risk treatments even if carefully designed and implemented might not produce the expected outcomes and could produce unintended consequences. Therefore monitoring and review need to be an integral part of risk treatment implementation to give assurance that the different forms of treatment become and remain effective. If the risk cannot be avoided, if there are no treatment options available or if treatment options do not sufficiently modify the risk then the risk should be kept under ongoing review.

Controls. A control is any active measure or action that modifies (i.e. treats) risk in the intended manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods, or devices. They can also be modifications to existing controls e.g. modifying existing vaccination training packages to incorporate the specific requirements of a new vaccine.

It is sometimes helpful to consider Pre-Event Controls and Post-Event Controls; both may be relevant in reducing a risk. Pre-Event Controls seek to reduce the likelihood of a risk event occurring, and Post-Event Controls seek to reduce the consequence(s) of a risk event if it occurs. Differentiating controls in this way can help in the prioritisation of management focus and coordination of risk management actions.

Example: ABS braking systems are a pre-event control designed to reduce the likelihood of vehicle collision, whereas seatbelts are a post event control designed to reduce driver/passenger injuries (consequence) if collision occurs.

Once imposed, risk treatments may subsequently fail to modify the risk or fail to operate in the way that was originally intended. It is also worth noting that newly created and imposed treatments may not be immediately effective – they need time to 'bed in'. An essential aspect of risk management is the prior identification, implementation and ongoing monitoring of the risk assurance process. The effectiveness of controls is assessed by internal and/or external assurance processes. Any currently absent or ineffective risk treatments are described as *Gaps in Control*. Any identified gaps in control are recorded on risk registers and subsequent actions to regain control are identified and recorded.

Example: An increase in suitably qualified and experienced (SQEP) staff has been identified as a risk treatment for a patient safety risk. This will be achieved through recruiting new SQEP staff and 'up' training existing staff. However, these new staff will take time to recruit, and a training provider is not yet identified– so there is a current gap in control. Corresponding action is to ensure the minimum essential cover needed to reduce the risk as low as reasonably practicable. This could be achieved through an altered shift pattern for the existing SQEP staff, temporary re-deployment of SQEP staff from another ward, and temporary use of SQEP agency staff.

Controls are any active measure or action that modifies risk in the intended manner.

Controls may subsequently fail to achieve the intended effect. Therefore monitoring of their ongoing effectiveness is required. Gaps in Control are revealed through internal or external assurance processes.

Gaps in Control should be recorded and subject to specific rectifying action.

1.2.6 Monitoring and Reviewing Risks

Risk is not static – it is dynamic and evolutionary. Therefore, continuous monitoring and reviewing of the risk control system is essential.

The 'vehicle' for the monitoring and review of risk is the risk register. The risk register must contain details related to the risk such as the type of risk, its context, the risk ratings, the agreed corrective measures/action plan, persons responsible and review dates.

Departments, Specialities and Clinical Boards will establish their own routines and processes for risk monitoring and review, and the rhythm of these routines will often be dictated by the timings of higher level UHB activity. Beyond specific risk review meetings there are frequent opportunities to incorporate risk monitoring and review into routine activity. For example Clinical Board meetings or multidisciplinary team meetings may have risk monitoring and review as standing items on their agendas. It is notable that most organisations with mature and highly effective risk management processes have their risk control systems embedded into routine management activity.

Due to the dynamic nature of risk it is important to monitor whether the nature of risk has changed over time, resulting in altered consequence and/or likelihood. Where time (or risk proximity) is relevant it is also good practice to monitor changes to the anticipated timing of a risk event, to ensure that triggers and reactive mitigations remain relevant.

Risk is dynamic therefore continuous monitoring of the risk control system is essential.

To optimise monitoring and management actions, the risk register must contain details related to the risk such as the type of risk, its context, the risk ratings, the agreed corrective measures/action plan, persons responsible and review dates.

PART 2: GUIDANCE ON RISK ASSESSMENT AND RISK REGISTER PROCESS

2.1 Process for Completing Risk Assessments

2.1.1 Decide a Risk Title. The purpose of the risk title is primarily to enable tracking of the risk as it develops and, if necessary, as it progresses through escalation. Therefore, the risk title should provide a succinct description of the risk and ensure distinction from other risks of a similar nature.

2.1.2 Write a Risk Description. Early creation of an accurate, succinct and structured risk description significantly improves the risk management process.

Some risks may need to be escalated, for example from Directorate Risk Register to Clinical Board Risk Register. As risks 'percolate' up the risk reporting hierarchy there is likely to be increasing unfamiliarity with terminology and abbreviations used by local level subject matter experts. It should also be noted that risks escalated to the Corporate Risk Register will be placed in the public domain and all registers held below this level may be released for public scrutiny following appropriate access requests. Therefore, when writing risk descriptions, and especially context, it is a good discipline to write with a 'lay reader' in mind and avoid (or succinctly explain) specialist terminologies or abbreviations.

A well-written risk description contains three main elements:

a. **Context –** A summary of the relevant background facts. These may include prior decisions, assumptions, timelines, dependencies and relevant objectives.

b. **Source(s) of uncertainty / Cause Event -** The currently existing conditions that create the risk i.e. the factors that may cause the risk to occur and/or influence the extent of its effect.

c. **Consequence / Impact -** The impact to the Programme, Service and/or Organisation in the event of the risk occurring. Consequence could also result in opportunities that may surface in managing the risk.

The structure of a risk description can be compared to the telling of a story in which there is a beginning, a middle and an end:

A beginning (i.e. a setting)	*'Due to….'*	Context
A middle (something of interest)	'*The following might occur…'*	Risk Cause or Risk Event
An end (significance/importance)	*'Which could result in…'*	Consequence or Impact

The following example illustrates the relationship between context, cause, risk and impact:

Context. Nursing staff on an acute medical ward are required to use 'X' infusion pump. The 'X' pump is a new design that differs significantly from the infusion pumps previously used. The pump may be used on up to 30 patient interventions per day. No other type of infusion pump is available.
Cause. An internal audit has identified that this piece of equipment is often used incorrectly as staff are not trained appropriately. A recent DATIX trend identifies near misses from the incorrect use of this equipment and an internal audit has confirmed the causation between absent relevant training and potential harm.

Risk. There is a risk that this equipment may be used incorrectly if staff are untrained.

Impact. This could lead to medication errors resulting in; patient harm, patient complaints, notifiable incidents, statutory non-compliance.

2.1.3 Risk Scoring

Complete the Initial Risk Score. The initial risk score is calculated <u>without</u> consideration of any risk treatment (controls). As such it represents the organic, worst case scenario.

The Risk Management and Board Assurance Framework Strategy (Appendix 3) provides descriptors of severity levels and frequency that are essential when deriving risk scores. The descriptors are designed to ensure that they can apply equally to the impact on the safety of patients and staff, the risk of complaints, adverse media coverage, business objectives etc.

The *consequence* is given a numerical score by considering the severity of the risk on the scale of Negligible (1) through to Catastrophic (5). The *likelihood* is measured by considering how often an event will occur on a scale of Rare (1) through to Almost Certain (5).

The *Consequence* and *Likelihood* are then multiplied to give the *Initial Risk Rating.* The *Initial Risk Rating* is plotted on the Risk Matrix (see Figure 3). This identifies whether the risk is a *Low (1-3), Moderate (4-6), High (8-12) or Extreme Risk* (15-25) to the UHB.

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1-3	Low risk
4-6	Moderate risk
8-12	High risk
15-25	Extreme risk

Figure 3: Risk Matrix *from The Risk Management and Board Assurance Framework Strategy*

Complete the Current Risk Score. The Current Risk Score takes the Initial Risk Score and re-assesses it <u>with</u> consideration of the effect these controls

have on consequence, and/or likelihood. These control measures should be prioritised so that the actions likely to have the best effect are taken first.

The consequence if a risk occurs will seldom alter but, with effective controls in place the likelihood of the risk should reduce. Therefore it will usual for the current risk rating score to be lower than that provided for the initial risk rating.

Complete the Target Risk Score. The target risk rating is the level of risk that the organisation is happy to tolerate. The UHB Risk Appetite statement provides further guidance on the level of tolerable risk. The target risk score can also be seen as a projection of how the risk should look once it is has been reduced as low as reasonably practicable.

There is a relationship between the current risk score and the target risk score. If the current risk score is higher than the target risk score there is a remaining requirement for 'action' to further reduce either the likelihood or consequence of the risk. This remaining action is the action plan described in the actions element of the risk assessment table.

2.1.4 Gaps in Controls

Having calculated and recorded the current risk rating the next step is to record current gaps in control (a full description of Gaps in Control is provided in Part 1). Any gaps in control will need to be closed and therefore actions to reduce or eliminate gaps in controls should be planned, monitored and recorded.

2.1.5 Assurances

Assurances are evidence that the controls are working in the intended manner (as described in Risk Treatment at Part 1).

Gaps in Assurance. A gap in assurance demonstrates that insufficient evidence is available to demonstrate that a control is working effectively. Gaps in assurance need to be closed and therefore actions to reduce or eliminate gaps in assurance should be planned, monitored and recorded.

2.1.6 Actions

The actions area of the risk assessment should list all actions required to further mitigate or manage the risks. More specifically the actions table is a list of actions needed to close gaps in control or actions needed to close gaps in assurance. Actions should be SMART[1] and have an owner assigned in addition to a target date for completion.

[1] **S**pecific, **M**easurable, **A**ssignable, **R**ealistic, **T**ime-Related.

2.2 Monitoring and Review of the Risk Assessment

Risk assessments should be *suitable* and *sufficient* and where the form has been fully completed and the latest information/guidelines considered, it is likely to meet these requirements. The Risk Assessment should be signed off by the Assessor, Risk Owner and Directorate Manager and assigned to the most appropriate risk register, according to its risk level.

The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and to whom it should be reported. General guidelines for risk escalation are as follows:

Risk Level	Score	Action
Extreme Risk	15 - 25	Risks greater than 20 to be reported immediately to the relevant Executive Director who will inform the Chief Executive. In the event that this may cause delay, the Clinical Board Director can report directly to the Chief Executive. **Risks of 20 or greater also reported to Risk and Regulation team for recording on the Corporate Risk Register.**
High Risk	8-12	Report to Clinical Board or for Corporate Directorates to the Executive Director. **Risk placed onto Clinical Board or Corporate Directorate Risk Register**.
Moderate Risk	4-6	Report to Heads of Service with proposed treatment/action plans, for specific monitoring. **Risk placed onto Ward/Departmental Risk Register**
Low Risk	1-3	Report to local manager for local action to reduce risk. **Risk placed onto Ward/Departmental Risk Register**

Figure 4: Actions according to Risk Level.

All recorded risk assessments must have a review date and all local risks should be reviewed and updated monthly as a minimum. The review date will initially be set by those recording the assessment but risk owning executives/managers may subsequently direct the review schedule according to how they are influenced by the risk rating.

As Risk Assessments are reviewed, the appropriate Risk Register should be updated to illustrate the date of review and any changes to controls, assurances or action plans.

Risk Assessments should be retained whilst they remain current, and for 12 months following the date of their acceptance or closure (as described in para 2.3.5).

2.3 Risk Registers

A risk register is a central collation of risks recorded in order to inform the decision making of managers, risk committees and potentially the UHB. The Risk Register records all identified risks; it then progressively describes their controls, their risk scores and any ongoing action necessary to reduce the risk as low as reasonably practicable.

Each risk should be assigned a Risk Owner (e.g. Ward Manager at Ward Level, Clinical Board Director at Clinical Board Level etc.). A UHB Board Committee should also be identified for all risks that are contained within the UHB's Corporate Risk Register for assurance purposes.

Each Directorate will maintain a central file of Risk Registers from their Wards/Departments. The Clinical Board Risk Lead will ensure that Directorate Registers are collated and amalgamated at a Clinical Board Level.

2.3.1 Low and Moderate Risks. These risks will be held on local level risk registers and will be managed by an appropriate risk lead at that departmental or speciality level. Risks at this level should be reviewed and updated at least quarterly.

However, following the implementation of all actions that are possible and practical at the local level there may be the need to report a risk by escalating it to the next level of management *irrespective of its risk rating score*. This may be necessary for the following reasons:

- Sufficient mitigation cannot be identified at the local level.
- Sufficient mitigation requires additional funding or authorisation not available at the local level.
- Where support is required from another area of the UHB to carry out risk mitigation.
- Where the risk consequences might adversely impact on another UHB area if the risk occurred.

2.3.2 High Risks. High risks should be escalated and recorded on the Directorate Risk Register. They should be managed by a senior and suitably empowered risk owner, and reviewed at least monthly.

2.3.3 Extreme Risks. Extreme Risks are those risk that score 15 or greater. Risks scoring 20 or greater require immediate escalation (see figure 4). Extreme risks will continue to be managed by the Clinical Board/Corporate Directorate but risks of 20 or greater should also be reported on the Corporate Risk Register and, if a threat to strategic objectives, further reported on the Board Assurance Framework.

2.3.4 The Corporate Risk Register. The Corporate Risk Register is a single document which brings together for Board oversight or decision the risks to the organisation in meeting its principal objectives, mapped against both the key controls in place and assurances of control effectiveness.

The Corporate Risk Register is reported at every Board Meeting and specific risks are also reported at appropriate Committees of the Board for further assurance, scrutiny and escalation where required. When risks are considered to have potential threat to the achievement of strategic objectives they will also be reported on the Board Assurance Framework.

2.3.5 Risk Acceptance or Closure. Risks are accepted when the risk score equals that of the target risk rating i.e. where all reasonable actions have been effectively carried out and the risk owner, cognisant of the risk appetite, is in all other respects confident that the risk has been reduced as low as reasonably practicable. A clear rationale for accepting the risk should be added to the risk register entry. Accepted risks should be held on a register and reviewed annually to see if anything changes.

Where risks have been agreed for removal from the Risk Register or are covered by an existing risk, the risk can be closed. The date of closure and the rationale for closure should be recorded on the risk register. Where closed risks have a potential for reoccurrence, an appropriate date for review should be recorded.

2.4 Glossary of Risk Terminology

Accepted Risk	Risks which are equal to or below the target score where all reasonable actions have been carried out, or there are no further actions possible, cannot be practically reduced any further. These risks may therefore be accepted by the risk owner. The rationale for acceptance must be recorded.
Adverse Event	Any event or circumstance leading to unintended harm and/or suffering which results in admission to hospital, or prolonged hospital stay, or significant disability at discharge or death
Assurance	The confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively so that objectives are being achieved. Sources of assurance include reviews, audits, and inspections (both internal and external).
Cause	An element which alone or in combination has the potential to give rise to risk
Closed Risk	A risk which is no longer relevant or is covered by another risk can be defined as closed on the Risk Register. The rationale for closure must be recorded.
Consequence	See **Impact**
Cost	Activities, both direct and indirect, which result in a negative outcome or impact for an individual or the organisation – cost includes money, time, labour, disruption, goodwill, political and intangible losses.
Control	Any measure or action that modifies risk in the desired manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods or devices.
Current Risk	The risk score with controls in place to manage the risk.

Escalation	The act of advancing a risk to a higher management level for resolution, action or attention.
Event	An occurrence or change in a set of circumstances. An incident or situation. Can be something that is expected which does not happen or something that is not expected which does happen. Events can have multiple causes and consequences and affect multiple objectives.
Frequency	A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time
Gaps (in controls or assurances).	Where an additional system or process is needed, or evidence of effective management of the risk is lacking.
Hazard	A source or situation of potential harm.
Inherent Risk	See **Initial Risk**
Initial Risk	The risk score where there are no controls in place to manage the risk. Precedes current risk.
Impact (or consequence)	The outcome of an event, being a loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organisation
Incident	Any unplanned event or circumstance resulting in, or having a potential to cause loss
Incident Reporting and Investigation	A formal structured process and approach to enable the occurrence of incidents to be reported, recorded and the root cause of reported incidents identified, in order to manage risk exposure and identify required corrective actions
Likelihood	A qualitative measure of the probability of a risk occurring.
Live Risk	An identified risk that has been approved and which is currently being managed.
Near Miss	A situation in which an event or omission (or a sequence of events or omissions), arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury/harm to the patient.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred
Patient Safety Incident	Any unintended or unexpected incident(s) that could have or did lead to harm of one or more persons receiving NHS funded healthcare
Pre-Event Controls	Risk controls intended to reduce the likelihood of a risk event occurring. Pre-event controls can be applied to a risk with or without post-event controls.
Post-Event Controls	Risk controls designed to reduce the impact of a risk event if it occurs. Post-event controls can be applied to a risk with or without pre-event controls.
Probability	The likelihood of a specific event or outcome occurring. Probability is usually expressed along a scale ranging from impossible to certain.
Residual Risk	See **Current Risk**.
Risk	The effect of uncertainty on the organisation's ability to achieve its objectives or successfully execute its strategies. Risk is usually expressed in terms of causes, potential events and their consequences (or impact).
Risk Analysis	A systematic use of available information to determine how often specified events might occur and the magnitude of their consequences if they were to occur.
Risk Appetite	The ISO 31000 risk management standard refers to risk

	appetite as the "Amount and type of risk that an organization is prepared to pursue, retain or take". This concept helps guide an organization's approach to risk and risk management. By defining its risk appetite, an organisation can arrive at an appropriate balance between uncontrolled innovation and excessive caution. It can guide people on the level of risk permitted and encourage consistency of approach across an organisation. Defined acceptable levels of risk also means that time/resources are not spent on further reducing risks that are already at an acceptable level.
Risk Avoidance	An informed decision not to become involved in a risk situation. For example termination of a risk generating activity.
Risk Escalation	A process that ensures identified risks deemed impossible or impractical to manage by a local team or function, and/or those risks with potential strategic impact are escalated to the appropriate level.
Risk Mitigation	Risk mitigation describes the compound effect of the *effective* actions and controls put in place to reduce or minimise the likelihood and/or impact should the risk occur.
Risk Owner	The senior person accountable for the risk; should have a decision making authority and be able to monitor the status of the risk.
Risk Treatment	Options likely to reduce the negative effects of the risk or enable the opportunities that may result from a risk being realised.
Target Risk	The risk level that the organisation is willing to accept in accordance with risk appetite.

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

RISK ASSESSMENT FORM

Clinical Board/Corporate Directorate:	Enter text	**Directorate:**	Enter text

Date Form Completed:	Enter a date
Main Risk Type:	Select One Item
	Other Risk Type (if applicable):

Risk Title	
Enter text.	
Risk Description	
Context	Enter text
Risk	Enter text
Causes/Sources/Events	Enter text
Impacts/Consequence	Enter text

Consequence	Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

1-3	**Low risk**
4-6	**Moderate risk**
8-12	**High risk**
15-25	**Extreme risk**

Step 1 – INITIAL RISK SCORE - Score Risk without Current Controls							
Consequence	Choose a score	x	**Likelihood**	Choose a score	=	**Initial Risk Score**	

Step 2 – Determining the Current Risk Score							
2a: List Controls Currently in Place:							
Controls							
2b: List the Assurances for these Controls:							
Assurances							
2c: CURRENT RISK SCORE – Score Risk with Current Controls							
Consequence	Choose a score	x	**Likelihood**	Choose a score	=	**Current Risk Score**	Choose a score

Step 3 – Determining the Target Risk Score		
3a: What extra controls are required to reduce this risk as low as reasonably practicable (ALARP)?		
Enter text		
3b: What actions are required to provide these extra controls or increase the assurance of controls?		
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Describe the action	Name the action lead	Target date for completion
Notepad:		

List here any other information that supports your risk assessment but which is not recorded elsewhere on this form							
3d: TARGET RISK SCORE – Considering all of the information you have on the controls and assurances how would you rate the risk when the actions are completed?							
Consequence	Choose a score	x	**Likelihood**	Choose a score	=	**Target Risk Score**	Choose a score

Name of Assessor:	Name of Assessor
Signature of Assessor:	
Date of Assessment:	Enter a date
Risk Owner:	Name of Risk Owner
Signature of Risk Owner:	
Date signed by Risk Owner:	Enter a date

Format of the Workbook

This workbook contains conditional formatting and protected areas. This will prevent you from deleting a row or column but you can delete the contents of a row.

Accepted or Closed Risks

Once risks are removed or accepted they should be cut and pasted onto the 'Accepted and Closed Risk' sheet.

Risk Acceptance. Risks are accepted when the risk score equals that of the target risk rating i.e. where all reasonable actions have been effectively carried out and the risk owner is in all other respects confident that the risk has been reduced as low as reasonably practicable (ALARP). A clear rationale for accepting the risk should be added to the risk register entry. Accepted risks should be held on the register and reviewed at least annually to see if they remerge.

Risk Closure. Where it is recognised that a risk no longer exists or is no longer relevant to the organisation the risk can be closed. Risks that are covered by another risk can also be closed. The date of closure and the rationale for closure should be recorded on the risk register. Where closed risks have a potential for recurrence an appropriate date for review should be recorded.

GUIDANCE FOR COMPLETING THE RISK REGISTER
Remember that all risks must have undergone a risk assessment prior to them being added to the Risk Register
Risk Reference Number: This should be sequential. In the event that a risk is accepted or closed and therefore archived to the accepted and closed sheet, there is no requirement to re-number the remaining open risks.
Strategic Objectives: The strategic objectives can be found in the comments box. Identify which objective(s) may be impacted if the risk event occurs, and record the corresponding number(s) in the box. For example the risk could adversely impact on the reduction of health inequalities and a planned care system where demand and capacity are in balance - therefore '1,6' are recorded.
Date Risk Added: Please enter in the format dd/mm/yyyy.
Risk Description: Introduce the topic, then state *there is a risk that if X happens then this could result in Y. The impact of this could be Z (or ZZ, ZZZ etc).* A well written risk description contains three main elements: 1. Context. A summary of the relevant background facts. 2. Source or Cause of Risk. The current conditions or factors that create the risk. 3. Impact. The impact on the programme/organisation objectives in the event of the risk occuring.
Executive Lead: This is the senior person, with decision making authority, best placed to monitor the risk. This person is accountable for the risk and should be aware of it's current status.
Initial Risk Rating: This is the risk score calculated without consideration of any risk treatment/controls i.e. what would the risk be if we did nothing to reduce it.
Controls: A control is any active measure or actrion that modifies (i.e. treats) risk in the intended manner. Controls may be policies, procedures, practices, processes, technologies, techniques, methods or devices. They can also be modifications to existing controls to increase their effectiveness. Controls should be listed in their priority order - bullet points are encouraged.
Assurances: List here evidence that existing controls are working in the intended manner. Examples of evidence include inspections, walk arounds, audits, training records, DATIX trends etc. There may be external as well as internal assurance processes.
Current Risk Rating: The Current Risk Score takes the Initial Risk Score and re-assesses it with consideration of the effect these controls have on consequence, and/or likelihood. These control measures should be prioritised so that the actions likely to have the best effect are taken first. The consequence if a risk occurs will seldom alter but, with effective controls in place the likelihood of the risk should reduce. Therefore it will usual for the current risk rating score to be lower than that provided for the initial risk rating.
Gaps In Control: These are controls which are required to reduce the risk but which are currently absent or only partially effective.
Actions: This is a bulleted list of the actions needed to provide/increase/improve controls or to provide assurance of control effectiveness.
Who is leading on these actions and **When** are they expected to be achieved?
Target Risk Rating: The target risk rating is the level of risk that the organisation is happy to tolerate. The UHB Risk Appetite statement provides further guidance on the level of tolerable risk. The target risk score can also be seen as a projection of how the risk should look once it is has been reduced as low as reasonably practicable.
Review Date: The Risk Management and Board Assurance Framework Strategy (UHB 470) described the required review periods.
Assurance Committee: For assurance purposes a UHB Board Committee should be assigned for any risks escalated to the Corporate Risk Register.

RISK REGISTER TEMPLATE	
CLINICAL BOARD/CORPORATE DIRECTORATE:	
SPECIALITY/DEPARTMENT:	

Risk Ref.	Strategic Objective	Date risk added dd/mm/yyyy	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Date of next review	Assurance Co
					Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total		
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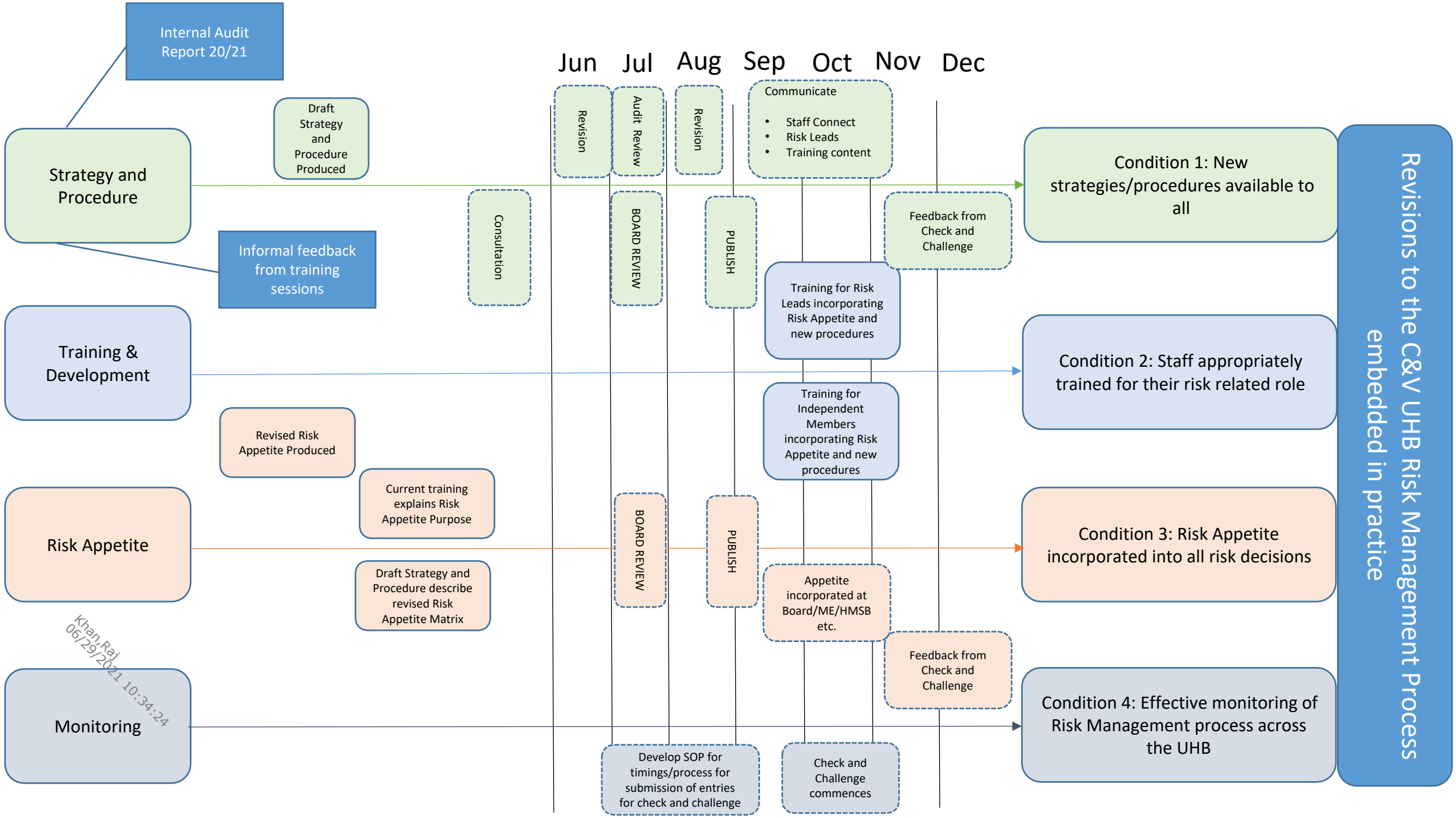
Accepted or Closed Risks

Risk Ref.	Strategic Objective	Date risk added (to original risk register)	Risk	Exec Lead	Initial Risk Rating			Controls	Assurances	Current Risk rating			Gaps in Control	Gaps in assurance	Actions	Who	When	Target Risk rating			Accepted or Closed?	Date accepted/closed	Rationale	Review date (If applicable)
					Consequence	Likelihood	Total			Consequence	Likelihood	Total						Consequence	Likelihood	Total				

Khan Raj
06/29/2021 10:34:24



Report Title:	**Audit and Assurance Committee Effectiveness Review 2020-21 Results**								
Meeting:	Audit and Assurance Committee					**Meeting Date:**	06/07/2021		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**X**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

It is good practice and good governance for Committees of the Board to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders.

The questions in this year's self-assessment mirror those included in last year's review; they are key considerations in the Good Governance Handbook and this approach enables us to reflect on progress with last year's action plan. Some additional questions were also incorporated for this year's survey. Survey Monkey was again used as a tool to gather the feedback.

ASSESSMENT

Attached are the results and comments made for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee.

Overall the responses show that the Committee has maintained standards and achieved improvement in a number of aspects of Committee effectiveness.

An action plan has been developed on areas identified for improvement and this is shown at appendix 1.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee's self-assessment Effectiveness Review for 2020-21.
- Approve the action plan at Appendix 1.

Shaping our Future Wellbeing Strategic Objectives *The UHB objectives relevant to this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x

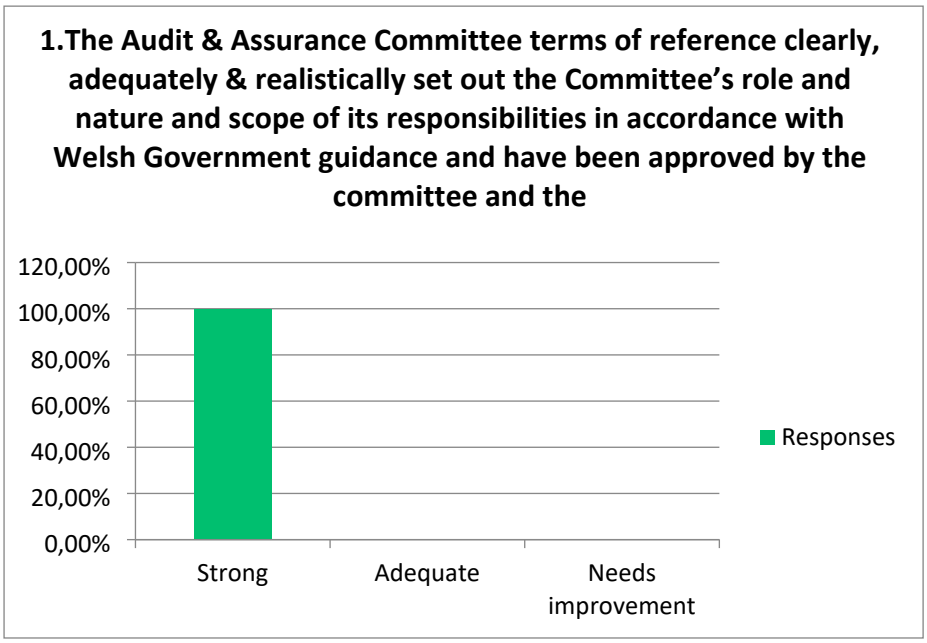
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce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

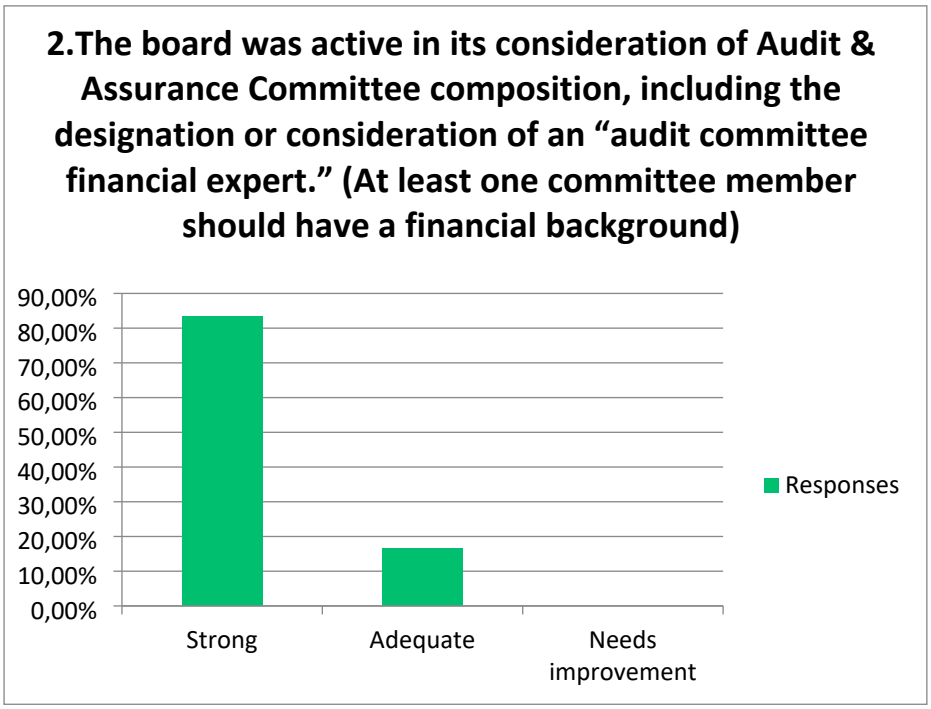
Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

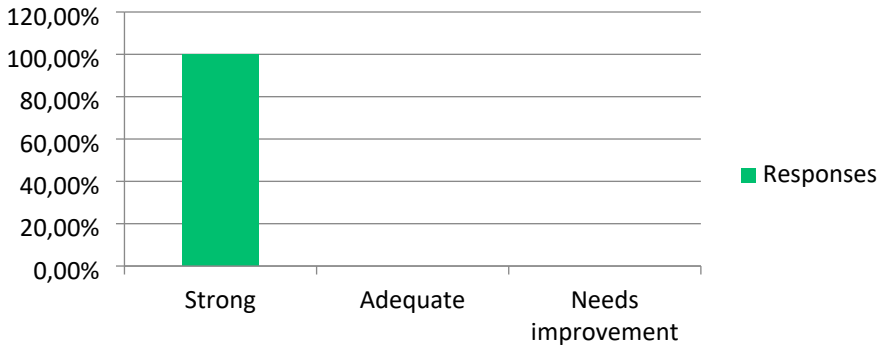
Audit and Assurance Committee Self-Evaluation 2020-2021

- 6 responses received.

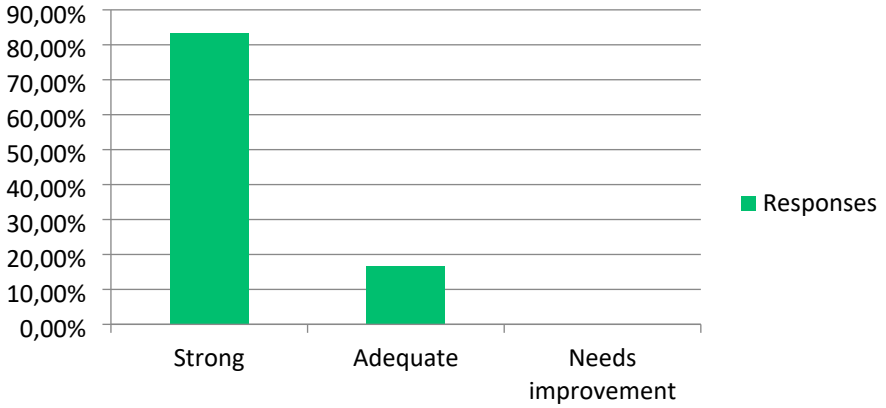




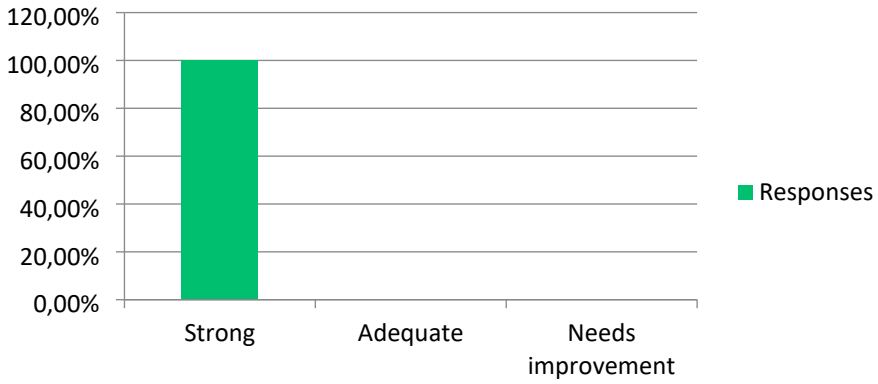
3.The Audit & Assurance Committee's actions reflect independence from management, ethical behaviour and the best interests of the Trust and its stakeholders.



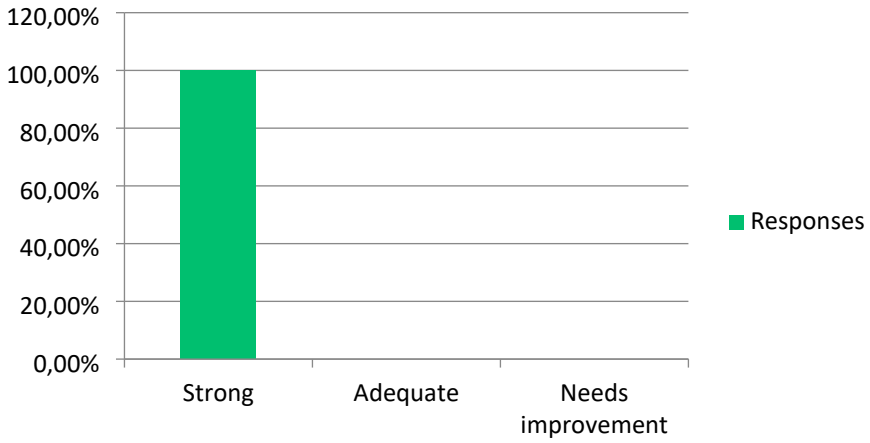
4.The Audit & Assurance Committee's meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible aft



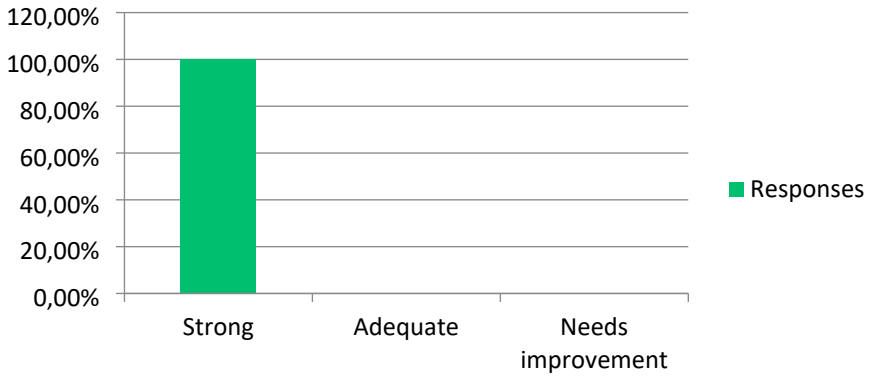
5. Audit & Assurance Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Audit & Assurance Committee's responsibilities.



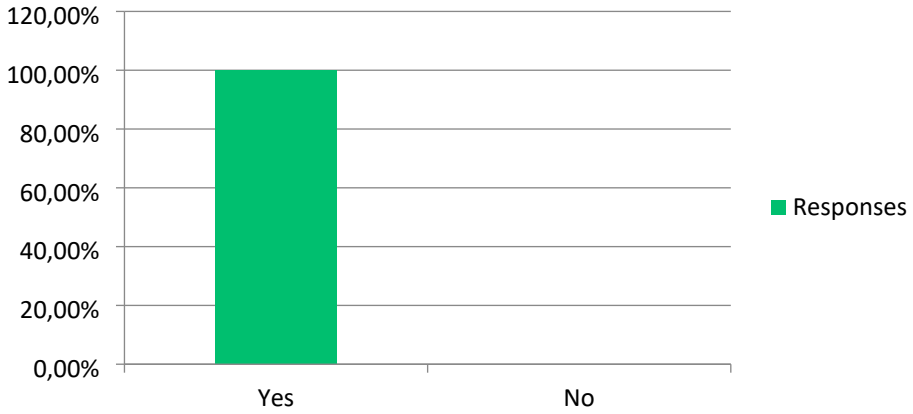
6.Appropriate internal or external support and resources are available to the Audit & Assurance Committee and it has sufficient membership and authority to perform its role effectively.

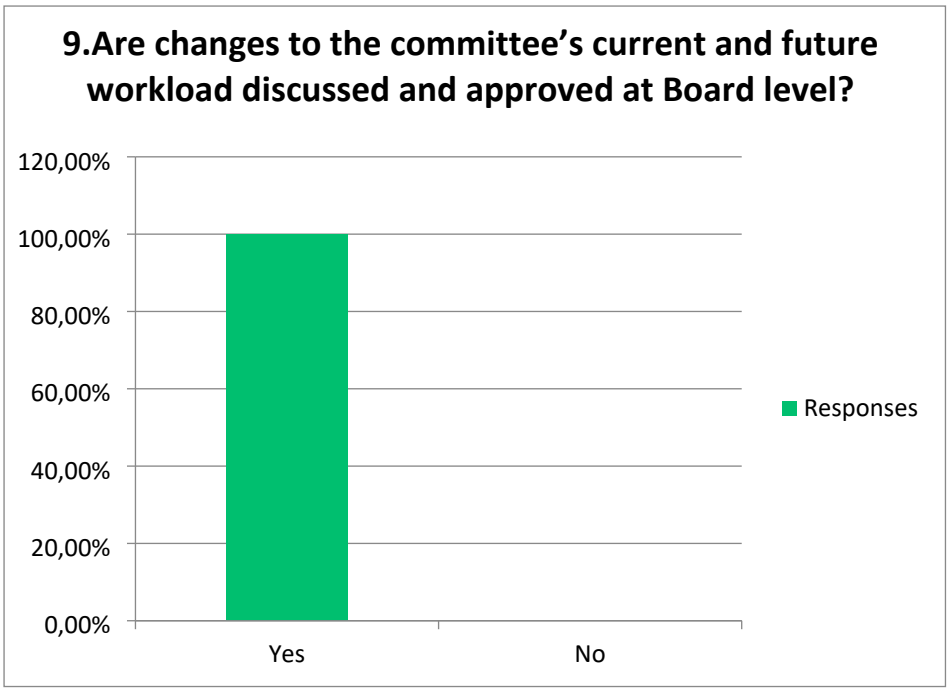


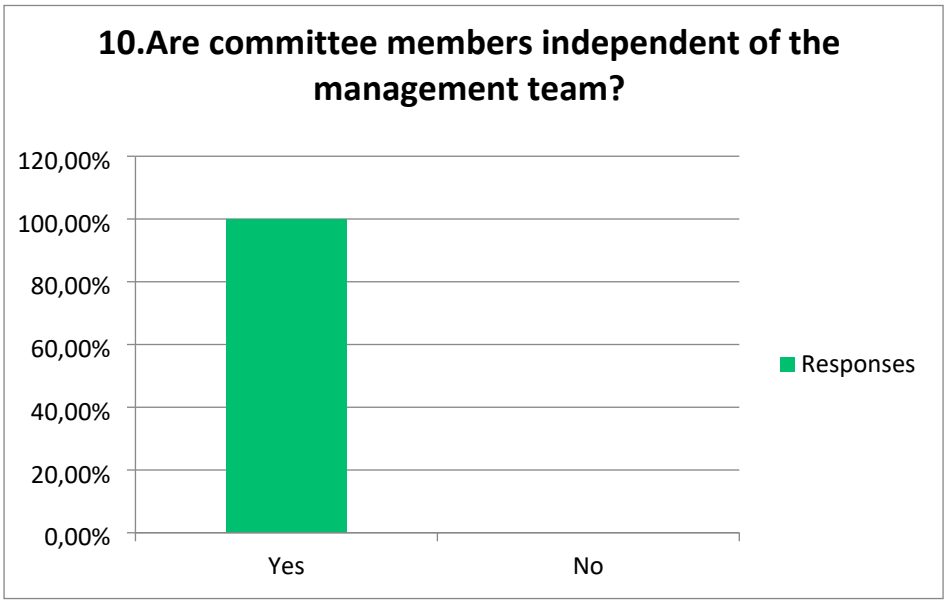
7. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.



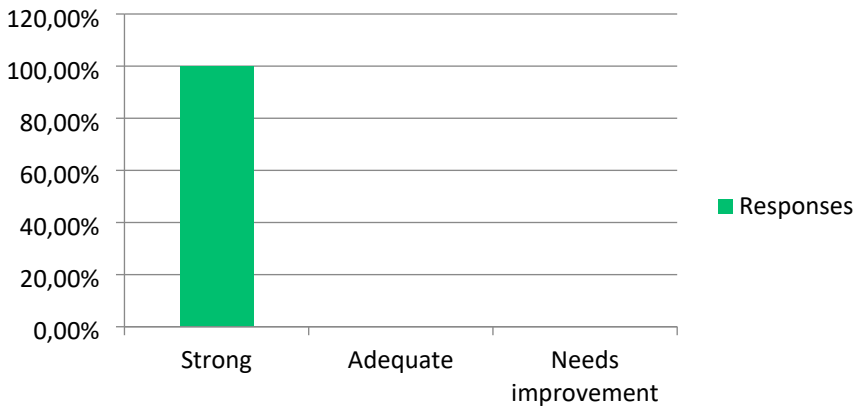
8. Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation?



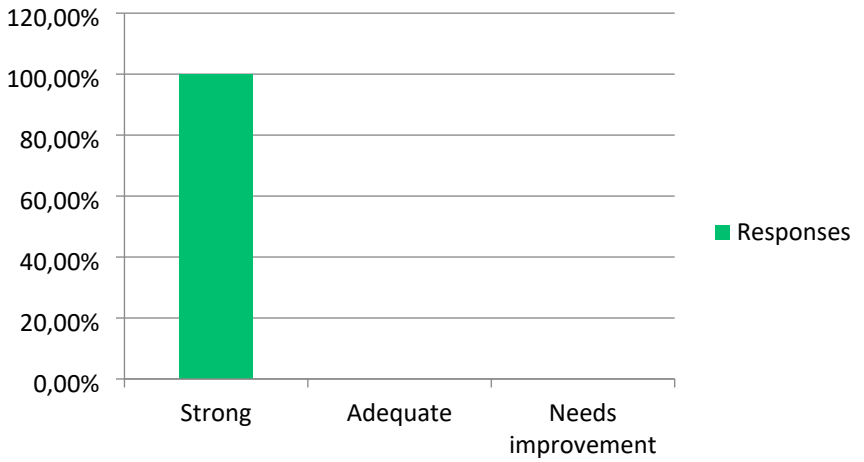


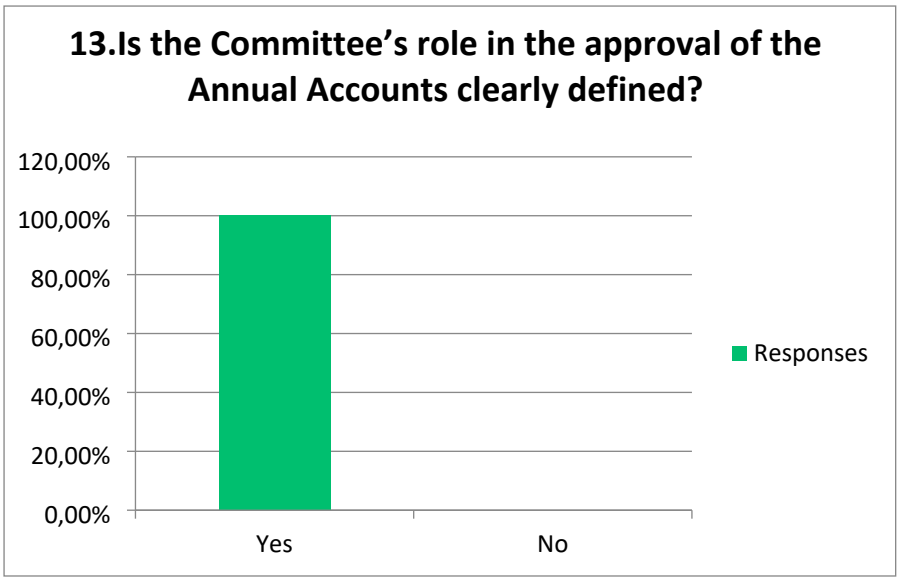


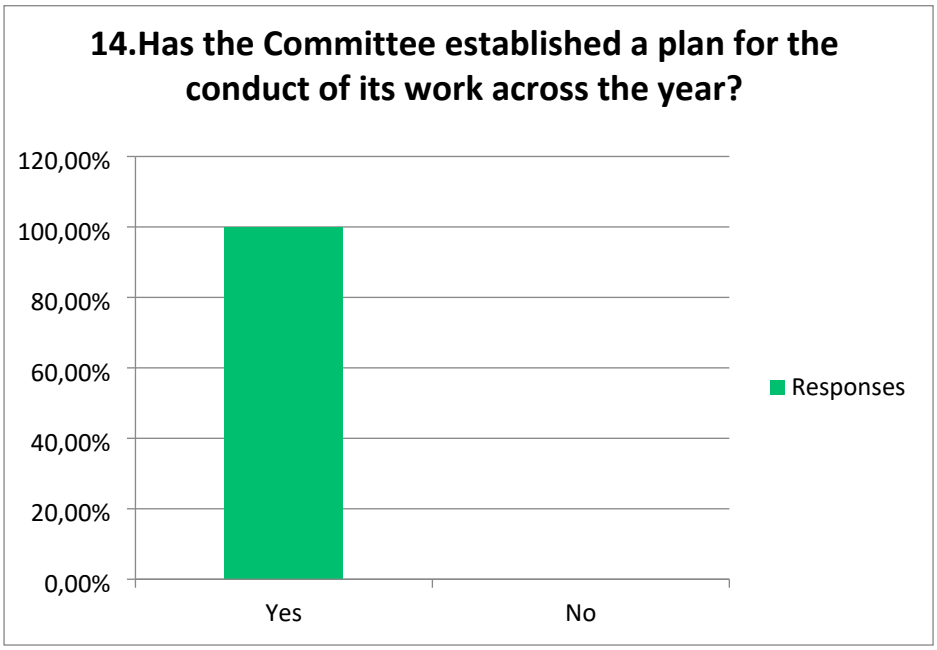
11.There is appropriate consideration of the UHB's financial reporting risks and the related internal controls, which are reflected in the audit committee's discussions and agenda items.

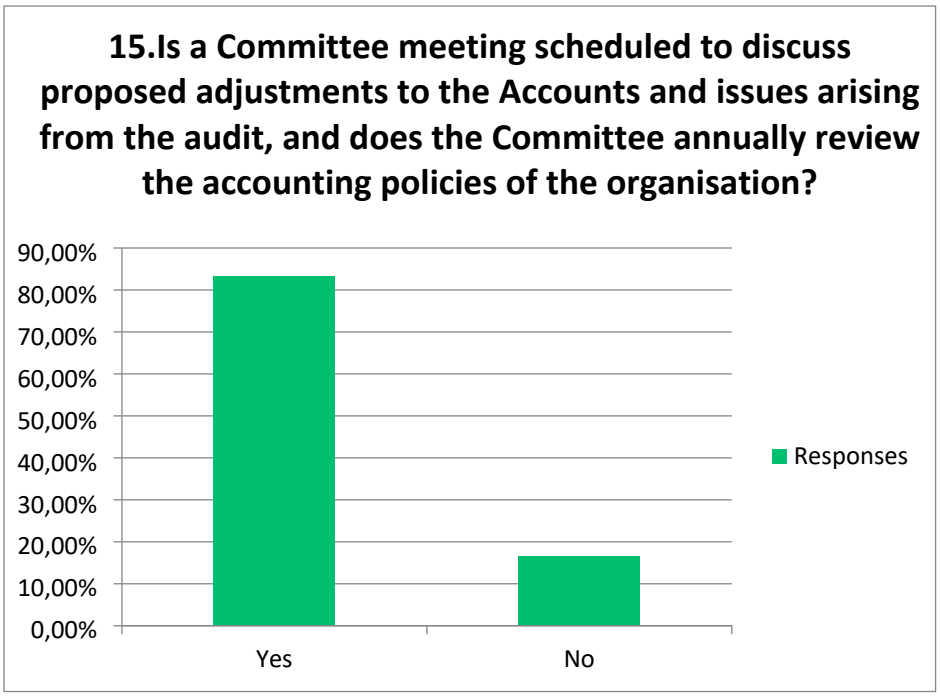


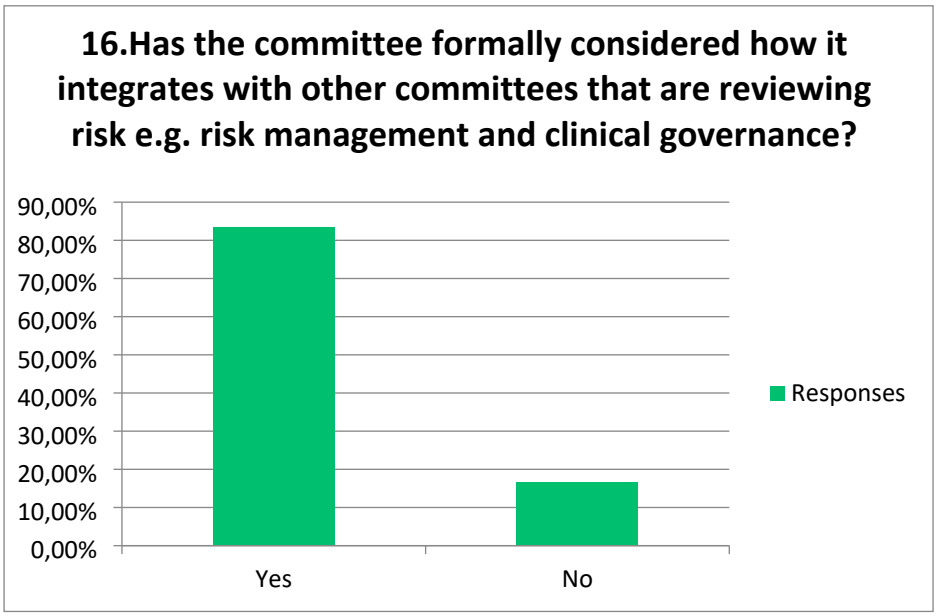
12.The Audit & Assurance Committee's agenda-setting process is thorough and led by the audit committee chair.





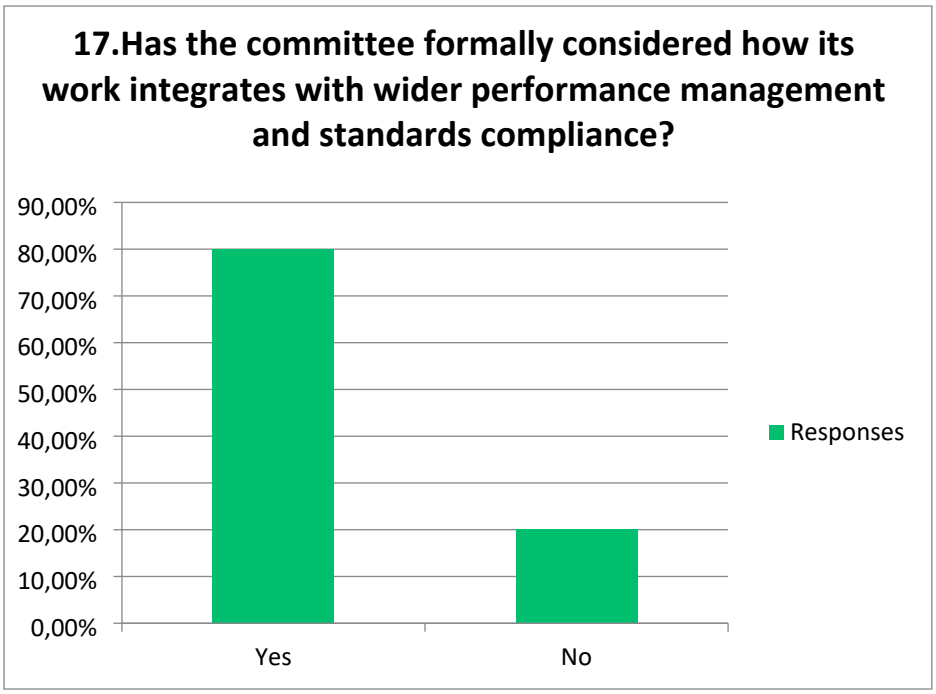


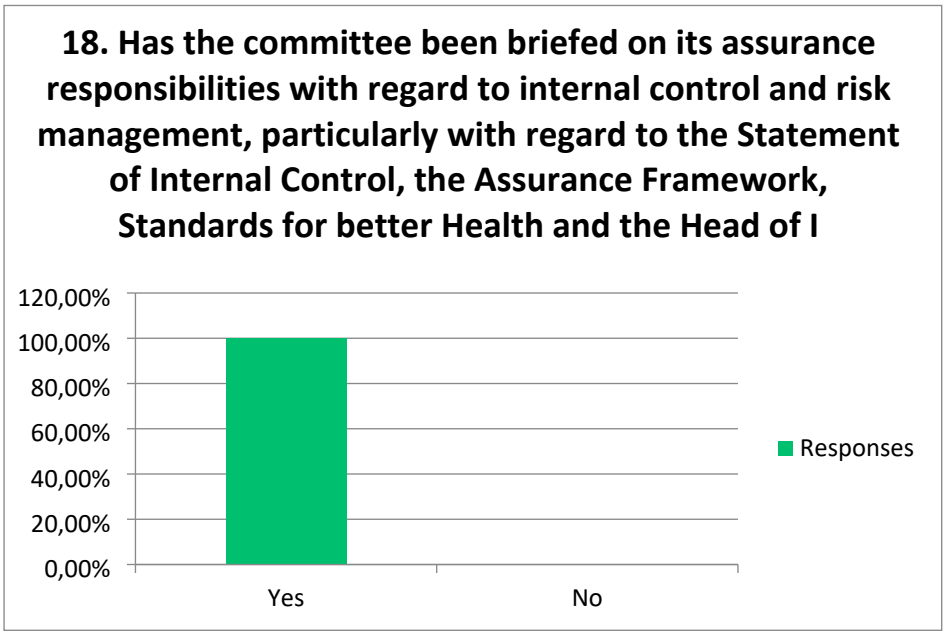




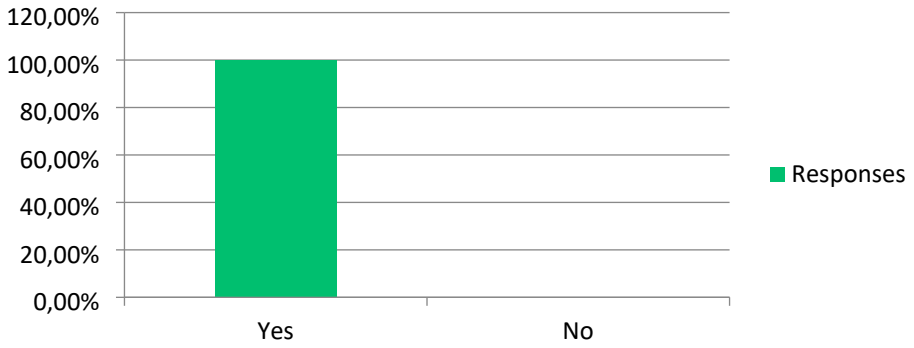
Comments received:

- *A report was presented to the Committee on the interrelationship with other Committee of the Board during the financial year*

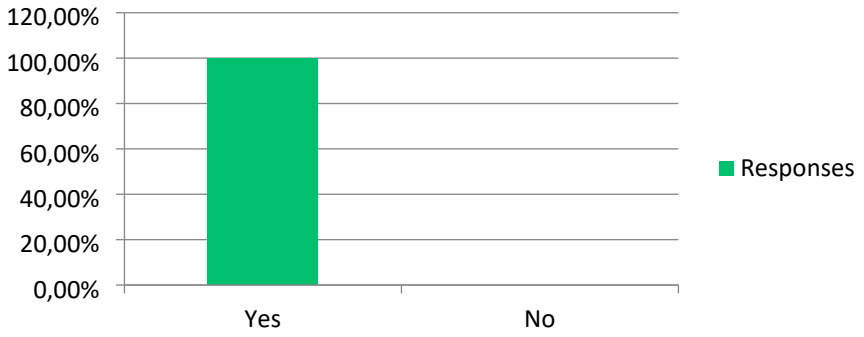


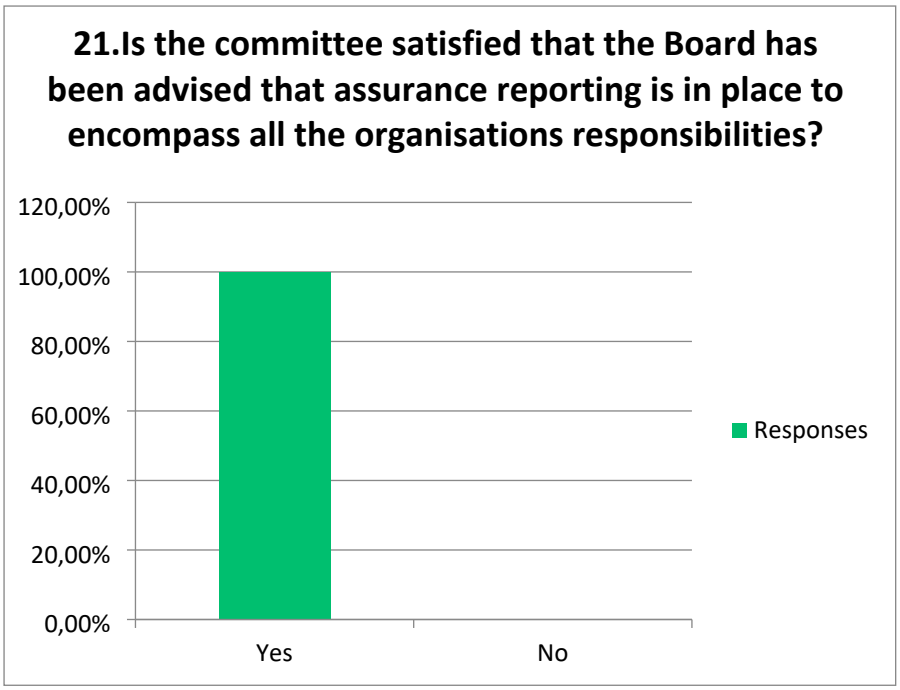


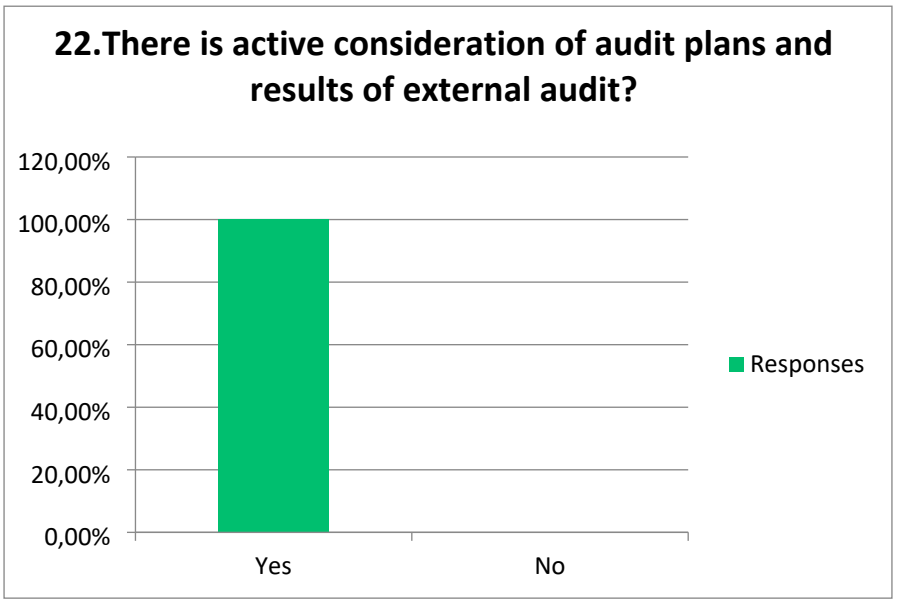
19. Has the committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discha

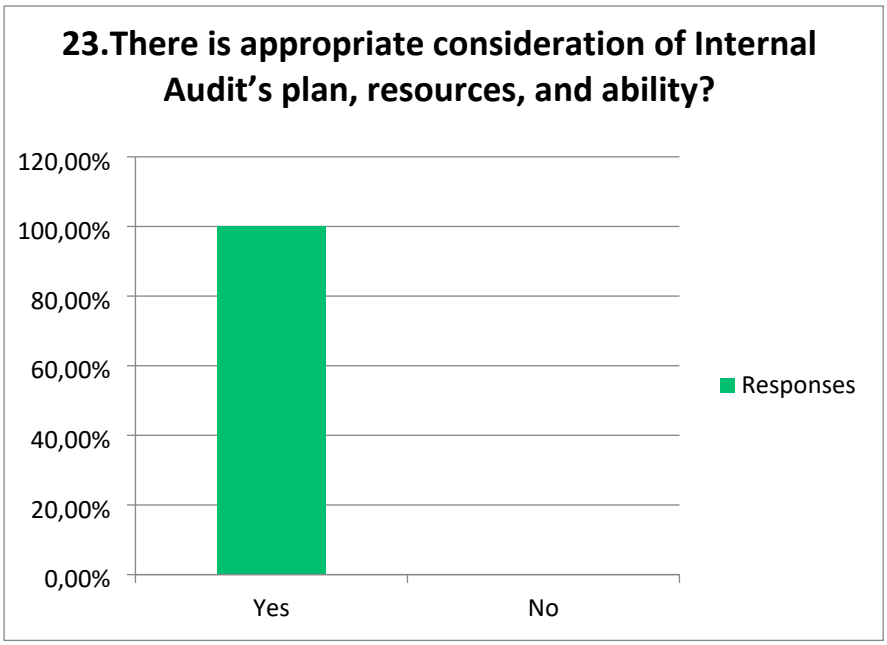


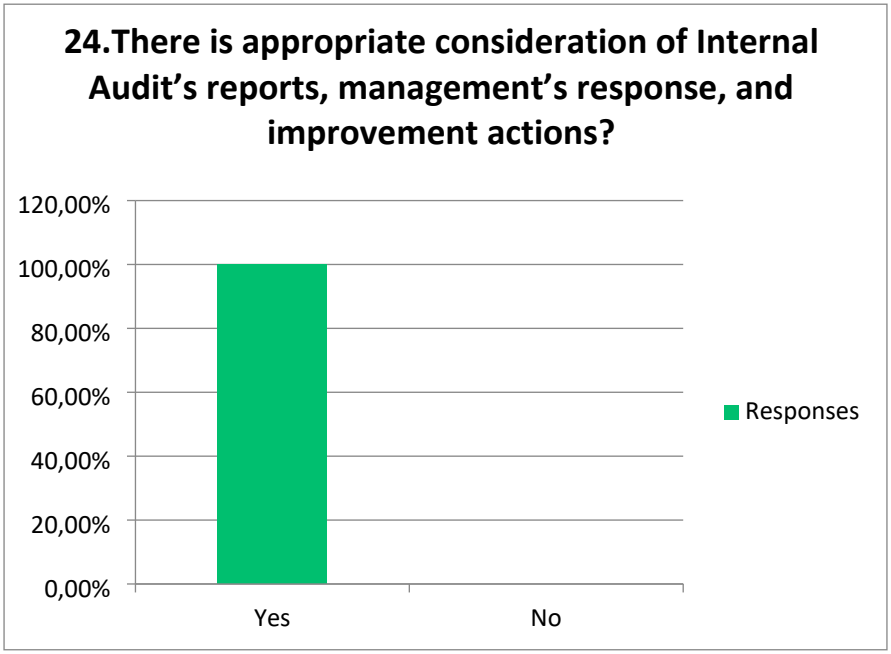
20.Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters?

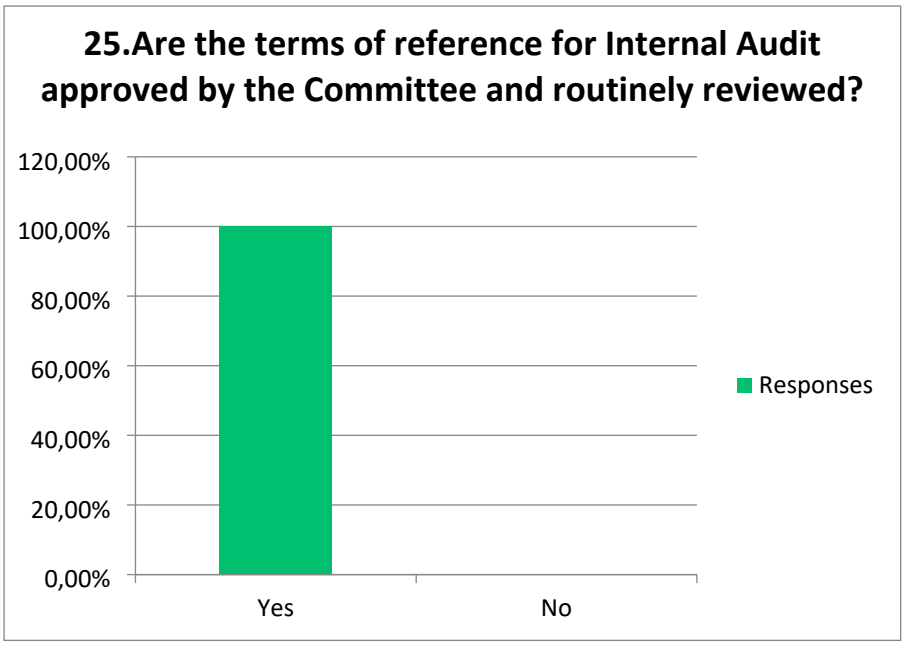






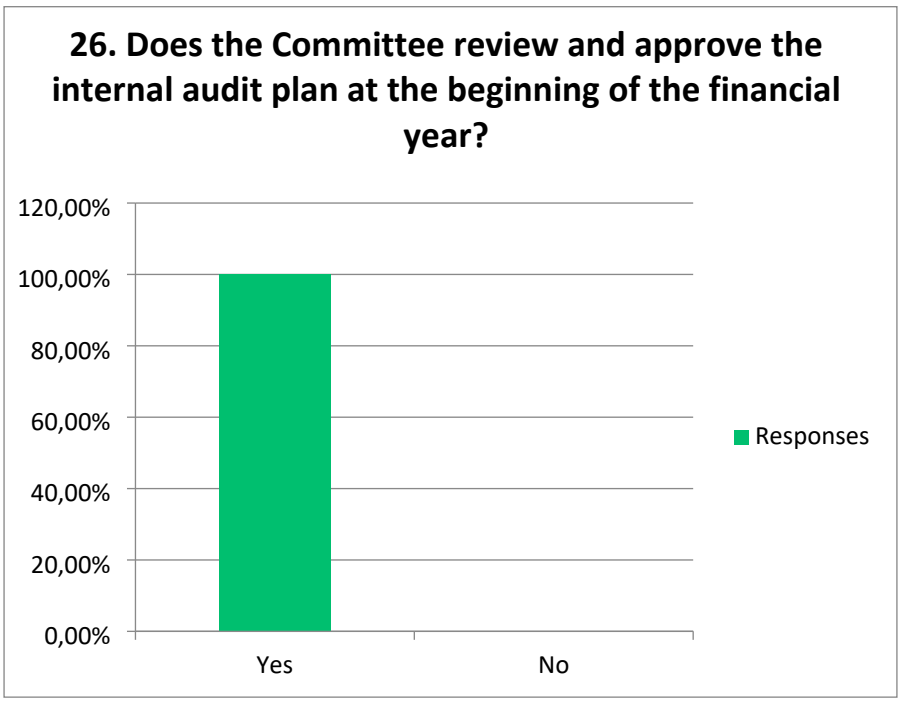


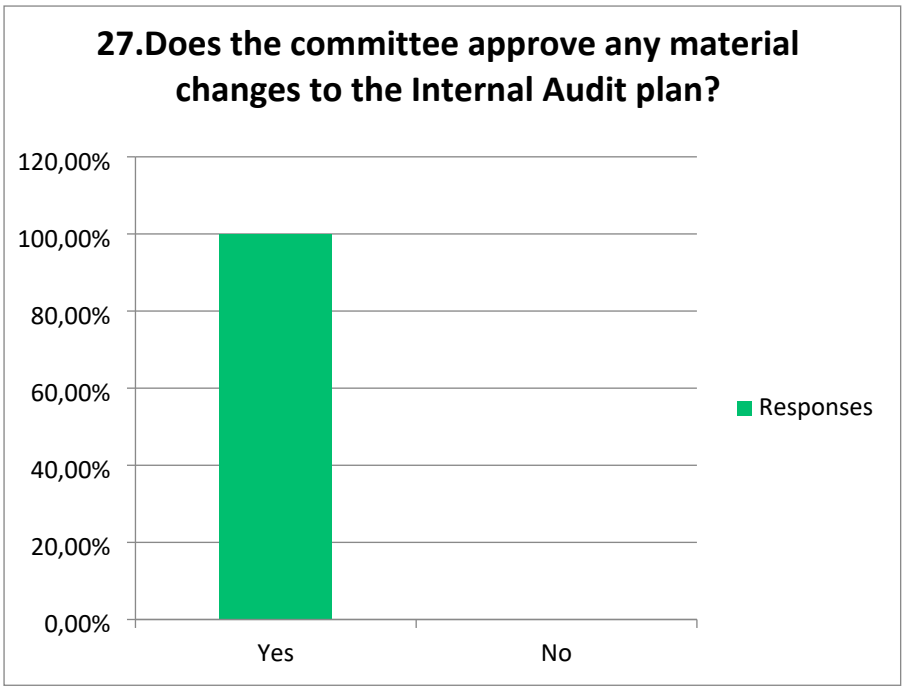




Comments received:

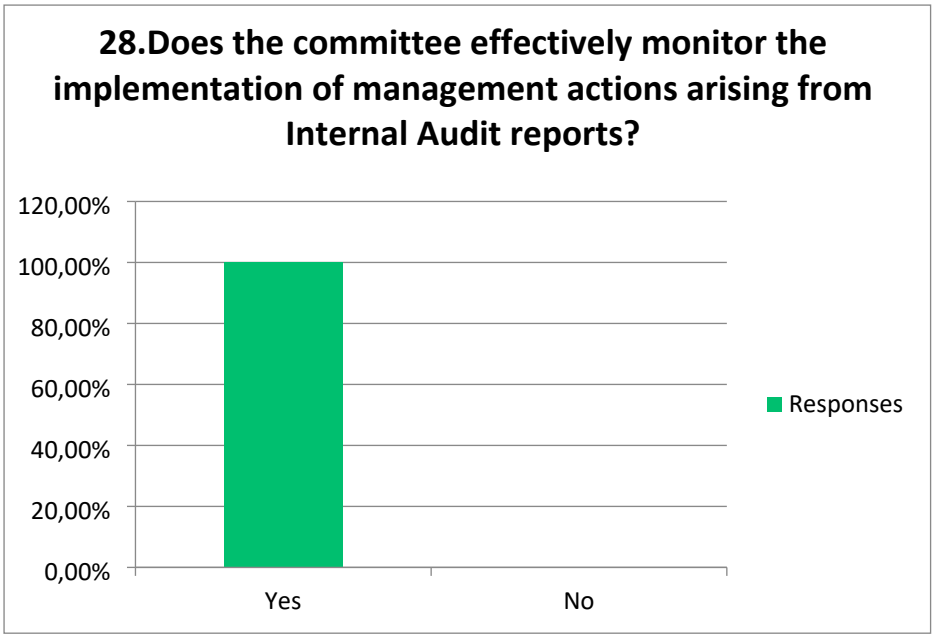
- *This is done as part of the annual plan for the year approval*





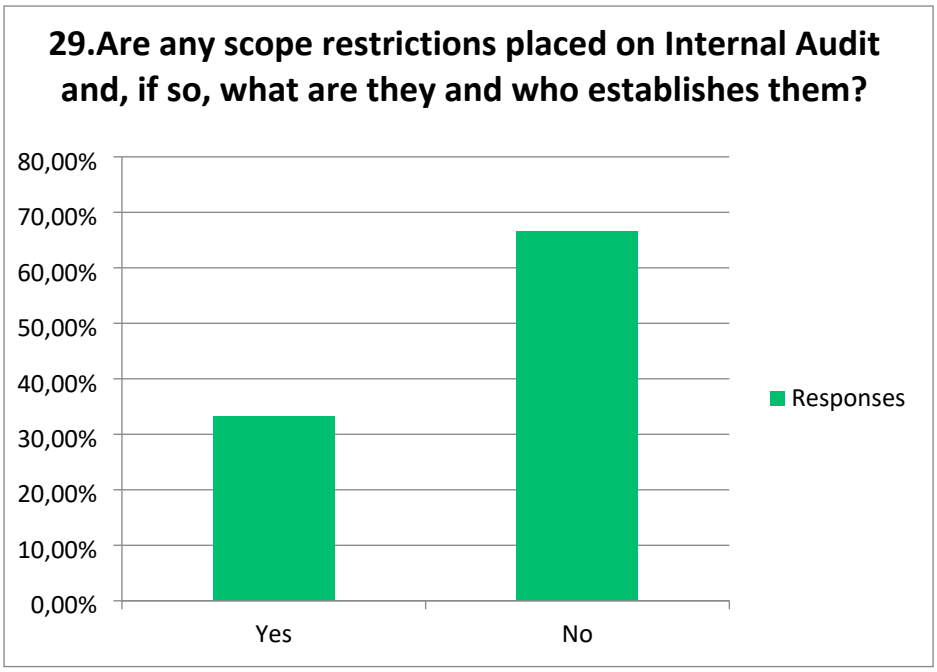
Comments received:

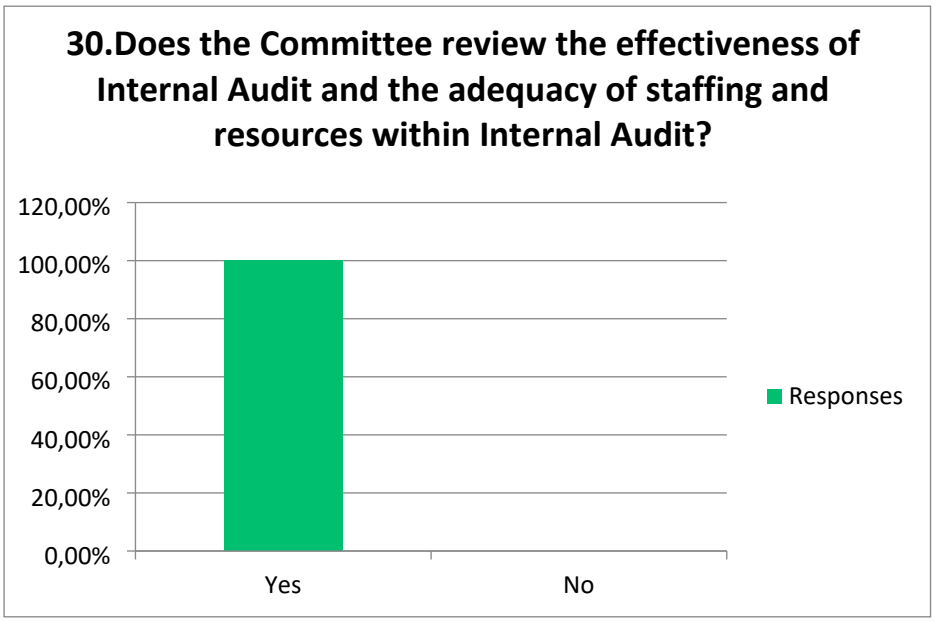
- *The Committee approved in addition to the Management Executive*

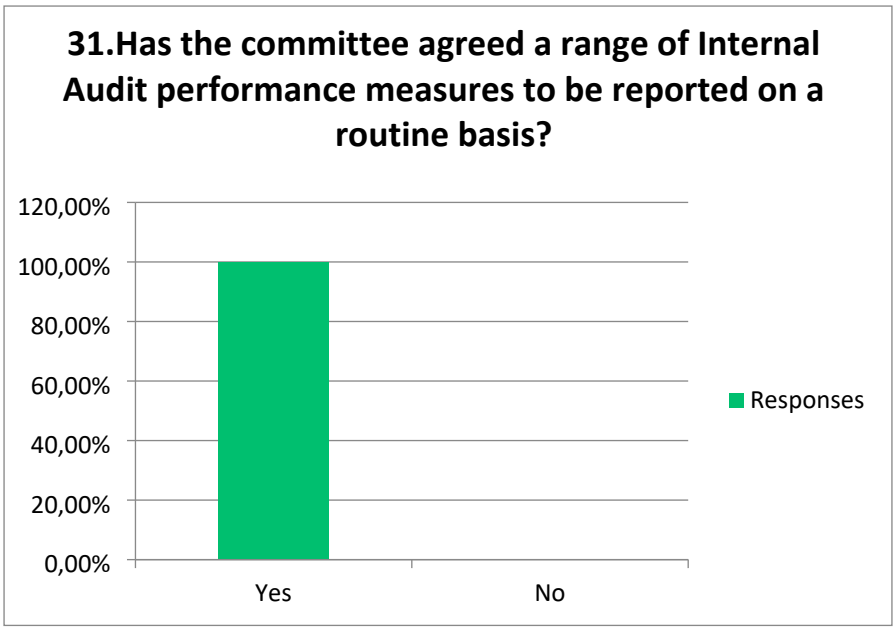


Comments received:

- *Tracking reports are presented to each Committee meeting*

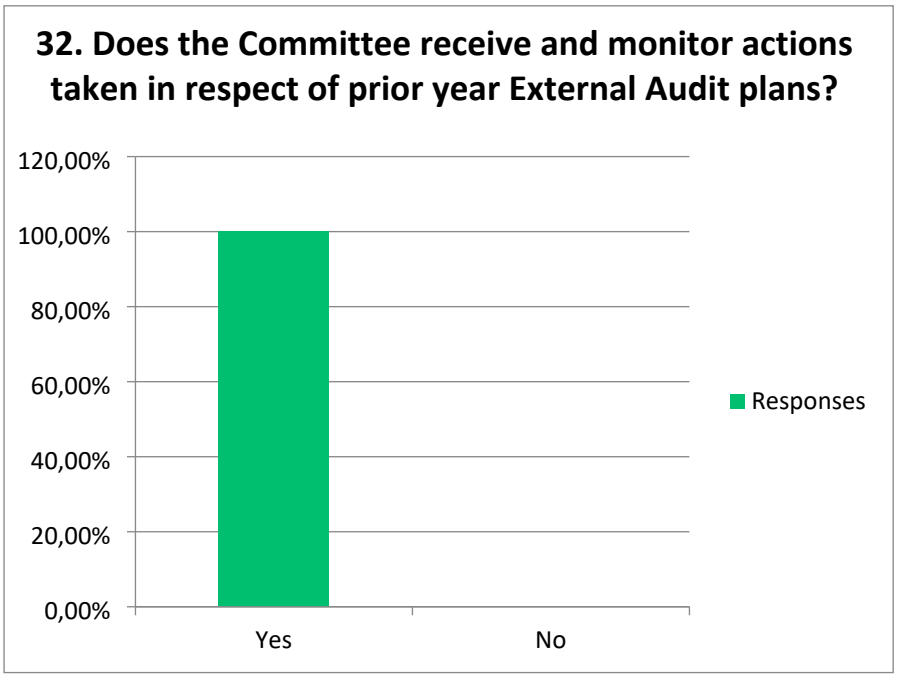






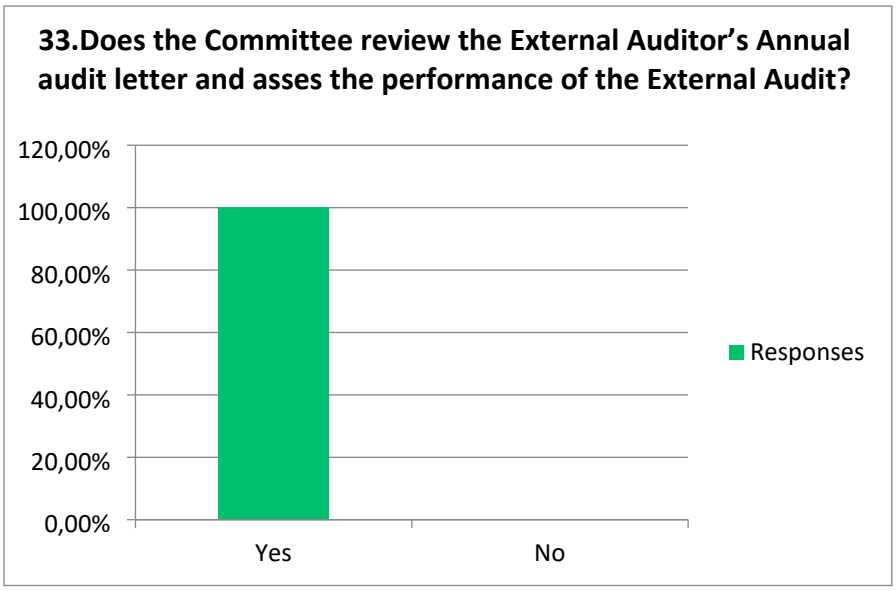
Comments received:

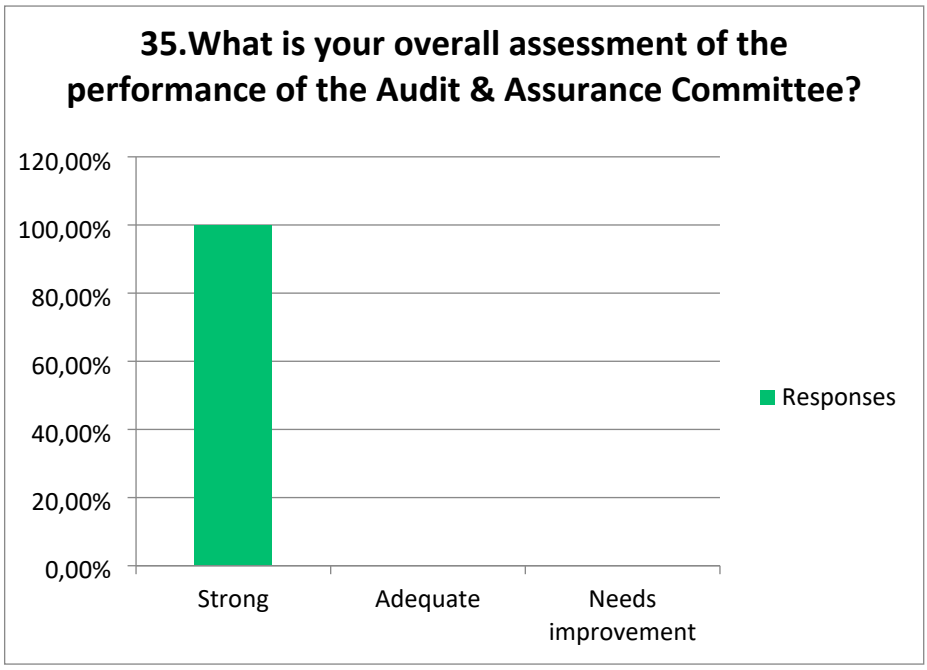
- *This is done as part of the annual planning process.*
- *Not sure.*



Comments received:

- *These are tracked at each Committee*





Appendix 1

Audit and Assurance Committee – Self Assessment 2021 Action Plan

Question asked	Action Required	Lead	Timescale to complete
Is a Committee meeting scheduled to discuss proposed adjustments to the Accounts and issues arising from the audit, and does the Committee annually review the accounting policies of the organisation?	This takes place on an annual basis both in the form of a workshop for the Audit Committee and an Audit Committee Meeting where audit changes and adjustments to the accounts are highlighted to Committee Members	Chair/Director of Finance	**Complete** – workshop and Special Audit Committee took place in May and June 2021 respectively.
Has the committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?	The Risk Management and Board Assurance Strategy is presented to the Committee prior to the Board. The Strategy details how other Committees of the Board review risk. Clinical Governance arrangements are reported to the Audit Committee and the Quality Safety and Experience Committee.	Director of Corporate Governance/ Executive Nurse Director/Executive Medical Director	**Partially complete** - The Risk Management Strategy is being presented to the Committee in July 2021 following that it will be presented to the Board. Arrangements for Clinical Governance will be presented to the Audit Committee once the review of Audit Wales is completed in addition to this it will be reported to the Quality Safety and Experience Committee with implementation being monitored by Audit Committee.
Has the committee formally considered how its work integrates with wider performance management and standards compliance?	An integrated Performance Report is currently being developed for the Board with a hierarchy or reporting from the Committees of the Board.	Executive Directors with responsibility for Performance/Director of Corporate Governance	**Partially complete** - First report presented to the Private Board in May 2021. Reporting in private will continue until Members are happy with the approach being taken and the Performance details being presented. Audit Committee will review standards of compliance on a regular basis once reporting in Public takes place.
Are any scope restrictions placed on Internal Audit and, if so, what are they and who establishes them?	The Annual Internal Audit plan is agreed by the Committee and a proactive approach taken to ensure Internal Audit work focuses on the Committee's assurance needs. There are no restrictions placed on Internal Audit.	Chair/Director of Corporate Governance/ Head of Internal Audit	**Complete**

Report Title:	**Outstanding Audit Recommendations Update – 2017/18**								
Meeting:	Audit Committee						**Meeting Date:**	6th July 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Head of Risk and Regulation								

Background and current situation:

The purpose of this report is to provide Members of the Audit Committee with and update on outstanding Internal Audit Recommendations for the year 2018/2019 and 2019/2020 and to put forward proposals for their management moving forward.

As of the 25th June 2021 the Health Board's Internal Audit Tracker records 45 recommendations for financial years 2018/19 (12) and 2019/20 (33). 9 of the 12 entries for 2018/19 and 8 of the 33 entries for 2019/20 are recorded as complete.

Details of outstanding recommendations for 2018/19 and 2019/20 including those recorded as complete, are appended to this report.

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

Following April's Committee meeting the Risk and Regulation his team have liaised with the executive leads for outstanding recommendations for 2018/19 and 2019/20 to understand whether their entries should continue to be recorded on the Internal Audit Tracker and, if so, what plans were in place to ensure that the recommendations are proactively managed.

Below you will find recommendations for the entries recorded for 2018/19 and 2019/20. For the avoidance of doubt, recommendations would not continue to be recorded on the register if they were complete, superseded by subsequent audit recommendations or were no longer relevant/appropriate.

- 2018/19 Entries

  9 of the 12 entries for 2018/19 are complete.

  The position of and proposals for the remaining three entries is as follows:

  Audit C&V 18/19 – 11 – Commissioning

  The ToR for the Strategic Commissioning meeting has been revised and now includes two Clinical Board representatives. The document will be reviewed again following the appointment of Catherine Phillips as Executive Director of Finance and an updated copy subsequently shared.

to reflect that we have a new Director of Finance following this an updated copy will be provided. Given the work undertaken on the Terms of Reference It is proposed that this recommendation is closed as complete.

Audit C&V 18/19 – 04 Legislative/Regulatory Compliance – Recommendations 5 and 6

Since this review the Health and Safety team, including the Fire Safety Teams, have been the subject of an independent audit. Further changes to the team and its management will be made following the output from that audit.

A further Legislative and Regulatory Compliance Internal Audit will also commence in July 2021. It is therefore proposed that these entries are closed and superseded by the output of the impending Legislative and Regulatory Compliance Audit.

- **2019/20 Entries**

8 of the 33 Entries for 2019/20 are complete.

The position of and proposals for the remaining three entries is as follows:

AUDIT CVU 2019/201 Legislative and Regulatory Compliance

This is a duplicate entry and will be removed at the next committee meeting.

AUDIT C&V 19/20 - 41 – Consultant Job Planning Follow Up (5 entries)

A further Consultant Job Planning Follow Up review took place during 2020/21 and it is proposed that these entries are closed and that the follow up entries for 2020/21 remain in place to reflect the present position.

AUDIT CUHB 19/20 – 23 - Freedom of Information

The Director of Digital and Health Intelligence has confirmed that the recommended training will be delivered this financial year. It is therefore proposed that the entry be closed.

AUDIT CUHB 19/20 – 30 - Medical Study Leave (5 entries)

Completion of these recommendations have been delayed due to Covid-19 pressures. It is recommended that these entries remain on the tracker pending further updates.

AUDIT CUHB 19/20 – 04 - Management of Health Board Policies and Procedures

Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on these recommendations will re-commence. It is proposed that these entries remain on the tracker.

AUDIT C&V 19/20 – 40 – Pre Employment Checks (8 entries)

No substantial update has been shared for these entries and it is proposed that they remain on the tracker pending further progress.

AUIDT C&V 19/20 – 08 – Strategic Planning IMTP

BCAG Terms of Reference currently await further review and it is proposed that this item remains on the tracker.

Assuming that the below proposals are agreed the Internal Audit Tracker will carry forward 18 recommendations for the year 2019/20 into September's meeting with the intention that further progress will be made prior to that meeting.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

There is a risk that continuing to record aged recommendations, which do not reflect current practice or impending changes to the Health Board's regulatory requirements, will divert energy and resource away from key service areas and impede the delivery of required change.

This risk will be mitigated by the closure of historic entries and the agreement of new, service specific reviews in the new financial year.

Recommendation:

The Audit Committee Members are asked to:

(a) **Note** the Outstanding Audit Recommendations Update – 2018/19 and 2019/20; and
(b) **Approve** the proposals for the future recording and removal of historic recommendations Health Board's Internal Audit Tracker.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect		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	x

				provide an environment where innovation thrives					

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	x	Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update from Committee meeting held in April 2021
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R1/6	H	Suitably qualified and experienced staff should be assigned specific responsibility for overseeing the pilot. This should include resolving all outstanding issues, developing management reports, monitoring and reporting progress of the pilot to an appropriate level of Estates Management and the final evaluation of the suitability of the system.	Business Manager, Estates	Closed	Agreed date not reached	C	Kronos has been introduced and evaluated and detrmined that it is only suitable for timekeeping and does not provide adequate benefits with its links with ESR. However, it has proved beneficial for basic functions.
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R4/6	M	Where overtime has been worked this should be reflected in the start and finish times recorded in Kronos, and should be authorised on the timesheets. Management should investigate the feasibility of including a 'reason for overtime' or Notes field on timesheets with the system providers so that in future all overtime can be claimed and authorised on individual timesheets	Business Manager, Estates	Closed	Agreed date not reached	C	Closed - All complete.
C&V-1819-46	2018-19	Kronos Time Recording System - Estates	Director of Planning	Reasonable	R5/6	M	Staff should be instructed to clock in no more than 27 minutes before the start of their shift. Where staff do clock in more than 27 minutes before the start of their shift, supervisors should amend the timesheet start time to the scheduled start time if the additional time is not to be paid as overtime. Supervisors should update timesheets with reasons why staff have not clocked in or out of the system prior to authorising them, for example annual leave, special leave, unpaid leave, working off site, system down etc. Supervisors should amend shift start and finish times on Kronos where it has been agreed that staff can work alternative shift patterns. Disciplinary action should be taken against staff that are persistently late and fail to work their assigned shift pattern.	Business Manager, Estates	Closed	Overdue by over 18 months under 24 months	C	Closed - All complete.
C&V 1819 - 11	2018-19	Commissioning	Director of Digital & Health Intelligence	Reasonable	R1/3	H	Strategic Commissioning Group Terms of Reference document should be revised and updated to state the quorate attendance level and its current membership. Additionally, its membership should include representation from the Clinical Boards to ensure a broad contribution and as such an improved strategic approach in full alignment with the Group's Terms of Reference.	Eleri Probert / Mel Wilkey	Open	Overdue by over 18 months under 24 months	PC	The ToR for the Strategic Commissioning meeting has been revised and now includes two Clinical Board representatives. The document will be reviewed again to reflect that we have a new Director of Finance following this an updated copy will be provided.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R2/7	M	The current position in respect of the backlog of remedial jobs, should be routinely reported to the Water Safety Group (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Closed - All complete.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R3/7	M	Training should be updated for all key staff with assigned water management responsibilities (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Completed
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R4/7	M	a) An audit trail should be maintained where routine checks are not completed, in cases where risk-based decisions dictate alternative monitoring/testing schedules will be applied. b) Key person dependency should be reviewed and removed, where possible, to facilitate the timely identification and completion of remedial work (O). See also recommendation 2 in relation to assessment and reporting of the backlog of remedial jobs.	Director of Capital, Estates & Facilities	Closed	Overdue by over 12 months but under 18 months	C	Closed - All complete.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R5/7	H	a) For those clinical boards identified in this audit as being non-compliant with required flushing practices, the Chair of the WSG should request assurance from the clinical boards that practices have been improved. b) The Chair of the Water Safety Group should ensure that flushing guidance is re-issued to all clinical boards for full circulation to relevant staff (O).	Chair of Water Safety Group	Closed	Overdue by over 12 months but under 18 months	C	IP&C Chair of Water Safety who are rsponsible to Nurse Director not Director of Planning.
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R6/7	H	The risk assessment process, including preparation of appropriate prioritised action plans to address the identified risks, should be completed as soon as possible (D).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Specialist Contractors are routinely appointed to undertake risk assessments and remedial work is actions accordingly
SSU CV 1819 03	2018-19	Water Safety	Director of Planning	Reasonable	R7/7	M	Progress, including highlighting of any delays, should be regularly reported to the Water Safety Group (O).	Director of Capital, Estates & Facilities	Closed	Agreed date not reached	C	Regular reports provided to water safety group
C&V-1819-04	2018-19	Legislative/Regulatory Complaince	Director of Planning	Reasonable	R5/7	H	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Philip Mackay / Mal Perrett	Open	Overdue by over 18 months under 24 months	PC	It should be recognised that the current all Wales FRA tool used by all Welsh Health Boards and managed by SSP does not evidence completion of actions making evidance of closure a laborious resource intensive task. However CEF intend to develop an alternative electronic system to enable closure of actions to be carried out by the responsible person attributed to each action resulting in evidence that is both current and auditable.
C&V-1819-04	2018-19	Legislative/Regulatory Complaince	Director of Planning	Limited	R6/7	H	The Senior Fire Safety Officer should ensure that there is appropriate attendance at the DFSM meetings from each of the Clinical Board Fire Safety Managers.	Philip Mackay / Mal Perrett	Open	Agreed date not reached	NA	This action if for the Fire Safety Manager to be followed up by end of June
CVU-2019-20	2019-20	Legislative / Regulatory Compliance	Director of Planning	Reasonable	R5/7	M	The Senior Fire Safety Office should ensure that sufficient evidence is available to support the completion of actions before they are recorded as complete on the Tracking Report.	Philip Mackay / Mal Perrett	Open	overdue over 12 months but under 18 months	PC	Duplicate entry - To be removed following July committee meeting.

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update from Committee meeting held in April 2021
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R1/6	H	Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	1. Clinical Board Directors – Monitor compliance on a monthly basis through the Clinical Board Performance Reviews with joint review of improvement trajectorymonitored via the Medical Director /Director of Workforce. Immediate request for improvement plan, documenting improvement trajectory over	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R2/6	H	The UHB job planning guidance should require consultants to use the standard Job Plan template contained within the guidance unless they can provide a valid reason for not doing so. Job Planning documentation should be completed in full and should include full details of the activities to be undertaken in each session. Line managers should ensure that the number and split of sessions recorded in ESR agrees to and is supported by a fully completed job plan.	1. Clinical Board Directors/Clinical Directors – one to three months. 2. Medical Director – Immediate.	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system.
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R3/6	H	Clinical Board management must ensure that all consultants complete the outcome measures template contained within the UHB Job Planning guidance as part of the job planning process.	1. Medical Director and AMD for Workforce and Revalidation - one month. 2. 15th June 2018 Medical Director/Director of Workforce.	Open	Over 6 months under 12 month	**PC**	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes the need to complete the outcome forms
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R4/6	H	In accordance with the guidance, Clinical Board management should ensure that individual, personalised schedules are completed for all consultants that are on Team or Annualised Hours Job Plans.	Clinical Board Directors action - Issues by Medical Director and AMD for Workforce and Revalidation - one month.	Open	Over 6 months under 12 month	**PC**	24/08/2020: First draft of procedure sent out to BMA for comments and to all CBDs and CDs for comments.Awaiting comments, this procedure will then go out for 28days consultation prior to approval. Procedure includes annualised job plans, with the annual job plan cycle aligned to the financial year. Please see procedure for details
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R5/6	L	The UHB should consider developing additional methods of communication and / or training for both line managers and consultants to improve the completion rate and quality of consultant job plans.	Assistant Medical Director Workforce Revalidation working with Medical Workforce Department/LED/Communications Team / Three months	Open	Over 6 months under 12 month	**C**	24/08/2020: Training has been provided by the AMD for Workforce and implemented. In line with the implementation of the e-JP system, a revised training plan will be developed to update all CDs with how this will work with the new system.
C&V -1920-41	2019-20	Consultant Job Planning Follow-up	Executive Medical Director	Limited	R6/6	M	All completed job plans must be signed by the Consultant and the clinical manager responsible for agreeing them. The standard Job Plan documentation included in the UHB Job Planning guidance should be updated to incorporate the use of digital signatures.	1. Clinical Board Director/CD - 3 months. 2. Assistant Medical Director - Workforce - 3 months reviewpilot progress.	Open	Over 6 months under 12 month	**PC**	24/08/2020: the e-JP system has been procured and contract start date is 31/08/2020. System build and training will take place throughout September and October. System will go live in October for directorates to put consultant Job Plans onto the system. The system will make use of digital signatures. Within procedure and system, noted that no response will be taken as assumed acceptance of JP.
CUHB-1920-23	2019-20	Freedom of Information	Director of Digital & Health Intelligence	Reasonable	R7/7	L	FoI certification or additional FoI training should be available for team members whose role involves processing and answering FoI requests.	Information Governance Manager	Open	Over 6 months under 12 month	**PC**	Training providers have been contacted with delivery expected by Q4 2021/22
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R1/6	M	The UHB Study Leave Procedure for Medical & Dental Staff should be reviewed and revised. The policy should more clearly specify: roles and responsibilities – of Directorates, Managers, Consultants; funding and budget guidance. monitoring and compliance arrangements including KPIs; and reporting arrangements. Once updated, the procedure flow chart that is appended should also be updated accordingly.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R3/6	M	Directorate administrative arrangements should be reviewed and strengthened in line with the revised Health Board Procedure and as a part of producing local operational procedures, particularly the recording of clinical authorisation on Intrepid. Procedures should include the checking of core data on an annual or rolling basis	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R4/6	M	The following arrangements are reviewed and strengthened:- budget setting, monitoring and reporting; payment of honorary staff expenses; and ability to access Trust funds to support study leave budgets.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Not Completed due to COVID pressures. Discussed at LNC, AE, RS, HS to Meet outside LNC, Date to be arranged
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R5/6	M	Assess and review the use of Intrepid as a tool for managing activities other than junior doctors and formulate a plan going forward.	Executive Director of Workforce and OD & Medical Director	Open	Over 6 months	**PC**	Ejob Planning Live 13% currently on system. Work Ongoing.

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update from Committee meeting held in April 2021
CUHB-1920-30	2019-20	Medical Staff Study Leave	Director of Workforce and Organisational Development	Reasonable	R6/6	M	Develop the Intrepid User Group to co-incide with the introduction of the updated Health Board Procedure and local operational procedures. Besides regularising practices, the group could be a forum to identify development opportunities and good practice. The ability of the system to generate 'team views' and reports should be considered as well. Once updated, the authorisations should be checked annually. A Terms of Reference should be put in place and all meetings should have minutes and action plans.	Assistant Medical Director (Workforce and Revalidation), Medical Workforce Manager and Medical Education Lead	Open	Over 6 months	PC	Ongoing
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R3/11	M	Induction content should be reviewed and updated to reflect current practice (O)	Health & Safety and Asbestos Manager	Closed	Over 6 months	C	completed. March 2020
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R8/11	L	A Permit to Work procedure should be developed, ratified and communicated to all relevant officers (D)	Head of Discretionary Capital & Compliance Health & Safety and Asbestos Manager March 2020	Closed	Over 6 months	C	Work remains ongoing to develop the procedure.
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R9/11	M	Management should collate the output of the contractor monitoring forms for reporting to an appropriate forum; for actions to be taken where required. (O)	Head of Discretionary Capital & Compliance	Closed	Over 6 months	C	Work remains ongoing. Completed reported monthly to the Estates H|&S committee
CUHB-1920-03	2019-20	Control of Contractors	Director of Finance	Reasonable	R10/11	M	Formal post completion review meetings of contractor performance should be undertaken in accordance with HSE guidance (O)	Head of Discretionary Capital & Compliance	Closed	Over 6 months under 12 months	C	Work remains ongoing. Annual audit completed for 2020
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R1/3	M	Management, in consultation with their advisers, should seek approval of plans for financing the shortfall in the 2020/21 financial year. Continued scrutiny will be applied of the reasonableness for further changes requested / required to the project. (O)	Director of Capital, Estates & Facilities	Closed	Over 3 months under 6 months	C	Project complete. Overspend is accountted for within the Discretionary Capital Programme 2021/22 and agreed at Management Execs.
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R2/3	M	The risk register will be updated to extend consideration of mitigation actions for the ten open risk identified; and consideration will be given for new risks as they arise. (O)	Director of Capital, Estates & Facilities	Closed	Over 12 months under 18 months	C	Project now complete.
SSU_CVU_1920_05	2019-20	Specialist Neuro & Spinal Rehabilitation and Older People's Services (Rookwood Relocation)	Director of Planning	Reasonable	R3/3	M	All payments should be made in accordance with the terms of the contract. (O)	Director of Capital, Estates & Facilities	Closed	Over 12 months under 18 months	C	Project now complete.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R1/5	H	The UHB should ensure policies are reviewed and updated within appropriate timescales.	Head of Corporate Governance	Open	Over 6 months under 12 months	PC	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R2/5	M	Review the 'register' for completeness. Assess if all policies, procedures and other written control documents available on the intranet and internet are current and then ensure they are all recorded appropriately in the 'register'.	Head of Corporate Governance	Open	Over 6 months under 12 months	PC	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R3/5	M	1. Review the readability of documents to make ways to write clearer, especially those available through internet to wider audience. From register, 372 out of 393, recorded as published on internet. 2. Correct and improve accessibility of documents. Review publishing process to ensure documents are circulated through correct location in internet and/or intranet sites. 3. A combined EHIA should be completed for all policies or where a Health Impact Assessment is not required this should be clearly stated. 4. The Corporate Governance Department should ensure the integrity of the 'Register', by reviewing accuracy of all key information.	Head of Corporate Governance	Open	Over 6 months under 12 months	PC	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R4/5	L	Review of record keeping process for when a request is made to create new written control document; from receipt of request to create, to issue of draft for consultation. Review of record keeping process for the consultation process; from request made, publishing and any feedback received.	Head of Corporate Governance	Open	Over 6 months under 12 months	PC	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
CUHB1920.04	2019-20	Management of Health Board Policies and Procedures	Director of Corporate Governance	Reasonable	R5/5	L	Review of record keeping process for notifying stakeholders of new, amended and exiting policies.	Head of Corporate Governance	Open	Over 6 months under 12 months	PC	Due to Covid-19 pressures and departures from the Corporate Governance team this work has stalled. A new Head of Corporate Governance will join the team in July 2021 following which work on thie recommendation will re-commence.
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R1/10	H	Temporary Staffing Management should revise their current pre-employmentchecks procedures. The following highlighted areas should be considered for revision:		Open	Over 3 months under 6 months	NA	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R2/10	M	Health Board managers should be reminded that internal applicants cannot commence in post prior to pre-employment checks being fully completed. Managers should also be reminded to take notice of the weekly Trac update		Open	Over 3 months under 6 months	NA	

Audit Reference	Financial Year Fieldwork Undertaken	Audit Title	Executive Lead for Report	Audit Rating	Rec No.	Rec. Rating	Recommendation	Operational Lead	Status	Recommendation Status [RAG Rating]	Please confirm if completed (c), partially completed (pc), no action taken (na)	Executive Update from Committee meeting held in April 2021
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R3/10	M	Temporary Staffing Department management to familiarise themselves with the NHS Employment Checks Standards and implement appropriate procedural guidance, ensuring it satisfies all requirements/criteria of the Standards.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R4/10	M	Management to review the process for Consultant reference checks to ensure it adheres to the relevant guidance.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R5/10	L	Management to review the Employment Services SLA.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R9/10	L	Management should review all supporting policies/procedures listed in the CVU Recruitment Policy. Management should review and consider updating the Secondment Policy to include the requirement for pre-employment checks to be completed before an employee can commence in a secondment post. Management should review the Recruitment of Locum Doctors and Dentists Policy, ensuring all terminology is relevant.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-40	2019-20	Pre-employment Checks	Director of Workforce and Organisational Development	Reasonable	R10/10	L	Temporary Staffing Department management to review the standard letter sent with the conditional offer and ensure it complies with the Identification Check NHS Standard.		Open	Over 3 months under 6 months	**NA**	
C&V-1920-08	2019-20	Strategic Planning - IMTP	Director of Planning	Reasonable	R4/4	L	Management should ensure the ToR are reviewed and updated as required.	Marie Davies	Open	over 6 months under 12 months	**PC**	BCAG will review ToR periodically going forward to ensure the role and function of group is updated if necessary.

Cardiff and Vale University Health Board

Annual Planning Process 2021 - 2022

Final Internal Audit Report

May 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Abigail Harris, Executive Director of Strategic Planning
Distribution:	Jonathan Watts, Head of Strategic Planning Marie Davies, Deputy Director Planning
Committee:	Audit Committee

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 Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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 Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of the annual planning process was completed in line with the 2020/21 Internal Audit Plan. The processes for developing and implementing the Cardiff and Vale University Health Board's Integrated Medium Term Plans have been covered in previous Internal Audit reviews.

The NHS Wales, Annual Planning Framework 2021 to 2022 was published on 14th December 2020, which notes, "*This framework is by necessity different from previous versions in that it requires organisations to provide an annual plan that builds on the quarterly operational planning arrangements of 2020/21*". The framework illustrates the trajectory of planning arrangements, providing the first steps towards the reset of Integrated Medium Term Plans.

Following the release of the planning framework, NHS Wales issued two letters, which provided further clarity of expectations, dated 29 January, and 11 March 2021.

The Framework sets out the core content expected within the Health Board's Plan, in context with Ministerial priorities. Since the beginning of the pandemic there has been a strong focus on the 'four harms', which provide the quality context for services and care. The Framework sets out the four harms, linked to key areas where action will be needed through 2021 – 2022, which annual plans should address.

The lead for the review was the Executive Director of Strategic Planning.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the annual planning process. The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

The review assessed the extent to which internal controls are being applied and provides assurance over the following areas:

- Appropriate governance arrangements are in place, which provide effective oversight of the annual planning process, ensuring the Plan is subject to scrutiny and review prior to submission to the Welsh Government;
- The University Health Board's annual planning process is aligned to the NHS Wales Annual Planning Framework 2021 – 2022, ensuring the Plan is developed cognisant of:
  - Ministerial priorities;
  - Current context and priorities, including the four harms;

- Enablers to support implementation of the Plan;
- Statutory requirements; and
- Timeline, format and process to ensure submission to Welsh Government by 31 March 2021.

3. Associated Risks

The potential risks considered in this review were as follows:

- Non-compliance with the NHS Wales Annual Planning Framework, including matters of quality, timeliness and oversight.
- The planning process fails to address patient outcomes, and the quality and resilience of services.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Annual Planning Process 2021 - 2022 is **Substantial assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

The planning environment for the NHS has been dynamic during the period that the Health Board has had to develop an Annual Plan for 2021 -2022. A letter from NHS Wales on 11 March 2021 acknowledges the complexities and how these should be addressed at in-committee sessions of the Board as draft plans.

Prior to the submission of the draft Plan to Welsh Government, we were satisfied that the Board had received sufficient opportunity to scrutinise and review. There was less clarity around the role and purpose of the Strategy and Delivery Committee, given updates were provided direct to the Board.

The Strategy Development and Delivery Group was a key management forum for overseeing the development of an integrated plan. The audit identified that the terms of reference for the group required review, management are aware of this and are currently reviewing the group's structure and remit.

The detailed Plan submitted to Welsh Government, aligned with the requirements of the NHS Wales Annual Planning Framework 2021 – 2022 and did not have any obvious gaps or inadequacies. A submission of the Plan was made by 31 March 2021, as required by Welsh Government, following Board consideration in private session on 25 March 2021.

We discussed with management the level of detail contained within the Plan to support the Welsh Government requirement of firm dates and commitments for the first quarter, which is captured within the '2021 – 2022 on a page' section of the Plan. Since submitting the draft Plan, a further Welsh Government letter to all Chief Executives of Health Boards on 20 April 2021 reinforces these expectations, which are to be reflected upon within the finalised Plan, to be submitted by the end of Quarter 1. We will test the Health Board's compliance with this further as part of our 2021/22 audit of 'Delivery of the 2021/22 Annual Plan'.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate governance arrangements are in place				✓
2	The annual planning process is aligned to				✓

Assurance Summary					
	the NHS Wales Annual Planning Framework 2021 – 2022				

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for the Annual Planning Process 21/22.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for the Annual Planning Process 21/22.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate governance arrangements are in place, which provide effective oversight of the annual planning process, ensuring the Plan is subject to scrutiny and review prior to submission to the Welsh Government.

We note the following areas of good practice:

- A Strategy Development and Delivery Group, which reports to the Executive Management Board and the Health Services Management Board, was in place to oversee the annual planning process and ensure delivery of the Plan;
- The Community Health Council and Local Partnership Forum were informed regarding the Plan's requirements and were given the opportunity to feed into its development;
- The Health Services Management Board, which comprises members of the Executive and Clinical Board Senior Leadership Team, was informed regarding the Plan's requirements and its members were required to

provide the necessary supporting information to feed into the Plan's development;

- The Board was informed regarding the Plan's requirements, was kept updated during its stages of development at both Board Development and formal Board meetings and was required to review and approve the final version prior to its submission to Welsh Government; and
- During the Plan's development, Welsh Government indicated that it was reassured that the Plan was on track for submission on schedule and that it provided a focused view within the greater strategic context that the framework required.

We identified the following findings:

- The 'Terms of Reference and Operating Arrangements' of the Strategy Development and Delivery Group have not been reviewed since July 2018 to ensure that its role and powers remains appropriate for current circumstances *(Recommendation 1 – Low Priority).*
- Consideration should be given to the role of the Strategy and Delivery Committee in developing future Plans, the Committee did note have prior opportunity to consider the Plan in advance of the Board *(Recommendation 2 – Low Priority)*.

Objective 2: The University Health Board's annual planning process is aligned to the NHS Wales Annual Planning Framework 2021 – 2022.

We note the following areas of good practice:

- The Plan submitted to Welsh Government was detailed and well-structured and did not have any obvious gaps or inadequacies.
- The Plan addressed all 7 Ministerial Priorities in the NHS Wales Annual Planning Framework 2021 – 2022:
  1. Prevention.
  2. Reducing health inequalities.
  3. Primary and community care.
  4. Timely access to services.
  5. Mental health.
  6. Decarbonisation.
  7. Social partnership.
- The Plan addressed current context and priorities, including the four harms:
  1. Harm from Covid itself.

2. Harm from overwhelmed NHS and social care system.
3. Harm from reduction in non Covid activity.
4. Harm from wider societal actions / lockdown.

- The Plan addressed the enablers required to support implementation of the Plan:
  1. Workforce.
  2. New technologies and ways of working.
  3. Finance.
  4. Regional working.
  5. Partnership working.
  6. Comms and engagement.
  7. Research and development.
- No obvious statutory requirement issues were identified from reviewing the Plan.
- The vast majority of the information required was submitted to Welsh Government by 31 March 2021, following its consideration by the Board in Private Session on 25 March 2021.

We identified the following finding:

- A small amount of information relating to the core activity sheet of the supplementary Minimum Data Set (MDS) spreadsheet was submitted two weeks late, as a result of resource issues. The submission of the MDS is an iterative process and we make no recommendation in this instance.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**0**	**2**	**2**

Finding 1 – The Terms of Reference of the Strategy Development & Delivery Group (Operating effectiveness)	**Risk**
The Strategy Development and Delivery Group was established as the senior management forum to oversee, on behalf of the Management Executive, the development of integrated strategic business plans and arrangements to monitor plan delivery. However, its Terms of Reference and Operating Arrangements have not been reviewed since July 2018.	The role and powers of the Strategy Development and Delivery Group may not be appropriate for current circumstances.
Recommendation	**Priority level**
The Terms of Reference and Operating Arrangements of the Strategy Development and Delivery Group should be reviewed, and where necessary updated, so that its role and powers remain appropriate for current circumstances.	**Low**
Management Response	**Responsible Officer/ Deadline**
As part of understanding the most robust and proportional plan development and delivery arrangements a re-fresh of the UHBs internal planning governance arrangements are already being considered. This includes a revised term of reference being developed for SDDG.	Marie Davies, Deputy Director Planning 30 September 2021 (Q2 21/22)

Finding 2 – The role of the Strategy and Delivery Committee (Operating effectiveness)	Risk
The agreed approach to developing the Plan included consideration of the Draft Plan by the Strategy and Delivery Committee, prior to its consideration by the Board. However, there was no evidence of prior consideration by the Committee, instead the Draft Plan went directly to the Board.	Confusion may arise regarding the process followed prior to the Draft Plan being submitted to the Board for consideration.
Recommendation	**Priority level**
Consideration should be given to the appropriate role of the Strategy and Delivery Committee in developing future Plans and this should be accurately reflected in the planning documents.	**Low**
Management Response	**Responsible Officer/ Deadline**
The corporate planning cycle for 22-23 is currently being developed for sign off by the UHBs management executive group and Board (June 2021). This approach will include a clear articulation of the role and function of the Strategy and Delivery Committee.	Jonathan Watts, Head of Strategic Planning 30 June 2021 (Q2 21/22)

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cardiff and Vale University Health Board

Engagement around Service Planning

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Olubanke Ajayi-Olaoye, Principal Auditor Wendy Wright, Deputy Head of Internal Audit
Executive sign off:	Abigail Harris, Executive Director of Strategic Planning
Distribution:	Marie Davies, Deputy Director of Planning Anne Wei, Strategic Planning and Partnership Manager
Committee:	Audit Committee

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

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

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1. Introduction and Background

The review of Engagement around Service Planning has been completed in line with the 2020/21 Internal Audit Plan.

The audit had initially been identified for inclusion in the 2019/20 audit plan, which was deferred due to COVID-19 and time/resource constraints. Engagement around service planning involves the consultation with a range of relevant stakeholders in planning, developing, and making decisions where there is a proposal for service change or development.

The Executive Director of Strategic Planning is the lead for this review.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the engagement around service planning, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of the system's objectives are managed appropriately. The areas that the audit sought to provide assurance on include:

- Appropriate governance arrangements, which provide effective oversight of the engagement on changes to health services, ensuring Welsh Government principles are met;
- The procedures / guidance to direct the level of engagement to be undertaken when proposing changes to health services;
- The Health Board follows due process in ensuring all relevant stakeholders are continuously and adequately involved in the engagement around service planning. The following three engagement activities were reviewed to determine the timeliness and effectiveness of processes:
    - Closure and relocation of Colcot Clinic, Barry: This involved a small and specific change relating to the move of a clinic;
    - Reconfiguration of Frail Older People Services: This involved a proposed change of service model in line with the Health Board's 'Shaping Our Future Wellbeing Strategy'; and,
    - Wellbeing Hub @Maelfa: The engagement around this service development was informed by the Shaping Our Future Wellbeing: In our Community programme. The wellbeing hub will enable the provision of primary, community and some elements of secondary care, in addition to a focus on wellbeing.
- Lessons learned exercises are undertaken as part of engagement processes.

3. Associated Risks

The potential risks considered in this review were as follows:

- Non-compliance with legislation or corporate and operational policies.
- Reputational damage if stakeholder groups are not effectively engaged and true opinion remains uncovered.
- Failure to recognise complex stakeholder issues and give sufficient time and resource to stakeholder engagement.
- Inadequate monitoring and scrutiny mechanisms of engagement.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the area of Engagement around Service Planning is **Reasonable assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The Health Board (HB) has developed guidance to support the engagement of service change and development, which aligns to the principles of the Welsh Government (WG) Guidance for engagement and consultation on changes to health services. An important point within the WG guidance notes, *"… the emphasis on the need for a new approach to change based on continuous engagement, rather than perfunctory involvement around specific proposals".* The HB's guidance supports this approach, *"Across the UHB, efforts are being made to strengthen our approach to continuous engagement with citizens and stakeholders based on the principles of co-production."*

It is noted that the WG guidance is over a decade in age. The external environment will evolve in the medium term, with Community Health Councils (CHC) being superseded by a new all-Wales Citizen Voice Body, which will represent the interests of people across health and social care from 2023.

This report makes recommendations to enhance the HB's engagement guidance, but it is acknowledged that external factors are evolving, which will impact on the guidance going forward.

A recommendation has also been raised to ensure compliance with the guidance. One instance was noted, where the form of engagement deviated from the timely use of a service change proforma and engagement plan. The deviation related to the Colcot Clinic and lessons learned have been identified by the HB. In this instance the CHC did make a referral to the Minister in 2019, although the Minister did not support the CHC position and did not require the HB to take any further engagement action.

Three recommendations of a low priority and considered good practice have been made to strengthen current arrangements, associated with oversight of engagement activity through a central repository, the formalisation of lessons learned and the adoption of a standard approach to illustrate stakeholder mapping.

Due to the impact of COVID-19, the HB's engagement with stakeholders for planned service change was put on hold in 2020/21. Focus was redirected to communication of temporary changes and adaptions to service provision made to respond to challenges that emerged due to the pandemic. As a result of this noted impact, the audit sample referred to engagement prior to 2020/21.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Appropriate Governance Arrangement				✓
2	Policies & Procedures			✓	
3	Application of due Process			✓	
4	Lessons Learned			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted **4** issues that are classified as weaknesses in the system control/design for the Engagement around Service Planning.

Operation of System/Controls

The findings from the review have highlighted **1** issue that are classified as weaknesses in the operation of the designed system/control for the Engagement around Service Planning.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Appropriate governance arrangements, which provide effective oversight of the engagement on changes to health services, ensuring Welsh Government principles are met.

The following areas of good practice were noted:

Through the engagement lens, the HB has adequate monitoring and reporting systems in place via the governance arrangements, as required by the Welsh Government guidance. The monitoring and reporting forums

for the Colcot Clinic, Wellbeing Hub @Maelfa and the Frail and Older People model pathway service change included (but not limited to):

- The Board, Cardiff and Vale University Health Board
- CVUHB / CHC Service Planning Committee

Specific to The Wellbeing Hub @Maelfa:

- Wellbeing Hub @Maelfa Project Team
- Wellbeing Hub @Maelfa Project Board
- Stakeholder Reference Group (SRG)

Specific to The Frail and Older People Model Pathway:

- CHC Medicine Oversight, Scrutiny and Performance Group
- Local partnership Forum (LPF)
- Stakeholder Reference Group (SRG)

The following finding was noted for this objective:

- There is currently no central repository of engagement activity to support service change / development. *(Recommendation 4 – Low Priority)*

Objective 2: The procedures / guidance to direct the level of engagement to be undertaken when proposing changes to health services.

The following areas of good practice were noted:

- The HB has a practical guide to engagement, a flowchart and a local framework for engagement and consultation on changes to health services (produced by the HB in collaboration with the CHC).
- The Welsh Government Guidance for Engagement and Consultation on changes to Health Services has been used as a guide to produce the local guidance.
- There are resources available on the intranet to support Clinical Boards, which includes the practical guides and templates.
- The strategic planning team presented the flowchart, framework for engagement and supporting resources to the HB's Operational Planning Group in September 2019 to update them on the guidance.
- In August 2020, a board development session was run by the Consultation Institute to enhance the Board's knowledge of relevant legislation and robust processes to engagement.

The following finding was noted for this objective:

- The HB's engagement guidance requires an update to reflect current processes. *(Recommendation 1 – Medium Priority)*

Objective 3: The HB follows due process in ensuring all relevant stakeholders are continuously and adequately involved in the engagement around service planning *(specific to the three areas sampled):*

The following areas of good practice were noted:

- The completion of Equality Health Impact Assessments.
- Engagement activity commenced in advance of the change / development being instigated.
- The timely completion of a service change proforma and stakeholder engagement plan, for the Frail and Older People Model Pathway.
- There was evidence of engagement in accordance with expected practice, outlined in the HB's guidance, with the CHC and other relevant stakeholders regarding the service change / development for the Wellbeing Hub and the Frail and Older People Model Pathway.
- Communication with staff was managed by the Communication Team, introducing the engagement in a range of internal communication mechanisms such as social media, newsletter, HB website etc.

The following specific areas of good practice were also noted:

<u>Colcot Clinic</u>

- The paediatric speech and language staff of the Clinic used a bilingual information leaflet to engage with families using the service, to explore possible issues of relocating the service to Barry Hospital.
- The HB ensured the users of the clinic were provided with continuous communication and update, by informing service users of the new location in Barry hospital when booking appointments.

<u>Wellbeing Hub @Maelfa</u>

- Early planning in 2015/16 informed the stakeholder engagement process, which fed into the engagement plan.
- Stakeholder mapping informed the initial stakeholder engagement plan.
- Community engagements, public meetings and stakeholder workshops / meetings were organised to ensure there was active engagement and contributions from relevant stakeholders and users of the hub.

Frail and Older People Model

- Stakeholder meetings and public engagement events took place, two of which were organised jointly with the CHC.

The following findings were noted for this objective:

- One of the three sampled engagement activities (Colcot Clinic) had no engagement plan and the service change proforma was not shared in a timely manner with the CHC. *(Recommendation 2 – Medium Priority)*
- There is currently no common approach to illustrate stakeholder mapping. *(Recommendation 5 – Low Priority)*

Objective 4: Lessons learned exercises are undertaken of engagement processes.

The following areas of good practice were noted:

- Where lessons learned have been identified, there is an awareness of how the learning can be applied.

The following finding was noted for this objective:

- The process of identifying lessons learned of engagement activity is not formally embedded into current processes. *(Recommendation 3 – Low Priority)*

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**2**	**3**	**5**

Finding 1 – Health Board Engagement Guidance (Control design)	Risk
The following findings were observed when reviewing the HB's engagement guidance and associated flowchart: • The flowchart includes a CHC operational group which no longer exists; • The Project Outline Document (POD) which is being referred to in the HB guidance and framework is no longer in use; • The guidance and engagement plan template currently do not require the need to undertake a risk assessment; • Further clarification is required of when a service change proforma is needed; • The guidance does not refer to the engagement plan template, which is currently available on the HB intranet; • Further illustration of stakeholder selection would be beneficial (finding 5); and, • Further clarification of HB governance regarding internal oversight and scrutiny of engagement processes.	Non-compliance with legislation or corporate and operational policies.
Recommendation 1	**Priority level**
Management should ensure that the Health Board's practical guide to engagement and associated flowchart is updated to reflect the current processes and made available on the HB intranet.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed. The UHB will work with the South Glamorgan CHC to review and update the joint Flowchart to reflect current processes in the UHB and CHC, and the UHB will review and update the internal practical guide to engagement to address the issues identified above.	Executive Director of Strategic Planning December 2021

Finding 2 - Deviation from service engagement guidance (Operating effectiveness)	Risk
The CHC service change proforma is a document that provides initial information to the CHC of a potential service change. The proforma outlines the case by identifying both the positive and negative consequences of the change. This is expected to be shared and agreed with the CHC as it allows for deliberation on decisions regarding the nature and scale of change and associated engagement. Information in the service change proforma feeds into an engagement plan and sets the scene for the stakeholder engagement process. One of the three sampled engagement activities had no engagement plan and the service change proforma was not shared in a timely manner with the CHC. The auditor was provided with an engagement timeline, which detailed key dates and actions. *(This instance related to the Colcot Clinic and lessons learned have been documented by management.)*	Failure to recognise complex stakeholder issues and give sufficient time and resource to stakeholder engagement.

Recommendation 2	Priority level
In accordance with the Health Board's guidance on engagement, management should continue to ensure that the Community Health Council is engaged at the earliest opportunity, through the appropriate means as soon as a service change is recognised, and documentation is shared in a timely manner.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The importance of timely completion of a CHC Service Change Proforma for discussion with the CHC when service change proposals are being developed will be reinforced with Clinical Boards consideration given to building it into IMTP templates.	Executive Director of Strategic Planning December 2021 - as part of the annual IMTP planning cycle

Finding 3 - Lessons Learned (Control design)	Risk
It was observed that the process of reflection and lessons learned from engagement activities was not embedded. There is no formal process in place to capture the learning to feed into future stakeholder engagement. For the three areas of engagement sampled, two had documented lessons learned by email.	Reputational damage as stakeholder groups are not effectively engaged and true opinion remains uncovered.

Recommendation 3	Priority level
Consideration should be given to developing a process to formally capture lessons learned from stakeholder engagement, which has the potential to enhance future engagement.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. A template for capturing lessons learnt for completion by those actively involved in designing and running an engagement (including CHC colleagues) is being tested by the Shaping Our Future Clinical Services programme team following a recent piece of corporate engagement. The resulting proforma and recommendations on where the output is considered within the UHB governance structure will inform a roll out.	Executive Director of Strategic Planning December 2021

Finding 4 – Schedule of Engagement Activity (Control design)	Risk
There is currently no central record of engagement activity to support service change / development. It would be beneficial for the HB to have a synopsis of engagement, for clarity and oversight. Management highlighted that a forward plan of engagement could stem from information in the organisation's Annual Plan / IMTP and could act as a good starting point. The following information could support a schedule of engagement activity:	Failure to recognise complex stakeholder issues and give sufficient time and resource to stakeholder engagement.

Service change name, description, lead staff / Clinical Board, status, start and end date of formal engagement, and formal consultation required / complete etc.	
Recommendation 4	**Priority level**
Consideration should be given to introducing a schedule of engagement activity to support service change / developments.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed, there is potential value of a forward looking schedule of engagement based on information in the organisation's Annual Plan/IMTP.	Executive Director of Strategic Planning December 2021

Finding 5 – Stakeholder Mapping (Control design)	**Risk**
The Welsh Government Guidance for Engagement and Consultation on changes to Health Services identifies specific stakeholders with whom the NHS is expected to engage. Audit testing identified an example of stakeholder mapping good practice, within the Wellbeing Hub - Stakeholder Engagement Plan. The process of identifying stakeholders was systematic, which demonstrated the overall rationale behind the stakeholder selection process, by placing the WG identified stakeholders and other relevant stakeholders into power and priority levels.	Failure to recognise complex stakeholder issues and give sufficient time and resource to stakeholder engagement.

Recommendation 5	Priority level
In support of identified HB good practice, it would be beneficial for a common stakeholder mapping process to be adopted, to illustrate stakeholder selection by power and priority levels, to inform the engagement of service change / development.	**Low**
Management Response	**Responsible Officer/ Deadline**
Agreed. The Engagement Plan Template, included as a supporting resource for the internal UHB Practical Guide to Engagement, will be reviewed and updated to include stakeholder mapping advice based on current best practice.	Executive Director of Strategic Planning December 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cardiff and Vale University Health Board

Data Quality Performance Reporting (Single Cancer Pathway)

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry – Chief Operating Officer David Thomas – Director of Digital and Health Intelligence
Distribution:	Caroline Bird – Deputy Chief Operating Officer Simon Rogers – Assistant Director Performance Delivery Scott Mclean – Director of Operations, Children & Women's Services Clinical Board Laura Owens – Cancer Services Lead Manager
Committee:	Audit Committee

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

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

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 Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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 Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Our review of Data Quality Performance Reporting has concentrated on the Single Cancer Pathway (SCP) and has been completed in line with the 2020/21 Internal Audit Plan for Cardiff & Vale University Health Board (the 'Health Board').

In November 2018 the Minister for Health and Social Services announced that *"NHS Wales would introduce a Single Cancer Pathway, starting from the moment a cancer is first suspected. This new 62-day waiting time measure includes patients referred from primary care or found to have cancer in hospital care. But most importantly of all, this new Single Cancer Pathway starts when cancer is first suspected."*

In November 2020 the Minister made a further announcement surrounding the SCP, which included the following key points,[1]

… from February 2021, we will report only against the Single Cancer Pathway and will no longer report the previous measures.

… the Single Cancer Pathway will not include any adjustments – we will report the real wait.

… our starting performance measure until March 2022 will be 75%. I expect the performance measure to be revised upwards in subsequent years."

The executive leads for the review are the Chief Operating Officer and Director of Digital & Health Intelligence.

2. Scope and Objectives

The overall objective of this audit is to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the SCP. The review will seek to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

The review sought to provide assurance over the following areas:

- Appropriate governance arrangements are in place, which provide effective oversight of the SCP data;
- SCP data is accurately recorded for all patients in accordance with Welsh Government guidance;
- There are suitable validation controls in place to protect the integrity, accuracy and completeness of the SCP data; and
- Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the Welsh Government (WG) and within the Health Board.

[1] Written Statement: Progress on the Single Cancer Pathway (18 November 2020) | GOV.WALES

3. Associated Risks

The potential risks considered in the review are as follows:

- The service does not meet performance measures due to ineffective monitoring and governance arrangements;
- There is a lack of trust in the data due to weaknesses in the accuracy and completeness of the patient management system; and
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Data Quality Performance Reporting audit is **Reasonable** assurance.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

It is important to note that our review did not scrutinise the compliance rates to the Welsh Government 62-day SCP target; rather we reviewed if the data that produced these results was accurate and reliable. However, it is worth noting that for our sample period of January 2021 (reported *against the Single Cancer Pathway)*, the reported percentage of treated pathways achieving this target was 58% (97 from a population of 168), WG has set an initial target of 75%.

Cancer Services has been evolving over the past 18 months and transitioning to a new system for capturing data. The Cancer Services Lead Manager joined the Health Board in March 2020 and is actively recruiting to key posts within the new structure, with the aim of driving service improvements once embedded. Given the changes to establishment structure and substantial process and system changes, the absence of procedures to support the current ways of working is not unexpected, but also known to management as an issue, which is scheduled to be addressed through the calendar year, once the onboarding of vacant posts is complete.

The audit also identified that the Health Board's wider Data Quality Policy and Procedure are out of data and require review, however, it is noted that management have commenced a review of these documents.

We identified that overall, the arrangements in place within the Health Board in relation to the Data Quality Performance Reporting of the SCP are of a reasonable standard. The following identifies the key controls which underpin this area:

- Regular meetings of the Operational Cancer Group* where Cancer performance is a standing agenda item, and the group feeds into the Executive Cancer Board;
- Improved validation controls of SCP data; and
- Consistent reporting of SCP data within the Health Board and to Welsh Government. Specifically, the March 2021 meeting of the Board received the SCP data, contained within the performance report, which highlighted 58% compliance for January 2021. This figure was reconciled to the January 2021 data return to Welsh Government that also highlighted 58% compliance.

* We were advised through 2020/21 that attendance of the Operational Cancer Group was impacted by COVID-19, this was evident from sampled minutes, but April 2021 presented an improved position.

Audit testing identified data accuracy and validation issues, which are further detailed within Appendix A - Finding 4. On discussion with management it was advised that the control environment has since been strengthened, with greater validation processes now in place. In support of the enhancements introduced, we further propose the introduction of an issues log, to identify any negative validation trends.

No high priority findings were noted within this review.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance arrangements			✓	
2	SCP data is accurately recorded			✓	
3	Validation controls - integrity, accuracy and completeness of the SCP data			✓	
4	Timely monitoring and reporting of the SCP data				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted one issue that are classified as weaknesses in the system control / design for Data Quality Performance Reporting.

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system / control for Data Quality Performance Reporting.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1 - Appropriate governance arrangements are in place, which provide effective oversight of the SCP data.

The following areas of good practice were noted:

- Cancer Services have a documented structure in place that details items such as staff numbers, accountability lines etc.
- Management has established two key forums where cancer performance including SCP data is discussed; Operational Cancer Group (OCG) and the Executive Cancer Board (ECB).
- The OCG meetings are held regularly on a monthly basis.
- The SCP performance is a standing item for the group with monthly reports on SCP data being produced.
- The OCG reports into the ECB and shares common members that ensures two-way communication.
- The ECB also has a defined TOR that includes key governance information such as membership, purpose, and escalation processes.

Three recommendations are made under this objective:

- The corporate data quality policy (UHB 298) and procedure (UHB 288) are currently out of date and do not reflect the current arrangements in place *(Recommendation 1 – Medium Priority).*
- Operational procedures for collecting and validation of the SCP data are not in place *(Recommendation 2 – Medium Priority).*
- The terms of reference for the OCG is to be formally approved by the ECB, and issues of non-attendance at the OCG are to be escalated to the ECB. *(Recommendation 3 – Medium Priority).*

Objective 2 - SCP data is accurately recorded for all patients in accordance with Welsh Government guidance

The following areas of good practice were noted:

- Cancer services have access to multiple clinical systems that assists in SCP data verification.

One recommendation is noted for this objective:

- Data accuracy and validation issues were noted within 4 out of our sample of 12 patient pathways *(Recommendation 4 – Medium Priority).*

Objective 3 - There are suitable validation controls in place to protect the integrity, accuracy and completeness of the SCP data

The following areas of good practice were noted:

- The auditor undertook a walk-through test with one of the senior trackers from within the Cancer Services team to understand the process. The auditor noted that the tracker verified the data back to the source documentation for key dates in the SCP process i.e. date of suspicion and date the SCP clock stopped.

One recommendation is made under this objective.

- Currently an issues log is not being maintained to capture any negative trends through the validation processes *(Recommendation 5 – Low Priority).*

Objective 4 - Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the Welsh Government and within the Health Board.

- The Cancer Services lead manager produces the SCP performance data for both the Health Board and Welsh Government to ensure consistency in approach and that a single message is being delivered.
- The SCP performance against the Welsh Government target is reported to the Strategy and Delivery Committee as part of the key performance indicators report.
- The Board also receives regular updates on the SCP performance position as part of its routine performance report.
- Monthly performance information is also submitted to the Welsh Government and the auditor identified that the reported percentage compliance figure for the January data set reconciled to that reported within the Health Board.

No recommendations are made under this objective.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**4**	**1**	**5**

Finding 1 - Data Quality Policy and Procedure (Operating effectiveness)	Risk
A Data Quality Policy (UHB 298) is in place and available on the Health Board's website, however, this was last approved in September 2015. Within the policy statement it references the Data Protection Act, however, this act was updated in 2018 to take account of the General Data Protection Regulations (GDPR) and we noted no reference to GDPR. There is also a Data Quality Management Procedure (UHB 288) available on the website, however, as above this was last approved in September 2015. This procedure makes the following key reference to data quality assurance: *"The UHB will gain assurance in regard to the quality of its data and information through:* 1. *Clinical Board and corporate department routine data quality checks* 2. *Reports from the Data Quality Group* 3. *Escalation reports from the Information Governance Sub Committee"* Audit did not document any reports from a "Data Quality Group" and we also note the Information Governance Sub Committee was merged with the Information Management and Technology sub-committee to form the Digital and Health Intelligence Committee. Management have advised that a review of the Policy is complete, and a review of the procedure is currently progressing, once complete, both documents will be jointly presented to the Board for approval.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.

Recommendation 1	Priority level
Management should continue as planned to finalise the review of the Data Quality Policy (UHB 298) (to reflect the General Data Protection Regulation framework), and the Data Quality Procedure (UHB 288). Once finalised, formal approval of the documents should be sought from the Board.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A review of the Data Quality Policy is now complete and a team from Information and Operations Performance have been tasked to complete a review of the Data Quality Procedure. Once complete, both documents will be presented to the Board for approval.	Director of Digital and Health Intelligence September 2021

Finding 2 - Operational Procedures (Control design)	Risk
Audit notes there was no standard operating procedure for the production of SCP data at the time of audit fieldwork. The Cancer Services Lead Manager owns this process and we were informed that the intention is to have procedures in place by the end of the calendar year, once recruitment to key posts has taken place. In terms of validation data for month end reporting, there was also no documented process and we have again been informed that the Cancer Services Lead Manager is in the process of drafting this guidance.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.

There is an inherent risk of a single point of failure in the knowledge surrounding these processes.	
Recommendation 2	**Priority level**
Operational procedures or guidance documents should be produced to ensure continuity and standardisation of the data quality processes.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The Operational procedures and guidance documents which were identified through the audit processes as being absent are now in a draft format. With the ongoing recruitment for key posts the intention is to have completed and signed off documents by the end of Quarter 2.	Cancer Services Lead Manager, 30 September 2021

Finding 3 – Oversight of the Operational Cancer Group (Operating effectiveness)	**Risk**
The main operational group that has responsibility for ensuring delivery of all cancer performance indicators (including the SCP) is the Operational Cancer Group (OCG). Audit reviewed the arrangements in place for the OCG and noted the following: • It was not clear when the Terms of Reference (TOR) had been approved; • There were no quorum requirements noted in the TOR.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.

Audit also reviewed the attendance of key personnel from the monthly OCG meetings covering the period December 2020 – March 2021 and noted a low level of attendance from certain key personnel. We have been advised that the COVID-19 pandemic has been a factor in attendance, however, we have subsequently reviewed the April 2021 meeting that has shown increased attendance.	
Recommendation 3	**Priority level**
The Executive Cancer Board (ECB) should approve the Operational Cancer Group Terms of Reference, including the membership. Any issues of non-attendance going forward are to be escalated to the ECB.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The terms of reference and the membership will be tabled for discussion and agreement at the next Cancer Operational Group to be held on 21st June 2021. The formal agreement of the Cancer Operational Group ToR will be tabled for the next meeting on 20th July 2021.	Cancer Services Lead Manager, 20 July 2021

Finding 4 - Accuracy and validation of SCP data (Operating effectiveness)	Risk
The audit reviewed a sample of 12 patient pathways that were treated in January 2021 in conjunction with Welsh Government guidance. The testing checked to see whether the data that was used to generate compliance statistics for the 62-day SCP target was accurate. Our sample reviewed 6 instances where the SCP target was achieved and 6 instances where the target was breached. The testing of our sample highlighted the following: • Three* instances were identified where the auditor could not accurately reconcile the point of suspicion date (the referral letter was not being accurately verified on the clinical portal). • Two instances were identified where the auditor could not reconcile the date where the SCP clock was stopped (there was ambiguity around when treatment started). From the sample of patient pathways which highlighted issues, only one instance would have impacted on the achievement of the SCP target (an impact of 0.6% on the January 2021 period) by breaching the 62 day target (* identified at the point of suspicion date).	There is a lack of trust in the data due to weaknesses in the accuracy and completeness of the patient management system.
Recommendation 4	**Priority level**
Management should ensure that stronger quality assurance checks are undertaken on the source data.	**Medium**

Management Response	Responsible Officer/ Deadline
With the recruitment of key posts the audit and validation processes will be strengthened. A validation tool is being developed by DHCW which will be adapted and implemented within the Health Board. The timeframe for this improvement is by the end of Q2 in line with the CaNISC replacement programme.	Cancer Services Lead Manager, 30 September 2021

Finding 5 - Data Validation (Operating effectiveness)	Risk
Within finding two of this report we have identified that there is no standard operating procedure (SOP) for the validation of SCP data. In the absence of SOPs, the auditor undertook a walk-through test with one of the senior trackers from the cancer services team to understand the validation process. The auditor noted that the tracker verified the data back to the source documentation for key dates in the SCP process i.e. date of suspicion and date the SCP clock stopped. The team currently do not hold an issues log, which could help identify any negative trends through data validation or reoccurring issues.	Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.

Recommendation 5	Priority level
Management should consider implementing an issues log to capture discrepancies in the data and help identify any negative trends.	**Low**
Management Response	**Responsible Officer/ Deadline**
With the recruitment of key posts an issues log will be established and maintained. This log will be used to raise technical concerns with the IT development team responsible for the main cancer tracking module. The log will also be used to identify individual and team training requirements. The time frame will be by end of Q2 in line with recruitment processes.	Cancer Services Lead Manager, 30 September 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Infrastructure / Network Management

Final Internal Audit Report

2020/21

Cardiff & Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

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1. Introduction and Background

In line with the 2020/21 Internal Audit Plan for Cardiff & Vale University Health Board (the Health Board) a review of the management of IT Infrastructure and the network has been undertaken.

The relevant lead for the assignment is the Director of Digital & Health Intelligence.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of the network and IT infrastructure, in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to provide assurance to the Audit Committee that a process is in place for ensuring that the infrastructure hardware is tracked, maintained and supported and that the network is managed sufficiently to provide services for the organisation.

The main areas that the review will seek to provide assurance on are:

- the IT infrastructure is maintained, with appropriate monitoring, support and risk management in place; and
- the use of the network is managed to ensure stability and capacity is appropriate for the organisation.

3. Associated Risks

The potential risk considered in the review was as follows:

- Loss of key processing or networking services.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with infrastructure and network management is reasonable assurance.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Processes are in place to provide server resource and network infrastructure, to monitor the operation of these and ensure problems are identified and resolved. The risks relating to the provision of the infrastructure using older equipment have been articulated and included on risk registers. Increased resource has been provided for replacement equipment, although not to the full identified value, accordingly the replacement program is on a risk based priority.

Although the processes within the teams responsible for managing the servers and network are operating appropriately, there is no overarching process for configuration management and no overall record of what equipment is held and the status. The teams managing the servers and the network are self contained with limited reporting outside of the teams and there are a lack of formal policies and procedures that would provide clarity to these functions.

There is work ongoing to increase the capacity of the network in order to resolve performance issues, however, there has been no full assessment of the future requirements for network capacity.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Infrastructure			✓	
2	Network management			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

Our findings from the review have highlighted no issues that would be classified as a weakness in the system control/design of infrastructure and network management.

Operation of System/Controls

Our findings from the review have highlighted five issues that are classified as weaknesses in the operation of the designed system/control for infrastructure and network management.

6. Summary of Audit Findings

In this section we highlight areas of good practice that we identified during our review. We also summarise the high and medium priority findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The IT infrastructure is maintained, with appropriate monitoring, support and risk management in place.

We note the following areas of good practice:

- there are records within the network team which record equipment managed by the Health Board;
- the network team uses software called Castlerock to monitor the network. This product includes maps showing where the equipment is sited and pictures of each cabinet which are labelled to identify the equipment;
- IT uses a colour coded cable system for infrastructure to better enable identification of equipment and reduce the risk of incorrect items being unplugged;

- the network team maximises the financial resource by getting as much use from equipment as possible. When equipment is replaced by newer items the older items are moved from the "core" to "edge" (from the central parts of the network to the outer parts);
- the server estate is largely virtualised and there is ongoing work to further increase this which reduces the risk associated with individual servers;
- there is a record of what desktops and laptops are in place using Snow Asset Management and Systrack;
- there are dashboards in place to monitor performance and risk for desktops and laptops;
- there are alerts set up on the physical hosts (servers) to provide warnings when key performance thresholds are breached, and monitoring agents in place which feed into a dashboard;
- the risks associated with old equipment have been identified and escalated, with £500K funding provided for ongoing replacement;
- there is a 5 year Infrastructure Sustainability Plan in place;
- replacements of infrastructure equipment is on a risk assessed basis within the funding envelope noted above;
- the risk relating to old access devices is included on the risk register; and
- IT keep a stock of equipment to enable rapid replacement of network items should one fail;

We note the following medium priority findings in relation to this objective.

- Equipment is not routinely kept up to date with patches / firmware, with updates mainly only applied to address security issues.
- There is no formal configuration management procedure or single record of equipment managed by IT, with the records of equipment managed by IT being disparate and incomplete.

Objective 2: The use of the network is managed to ensure stability and capacity is appropriate for the organisation.

We note the following areas of good practice:

- there is a team in place with responsibility for managing the network, with a dedicated (sub)team for the wireless network;
- the network is heavily segmented with subnets for non domain devices eg medical devices / tills in cafes etc.;
- device level authentication is used to increase security;
- there are network diagrams available (produced on installation);

- all changes are tracked within a workbook so history is maintained;
- there has been investment in the network infrastructure to resolve the stability and availability issues that have occurred due increased homeworking and use of cloud based services;
- there is a process to monitor the network on a live basis using visual representation of the network;
- in addition to the visuals there are also alerts to provide warnings when key thresholds are breached which indicate problems, these are also colour coded;
- the network team are implementing Cisco DNA centre, and starting to develop reporting; and
- there are how to guides in place. These are being developed as "wikis" (information developed collaboratively) by the new staff members and show how to undertake specific tasks within the network team.

We note the following medium priority findings in relation to this objective.

- Both the network and server management teams are relatively small and self contained with little information on the detail of their roles reported outside of the team. In addition although there are "how to" guides for parts of the network management team function which are being developed, there is no overarching procedure or statement that sets out the aims of network management, what to do and how to do it.
- The network is actively monitored, however there are a large number of alerts generated on a daily basis and there is little consolidated reporting and use of active dashboards.
- Although additional network capacity has been added in response to the Covid related escalation of the use of home working and cloud based services, there has been no formal assessment of the likely demand in the future. The use of cloud based services is increasing across the Health Board and the links between clinical boards and the network team are not currently sufficient to ensure that network capacity is considered by Clinical Boards prior to decisions on the use of these services.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority are outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**5**	**0**	**5**

Finding 1– Patching / Updates (Operating Effectiveness)	Risk
Equipment is not routinely kept up to date with patches / firmware, with updates mainly only applied to address security issues. We note that there is a balance between the requirement to update and the risks associated with updating, alongside the requirement to reboot. However the decisions over what and when to patch or update are not formally recorded and there is no patch policy or procedure that sets this out, alongside the processes for undertaking patching and updates.	Loss of key processing or networking services.
Recommendation	**Priority level**
A formal patch and update policy and procedure should be developed which clearly articulates the decisions relating to patching and updates, and which sets out the process for applying patches and updates in a secure manner to reduce the risks associated with these. We note that this recommendation was also included in the IT Assessment Internal Audit Report.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed The ability to implement this will be subject to directorate and service maintenance windows being agreed and application patch availability.	Russell Kent, Head of Digital operations October 2021

Finding 2– Configuration Management (Operating effectiveness)	Risk
There is no formal configuration management procedure or single record of equipment managed by IT, with the records of equipment managed by IT being disparate and incomplete. Without a structured configuration management process, underpinned by a complete record of equipment the Health Board will not be able to fully track its equipment and manage a consistent configuration.	Loss of key processing or networking services.
Recommendation	**Priority level**
A configuration management policy / procedure should be defined in order to enable efficient and effective control over IT assets and fully understand the configuration of each component that contributes to IT Services in order to: • account for all IT components associated with the Service; • provide accurate information and documentation to other Service Management processes; and • to provide a sound basis for Incident, Problem, Event, Change and Release Management (e.g. reduction of the amount of failed Changes). This should be underpinned by a configuration management record which records all items and their status.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed. The Digital Health and Intelligence Department has procured and new helpdesk system and will be implementing configuration management and change management processes as part of this initiative.	Russell Kent, Head of Digital Operations. November 2021

Finding 3– Procedures (Operating effectiveness)	Risk
Both the network and server management teams are relatively small and self contained with little information on the detail of their roles reported outside of the team. In addition although there are "how to" guides for parts of the network management team function which are being developed, there is no overarching procedure or statement that sets out the aims of network management, what to do and how to do it. This leads to a lack of clarity over the detail of the function of the team, in particular in relation to how the network is actively monitored and managed and to a risk that organisational knowledge may be lost should key staff not be available.	Loss of key processing or networking services.
Recommendation	**Priority level**
An overall statement or procedure should be developed that sets out the aims for network monitoring and management, and how this will be done. The procedure should note that the aim is to ensure that that relevant staff have alerts and reports so that imminent problems are detected and reported for prompt response and actions. Guidance should then be provided on the mechanism by which this is done	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed Departmental responsibilities will be clarified as part of the ITIL Support Framework Helpdesk implementation. Procedure documents will be focussed on key operations using a risk based priority approach.	Russell Kent, Head of Digital Operations December 2021

Finding 4– Network Reporting (Operating effectiveness)	Risk
The network is actively monitored, however there are a large number of alerts generated on a daily basis and there is little consolidated reporting and use of active dashboards. We note that the network team have started to install Cisco DNA which will allow for greater reporting capacity. Without reporting there is a lack of clarity over the status of the network outside of the network team and without active dashboarding linked to the tailored configuration of alerts there is a risk that underlying issues may not be identified rapidly.	Loss of key processing or networking services.
Recommendation	**Priority level**
Work should continue to develop the dashboard to highlight areas such as areas of high packet loss or latency, and the reporting functionality. With consideration given to reporting of key information outside of the network team such as: • availability up/down, last week, last month, last year; • response time and packet loss; • physical memory usage used/available; • network latency; and • network routing.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed Due to the size of the disperse networking at CAV, this will be focussed on the management and monitoring of the core networking elements in UHW, UHL and CRI.	Russell Kent, Head of Digital Operations October 2021

Finding 5– Network Capacity (Operating effectiveness)	Risk
Although additional network capacity has been added in response to the Covid related escalation of the use of home working and cloud based services, there has been no formal assessment of the likely demand in the future. The use of cloud based services is increasing across the Health Board and the links between clinical boards and the network team are not currently sufficient to ensure that network capacity is considered by Clinical Boards prior to decisions on the use of these services. We note that the ongoing development of the Digital Management Board should work to improve this position, however without the inclusion of the network team in all projects (in an advisory capacity) there is a risk that the Health Board will purchase solutions which will not be fully functional due to network capability.	Loss of key processing or networking services.
Recommendation	**Priority level**
The links between the network team and Clinical Board IT projects should be defined to ensure consultation. An assessment of the future network requirements should be undertaken that considers the use of cloud based services across the whole of the Health Board.	**Medium**

Management Response	Responsible Officer/ Deadline
Agreed The DH&I Department will ensure linkage between Network team and Digital Management Board and review the resource implications of providing appropriate levels of support to UHB users of cloud-based services.	Russell Kent, Head of Digital Operations December 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cardiff and Vale University Health Board

Children & Women's Services Clinical Board –

Rostering in Community Children's Nursing Service

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Executive sign off:	Steve Curry, Chief Operating Officer
Distribution:	Scott Mclean, Director of Operations, Children & Women's Services Clinical Board Cath Heath, Director of Nursing, Children & Women's Services Clinical Board Rose Whittle, Directorate Head of Operations and Delivery Paula Davies, Lead Nurse Alison Davies, Senior Nurse
Committee:	Audit Committee

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

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

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1. Introduction and Background

Our review of Rostering within the Children's Community Nursing Service (CCNS), Children and Women Clinical Board, was completed in line with the 2020/21 Internal Audit Plan for Cardiff & Vale University Health Board (the 'Health Board'). The audit was incorporated into the audit plan at the request of the Clinical Board.

The Community Child Health Team provide a skilled nursing resource for children, young people and their families within the community environment, reducing hospital admissions and facilitating early discharge.

The team work as professionals alongside families to support their needs from birth to 18. They also provide services to children with disabilities and complex needs, those with developmental difficulties, emotional and behavioural difficulties and children and young people in special circumstances such as those in care.

The CCNS service, as at April 2021 held an establishment of 47 nurses and 4 Nursing Team Leaders, covering a total of 41 children across the three Localities of Cardiff North, Cardiff South and Vale of Glamorgan. Four additional nurses joined the service in April 2021.

The Directorate works closely in partnership with other organisations to provide support to families and to safeguard the health and wellbeing of children in Cardiff and the Vale of Glamorgan.

The Community Child Health Directorate's Charter sets out how the Directorate works with children, young people and families, how it provides services, and how to ensure those who use the care will be actively involved.

The executive lead for the review is the Chief Operating Officer.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Clinical Board for the rostering of children's community nurses.

The review sought to provide assurance to the Health Board's Audit Committee that risks material to the system's objectives are managed appropriately.

The areas that the review sought to provide assurance on are:

- There is a clear and documented process in place for rostering of Children's Community Nursing staff within the Clinical Board, which provides clear guidance on the processes to be applied.
- Rotas are produced in advance with requests for external providers only made after all other forms of cover have been investigated.

- Children's Community Nursing rotas are fit for purpose with deployment of sufficient numbers and an appropriate skill mix to ensure safe, high quality standards of care.
- Nursing rotas are in place to ensure that staff work contracted hours.
- There are appropriate management systems in place for reviewing and reporting the effectiveness of the rostering process.

3. Associated Risks

The potential risks considered in the review were as follows:

- A lack of documented procedures in place to direct the rostering process.
- Staff rotas are not drawn up in advance.
- Shifts do not have the appropriate skill mix.
- Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.
- Ineffective review and reporting of the rostering process.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Children and Women Clinical Board - Rostering in Community Children's Nursing Service is **Reasonable assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The audit identified no high priority recommendations, but issues of a low to moderate nature have arisen, which if addressed would enhance the current controls in operation.

Prior to the commencement of the audit there were no formalised, documented procedures in place in respect of rota management processes and those of the duty desk operations. The auditor as part of the review provided advice and facilitation to aid the creation of these so as to provide clear structure, approach and guidance to the new Administrative Operational Manager and the Team Leaders, as well as nursing staff themselves.

Management acknowledged at the commencement of the review the desire to enhance the efficiency and effectiveness of current rostering arrangements, through greater utilisation of electronic rostering. This is currently being explored and no solution yet procured. The rostering of community nurses presents multiple variables, which fall outside the capability of RosterPro, although this is utilised to capture hours worked. The newly documented procedures will support and inform the process of acquiring an electronic rostering system, fully cognisant of current end to end processes.

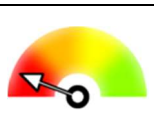
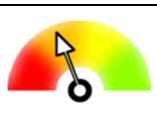
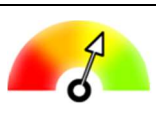
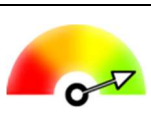
Currently in draft, the service intends to roll out a 'Memorandum of Understanding' with families as a means of clarifying the partnership and support offered, to strengthen relationships.

It is noted that the COVID-19 pandemic has impacted on training and this is currently being addressed by management.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Rostering Process and Guidance			✓	
2	Advance Rota Creation and Bank & Agency Usage				✓
3	Sufficient Staffing Levels and Appropriate Skill Mix			✓	

Assurance Summary					
4	Rotas Ensure Contracted Hours Are Worked			✓	
5	Review and Reporting of Rostering Effectiveness				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted five issues that are classified as weaknesses in the system control/design for Children and Women's Clinical Board - Rostering in CCNS.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system/control for Children and Women's Clinical Board - Rostering in CCNS.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: There is a clear and documented process in place for rostering of Child Community Nursing staff within the Clinical Board, which provides clear guidance on the processes to apply.

We identified the following findings:

- The absence of documented CCNS rostering processes and desktop procedures *(Recommendation 1 – Medium Priority and Recommendation 2 – Low Priority).*
- The service would benefit from finalising the CCNS 'Memorandum of Understanding: Home Based Continuing Care Packages' *(Recommendation 4 – Low Priority).*

Objective 2: Advance Rota Creation and Bank & Agency Usage

We identified the following areas of good practice:

- Rotas are compiled two months in advance and are issued a month in advance upon completion and finalisation based upon the inclusion of nurses requesting planned/known absence.
- There are prescribed 'cut off' dates for nurse requests of known absence to allow for efficient allocation and to avoid any last minute decisions or changes to existing requests which could impede the planning process.
- No bank or agency nurse usage is undertaken (except in the case of specifically funded packages relating to Continuing Healthcare packages which sit outside the control and remit of the CCNS).

We did not identify any findings under this objective.

Objective 3: Sufficient Staffing Levels and Appropriate Skill Mix

We identified the following areas of good practice:

- Finalised off-duty rotas are subject to review and analysis to ensure sufficient staffing levels prior to dissemination to nursing staff.
- Nurse role specific training is provided on clinical skill training days which occur throughout the year that encompass all the clinical needs of any of the children on their caseload.
- A detailed training database is in place for Children's Community Nursing staff. Current Training Needs Analyses are in place for all Children's Community Nursing staff.

We identified the following findings:

- Child Specific Needs Analysis, Staff Skills Matrix and Staff to Child Strengths and Weaknesses Map documentation, used as part of the shift allocation process should be updated by Team Leaders and subject to regular review, and revised iterations incorporated into the desktop rota procedures *(Recommendation 3 – Medium Priority)*.
- Non-compliance of nurse training categories across all three Community Localities of Cardiff North, Cardiff South and the Vale of Glamorgan (compliance impacted by COVID-19) *(Recommendation 7 – Low Priority)*.
- Finalised rotas are not formally reviewed and signed-off by Team Managers or the Administrative Operational Manager prior to dissemination to CCNS nursing staff *(Recommendation 6 – Low Priority).*

Objective 4: Rotas Ensure Contracted Hours Are Worked

We identified the following areas of good practice:

- Majority of sampled shifts were supported by documentary evidence stating that contracted hours were worked in full and any changes were recorded on the Duty Desk Notes and a subsequently revised Off Duty rota.
- Processes are in place that satisfactorily manage and monitor under/over worked hours and these are accurately recorded on RosterPro.

We identified the following findings:

- A shift relating to one of the nurses sampled could not be verified via PARIS nursing notes as having been completed in full *(Recommendation 5 – Medium Priority).*

Objective 5: Review and Reporting of Rostering Effectiveness

We identified the following areas of good practice:

- Review and monitoring of the Off-Duty rotas subsequent to their being issued is undertaken on a 'live' working week daily basis via the Duty Desk activity which deals with real time changes to rotas and is documented in a comprehensive manner.

<u>Risk Management</u>

- Risks pertaining to CCNS form part of the Children Young People & Family Services Directorate risk register.
- The risk register is reviewed as a standing agenda item on a monthly basis within the Quality, Safety & Patient Experience Group minutes.

<u>Incident Reporting</u>

- Incidents pertaining to CCNS are actively managed and actioned via the Datix incident reporting database.
- Incident reporting is also a standing agenda item within the monthly Quality, Safety & Patient Experience Group minutes.

We did not identify any findings under this objective.

Outside of audit scope

The Health Board's approach to rostering is documented within the Rostering Procedure for Nurses and Midwives' reference number UHB 339, which was due for review in November 2019. It was noted that the procedure is overdue a review and internal audit will advise the Executive

Nurse Director. A recommendation has not been made in this review, to avoid impacting the overall assurance rating directed at CCNS rostering.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**3**	**4**	**7**

Finding 1 - Rostering Procedures and CCNS Service Guidance (Control design)	Risk
The Health Board's approach to rostering is documented within the 'Rostering Procedure for Nurses and Midwives' reference number UHB 339, which was due for review in November 2019. The focus of the procedure is on ward based rostering, rather than in the context of CCNS, although the objectives of the procedure provide a framework for producing rosters. Whilst there are processes in place for the creation and day-to-day management of rostering that are supported by appropriate record keeping, they are not currently formalised or available in a written format for practical use. During the audit the Team Leader and Administrative Operational Manager responsible for centralisation of the rostering process developed rostering desktop procedures, with advice given on the adequacy of controls by the auditor. The duty desk processes which underpins and actively informs day-to-day roster management also requires formalisation.	A lack of documented procedures in place to direct the rostering process.

Recommendation 1	Priority level
The draft rostering desktop procedures should be reviewed by Team Leaders for accuracy and alignment with the objectives of the wider Health Board rostering procedure (UHB 339), thereafter they should be formally approved and adopted by CCNS. The approved rostering procedures should be disseminated to all CCNS nurses to formally advise them of the processes in place.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Draft rostering procedures currently being finalised by the CCNS Operational Managers. To be presented and ratified at Directorate and Clinical QSPE meetings in June 2021. Development of rostering guidelines for staff explaining the procedure will be drafted. The guidelines will discussed and disseminated via CCNS team meetings. Smaller team meetings will need to be held due to Covid restrictions, hence timescale needs to provide time for this.	Alison Davies, Senior Nurse 30th June 2021 Operational Managers, CCNS Paula Cooper & Jayne Keddie 31st August 2021

Finding 2 - Revision of Draft Rostering Procedures to include management of Under/Over Hours Worked (Control design)	Risk
The review of the rostering process identified that as part of the rostering compilation and/or post-roster changes there are instances where due to short staffing or changes to shifts staff may be under or over on their hours worked. Whilst these are monitored daily and recorded in Team Leader diaries, RosterPro and are subject to the Administrative Operational Manager's approval, the draft desktop rostering procedures do not currently document the management and application of these processes. However, an alternative version of the procedure for nursing staff does include the guidance in respect of the management of under/over hours.	A lack of documented procedures in place to direct the rostering process.
Recommendation 2	**Priority level**
The draft desktop rostering procedures, developed through the course of the audit should be updated to include the management of under/over hours worked.	**Low**
Management Response	**Responsible Officer/ Deadline**
The management of staff's annualised hours & balance will be included in the new rostering procedures. Version control will support this being regularly updated.	Alison Davies, Senior Nurse 30th June 2021

Finding 3 – Key documentation to support the rostering process (Control design)	Risk
Roster planning is informed by three key documents: Child Specific Needs Analysis, Staff Skills Matrix, and Staff to Child Strengths and Weaknesses Map. All three documents directly inform the planning and allocation process and feed into and out of each other; however, they are not currently subject to ownership and regular review by the Team Leaders to ensure accuracy of clinical needs / requirements, nor do any of these documents state revision dates and version control.	Shifts do not have the appropriate skill mix.
Recommendation 3	**Priority level**
The Child Specific Needs Analysis, Staff Skills Matrix and Staff to Child Strengths and Weaknesses Map should be revised and updated by the Team Leaders to reflect current clinical need / requirements and subject to regular review to ensure accuracy of content. Additionally, these key documents should be incorporated into the rostering procedures for use during the monthly roster creation process.	**Medium**

Management Response	Responsible Officer/ Deadline
These documents will be manually updated by the Operational Managers and Team leaders on a monthly basis at their Operational Management Meeting in collaboration with the Practice Educator. The OM's will provide assurance and a process for sign off so that there is an audit trail. This will be incorporated into the rostering procedures.	Alison Davies, Senior Nurse 30th June 2021
The Directorate is currently exploring more advanced electronic rostering systems, which support community services and which may provide solutions to matching staff to patients which Rosterpro is unable to achieve. This would improve efficiency and patient safety.	Paula Davies, Lead Nurse Alison Davies, Senior Nurse December 2021

Finding 4 – Finalisation of CCNS Memorandum of Understanding: Home Based Continuing Care Packages (Control design)	Risk
The draft 'Memorandum of Understanding: Home Based Continuing Care Packages' (MoU) is a document that outlines a formal agreement between parent(s)/carers and the CCNS in respect of the rights, responsibilities of each party relating to home based care service delivery as outlined in the Continuing Care package. The MoU is currently in draft, with the most recent iteration dated April 2018. However, it is outdated in some of its content and requires further revision and review by CCNS Team Leaders, families and NWSSP Legal & Risk solicitors with a view to dissemination to all parties, including all CCNS nurses. It is acknowledged that work on this document has stalled due to the lengthy review of content by NWSSP Legal & Risk solicitors, and the cancellation of consultation workshops with families to discuss content due to the COVID-19 pandemic.	A lack of documented procedures in place to direct the rostering process.
Recommendation 4	**Priority level**
The CCNS Memorandum of Understanding: Home Based Continuing Care Packages should be updated, approved by senior management at both departmental and Clinical Board level for dissemination to parents/guardians as soon as is practicable so as to formalise mutual arrangements between the UHB and parent(s)/carers of children under the department's care.	**Low**

Management Response	Responsible Officer/ Deadline
The Memorandum will be updated to include some recent requirements and re-checked by UHB Legal & Risk. Following this, we will provide opportunity for consultation with families and staff and disseminate.	Paula Davies, Lead Nurse Alison Davies, Senior Nurse 15th December 2021

Finding 5 - Contracted Shift Hours: Completion of PARIS Nursing Notes (Operating effectiveness)	Risk
A sample of rosters were reviewed to ascertain whether contracted hours had been completed. Evidence to support this came in the form of extracts from the nurse shift diary entries within the PARIS patient notes database, in addition to the emailed list of hours worked, submitted to Team Leaders at month end. Testing identified that the majority of shifts sampled were supported by documentary evidence showing that nurses contracted hours were worked in full and any changes were recorded on the duty desk notes and a revised off duty rota. However, a shift relating to one of the nine nurses sampled could not be verified as having been completed in full as the notes recorded on PARIS terminated just over halfway through a shift. At the time of the audit it was unclear why this was the case, but the nurse's colleague made no reference to any absence within their handwritten nursing notes.	Inappropriate shift patterns mean staff do not work contracted hours or do not have appropriate breaks.

Recommendation 5	Priority level
All contracted shift hours must be fully substantiated via accurate documentation of time recorded entries on the PARIS database.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Staff have been reminded to record handover to parent /carer at the end of each shift and sign out on PARIS, in accordance with the record keeping policy. The team leaders regularly audit compliance with this and address any individual issues with staff.	Completed

Finding 6 – Evidence of review and approval of finalised rotas (Control design)	Risk
As part of the current rostering process the finalised rotas are reviewed and approved by a Team Leader, but there is no documentary evidence to formally confirm that the rota is appropriate and fit for purpose, prior to dissemination to CCNS nurses.	Shifts do not have the appropriate skill mix.
Recommendation 6	**Priority level**
Each finalised rota should be formally signed-off by a Team Leader or the Administrative Operational Manager, prior to dissemination to CCNS nursing staff. The sign-off could take the form of an email to the Administrative Operational Manager stating approval and as such a stronger audit trail would be in place to close that period's rostering cycle.	**Low**
Management Response	**Responsible Officer/ Deadline**
Operational Managers and Team leaders have been informed of the need to provide written approval of completed rotas, and maintain an audit trail of this, particularly going forward as the new administrative officer will be completing the rota. Compliance with this will be checked.	Alison Davies, Senior Nurse Completed

Finding 7 – Non-compliant levels of training for CCNS Nursing staff (Operating effectiveness)	Risk
A review of the CCNS Nurse Training Record for 2021 identified high levels of non-compliance across all types of training categories (including mandatory role specific training, Continuing Professional Development and UHB training) and all staff grades across the three Community Localities of Cardiff North, Cardiff South and the Vale of Glamorgan. It is acknowledged that this is due largely to the impact of the COVID-19 pandemic and there are plans are in place to start addressing this, but the current scale of non-compliance does warrant further work to ensure maximum compliance across all staff as soon as is safe and practicable.	Shifts do not have the appropriate skill mix.
Recommendation 7	**Priority level**
Management should continue as planned to ensure the gaps in staff training across CCNS are addressed.	**Low**
Management Response	**Responsible Officer/ Deadline**
The service is usually compliant with mandatory training targets and has service specific training. The low compliance does correlate to COVID-19, increased staff absence and deployment during this period. An action plan for the service is in place to recover and improve compliance.	Paula Cooper, Operational Manager Jayne Keddie, Operational Manager November 2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings


Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.


Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.


Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.


No assurance - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Cardiff and Vale University Health Board

Staff Recruitment

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Executive sign off:	Rachel Gidman, Interim Executive Director of Workforce & Organisational Development
Distribution:	Julie Cassley, Deputy Director of Workforce & Organisational Development Carys Fox, Director of Nursing – Strategic Nursing Workforce
Committee:	Audit Committee

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

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

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 Internal Audit Charter and the Annual Plan, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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 Cardiff and Vale University Health Board, no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The review of Staff Recruitment was completed in line with the 2020/21 Internal Audit plan for Cardiff and Vale University Health Board.

Across Wales there are increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led to an increasing need for staff. This has been further exacerbated with Covid-19, winter pressures and the Mass Immunisation Programme.

Filling registered nurse vacancies is an on-going high priority for the UHB in order to ensure provision of effective patient care.

The Health Board has also had to recruit high numbers of temporary and bank staff at pace in order to support the provision of services during the Covid-19 pandemic.

The relevant lead Executive for this review is the Executive Director of Workforce and Organisational Development.

2. Scope and Objectives

The overall objective of the review was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for staff recruitment; in order to provide assurance to the Health Board's Audit Committee that risks material to the achievement of system's objectives are managed appropriately.

The purpose of the review was to establish if the Health Board has appropriate processes in place for the governance and management of staff recruitment focussing on registered nurse recruitment and also recruitment of temporary additional posts as a result of the Covid-19 pandemic.

The areas that the review sought to provide assurance on were:

- The Health Board has identified appropriate plans and processes for the recruitment of registered nurses;
- Effective governance arrangements are in place for the approval of the identified plans and processes and the on-going monitoring and reporting of their implementation;
- The plans implemented to date have led to the successful appointment and retention of additional registered nurses; and
- Appropriate governance arrangements are in place for the appointment of temporary and bank staff to support the Covid response.

3. Associated Risks

The potential risks considered in this review were as follows:

- Patient safety is compromised due to insufficient nurse staffing;
- Non compliance with legislation; and
- Temporary staff are recruited without appropriate authorisation or checks taking place.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Recruitment of Staff is **Reasonable assurance.**

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

Overall the arrangements in place for staff recruitment for the areas reviewed were of a good standard.

Our review of the arrangements in place for International Nurse Recruitment confirmed that they were of a very high standard.

We have identified a few minor weaknesses in respect of recruitment plans and reporting arrangements.

We were however unable to provide any assurance on the objective 'appropriate governance arrangements are in place for the appointment of temporary and bank staff to support the Covid response' as we were unable to undertake any fieldwork in this area. This has impacted on the overall assurance rating that we are able to provide at the current time. We would recommend that this area is covered in a future audit review.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	The Health Board has identified appropriate plans and processes for the recruitment of registered nurses.				✓
2	Effective Governance arrangements are in place for the approval of the identified plans and processes and the on-going monitoring and reporting of their implementation.				✓
3	The plans implemented to date have led to the successful appointment and retention of additional registered nurses.				✓
4	Appropriate governance arrangements are in place for the	✓			

Assurance Summary					
	appointment of temporary and bank staff to support the Covid response				

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the system control/design for the Recruitment of Staff.

Operation of System/Controls

The findings from the review has highlighted one issue that is classified as a weakness in the operation of the designed system/control for the Recruitment of Staff.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Health Board has identified appropriate plans and processes for the recruitment of registered nurses.

We noted the following areas of good practice:

- The Health Board has an approved strategy in place for the recruitment of international registered nurses;
- To support the Strategy a contracting Framework was drawn up in association the NHS Wales Shared Services Partnership Procurement Services and a contract agreed with the company Medacs;
- Cohort 3 for International Recruitment focussed on the need for Perioperative registered nurses. The need for these nurses was identified by a Business Case drawn up by the Surgical Clinical Board; and
- There is a project in place, Project 95, whose aim is to have 95% of all Band 5 registered nurses in post. The project has identified a number of 'areas' in addition to international recruitment for the 'recruitment' of nurses such as:
  - Student Nurse Streamlining;

- Adaptation;
- Return to Practice; and
- UHB Campaign Events and Open Days.

We identified the following minor issue:

- There are no specific recruitment plans in place for the individual recruitment ' areas' identified in Project 95.

Objective 2: Effective Governance Arrangements are in place for the approval of the identified plans and processes and the on-going monitoring and reporting of their implementation.

We identified the following areas of good practice:

- We evidenced approval by the Health Board's Management Executive to recruit a third cohort of International Nurses;
- Updates have also been reported to the Health Board's Management Executive of progress on international nurse recruitment as well as general nurse recruitment;
- The Strategic and Delivery Committee also receives updates from the Executive Director of Workforce on recruitment; and
- The Deputy Director of Workforce receives regular updates regarding job offers and progress on the recruitment process for the international nurses appointed.

We identified the following minor issue for this objective:

- Currently updates on nurse recruitment is on an exception basis.

Objective 3: The Plans implemented to date have led to successful appointment and recruitment if additional registered nurses.

We noted the following areas of good practice:

- The International Nurse Recruitment Strategy has been successful with the following information noted:
  - 1st Cohort approval for 67 posts with 65 nurses now in post;
  - 2nd Cohort approval for 75 posts and 15 nurses now in post;
  - 3rd Cohort approval for 43 nurses and 4 nurses in post; and
  - Offers have been made to 169 out of 185 posts approved.
- Of the International nurses that commenced employment within the Health Board only 3 staff have left their employment.

We identified the following issue for this objective:

- The Health Board does not set targets or record appointments for all the 'areas' that registered nurses are recruited from.

Objective 4: Appropriate governance arrangements are in place for the appointment of temporary and bank staff to support the Covid response

We were unable to undertake any fieldwork on this objective and so are unable to provide any assurance on this area.

Additional Observations

Whilst undertaking the fieldwork for the audit we met with the Director of Nursing, Strategic Nursing Workforce to establish the arrangements in place for the recruitment of registered nurses. We were advised of a number of constraints in place that were impacting on the ability to recruit. We were advised that availability of suitably sized rooms during the working week for recruitment events was limited which meant such events had to be arranged for weekends which could impact on number of attendees.

The other concern mentioned was the staff resource that is in place for the department. At the time of the audit the department had an additional 3 temporary members of staff (graduates) in place to support the recruitment process. Whilst 2 of the staff have had their appointments temporarily extended a permanent solution should be considered.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**0**	**0**	**3**	**3**

Finding 1 - Nurse Recruitment Information (Control design)	Risk
We were unable to determine how many registered nurses successfully recruited via the different 'areas' are still employed by the Health Board as the Health Board does not currently set targets for the different recruitment 'areas'. Neither does the Health Board record now many nurses have been recruited for all the individual 'areas'. However, we do acknowledge that such information is recorded for International Nurse Recruitment.	Health Board is unable to determine success of the different 'supply chain' if data not collected and reported.
Recommendation	**Priority level**
Management should consider developing a system that is able to record key recruitment data for the different recruitment 'areas' for registered nurses in order to assess the effectiveness of each one.	**Low**
Management Response	**Responsible Officer/ Deadline**
The Executive Nurse Director and Clinical Board Directors of Nursing are currently reviewing nursing establishments which is an annual exercise. This will enable the re-setting of Posts within Wards and Community which will enable improved reporting and monitoring of vacancies and retention of nurses. Recently we have reviewed nursing turnover which is running at a reasonable level given the circumstances of the past year. Please see below.	Clinical Board Directors of Nursing are re-setting establishments in ESR by July 2021.

Labour Turnover Rate - Nursing Bands 5 & 6

Org L4	Avg FTE	Leavers FTE	LTR FTE %
001 All Wales Genomics Service	1.1400	0.0000	0.0000%
001 Children & Women Clinical Board	254.6893	17.5093	6.8748%
001 Clinical Diagnostics & Therapeutics Clinical Board	28.0033	4.4133	15.7600%
001 Corporate Executives	19.9200	1.0000	5.0201%
001 Medicine Clinical Board	598.0288	51.9333	8.6841%
001 Mental Health Clinical Board	386.8313	34.0869	8.8118%
001 Primary, Community Intermediate Care Clinical Board	258.3779	25.0088	9.6792%
001 Specialist Services Clinical Board	627.2081	70.2723	11.2040%
001 Surgical Services Clinical Board	353.6016	43.7467	12.3717%
uHB	**2527.80**	**247.97**	**9.81%**

Finding 2 - Recruitment Plans (Control design)	Risk
In 2018 the Health Board introduced 'Project 95%' with the following aims around nurse recruitment: • to ensure the adequate supply of the appropriately skilled nursing workforce to meet current and future service needs; • To reduce the reliance on nursing agency staffing including removing unnecessary and avoidable agency spend; and • To establish a sustainable nursing workforce. The project had developed plans around a number of 'supply areas' including: • International Recruitment; • Bank to substantive staff; • Return to practice; and • Adaptation. We note that recently the Health Board's recruitment has been necessarily focussed on responding to the Covid pandemic and mass vaccinations programme. This means that, apart from the ongoing International Registered Nurse Recruitment, there are currently no specific plans in place for the other nurse recruitment supply 'areas'.	Patient safety is compromised due to insufficient nurse staffing levels.

Recommendation	Priority level
Looking forward management should consider if there is a need to refresh the Project 95% and draw up specific plans for the nurse recruitment supply 'areas' once the pressures associated with the Covid pandemic and mass vaccinations centres have abated.	**Low**
Management Response	**Responsible Officer/ Deadline**
Recruitment Campaigns have restarted; with Children and Women and Mental Health Boards having run their own events during May 2021. Also a UHB wide event was held on 14.05.021 in the Lakeside Wing – aimed at engaging with students who will be qualifying this summer and attracting permanent registered nurses further afield. The event was well attended. We have received feedback that people want to attend face to face events; with social distancing measures in place. Further events will be planned for the Autumn.	Deputy Director of Workforce & OD, Clinical Board Nurse Director for Strategic Workforce, Nurse Resourcing Manager. September 2021

Finding 3 - Nurse Recruitment Reporting (Operating effectiveness)	Risk
Whilst updates on Nurse Recruitment have been provided to the Health Board's Management Executive and Strategic and Delivery Committee it is on an ad hoc basis. Nurse recruitment has also historically been discussed within the Nurse Productivity Group (NPG), with Clinical Boards presenting their recruitment plans and the Assistant Director of Workforce providing general updates. This group has however been stood down during the pandemic and it is currently unclear if or when meetings will resume. At the time of the audit it was unclear what the reporting arrangements were for the NPG.	Patient safety is compromised due to insufficient nurse staffing.
Recommendation	**Priority level**
Management should consider formalising the monitoring and reporting process for nurse recruitment that addresses the frequency of the updates and the meetings that will receive the information. Management should also ensure that the reporting arrangements for the NPG are formalised.	**Low**
Management Response	**Responsible Officer/ Deadline**

Further regular updating will be considered through NPG. Bi monthly meetings are held with representatives from the Clinical Boards, chaired by the Deputy Director of Workforce & OD. Monitoring of vacancies is undertaken at Clinical Board level within the Workforce Plan and via the CB Nurse Director and Heads of Workforce & OD.	Executive Nurse Director; Clinical Board Directors of Nursing, Heads of Workforce & OD - ongoing

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Wellbeing Hub at Maelfa

Final Internal Audit Report

2020/21

Cardiff & Vale University Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

Reasonable Assurance

Previous review rating Reasonable Assurance

CONTENTS Page

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Executive sign off	Abigail Harris, Executive Director of Strategic Planning
Distribution	○ Geoff Walsh, Director of Capital, Estates and Facilities ○ Tony Ward, Head of Discretionary Capital ○ David Taylor, Capital Planning Manager ○ Jonathan Aver, Project Manager, Capital Planning ○ Robert Wilkinson, Capital Planning Programme Support Manager, Strategic & Service Planning
Committee	Audit & Assurance Committee

ACKNOWLEDGEMENT
NHS Wales Audit & 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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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 Internal Auditors.

1. Introduction and Background

In December 2017, the Welsh Government outlined their plan to build 19 new integrated health and care centres across the country. It is a £68m programme (Primary & Community Care pipeline) and forms a part of the Welsh Government's commitment to move care closer to home. The centres are also to act as community hubs bringing together a range of public services on one site.

This programme of works is the biggest targeted investment of Primary & Community Care Infrastructure delivered by the Welsh Government to date.

The Wellbeing Hub at Maelfa is one of three Cardiff & Vale University Health Board (the 'UHB') projects included within the Primary & Community Care pipeline programme.

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

Approved funding of £12.372m for the project was announced by the Welsh Government on 15 January 2021. Work commenced on site on 15 February 2021, and completion of the project is anticipated by October 2022.

This was the second audit of the project and was undertaken in order to evaluate the processes and procedures that support the delivery of the Wellbeing Hub at Maelfa.

Noting the impact of Covid-19, the delivery of this assignment has involved an increased element of remote working.

2. Scope and Objectives

The review was undertaken to undertaken to determine the adequacy of, and operational compliance with, the systems and procedures of the UHB and the performance of the project against its key delivery objectives i.e. time, cost and quality.

An objective of the audit was to evaluate the systems and controls in place within the UHB, with a view to delivering reasonable assurance to the Audit Committee that risks material to the objectives of the areas of coverage are appropriately managed.

Accordingly, the scope and remit of the audit included the following:

- **Follow Up** - assurance that previously agreed recommendations have been implemented (see **Appendix B**).
- **Project Management –** the effective use of appropriate project management tools, including the management control plan, construction programme and risk management processes.

- **Contract Documentation –** assurance that all contract documentation had been appropriately completed to the current stage of development.
- **Cost Monitoring & Reporting -** assurance that costs have been reasonably budgeted, contractually agreed and controlled, that interim payments had been progressed in accordance with the contract.
- **Change Management –** compliance with agreed change management processes (including the requesting/ approval of technical submissions and derogations).
- **Covid-19 -** assurance that the financial and delivery implications of procurement & contractual issues have been appropriately managed. Ensure that safe working practices had been established and monitored.

3. Associated Risks

The potential risks considered at the review were as follows:

- Failure to achieve key project delivery objectives;
- Appropriate approvals were not in place;
- Failure to apply robust change management arrangements;
- The contract and method of execution does not adequately protect the interests of the UHB;
- Appropriate project management tools were not employed effectively;
- Poor budgetary control resulting in cost escalation; and
- Unsafe working practices.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

The review was undertaken to determine the performance of the project against its key delivery objectives i.e. time, cost and quality and ensure the adequacy of, and operational compliance with, the UHB's systems and procedures.

Whilst recommendations have been made to improve the systems of control, generally these were positively assessed (see **Section 5: Assurance Summary**).

In the context of the timing of this review (shortly after commencement of construction), it is recognised that the recommended improvements were

in some cases already in hand, with wider project control arrangements generally robust. **Reasonable assurance** has therefore been determined.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that the project achieved its key delivery objectives and that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to an audit is dependent on the severity of the findings as applied against the specific audit objectives and should therefore be considered in that context.

4.1 Systems of Control

Reasonable control arrangements were found to have operated in a number of key areas, including:

- application of appropriate project management tools;
- robust cost control and review mechanisms, including scrutiny of the target cost and subsequent changes; and
- management of Covid-19 implications, including contractual arrangements and site operating practices.

The audit identified the following control weaknesses:

- Contractual documentation for the current stage had not been finalised and executed (***recommendations 5-8***); and
- Delays in the timeliness of payments to the Supply Chain Partner and in the authorisation of project changes (***recommendations 9 & 10***).

A number of further enhancements have also been recommended (see **Appendix A**).

4.2 Project Objectives

The audit also sought to assess project performance, at its current stage, against the key parameters of time, cost and quality.

Time and quality

At the time of the audit, recognising the early stage of construction (commenced on site February 2021), the project was reported as being on programme, with no significant quality issues noted.

Cost

At the time of the audit, the Cost Adviser was reporting that the project was anticipating an overspend of £124,663, being attributed to Covid-19 related costs incurred by the Supply Chain Partner for the first six months on site. In accordance with Welsh Government guidance, the additional costs are to be managed within the approved budget to the end of the contract at which point, any additional resource requirement over the approved sum can be clearly and robustly set out. The provision of additional funding will be subject to Ministerial approval.

At the time of reporting the UHB has sufficient contingency sums to accommodate the additional Covid costs *(**recommendations 11 & 12***).

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Follow Up				✓
2	Project Management			✓	
3	Contract Documentation		✓		
4	Cost Monitoring & Reporting			✓	
5	Change Management			✓	
6	Covid-19			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the audit have highlighted **one** issue that is classified as a weakness in the system control/design in the management of the Maelfa Wellbeing Hub Project.

Operation of System/Controls

The findings from the audit have highlighted **eleven** issues that are classified as weaknesses in the operation of the designed system/control in the management of the Maelfa Wellbeing Hub Project.

6. Summary of Audit Findings

Follow Up

That previously agreed management actions had been implemented.

The status of the actions arising from the prior audit was as follows:

Closed	Outstanding	Partially Implemented	Superseded	Total
2	1	-	1	**4**

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

Recognising the action taken to date, with only one low priority recommendation outstanding, **substantial assurance** has been determined.

Project Management

That project management tools were used effectively.

A range of project management tools have been appropriately applied at the project, including:

- A Project Execution Plan, updated for the current stage (however, see **Appendix A, ref 1** for outstanding minor amendments);
- An agreed construction programme;
- A comprehensive risk register, reviewed and updated at Project Team meetings; and
- Key Performance Indicators completed to the current stage, with no performance issues noted to date.

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

The forums had been routinely attended by the Senior Responsible Owner (at the Delivery Group) and the Maelfa Project Director (at both forums), and other key officers from the defined group memberships (as per the terms of reference),for the period reviewed. However, as previously reported in 2019/20, continuing issues were identified in respect of wider membership attendance (**recommendation 1**).

Whilst the terms of reference for both forums had been updated for Full Business Case submission in readiness for the construction stage, project officers referenced earlier versions during the audit, with membership lists out of date (**recommendation 2**).

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

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

Workstream arrangements had been reviewed and updated for the Full Business Case, with a work programme developed for the Art Strategy and Communications & Engagement workstream and reported to the Project Team. Noting the early stage of construction, formal action plans (including timescales / deadlines) for the other workstreams were not yet required. The performance of these workstreams will therefore be reviewed at subsequent audits.

Monthly project reporting was observed via the Project Manager's report, Cost Adviser's cost report, Capital Highlight Report and Flash Report, with the latter two reports presented to both the Project Team and Delivery Group.

However, the reports shared with the Project Team and Delivery Group had not, to date, included a budget summary statement setting out details of over/underspend, remaining contingency etc. The reporting of the Welsh Government Project Progress Returns to an appropriate forum, to enable appropriate scrutiny and challenge, has also been recommended (**recommendations 3 & 4**).

Noting the application of appropriate project management tools and recognising that in the context of the stage of the review (shortly after commencement of construction), some supporting processes were still in development, **reasonable assurance** has been determined.

Contract Documentation

That all contract documentation had been appropriately completed to the current stage.

Construction works commenced on site on 15 February 2021. However, at the date of reporting (May 2021), Confirmation Notice no.2, covering stages 4, 5 and 6 of the project, had yet to be finalised and executed. It is, however, recognised that delays have been encountered whilst legal advice was sought in respect of the Supply Chain Partner's request for amendments to certain clauses within the agreement. The delay has also impacted on the implementation of the Project Bank Account

Noting the ongoing contractual discussions, project risks associated with the same while progressing on site have not been reflected in the project risk register (**recommendations 5-7**).

Adviser agreements (Cost Adviser and Project Manager) for the current stage had not yet been executed by all parties (**recommendation 8**).

Whilst recognising the status of Confirmation Notice no.2 had been appropriately reported to the Project Team, and was being escalated at the time of review to ensure completion as soon as possible, the UHB remained without full contractual cover for the main contract or its advisers at the time of reporting. **Limited assurance** has therefore been determined in respect of contract documentation.

Cost Management & Reporting

That costs have been reasonably budgeted, contractually agreed and controlled, and that interim payments have been progressed in accordance with the contract.

The target cost was agreed in the sum of £10,238,800.

The total target cost was subject to appropriate market testing by the Supply Chain Partner, and subsequently scrutinised and substantiated by the UHB's Cost Adviser.

A review of seven market tested packages (with a combined value of £3,170,308 / 31% of the total target cost) was undertaken at this audit. At each package the lowest tender had been selected for inclusion within the target cost.

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

Whilst the cost information has been robustly reported and reviewed by the members of the Capital Planning Team, improved cost reporting to the

Project Team and Delivery Group has been recommended (see **recommendation 3**).

A forecast overspend of £124,663 was reported in the May 2021 cost report (attributed to recently agreed Covid-19 related costs). However sufficient contingency sums are currently available to accommodate the same. In accordance with Welsh Government guidance, these costs should be managed within the approved project budget where possible (see ***Covid-19*** section).

At the time of the audit fieldwork, total contractor payments (from the commencement of the project) were £1,489,094.27. A sample of six payments (39% of the total) were reviewed to confirm completeness and timeliness. Four of the payments reviewed had been made after the due date (**recommendation 9**).

Appropriate cost management controls were evidenced through the robust scrutiny of the target cost, and cost reporting mechanisms in place. However, noting the late payments identified and the further recommended improvements in the reporting mechanisms, **reasonable assurance** has been determined in this area.

Change Management

That changes, including technical submissions and derogations, were compliant with the agreed change management process.

The Project Execution Plan appropriately detailed the change management process; and there have been minimal changes since the commencement of construction on site.

Review of the latest Project Manager report (April 2021) noted 21 changes since the previous audit report (October 2019). These changes total a net increase of £281,535.

A sample of six changes were selected for testing, with a value of £214,242 (representing 76% of the total value of changes within the period of review).

All changes had been appropriately assessed by the Cost Adviser in a timely manner; and authorised by the Project Manager and Project Director in line with agreed delegated remits. However, five of the six Project Issues Forms had not been authorised in a timely manner following the Cost Adviser’s assessment (**recommendation 10**).

Technical submissions were recorded and managed via the Request for Information (RFI) process. RFIs were logged by the Supply Chain Partner but were not incorporated into the Project Manager’s Change Control Log reported to the UHB. Management advised they had requested this to be included going forward to enable improved central monitoring.

The derogations schedule had been appropriately approved by the Project Director and included within the Estates Annex of the Full Business Case.

Recognising the generally robust change control processes operating, **reasonable assurance** has been determined in respect of change management.

Covid-19

That the contractual, financial and delivery implications of Covid-19 have been appropriately managed; and that safe working practices have been established and monitored.

Confirmation Notice No. 2 had been prepared based on legal advice obtained, including reference to Covid-related clause amendments as requested by the Supply Chain Partner, which were rejected as advised. As referenced within the ***Contract Documentation*** section, finalisation and execution of the contract remained outstanding at the date of the audit.

As advised by NWSSP: Specialist Estates Services (SES), forecast Covid-19 cost implications were held outside the target cost, with a separate risk provision included within the Full Business Case.

SES Notification 20/17 (issued August 2020) provides further guidance on the management of Covid-related costs: stating the Welsh Government will consider the additional funding of such, once other possible means of funding within the project have been exhausted, and on assessment of any claims submitted (**recommendations 11 & 12**).

One Covid-related Compensation Event has been assessed to date, representing additional costs (£118k) incurred by the Supply Chain Partner to implement safe working practices on site. The change covered the first six months of construction, with no additional time implications.

The UHB was appropriately informed of the Supply Chain Partner's Covid-safe working procedures, with monitoring and reporting of issues via the monthly progress reports.

Noting management actions to address the implications of Covid-19 to date, **reasonable assurance** has been determined in this area.

7. Summary of Recommendations

The audit findings, recommendations are detailed in **Appendix A** together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of new (and / or superseded) recommendations raised	-	7	5	**12**
Recommendations outstanding from the 2019/20 audit	-	-	1	**1**
Total recommendations to be addressed	**-**	**7**	**6**	**13**

Appendix A

Management Action Plan

Finding 1: Project Management – Delivery Group & Project Team	Risk
The terms of reference for the Shaping Our Future Wellbeing: In Our Community (SOFW:IOC) Delivery Group and Maelfa Project Team had been reviewed and updated for the Full Business Case submission, in readiness for the construction stage. Membership lists, whilst acknowledged by management as being lengthy, were necessarily so in order to represent the full range of stakeholders involved in the project. Attendances were assessed against the current membership listings, to ensure key parties were sufficiently represented, with findings as follows: • At the last three Delivery Group meetings (February 2021, December 2020 and October 2020), the Senior Responsible Owner and Maelfa Project Director were in attendance at each meeting. However, a number of agreed members did not attend the three meetings reviewed. • At the last five Project Team meetings (May 2021, March 2021, January 2021, July 2020 and June 2020), issues were noted of routine non-attendance from a number of agreed members. It is acknowledged that the above period of review included the interim stage between Full Business Case submission and approval, the UHB's focus on the Covid pandemic and was prior to commencement of works on site; therefore attendance by all parties at every meeting may not have been required. However, noting that attendance issues were reported at the 2019/20 Internal Audit report, it should be ensured that key parties are committed to their role of members of these forums, to ensure they can operate as intended as the project progresses.	Inadequate organisational and governance arrangements are in place. The project progresses at risk without appropriate scrutiny and approvals.

It was also noted that, whilst updated terms of reference had been included at the Full Business Case, project officers were still referring to the previously agreed terms containing incorrect membership details.	
Recommendations 1 & 2	**Priority level**
1. Attendances at Project Team and Delivery Group should be reviewed, to ensure key parties are reminded of their responsibilities as members of these forums and are present where possible at relevant stages (**O**).	**Low**
2. It should be ensured that all parties reference the most up to date terms of reference for the Project Team and Delivery Group (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
1. Agreed. Attendances will be reviewed to ensure they are sufficient for the current stage and members reminded of their responsibilities. Whilst noting attendance issues by some parties, it is not considered to have impacted to date on critical decision making at key project development stages. 2. Agreed. It will be ensured the relevant documents are up to date.	Capital Planning Programme Support Manager (Strategic & Service Planning) in consultation with Director of Capital, Estates & Facilities July 2021

Finding 2: Project Management - Reporting	Risk
Project Team responsibilities set out in the terms of reference include "*to ensure that the capital spend is in line with the identified budget*." The Project Team receives the following at each meeting: • Capital Highlight Reports – prepared by the Capital Planning Team as a summary of the external Project Manager and Cost Adviser reports; and • Flash Reports – prepared by the Capital Planning Programme Support Manager (Strategic & Service Planning), presenting an overview of project activity during the last month (including deliverables and key issues / risks). However, neither report incorporated a project budget statement (including details of any overspend / underspend, and balance of contingency funds). This key cost information should be reported more formally in the form of the Cost Adviser report. It is acknowledged that this issue had already been noted at the Project Team meeting held in May 2021, with an instruction given that reporting be improved for submissions. Further, it is noted that the Delivery Group are not sufficiently informed of the project cost information. The members only receive the minutes of the Project Team and above reports. It was also noted that the Welsh Government Project Progress Reports have not been shared with the Project Team, Delivery Group or other forums. The inclusion	The Project Team is not adequately informed on project financial information.

of these reports on appropriate meeting agendas would ensure members were sighted on the information being presented to Welsh Government enabling improved scrutiny, challenge, openness and accountability. If submission deadlines do not enable these to be presented in advance, retrospective review would ensure any issues identified can be addressed at future submissions. For example, review of the April 2021 submission, at the date of audit fieldwork, noted outdated information had been submitted in respect of the budget and risk position.	
Recommendations 3 & 4	**Priority level**
3. The Project Team and Delivery Group should receive formal cost reporting at each meeting, including any over/underspend, and the balance of contingency funds (**O**).	**Medium**
4. Welsh Government Project Progress Reports should be shared with an appropriate forum (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
3. Agreed. Financial information would normally be included, however we have been awaiting closure of year end and receiving the ledgers. These have now been received and, going forward, the highlight reports prepared will include spend profile and surplus / deficit. 4. Agreed. The inclusion of the Welsh Government Project Progress Reports on the Project Team agenda is not considered appropriate, recognising the quantum of information currently being presented. However, inclusion of the	Director of Capital, Estates & Facilities July 2021

reports within the papers submitted to the Capital Management Group would enable improved scrutiny and challenge.	

Finding 3: Contract documentation – Confirmation Notice no.2	Risk
Mobilisation and early works commenced on site on 15th February 2021. However, Confirmation Notice no.2, covering contract stages 4/5/6, had not been finalised and executed at the time of review (mid-May 2021). It is acknowledged that UHB contract signature has been delayed whilst legal advice is obtained in respect of contract amendments included by the Supply Chain Partner (to the returned, signed contract documents). The risk of proceeding with the works on site without formal contract documentation in place, has not been reflected in the project risk register. The key contract clause relates to the Fire Safety Strategy (and related specifications etc), and associated installation and building regulation approval of the requirements of the same. The clause would mean that building regulation approval would prevent the UHB from raising a claim against the Supply Chain Partner in respect of issues arising from the Fire Strategy, which may come to light at a later date. Legal advice provided to date indicates the clause should be rejected. However, if it is to be included, the Supply Chain Partner should demonstrate that, as claimed, this requirement arises from their insurers. At the date of reporting, management advised that confirmation had been received from the Supply Chain Partner that they were withdrawing their requirement to incorporate the additional clause. The relevant amendments (i.e. strike-through of the clause) will be made in order to allow execution of the contract documents. The NHS Wales Infrastructure Investment Guidance requires all projects over £2m in value to have a Project Bank Account. This has been delayed whilst both	The project progresses at risk without appropriate contractual cover in place.

the contractual issues are resolved and administration requirements with the bank are finalised.	
Recommendations 5, 6 & 7	**Priority level**
5. The risk register should be updated to reflect current contractual issues (**O**).	**Low**
6. Confirmation Notice no. 2 should be finalised and executed as soon as possible (**O**).	**Medium**
7. Management should continue to seek the early resolution of the Project Bank Account provision (**O**).	**Low**
Management Response	**Responsible Officer/ Deadline**
5. Agreed. The risk register will be updated to reflect the contractual issues. 6. Agreed. We are in possession of the SCP's Confirmation Notice Nr 2, Signed and Sealed on behalf of the SC. The delay is due to one issue that based on the advice from NWSSP SES and the Framework Lawyers could be accepted if proven to be a requirement of the SCP's Insurers. Given the Health Board holds signed copies of the Confirmation Notice Nr 2, the risk to the Health Board could be considered low. Further, noting the update received from the Supply Chain Partner regarding withdrawal of their requirement for the	Director of Capital, Estates & Facilities July 2021

additional clause, we will now be able to progress the execution of the contract documents. 7. Agreed. The Project Bank Account will be entered into upon completion of engrossment of Confirmation Notice Nr 2 and resolution of wider issues in relation to implementation of the account.	

Finding 4: Contract Documentation – Adviser contracts	Risk
External Project Manager and Cost Adviser agreements for Stages 4/5/6 had similarly not been executed at the time of review. Whilst the Cost Adviser had provided signatures, a response was awaited from the Project Manager. Neither agreements had been signed by the UHB. The priority rating assigned reflects the recurrent nature of this issue, with recommendations previously raised at prior project audits.	The project progresses at risk without appropriate contractual cover in place.
Recommendation 8	**Priority level**
Adviser agreements should be executed in a timely manner prior to duties commencing (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The contract will be executed as a matter of priority. The Cost Advisor Confirmation Notice Nr 2, signed and sealed by the CA is with the Health Board and will be engrossed by the Health Board shortly. The Project Managers Confirmation Notice Nr 2 is expected to be provided shortly; and no further payments will be made until this has been resolved.	Director of Capital, Estates & Facilities July 2021

Finding 5: Cost Monitoring & Reporting - Payments	Risk
The NEC contract states, in respect of payment timeframes: (51.2)*"Each certified payment is made within three weeks of the assessment date. If a certified payment is late, or if a payment is late because the Project Manager does not issue a certificate which he should issue, interest is paid on the late payment."* A sample of the last six payments made to the Supply Chain Partner were reviewed for timeliness, totalling £689,881. Four of the six payments were made outside the contractual timeframe, as follows:	Breach of agreed payment terms. Potential incurring of interest charges.

Certificate no.	Value	Date of Cost Adviser's assessment	Contractual due date	Oracle Payment date	No. days late
18	£12,379.80	21/07/2020	11/08/2020	05/08/2020	-
19	£51,361.39	18/08/2020	08/09/2020	25/09/2020	17
20	£23,729.65	18/09/2020	09/10/2020	16/11/2020	38
21	£5,425.74	18/10/2020	08/11/2020	25/11/2020	17
22	£19,216.30	28/02/2021	21/03/2021	30/03/2021	9
Stage 4: 1	£462,788.21	25/03/2021	21/04/2021	30/03/2021	-

At the time of the audit, the Capital Planning team had identified that delays within the internal governance process for variations to order values (affecting all capital projects) were contributing to these timeliness issues. A new payment

monitoring system was being trialled with a view to roll out to all current projects (including Maelfa) by the end of June 2021.	
Recommendation 9	**Priority level**
Payments should be made in accordance with the terms of the contract (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. The delay in payment after sign off and approval of invoices is largely due to the process of having to uplift the order value for compensation events issued on the contract, specifically during OBC & FBC production. This has been recognised and an updated process approved for the inclusion of monies in order values to allow for Health Board risk/contingency. This will reduce the time required to secure additional authorisations at key junctures of the project and improve the timeliness of payments.	Director of Capital, Estates & Facilities July 2021

Finding 6: Change Management	Risk
The project's change management process was appropriately documented at the Project Execution Plan, as follows: • Following the Cost Adviser's assessment of the Supply Chain Partner's quotation, the Project Manager is to seek UHB approval via the Project Issues Form; and • On approval of the Project Issues Form, the formal Project Manager's Instruction can then be issued. A total of £619,857 changes had been recorded at the time of review. A sample of six Compensation Events, totalling £214,242 (76% of the total changes since the prior audit in 2019/20), were selected for review (covering both Stages 2/3 and Stage 4). All Compensation Events were adequately supported by substantiating information and had been assessed by the Cost Adviser in a timely manner from receipt of the Supply Chain Partner's quotation. Additionally, all had been appropriately authorised in accordance with agreed UHB delegated remits. However, delays (ranging from 34 to 205 days) were observed from the date of the Cost Adviser's assessment to the date of authorisation of the Project Issues Form (PIF) in four of the six cases. Refer to the following table for details of testing:	Changes may not be agreed within contractual timeframes. Project time and cost is not appropriately controlled.

CE Ref	PIF Ref	Value	Date of Cost Adviser's assessment	Date of External Project Manager's PIF Signature	Date of Project Director's PIF Signature
024	024	£7,039.40	29/1/2020	25/2/2020	6/3/2020
028	029	£18,152.44	27/2/2020	17/3/2020	17/6/2020
032	034	£21,792.00	24/6/2020	8/7/2020	28/7/2020
033	038	£47,504.00	25/8/2020	11/3/2021	18/3/2021
Stage 4: 01	01	£1,714.10	15/3/2021	17/3/2021	18/3/2021
Stage 4: 02	04	£118,039.94	21/4/2021	21/4/2021	27/5/2021

Whilst acknowledging that additional information can sometimes be sought before the PIF is authorised, the above delays appear extensive in some cases, noting the Cost Adviser has already undertaken his assessment.

Recommendation 10	Priority level
The UHB should implement improved monitoring and control arrangements to ensure Project Issue Forms are prepared and authorised in a timely manner following the Cost Adviser's assessment (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
Agreed. As noted additional information and appropriate evidence is sought for PIF's, this can often cause delay in sign off by the Health Board. The timescale can be further extended due to the value of the PIF being greater than £25,000.	Director of Capital, Estates & Facilities July 2021

Regarding PIF 29 – this is suspected not to have been received by email as there had been known issues of not receiving emails from the external Project Manager's organisation. Moving forward we will more closely monitor the timeliness of these authorisations and raise any issues with the external project manager.	

Finding 7: Covid-19 - Funding risk	Risks
NWSSP: SES have published a Covid funding procedural note on behalf of Welsh Government i.e. *"Potential Financial Consequences Resulting from COVID on Existing DFL Contracts and Future DFL Contracts".* The procedural note states that: *"In the event that Projects incur additional costs due to Covid-19 the following process should be followed:* ○ *SCP's, Health Organisations, Project Managers and Cost Advisors to demonstrate that all possible risk mitigation measures have been explored. (Such as deferring equipment purchase to a later date or delay some external works for future completion)* ○ *The PM and CA to confirm that any Compensation Event is COVID 19 related.* ○ *The PM and CA to confirm that all reasonable due diligence has been carried out in relation to each Compensation Event.* ○ *The Health Organisations, PM and CA to explore all other cost headings within the budget where funding could be managed from should underspends be currently predicted / realised:* ➢ *Fees* ➢ *Non Works costs* ➢ *Equipment Costs (equipment that could be purchased at a later date)* ➢ *Contingency*	Funding risk is not recognised.

➢ *VAT reclaim* ➢ *Inflation (VOP projects)* ➢ *Gain Share* ○ *Health Organisations to provide a statement on the monthly Project Progress Report to Welsh Government regarding Compensation Events related to COVID19.* *For the avoidance of doubt, the initial expectation will be that Health Organisations will manage within the approved budget to the end of the contract at which point, any additional resource requirement over the approved sum can be clearly and robustly set out to the Welsh Government. The provision of additional funding will be subject to Ministerial approval.* *NWSSP-SES will scrutinise the COVID19 financial consequences case and advise Welsh Government whether the case has been made and that all cost headings and opportunities to mitigate the financial risk has been taken."* Good practice is recognised in that project contingencies have been determined from a costed assessment of potential risks arising at the project. However, variances in Project Manager and Cost Adviser's reporting of the Covid-19 costs and contingency position were noted. Management have acknowledged that the risk of the above costs should be included on the project risk register, along with other emerging risks and early warning notices, and confirmed this will be updated accordingly. Given the financial position of the project, specific risk management/mitigation arrangements are required (recognising the work has to be instructed at risk pending future funding approval). Careful management of contingencies and	

other budget headings will be required through the remainder of the contract/project noting the Welsh Government requirements to meet Covid costs within original allocations.	
Recommendations 11 & 12	**Priority level**
11. The management of risks and contingency, including Covid-19 and other costs, should be consistently reported (**D**).	**Low**
12. Specific Covid funding risks, and its impact on project funding (as per Welsh Government requirements) will be highlighted and regularly reported to relevant forums (**O**).	**Medium**
Management Response	**Responsible Officer/ Deadline**
11. Agreed. It will be ensured the Project Manager's report aligns with the presentation in the Cost Adviser's report, and that the risk register is updated to reflect the Covid risk and Early Warning Notices as they arise. 12. Agreed. The Covid funding risks will be highlighted in the reporting to the Project Team and Delivery Group.	Director of Capital, Estates & Facilities July 2021

Appendix B

Follow up of previously agreed recommendations

Ref	Recommendation	Previous Responsibility & Timescale	Priority Rating	Status as at May 2021	Updated Responsibility & Timescale
1	The PEP should be updated accordingly and resonate with other supporting documentation (i.e. terms of reference).	Director of Capital, Estates & Facilities In line with the Full Business Case	**Low**	**Outstanding** The Project Execution Plan (PEP) had been updated in readiness for the construction stage. However, the previously identified issues, in respect of the role of the Capital Planning Manager, and inconsistent references to the frequency of Delivery Group meetings, remained in the updated version. It is also noted that references remain to the prior Head of Capital Planning (e.g. at page 11 of the PEP) in respect of delegated authorities. Recognising further imminent changes to key project officers, it is recommended the PEP be updated holistically on appointment of the new Head of Capital Planning.	Director of Capital, Estates & Facilities July 2021
2	As the project gains momentum, Project Board and Project Team members should be reminded of the importance of attendance to ensure all discussions / decisions taken are suitably informed.	Director of Capital, Estates & Facilities End November 2019	**Low**	**Superseded** A current review of Project Team and Delivery Group attendances found continuing issues in this area.	N/A

Ref	Recommendation	Previous Responsibility & Timescale	Priority Rating	Status as at May 2021	Updated Responsibility & Timescale
				A new recommendation has been raised in the main body of the audit (**see Finding 1, Appendix A**).	
3	Work stream leads should produce resource/ activity plans for the attention of the Project Team/ Board.	Director of Capital, Estates & Facilities End November 2019	**Low**	**Closed** Central FBC development and control of the timing of inputs etc. was managed by the appointed external business case consultant. Periodic reporting of workstream activity to the Project Team was also evidenced. Whilst noting therefore that workstreams did not have their own activity plans against which to manage progress, as agreed at the 2018/19 recommendation, the alternative controls are recognised as above. Current workstream activity has been reviewed in the main body of the audit (**see Finding 2, Appendix A**).	N/A
4	Arrangements should be made to ensure the correct section of the contract is signed by both parties.	Director of Capital, Estates & Facilities End October 2019	**Medium**	**Closed** The UHB obtained legal advice in November 2019 in respect of the mis-signed call off contract. The advice confirmed there was no legal benefit in the contract being re-signed. It did however recommend the UHB obtained the Supply Chain Partner's copy of the contract, to append to the	N/A

Ref	Recommendation	Previous Responsibility & Timescale	Priority Rating	Status as at May 2021	Updated Responsibility & Timescale
				UHB's version, for completeness. This was evidenced as actioned at the time of reporting.	

Appendix C

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that the project achieved its key delivery objectives and that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that the project achieved its key delivery objectives and that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that the project achieved its key delivery objectives and that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that the project achieved its key delivery objectives and that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Counter Fraud Services in NHS Wales

Operational Performance Report 2020/21

Quarter 4 – 1st January 2021 to 31st March 2021

Contents

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Introduction

This quarterly report format summarises the operational resources, referrals and performance of the Counter Fraud Service (CFS) Wales National Team and the network of Local Counter Fraud Specialists (LCFS) based at health bodies in NHS Wales during Quarter 4 of 2020/21 (1st January 2021 to 31st March 2021). The NHS Counter Fraud Authority (NHSCFA) continue to report to Welsh Government (WG) via a separate quarterly report document.

1 Resources

1.1 NHS Counter Fraud Service (CFS) Wales

The NHS CFS Wales team is hosted by NHS Wales Shared Service Partnership, part of Velindre NHS Trust who employ the team members. The CFS Wales consists of 6.0 wte experienced investigators and 1.0 wte operational support, their primary role is the investigation and prosecution of serious, complex or large-scale economic crimes. This includes offences that may involve more than one organisation, cross border investigations and all corruption and bribery cases in NHS Wales. They also provide support and guidance to the LCFS network in Wales and conduct presentations to key stakeholders in NHS Wales.

The CFS Wales team provide a specialist independent investigation resource to NHS Wales. This is designed to provide an impartial investigation service if senior NHS executives or management may be implicated, as suspects or witnesses, to provide the health bodies with the independent assurance required. The CFS Wales team's employers are listed as a regulatory body under POCA 2002, this enables the accredited financial investigators (2.0 wte) on the CFS Wales team to conduct financial investigations or restrain and recover funds from convicted persons. The CFS Wales team also work closely with the LCFSs often providing guidance on investigations or jointly investigating suitable cases.

1.2 Local Counter Fraud Specialists (LCFS)

WG Directions require each health body to nominate a qualified LCFS who is accredited by the Counter Fraud Professional Accreditation Board. LCFSs are the primary point of contact for all economic crime concerns within their health body, they have a key proactive role in raising fraud awareness, identifying risks and preventing fraud at their health bodies, while also investigating offences reported at a local level in collaboration with CFS Wales.

The LCFS work is closely aligned to the delivery of the current Fraud, Bribery and Corruption Standards for NHS bodies (Wales), which are reviewed and updated annually by the NHS Counter Fraud Authority (NHSCFA) under their SLA with WG. The Standards are split into four key principles: Strategic Governance, Inform & Involve, Prevent & Deter and Hold to Account. Work has been completed to align the NHSCFA standards with the new Cabinet Office Standards on Counter Fraud Work and NHS Wales will adopt the new Cabinet Office Functional Standards for the 2021/22 financial year.

The table below summarises the counter fraud resources in NHS Wales during Q4 of 2020/21. This is consolidated from data provided to CFS Wales by the Lead LCFS at each health body. The health board with the most LCFS resources is SB UHB at 3.29 wte as SB UHB has recently recruited new 2 LCFS and one new Admin Support. The Trusts and HEIW are smaller organisations with less fraud reported. Their lower LCFS provision generally reflects the level of potential risk although WAST has two full time LCFSs for a relatively small number of employees (3,488 wte).

The total LCFS provision plus admin support staff in NHS Wales has increased from **14.3 wte** in April 2014 to **19.51 wte** with **3.6 wte** admin support roles as at 31st March 2021. The table at **Appendix 1** provides details of the LCFS provision in 2014/15 for comparison purposes.

NHS WALES COUNTER FRAUD RESOURCE 2020/21							
Health Body	**LCFS Annual WTE**	**Admin Support Annual WTE**	**Annual Planned LCFS days**	**Q4 LCFS days**	**YTD LCFS Days**	**Salary Costs Q4**	**Annual Staffing budget**
AB UHB	2.6	1	536	134	536	£31,629	£126,514
BCU HB	2.91	0.6	620	163.75	646.75	£37,276	£148,835
CV UHB *	1.8	0.5	440	110	440	£22,703	£90,812
CTM UHB **	2.6	0	530	92	354	£37,762	£151,050
HEIW *	0.2	0.125	50	12.5	50	£4,200	£14,000
HD UHB	2.0	0	420	66.5	352	£18,646	£77,089
NWSSP *	0.3	0.125	75	18.75	75	£5,600	£21,000
PtHB **	1.11	0	270	61	185	£9,100	£36,398
PHW NHST *	0.3	0.125	100	25	100	£5,000	£25,000
SB UHB **	3.29	1.0	540	117	540	£33,536	£153,898
V NHST*	0.4	0.125	110	23.75	95	£5,600	£26,000
WAST	2.0	0	440	110	440	£28,193	£117,013
TOTAL	**19.51**	**3.6**	**4,131**	**924.25**	**3,813.75**	**£239,232**	**£948,706**
CFS WALES	6	1	1,314	328	984	£97,683	£390,734
ALL WALES TOTAL	**25.51**	**4.6**	**5,445**	**1,252.25**	**4,797.75**	**£336,915**	**£1,339,440**
NHS Counter Fraud Authority Services via Welsh Government SLA							**£207,000**
NHS Counter Fraud Service Provision / All Wales Total							**£1,546,440**

- The C&V UHB LCFS Team also provide an LCFS service to Velindre NHS Trust, NWSSP, HEIW and PHW via an annual SLA.
- ** The Swansea Bay UHB LCFS Team also provide an LCFS service to CTM UHB and Powys tHB via an annual SLA.

1.3 NHS Counter Fraud Authority (NHSCFA)

The WG purchase specialist support services from the NHSCFA for NHS Wales under the terms of an annual Service Level Agreement. The NHSCFA provide separate quarterly and annual reports to WG to account for the specialist services provided to NHS CFS Wales and LCFSs in Wales for an annual cost of £207,000. The services include Forensic Computing, Dental Advisor, Fraud Training, Risk Measurement and Quality Assurance Services which are reviewed and monitored via the quarterly reports and 6 monthly meetings between NHSCFA, WG and CFS Wales. A NHSCFA senior management representative also attends the quarterly NHS Wales Counter Fraud Steering Group (CFSG) Meetings.

The NHSCFA Risk Measurement Exercise on Procurement Fraud in NHS England and Wales commenced during 2019/20. The data for Phase 1 was submitted by NHS Wales health bodies to the NHSCFA and was reviewed. Additional data and information on specific procurement contracts in NHS Wales was requested for further analysis by NHSCFA, and although the process was delayed by the Covid 19 situation, a full report on the risk exercise was issued to health bodies and NHS Wales in early April 2021.

2 Counter Fraud Awareness - Inductions and Presentations conducted by LCFS during Q4 of 2020/21

The following table summarises the number of counter fraud awareness presentations and induction courses completed at each health body during Quarter 4 of 2020/21. The presentations and inductions have been significantly reduced due to the Covid 19 situation. This has led to new presentation formats, AB UHB LCFS have provided an on-line counter fraud video presentations for staff to access during their induction process, while other health boards have used new virtual presentations formats to raise fraud awareness with staff, SB UHB conducted 11 presentations, BCU HB 5 presentations and HD UHB 4 presentations in Q4 with a total of 205 staff completing inductions and 712 staff attending virtual presentations in Wales during this difficult period.

Cardiff & Vale UHB LCFSs also provide an LCFS service to Velindre NHS Trust, Public Health Wales, Health Education & Improvement Wales and NHS Wales Shared Service Partnership, while Swansea Bay UHB LCFSs also provide the LCFS service to Cwm Taf Morgannwg UHB and Powys tHB.

Presentations & Inductions 2020/21	Inductions Q4		Presentations Q4		Total Staff Q4	Total Staff 01/04/20 - 31/03/21	Health Body Employees (as at August 2019)
	No Conducted	No Staff	No Conducted	No Staff			
Aneurin Bevan UHB	0	175 *	1	20	195	285	13,382
Betsi Cadwaladr UHB	0	0	5	128	128	178	18,098
Cardiff & Vale UHB	0	0	3	42	42	183	14,754
Cwm Taf Morgannwg	0	0	2	7	7	40	11,810
HEIW	0	0	3	23	23	218	348
Hywel Dda UHB	0	0	4	189	189	1,602	9,732
NWSSP	0	0	2	25	25	89	2,234
Powys tHB	3	30	2	8	38	112	2,215
Public Health Wales	0	0	0	0	0	0	1,849
Swansea Bay UHB	0	0	11	182	182	541	12,801
Velindre NHST	0	0	1	11	11	48	2,126
Welsh Ambulance NHST	0	0	2	77	77	282	3,488
TOTAL	**3**	**205**	**36**	**712**	**917**	**3,578**	**92,837**

* number of staff who accessed/completed the AB UHB on-line CF induction

The LCFS induction and presentations data for the 2019/20 financial year is available at Appendix 2 for comparison purposes.

3 Counter Fraud Awareness E-Learning Staff Completion Figures 1st January 2021 to 31st March 2021

The data below is compiled and provided by NWSSP Digital Learning and lists the number of staff at each health body that completed the NHS Wales Counter Fraud E-Learning Module in Q4.

	Staff Completion Q4 1st January 2021 to 31st March 2021	Cumulative from March 2015 to 31st March 2021	Health Body Employees (Aug 2019)
Aneurin Bevan UHB	0	2,974	13,382
Betsi Cadwaladr UHB	6	2,976	18,098
Cardiff & Vale UHB	1	1,018	14,754
Cwm Taf Morgannwg UHB	8	330	11,810
Hywel Dda UHB	5	301	9,732
Powys tHB	0	290	2,215
Public Health Wales Trust	15	323	1,849
Swansea Bay UHB	59	856	12,801
Velindre / NWSSP / NWIS / HEIW	0	739	4,708
Welsh Ambulance NHS Trust	7	292	3,488
TOTAL	**101**	**10,099**	**92,837**

Source: Digital Learning, NWSSP

4 NHS CFS Wales Statistics / Operational Outcomes – 1st January 2021 to 31st March 2021

The table below summarises the CFS Wales operational data and sanctions secured in Quarter 4.

The CFS Wales team were investigating 37 cases at the start of the quarter and were dealing with 33 active cases at the end of Q4, with 4 new referrals received and 8 cases closed during the reporting period. During Q4, there was one criminal sanction and one disciplinary sanction. The criminal sanction was a Doctor employed by C&V UHB who pleaded guilty to multiple fraud offences while the disciplinary was a pharmacist from the CTM UHB area who was struck off by the GPhC following his criminal conviction and prison sentence for fraud offences.

The sanitised list of active CFS Wales investigations is at Appendix 3 for review.

NHS CFS Wales Team (CFS Wales) – Q4										
NHS Organisation	No of open cases as at 01/01/21	No of referrals received	No of cases closed	No of open cases at 31/03/21	Recoveries £	Sanctions				
						Criminal			Disciplinary	Civil
						Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	3	1	1	3	0	0	0	0	2	0
Betsi Cadwaladr UHB	8	1	1	8	0	0	0	0	0	0
Cardiff & Vale UHB	9	2	4	7	£40	1	0	0	1	0
Cwm Taf Morgannwg UHB	8	0	2	6	£1,500	0	0	0	0	0
Hywel Dda UHB	2	0	0	2	0	0	0	0	0	0
HEIW	0	0	0	0	0	0	0	0	0	0
NHS Wales SSP	0	0	0	0	0	0	0	0	0	0
Powys tHB	1	0	0	1	£58,520	0	0	0	0	0
Public Health Wales Trust	0	0	0	0	0	0	0	0	0	0
Swansea Bay UHB	2	0	0	2	0	0	0	0	0	0
Velindre NHS Trust	2	0	0	2	0	0	0	0	0	0
Welsh Ambulance NHS Trust	2	0	0	2	0	0	0	0	0	0
All-Wales / Multi Organisations	0	0	0	0	0	0	0	0	0	0
TOTAL	37	4	8	33	£60,060	1	0	0	3	0

Recoveries include agreed monthly repayments, the relevant civil sanction was previously recorded at the commencement of the repayment plan

NHS CFS Wales Team (CFS Wales) – 2020/21 Cumulative										
NHS Organisation	No of open cases as at 01/04/20	No of referrals received	No of cases closed	No of open cases at 31/03/21	Recoveries £	Sanctions				
						Criminal			Disciplinary	Civil
						Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	3	1	1	3	0	0	0	0	2	0
Betsi Cadwaladr UHB	4	5	1	8	0	0	0	0	0	0
Cardiff & Vale UHB	7	8	8	7	£900,522	1	0	0	1	1
Cwm Taf Morgannwg UHB	6	3	3	6	£6,540	0	0	0	1	0
Hywel Dda UHB	3	1	2	2	0	0	0	0	0	0
HEIW	0	0	0	0	0	0	0	0	0	0
NHS Wales SSP	0	0	0	0	0	0	0	0	0	0
Powys THB	1	0	0	1	£58,520	0	0	0	0	0
Public Health Wales Trust	0	0	0	0	0	0	0	0	0	0
Swansea Bay UHB	2	0	0	2	0	0	0	0	0	0
Velindre NHS Trust	2	0	0	2	0	0	0	0	0	0
Welsh Ambulance NHS Trust	1	1	0	2	0	0	0	0	0	0
All-Wales / Multi Organisations	0	0	0	0	0	0	0	0	0	0
TOTAL	29	19	15	33	£965,582	1	0	0	4	1

Recoveries include agreed monthly payments, the civil sanction was previously recorded at the commencement of the repayment plan

During the 2020/21 financial year, CFS Wales recovered a total of £965,582 via 1 criminal sanction, 4 disciplinary and 1 civil sanction recorded during the period which was obviously impacted by the Covid 19 situation.

5 LCFS Statistics / Operational Outcomes – 1st January 2021 to 31st March 2021

The table below summarises the NHS Wales LCFS operational data and sanctions secured in Quarter 4 of 2020/21. The LCFSs were investigating a total of 156 cases at the start of the quarter, 49 cases were closed during the quarter with 33 new referrals reported for investigation leaving a total of 140 cases under LCFS investigation as at 31st March 2021.

The LCFS investigations secured 4 Disciplinary Outcomes and 8 Civil Recoveries which recovered £63,758 for NHS Wales in Q4. SB UHB continue to have the highest number of active investigations with 33 open cases at the end of Q4 while BCU HB (25), AB UHB (21) and WAST (20) have the next highest number of open investigations. SBUHB (8), ABUHB (7) and HDUHB (6) had the highest number of new referrals during the quarter with ABUHB (11) closing the highest number of cases in Q4.

A Police Community Resolution is an alternative way of dealing with less serious crimes, allowing police officers to use their professional judgement when dealing with offenders where the victim has agreed that they do not want to take formal action. The community resolutions are not recorded on the PNC but are recorded locally and can be accessed for intelligence purposes, examples include a simple apology, an offer of compensation or to rectify any criminal damage. The Police Adult Community Resolution recording was introduced in Q3 with one sanction recorded during 2021/21 for SBUHB, it is anticipated that there will be an increase in PCR sanctions going forward.

There is a sanitised list of **active LCFS investigations** at NHS Wales health bodies at **Appendix 4.** A sanitised list of CFS Wales and LCFS investigations closed during Q4 is included at **Appendix 5.**

Local Counter Fraud Specialists in NHS Wales Q4										
NHS Organisation	No of open cases as at 01/01/21	No of referrals received	No of cases closed	No of open cases at 31/03/21	Recoveries £	Sanctions				
						Criminal			Disciplinary	Civil
						Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan	25	7	11	21	0	1	0	0	0	0
Betsi Cadwaladr	28	1	4	25	£11,735	0	0	0	0	1
Cardiff & Vale	12	4	7	9	£14,151	0	0	0	1	1
Cwm Taf Morgannwg	17	1	5	13	£16,719	0	0	0	0	2
HEIW	0	0	0	0	0	0	0	0	0	0
Hywel Dda	10	6	7	9	£12	0	0	0	1	1
NHS Wales Shared Services	3	2	1	4	0	0	0	0	0	0
Powys	7	2	3	6	0	0	0	0	0	0
Public Health Wales	0	0	0	0	0	0	0	0	0	0
Swansea Bay	29	8	4	33	£6,560	0	0	0	0	1
Velindre	0	0	0	0	0	0	0	0	0	0
Welsh Ambulance	25	2	7	20	£14,581	0	0	0	2	2
TOTAL	156	33	49	140	£63,758	1	0	0	4	8

Recoveries include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan

Local Counter Fraud Specialists in NHS Wales 2020/21 Cumulative										
NHS Organisation	No of open cases as at 01/04/20	No of referrals received	No of cases closed	No of open cases at 31/03/21	Recoveries £	Sanctions				
						Criminal			Disciplinary	Civil
						Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan	24	24	27	21	£38,914	2	0	0	6	3
Betsi Cadwaladr	27	3	5	25	£33,735	0	0	0	0	1
Cardiff & Vale	15	11	17	9	£45,052	0	1	0	2	7
Cwm Taf Morgannwg	18	9	14	13	£28,994	0	1	0	1	4
HEIW	1	0	1	0	0	0	0	0	1	0
Hywel Dda	7	19	17	9	£21,843	1	0	0	2	5
NHS Wales Shared Services	2	5	3	4	£10,013	0	0	0	1	1
Powys	14	3	11	6	0	0	0	0	2	0
Public Health Wales	0	0	0	0	0	0	0	0	0	0
Swansea Bay	50	19	36	33	£13,826	0	3	1	7	4
Velindre	0	0	0	0	0	0	0	0	0	0
Welsh Ambulance	25	13	18	20	£16,212	0	0	0	3	4
TOTAL	183	106	149	140	£208,589	3	5	1	25	29

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan.

During 2020/21, the LCFSs at AB UHB received the highest number of referrals (24), followed by SB UHB (19) and HD UHB (19), while SB UHB closed the most referrals (36) followed by AB UHB (27) and WAST (18). The combined recoveries by LCFSs in Wales amounted to £208,589 with 3 criminal sanctions, 5 police cautions, 1 Police CR, 25 disciplinary sanctions and 29 civil recoveries recorded.

The low number of referrals (3 in total for 2020/21) at BCU HB, the largest health body in Wales is noted.

A review of the combined data for CFS Wales and LCFS in Wales on page 12 confirms a drop in referrals for 2020/21 (125 referrals compared to 162 in 2019/20). This is considered largely due to the impact of the Covid 19 situation which initially reduced proactive work and presentations to staff.

The total recoveries secured in 2020/21 of £1,174,171 compares favourably with previous years in the chart at Page 12, although the combined number of criminal sanctions (9 : 16), Civil recoveries (30 : 55) with the same number of Disciplinary outcomes (29 : 29) when compared with 2019/20.

6 Working in Partnership

CFS Wales and Lead LCFSs reviewed the recent Audit Wales reports on counter fraud resources in the public sector in Wales, the reports were tabled at Audit Committees with a response plan agreed for each health body. CFS Wales has contributed to the CFSG RAG review of the NHS Wales Audit Wales Report which was presented at a DOFs meeting in Q4 and have also contributed to the CFSG review and response to the recent NHSCFA Risk Measurement Exercise on Procurement Fraud in NHS Wales.

CFS Wales assisted in several LCFS recruitment exercises during 2020/21 and continued to attend the Financial Governance Group which reviews and endorses high value PPE equipment purchases for NHS Wales. CFS Wales has routinely shared counter fraud articles with LCFS colleagues and ensured that all risk alerts and updates including Covid 19 risks were swiftly circulated to key stakeholders, a total of 55 fraud alerts and articles were circulated during Q1 – Q4. CFS Wales staff are due to appear in Fraud Squad on BBC1 in mid- May which features a high profile Pharmacy fraud conviction in the CTM UHB area.

CFS Wales staff have attended NHS CFA and NAFN events and training modules during Q4. CFS Wales staff and LCFSs work closely together and often jointly attend meetings with key stakeholders e.g. CFSG or PPV meetings and also jointly progress suitable investigations. During Q4, CFS Wales staff attended virtual meetings with WG, NWSSP, NHSCFA, PPV, Lead LCFSs, CFSG and CPS and also conducted induction training events to NHS Staff.

CFS Wales staff helped NHSCFA pilot Clue the new case management system in Q4, the Clue system and a virtual training program was then provided by NHSCFA to LCFS from 01/04/21. Clue will replace FIRST the old case management system which had been in use for fifteen years.

The following table indicates the operational outcomes combined for CFS Wales and LCFS for the **5-year period 1st April 2016 to 31st March 2021.** A total of 770 referrals have been investigated in the five-year period which have secured 64 criminal sanctions (including 1 x PCR), 151 disciplinary outcomes and 189 civil recoveries which have secured £3,203,910- in recoveries for NHS Wales.

	NHS CFS Wales and LCFS Sanctions April 2016 to March 2021					
	Referrals	Recoveries	Sanctions			
			Criminal	PCR *	Civil	Disciplinary
2016/2017	140	£335,127	7	0	35	20
2017/2018	191	£225,499	15	0	33	42
2018/2019	152	£522,030	16	0	36	31
2019/2020	162	£947,083	16	0	55	29
2020/2021	125	£1,174,171	9	1	30	22
TOTAL	**770**	**£3,203,910**	**63**	**1**	**189**	**151**

** Police Community Resolution (PCR) - introduced in Q3 2020/21 and included as a criminal sanction*

NHS Wales Counter Fraud Resources 2014/15

NHS Wales Local Counter Fraud Provision 2014/15				
Health Body	Resource Allocation (LCFS days)	LCFS WTE	Admin Support WTE	Budgeted Salary Cost
Abertawe Bro Morgannwg	559	2.6	0.10	£110,096
Aneurin Bevan	602	2.8	1.00	£122,902
Betsi Cadwaladr	645	3	0.50	£156,822
Cardiff & Vale	387	1.8	0.25	£83,512
Cwm Taf	215	1.0	0.50	£61,977
Hywel Dda	201	0.9	0.00	£57,900
Powys	92	0.4	0.00	£23,704
Public Health Wales	107.5	0.5	0.00	£25,000
Velindre / NWSSP	150.5	0.7	0.25	£47,600
Welsh Ambulance	125	0.6	0.00	£25,968
TOTAL	**3084**	**14.3**	**2.60**	**£715,481**
NHS CFS Wales Regional Team	1032	4.8	1	£234,996
ALL WALES TOTAL	**4116**	**19.1**	**3.6**	**£950,477**

NHS Wales LCFS Fraud Awareness Presentations and Induction Sessions 2019/20

	Inductions		Presentations		Total Staff 2019/20	Staff Headcount (2019)
	No Conducted	No Staff	No Conducted	No Staff		
Aneurin Bevan UHB	36	710	13	330	1040	13,382
Betsi Cadwaladr UHB	89	2355	37	1141	3496	18,098
Cardiff & Vale UHB	17	611	22	915	1526	14,754
Cwm Taf Morgannwg	0	0	17	432	432	11,810
HEIW	1	20	2	30	50	348
Hywel Dda UHB	56	1282	27	628	1910	9,732
NWSSP	6	95	8	127	222	2,234
Powys tHB	1	20	4	121	141	2,215
Public Health Wales	2	42	3	112	154	1,849
Swansea Bay UHB	0	0	71	2264	2264	12,801
Velindre NHST	0	0	10	116	116	2,126
Welsh Ambulance NHST	0	0	3	29	69	3,488
TOTALS	**208**	**5135**	**217**	**6245**	**11420**	**92,837**

NHS CFS Wales Summary of Open Cases as 31st March 2021 (33 open investigations) Appendix 3

Case Reference		Health Body	Start Date	Subject	Potential Offences
1	Clue Ref Inv/21/00007	Cardiff & Vale UHB	07/01/2021	Estates Contract	Fraud by False Representation / Fraud by Abuse of Position.
2	WARO/21/00022 / Clue Reference: INV/21/00006	Cardiff & Vale UHB	19/02/2021	Pharmacy	Fraud by False Representation / Fraud by Abuse of Position
3	Clue Ref inc/21/00001	Betsi Cadwaladr UHB	07/01/2021	Estates Contract	Corruption/ Fraud by false representation
4	WARO 21/00005 Clue Reference INV21/000021	Aneurin Bevan UHB	11/01/2021	Dentist	Fraud by False Representation/Abuse of Position
5	WARO/21/00010	Betsi Cadwaladr UHB	02/11/2020	Dentist	Fraud by False Representation/Abuse of Position
6	WARO/21/0009	Betsi Cadwaladr UHB	02/11/2020	Dentist	Fraud by False Representation/Abuse of Position
7	WARO/21/00008	Betsi Cadwaladr UHB	02/11/2020	Dentist	Fraud by False Representation/Abuse of Position
8	WARO/21/00007	Betsi Cadwaladr UHB	02/11/2020	Dentist	Fraud by False Representation/Abuse of Position
9	WARO/20/00096	Cwm Taf Bro Morgannwg UHB	18/09/2020	Contractor	Fraud by False Representation.
10	WARO/20/000883 / Clue Reference INV/20/00016	Welsh Ambulance NHST	21/09/2020	Patient	Fraud by False Representation / Misuse of Controlled Drugs offences
11	WARO/20/00087	Cwm Taf Bro Morgannwg UHB	21/09/2020	Contractor	Fraud by False Representation
12	WARO/20/00079	Cardiff & Vale UHB	17/08/2020	Contractor	Fraud by False Representation
13	WARO/17/00097	Cardiff & Vale UHB	11/08/2020 case re-opened	Patient	Fraud by False Representation
14	WARO/18/00151	Betsi Cadwaladr UHB	31/10/2018 case opened by LCFS 24/01/2020 transferred to CFS Wales	GP	Fraud by False Representation
15	WARO/20/00007	Cwm Taf Bro Morgannwg UHB	10/01/2020	Consultant	Fraud by False Representation/Abuse of Position
16	WARO/19/00141	Velindre NHST	02/11/2019	External Supplier	Fraud by false representation
17	WARO/19/00092	Betsi Cadwaladr UHB	08/08/2019 by LCFS, and transferred to CFS wales on 04/12/2019.	GP	False Declaration
18	WARO/19/00088	Velindre NHST	08/08/2019	External Supplier	Conspiracy to Defraud / Abuse of position of trust/Fraud by False Rep
19	WARO/19/00027	Cwm Taf Bro Morgannwg UHB	08/03/2019	Healthcare Support Worker	Theft/Money Laundering
20	WARO/19/00021	Cardiff & Vale UHB	20/02/2019	Specialist Registrar	Theft/Fraud
21	WARO/19/00014	Cwm Taf Bro Morgannwg UHB	09/02/2019	Doctor	Theft of overpayment of salary

Case Reference		Health Body	Start Date	Subject	Potential Offences
22	WARO/19/00010	Welsh Ambulance NHST	Opened by LCFS on 04/02/2019 and transferred to CFS Wales on 26/06/2019	Private Company	Fraud
23	WARO/18/00164	Aneurin Bevan UHB	15/11/2018	Dentist	Fraud by False Representation
24	WARO/18/00140	Swansea Bay UHB	10/10/2018	Credit to Incorrect Bank Account	Fraud by False Representation
25	WARO 18/00094	Cwm Taf Bro Morgannwg UHB	04/07/2018	Nurse	Theft/Money Laundering
26	WARO/18/00082	Aneurin Bevan UHB	01/06/2018	Optical Contractor	Fraud by False Representation / False Accounting
27	WARO/17/00155	Cardiff & Vale UHB	04/12/2017	Dentist	Fraud by False Representation / False Accounting
28	WARO/17/00154	Hywel Dda UHB	02/12/2017	Healthcare Support Worker	Theft
29	WARO/17/00093	Hywel Dda UHB	14/08/2017	Ex-Employee	Theft / Retaining a Wrongful Credit
30	WARO/15/00060	Cardiff & Vale UHB	29/06/2015	Dentist	Fraud by False Representation / False Accounting
31	WARO/15/00058	Powys Teaching Health Board	16/06/2015	NHS Estates Staff	Corruption / Fraud by False Representation
32	WARO/14/00068	Swansea Bay UHB	28/05/2014	Dentists	Fraud by False Representation
33	WARO/14/00062	Betsi Cadwaladr UHB	09/05/2014	Senior Managers / Contractors	False Accounting / Misconduct in Public Office / Conspiracy

LCFS Summary of Open Cases as at 31st March 2021

Appendix 4

Case No		Health Body	Start Date	Subject Category	Fraud Type
1	WARO/18/00048	Aneurin Bevan UHB	14/03/2018	Community Pharmacy	Fraud False Rep
2	WARO/18/00084	Aneurin Bevan UHB	08/06/2018	Consultant	Fraud Fail to disclose
3	WARO/18/00106	Aneurin Bevan UHB	27/07/2018	Nurse	Fraud Fail to disclose - working on sick
4	WARO/18/00122	Aneurin Bevan UHB	22/08/2018	Doctor	Fraud Fail to disclose -working on sick
5	WARO/18/00136	Aneurin Bevan UHB	08/10/2018	Admin Staff	Fraud False Rep - timesheet
6	WARO/19/00034	Aneurin Bevan UHB	03/04/2019	HCA	Abuse of Position
7	WARO/19/00122	Aneurin Bevan UHB	15/10/2019	GP	Fraud by False Rep - Application/Failing to disclose
8	WARO/19/00145	Aneurin Bevan UHB	17/12/2019	Consultant	Fail to Disclose
9	WARO/20/00020	Aneurin Bevan UHB	11/02/2020	Nurse	Fraud Fail to disclose - working on sick
10	WARO/20/00046	Aneurin Bevan UHB	30/04/2020	Agency Nurse	Fraud by False Rep - timesheet
11	WARO/20/00051	Aneurin Bevan UHB	02/06/2020	Hospital Doctor	Fail to Disclose - working elsewhere breach of contract
12	WARO/20/00066	Aneurin Bevan UHB	10/07/2020	Doctor GP	Abuse of Position
13	WARO/20/00070	Aneurin Bevan UHB	29/07/2020	Former Practice Manager	Abuse of Position
14	WARO/20/00099	Aneurin Bevan UHB	09/10/2020	HCA	working on sick
15	WARO/20/00101	Aneurin Bevan UHB	14/10/2020	Doctor	working on sick
16	WARO/20/00108	Aneurin Bevan UHB	11/11/2020	Dentist	False Representation
17	WARO/20/00110	Aneurin Bevan UHB	12/11/2020	Nurse	Theft
18	WARO/20/00111	Aneurin Bevan UHB	17/11/2020	HCA	False Representation
19	WARO/21/00001	Aneurin Bevan UHB	04/01/2021	HCA	False Representation
20	WARO/21/00003	Aneurin Bevan UHB	06/01/2021	Nurse	Theft of drugs/Abuse of position
21	WARO/21/00039	Aneurin Bevan UHB	05/03/2021	Admin Staff	timesheet
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/13/00071	Betsi Cadwaladr UHB	08/07/2013	Pharmacist (Community)	Miscellaneous/other
2	WARO/11/00099	Betsi Cadwaladr UHB	18/07/2011	Nurse (NHS)	Miscellaneous/other
3	WARO/16/00051	Betsi Cadwaladr UHB	03/06/2016	Miscellaneous (IM&T)	Theft
4	WARO/16/00052	Betsi Cadwaladr UHB	03/06/2016	Miscellaneous (Locum)	Timesheet Fraud
5	WARO/17/00003	Betsi Cadwaladr UHB	10/01/2017	Speech & Language Therapist	Working while sick
6	WARO/17/00074	Betsi Cadwaladr UHB	05/07/2017	General Practitioner with Special Interest	Miscellaneous/other
7	WARO/17/00167	Betsi Cadwaladr UHB	20/12/2017	Dentist	Submission of fraudulent claims
8	WARO/18/00010	Betsi Cadwaladr UHB	15/01/2018	Consultant / Surgeon (NHS)	Working elsewhere whilst sick
9	WARO/18/00014	Betsi Cadwaladr UHB	17/01/2018	Health Care Support Worker	Payroll Fraud / Salary Overpayment
10	WARO/18/00037	Betsi Cadwaladr UHB	13/02/2018	Voluntary Driver	Overcharging of transport charges
11	WARO/18/00042	Betsi Cadwaladr UHB	21/02/2018	Nurse Practitioner/ Independent Prescriber	Prescription fraud
12	WARO/18/00134	Betsi Cadwaladr UHB	02/10/2018	Senior Management	Miscellaneous/other
13	WARO/18/00156	Betsi Cadwaladr UHB	07/11/2018	Works & Estates / Health & Safety staff	Payroll Fraud / Salary Overpayment
14	WARO/18/00163	Betsi Cadwaladr UHB	15/11/2018	General Practitioner	Prescription fraud
15	WARO/18/00172	Betsi Cadwaladr UHB	29/11/2018	Consultant / Surgeon (NHS)	Dual employment/failure to complete contracted NHS hours
16	WARO/19/00017	Betsi Cadwaladr UHB	29/11/2018	Radiographer	Working while sick
17	WARO/19/00037	Betsi Cadwaladr UHB	05/04/2019	Consultant / Surgeon (NHS)	Payroll Fraud / Salary Overpayment
18	WARO/19/00041	Betsi Cadwaladr UHB	17/04/2019	General Practitioner	Miscellaneous/other
19	WARO/19/00097	Betsi Cadwaladr UHB	23/08/2019	Patient (optical)	Evasion of NHS charges

20	WARO/19/00123	Betsi Cadwaladr UHB	21/10/2019	Dentist	Submission of fraudulent claims
21	WARO/19/00135	Betsi Cadwaladr UHB	14/11/2019	Nurse (NHS)	Working while sick
22	WARO/20/00011	Betsi Cadwaladr UHB	28/01/2020	Consultant / Surgeon (NHS)	Abuse of Position
23	WARO/20/00024	Betsi Cadwaladr UHB	14/02/2020	Consultant / Surgeon (NHS)	Abuse of Position
24	WARO/20/00065	Betsi Cadwaladr UHB	03/07/2020	Administrative & Clerical	Tendering process
25	WARO/20/00078	Betsi Cadwaladr UHB	12/08/2020	General Practitioner	Making and supplying of articles used in fraud
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/19/00079	Cardiff & Vale UHB	20/03/2019	Registrar	Theft and Money Laundering
2	WARO/20/00013	Cardiff & Vale UHB	28/01/2020	Senior Nurse	False Representation
3	WARO/20/00018	Cardiff & Vale UHB	04/02/2020	Qualified Nurse	False Representation
4	WARO/20/00050	Cardiff & Vale UHB	28/05/2020	GP Receptionist	False Representation, Unauthorised Modification of Computer Material and Abuse of Position
5	WARO/20/00117	Cardiff & Vale UHB	25/11/2020	Qualified nurse	Abuse of position
6	WARO/21/00034	Cardiff & Vale UHB	22/02/2021	Estates Worker	False Representation and Failure to Disclose Information
7	WARO/21/00040	Cardiff & Vale UHB	05/03/2021	Qualified Nurse	False |Representation Working while sick
8	WARO/21/00041	Cardiff & Vale UHB	18/03/2021	Patient	False Representation
9	WARO/21/00043	Cardiff & Vale UHB	18/03/2021	Pharmacist	Abuse of position
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/17/00114	Cwm Taf Bro Morgannwg UHB	08/06/2017	Ward Manager	Fraud by False Representation
2	WARO/17/00162	Cwm Taf Bro Morgannwg UHB	19/10/2017	Advanced Nurse Practitioner	Fraud by False Representation
3	WARO/18/00055	Cwm Taf Bro Morgannwg UHB	06/12/2017	Speciality Mental Health Doctor	Fraud by Abuse of Position
4	WARO/19/00050	Cwm Taf Bro Morgannwg UHB	02/05/2019	Receptionist	Fraud by Abuse of Position
5	WARO/19/00090	Cwm Taf Bro Morgannwg UHB	24/07/2019	Job applicant	Fraud by False Representation
6	WARO/19/00091	Cwm Taf Bro Morgannwg UHB	16/05/2019	Member of the public	Fraud by False Representation
7	WARO/19/00093	Cwm Taf Bro Morgannwg UHB	12/08/2019	Admin Assistant	Fraud by False Representation
8	WARO/19/00138	Cwm Taf Bro Morgannwg UHB	23/10/2019	Member of the public	Fraud by False Representation
9	WARO/20/00032	Cwm Taf Bro Morgannwg UHB	24/01/2020	Ward Manager	Theft
10	WARO/20/00033	Cwm Taf Bro Morgannwg UHB	02/10/2019	HCSW	Fraud by False Representation
11	WARO/20/00082	Cwm Taf Bro Morgannwg UHB	28/08/2020	Clerical Officer	Fraud by False Representation
12	WARO/20/00084	Cwm Taf Bro Morgannwg UHB	11/09/2020	Domestic	Fraud by False Representation
13	WARO/21/00045	Cwm Taf Bro Morgannwg UHB	30/03/2021	Former Nurse	Theft
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/21/00044	Hywel Dda	19/03/2021	Employee	False representation
2	WARO/21/00028	Hywel Dda	15/02/2021	Employee	False representation
3	WARO/21/00027	Hywel Dda	11/01/2021	Continuing Healthcare	False representation
4	WARO/21/00023	Hywel Dda	22/01/2021	Primary Care	False representation
5	WARO/21/00021	Hywel Dda	02/02/2021	Patient	False representation

6	WARO/21/00018	Hywel Dda	02/02/2021	Patient	False representation
7	WARO/20/00103	Hywel Dda	22/10/2020	Contractor Pharmacy	False representation
8	WARO/20/00069	Hywel Dda	24/07/2020	Employee	False representation
9	WARO/20/00090	Hywel Dda	22/09/2020	Public	False representation
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/20/00039	Velindre/NWSSP	27/03/2020	Nurse (student)	False Claim for Bursary
2	WARO/20/00086	Velindre/NWSSP	10/09/2020	Health Courier	False Declaration
3	WARO/21/00033	Velindre/NWSSP	18/02/2021	Doctor	Payroll Fraud/Overpayment
4	WARO/21/00042	Velindre/NWSSP	15/03/2021	Nurse (student)	False Claim for Bursary
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/19/00119	Powys THB	14/10/2019	Nurse	Making articles for use in fraud
2	WARO/19/00099	Powys THB	27/08/2019	Consultant/Surgeon (NHS)	Abuse of position
3	WARO/18/00070	Powys THB	11/05/2018	Nurse	Abuse of position
4	WARO/20/00105	Powys THB	11/11/2020	Patient	Making articles for use in fraud
5	WARO/21/00012	Powys THB	19/01/2021	Administration & Clerical	Prescriptions
6	WARO/21/00030	Powys THB	16/02/2021	Nurse	Prescriptions
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/16/00087	Swansea Bay UHB	17/08/2016	Senior House Officer	Salary Overpayment
2	WARO/17/00052	Swansea Bay UHB	05/06/2017	Community Mental Health Nurse	Working whilst sick
3	WARO/17/00081	Swansea Bay UHB	09/07/2017	Nurse	Working whilst sick
4	WARO/17/00144	Swansea Bay UHB	17/11/2017	Psychiatrist	Working whilst sick
5	WARO/17/00147	Swansea Bay UHB	23/11/2017	Nurse (NHS)	Prescription
6	WARO/18/00068	Swansea Bay UHB	10/05/2018	Cardiac Perfusionist	Timesheet Fraud
7	WARO/18/00096	Swansea Bay UHB	11/07/2018	Administrative & Clerical	Travel Expenses
8	WARO/18/00129	Swansea Bay UHB	12/09/2018	Nurse	Working whilst sick
9	WARO/18/00149	Swansea Bay UHB	31/10/2018	Orthopaedic Technician	Timesheet Fraud
10	WARO/18/00160	Swansea Bay UHB	09/11/2018	Practice Staff	Abuse of Position
11	WARO/19/00063	Swansea Bay UHB	24/06/2019	Agency Nurse	Failure to disclose information
12	WARO/19/00069	Swansea Bay UHB	04/07/2019	Nurse	Working whilst sick
13	WARO/19/00071	Swansea Bay UHB	08/07/2019	Agency Nurse	Timesheet Fraud
14	WARO/19/00082	Swansea Bay UHB	23/07/2019	Manager	Conspiracy to defraud
15	WARO/19/00137	Swansea Bay UHB	15/11/2019	General Practitioner	Possession of articles for use in fraud
16	WARO/19/00151	Swansea Bay UHB	30/12/2019	Doctor	Making articles for use in fraud
17	WARO/20/00022	Swansea Bay UHB	11/02/2020	Specialist Registrar	Timesheet Fraud
18	WARO/20/00030	Swansea Bay UHB	27/02/2020	HCSW	Payroll Fraud / Salary Overpayment
19	WARO/20/00057	Swansea Bay UHB	16/06/2020	Nursing Agency	Failure to disclose information
20	WARO/20/00058	Swansea Bay UHB	16/06/2020	Patient	False identity
21	WARO/20/00059	Swansea Bay UHB	16/06/2020	Nurse	Timesheet Fraud
22	WARO/20/00063	Swansea Bay UHB	23/06/2020	Agency Nurse	Timesheet Fraud
23	WARO/20/00102	Swansea Bay UHB	14/10/2020	Consultant	Prescription
24	WARO/20/00104	Swansea Bay UHB	09/11/2020	Administrative & Clerical	Timesheet Fraud
25	WARO/20/00119	Swansea Bay UHB	04/12/2020	Administrative & Clerical	Failure to disclose information
26	WARO/21/00013	Swansea Bay UHB	03/02/2021	Agency Nurse	Timesheet Fraud
27	WARO/21/00014	Swansea Bay UHB	03/02/2021	Agency Nurse	Timesheet Fraud
28	WARO/21/00015	Swansea Bay UHB	03/02/2021	Agency Nurse	Timesheet Fraud
29	WARO/21/00016	Swansea Bay UHB	03/02/2021	Nurse	False Representation
30	WARO/21/00031	Swansea Bay UHB	16/02/2021	Nurse	Payroll Fraud / Salary Overpayment

31	WARO/21/00032	Swansea Bay UHB	16/02/2021	Nurse	Payroll Fraud / Salary Overpayment
32	WARO/21/00035	Swansea Bay UHB	23/02/2021	Radiographer	Working whilst sick
33	WARO/21//00036	Swansea Bay UHB	26/02/2021	Nurse	Payroll Fraud / Salary Overpayment
Case No		**Health Body**	**Start Date**	**Subject Category**	**Fraud Type**
1	WARO/17/00121	Welsh Ambulance NHST	06/10/2017	Advanced paramedic practitioner	Timesheet expenses fraud
2	WARO/18/00148	Welsh Ambulance NHST	30/10/2018	Service manager	Bribery Act 2010 / corruption
3	WARO/19/00006	Welsh Ambulance NHST	16/01/2019	NEPTS Manager	Sickness fraud - section 2
4	WARO/19/00054	Welsh Ambulance NHST	23/05/2019	Paramedic	Abuse of Position - working whilst suspended
5	WARO/19/00143	Welsh Ambulance NHST	04/12/2019	NEPTS Driver	Timesheet Fraud
6	WARO/20/00010	Welsh Ambulance NHST	24/01/2020	NEPTS Call handler	Sickness fraud - section 2
7	WARO/20/00014	Welsh Ambulance NHST	29/01/2020	Service Manager	timesheet fraud - section 2 / overpayment
8	WARO/20/00027	Welsh Ambulance NHST	19/02/2020	Service provider / external contractor	Invoice fraud
9	WARO/20/00037	Welsh Ambulance NHST	25/03/2020	Ambulance technician	Sickness fraud - section 2
10	WARO/20/00047	Welsh Ambulance NHST	11/05/2020	CFR	theft / abuse of position
11	WARO/20/00052	Welsh Ambulance NHST	04/06/2020	CCC operator	Sickness fraud - section 2
12	WARO/20/00074	Welsh Ambulance NHST	04/08/2020	Paramedic	Fraud - abuse of position / false rep / failing to disclose
13	WARO/20/00076	Welsh Ambulance NHST	12/08/2020	EX Paramedic	Theft / abuse of position
14	WARO/20/00080	Welsh Ambulance NHST	19/08/2020	Ambulance technician	Fraud - section 2 sickness fraud, working elsewhere
15	WARO/20/00093	Welsh Ambulance NHST	22/09/2020	Paramedic	Fraud / abuse of position - Theft act
16	WARO/20/00120	Welsh Ambulance NHST	07/12/2020	Operational Team Leader	working whilst suspended
17	WARO/20/00125	Welsh Ambulance NHST	16/12/2020	Paramedic	failure to disclose
18	WARO/20/00126	Welsh Ambulance NHST	21/12/2020	service provider	invoice fraud and corruption
19	WARO/21/00029	Welsh Ambulance NHST	16/02/2021	Paramedic	Sickness fraud - section 2
20	WARO/21/00037	Welsh Ambulance NHST	01/03/2021	EMT	Abuse of Position / False representation - application failure

Summary of NHS CFS Wales Cases Closed 1st January 2021 to 31st March 2021 Appendix 5

Case No		Health Body	Date Opened / Date Closed	Subject	Offence	Case Summary / Outcome
1	WARO 20/00097	Cardiff & Vale UHB	05/10/2020 - 23/03/2021	Doctor	Fraud by False Representation	LCFS referred this matter to CFSW. The subject was employed by the HB as a Dentist. In September 2020, the subject was awarded £100,000- in compensation by the HB following an employment dispute. The subject subsequently terminated their employment with the HB. In October 2020, it was discovered that due to a processing error by Accounts Payable, the subject had been incorrectly paid £1,000,000- leading to a £900,000- overpayment. The HB tried to contact the subject but received no response. CFSW located and visited the subject to confirm residence and to issue a letter confirming the error and CFSW's investigation. At that time, the subject denied any knowledge of the overpayment but repaid £900,000 in October 2020. An advice file was submitted to CPS for independent legal advice and CPS confirmed that it is in the public interest to progress the investigation. A request for information was made to the HB in relation to the employment dispute. the HB sought legal advice and the CFSW request was refused on the grounds of confidentiality. As this information was important to the investigation, further advice was sought from CPS who confirmed that without this information the investigation could not proceed. The investigation therefore could not be progressed any further and was closed in Q4.
2	WARO/20/00123	Cardiff & Vale UHB	15/12/2020 - 23/03/21	Mandate Fraud	Fraud by False Representation	This investigation has a similar MO to WARO/20/00124. LCFS referred this matter to CFSW. The HB Accounts Payable Section had received an Invoice purporting to be from a Care Home wherein the bank account details had been altered from the previous genuine Invoice. There was no loss to the HB as the Accounts Payable Section identified the potential risk and contacted the HB LCFS. CFSW Financial Investigator conducted a number of intelligence enquiries and established the identity of the account holder of the altered bank account. Enquiries conducted with the account holders bank confirmed that the account had been suspended by the bank in November 2020 due to suspicious activity. CFSW liaised with South Wales Police, Operation Tarian team who specialise in Organised Crime Group activity. It was concluded that this fraud was being facilitated via these groups who would usually purchase genuine bank account details from the Dark Web and then issue fraudulent Invoices to various organisations in order to defraud them. They would then "hack" the genuine bank account and launder the defrauded monies through that account. CFSW informed the bank of this issue with a view that the bank take appropriate action. CFSW/LCFS has provided the HB with recommendations to prevent further attempts being successful. CFSW have collated the information and referred it to NHS CFA Intelligence. Investigation closed in Q4.

3	WARO/20/00124	Cardiff & Vale UHB	15/12/2020 - 24/3/2021	Mandate Fraud	Fraud by False Representation	LCFS referred this matter to CFSW. The HB Accounts Payable Section had received an Invoice purporting to be from a Cardiff Care Home wherein the bank account details had been altered from the previous genuine Invoice. There was no loss to the HB as the Accounts Payable Section identified the potential risk and contacted the HB LCFS. CFSW Financial Investigator conducted a number of intelligence enquiries and established the identity of the account holder of the altered bank account. Enquiries conducted with the account holders bank confirmed no suspicious activity. CFSW liaised with South Wales Police, Operation Tarian team who specialise in Organised Crime Group activity. It was concluded that this fraud was being facilitated via these groups who would usually purchase genuine bank account details from the Dark Web and then issue fraudulent invoices to various organisations in order to defraud them. They would then "hack" the genuine bank account and launder the defrauded monies through that account. CFSW informed the bank of this issue with a view that the bank take appropriate action. CFSW/LCFS has provided the HB with recommendations to prevent further attempts being successful. CFSW has collated the information and referred it to NHS CFA Intelligence. Investigation closed in Q4..
4	WARO/20/00081	Cwm Taf Morgannwg UHB	26/08/2020 - 30/3/2021	External Supplier	Fraud by False Representation	Surgical Medical Testing Laboratory (SMTL) is part of NHS Wales and have been contacted by a gentleman from a company who was trying to purchase PPE equipment (gloves) as the suppliers from whom they intended to purchase the PPE equipment have supplied false / altered SMTL test certificates. The company supplying the certificates is under investigation, Gumtree have been contacted and details of the relevant advert supplied. Enquiries were made with NAFN but they are unable to provide communications data to CFS Wales. Enquires were made with the company whose details have been falsely used to supply the PPE but CFS Wales has not been able to identify the suspect. A referral has been made to Action Fraud to ensure that relevant details are collated at a national level for intelligence purposes. Case closed in Q4.
5	WARO/20/00025	Cardiff & Vale UHB	17/02/2020 - 29/03/2021	NHS Manager	Fraud by False Representation/Abuse of Position	An allegation has been received that an NHS band 7 manager has not been working contracted hours, the allegation states that they have been routinely coming in late and leaving early from work but time sheets have been submitted to show the full contracted hours have been worked. The suspect was interviewed and admitted to routinely coming in late and leaving early but claims that he was working from home despite not having their Line Managers permission or IT facilities. CPS advice was sought, they advised that this case is not suitable for any criminal charges and the subject should face disciplinary action from the UHB. CFS Wales were awaiting the final outcome of the internal disciplinary action. The subject has recently received a verbal warning and has been relocated within the HB. This case was closed in Q4.

6	WARO/19/00025	Cwm Taf Morgannwg UHB	07/03/2019 - 25/2/2021	Nurse	Theft/Money Laundering	This case was referred to CFSW by the Cwm Taf LCFS as a result of a salary overpayment being identified. The nurse under investigation has been paid her full salary for six months after taking a career break from the NHS. The overpayment has been calculated as £9,592.90 gross and £7,663.96 net. The subject had resigned from their post and is now living in Australia. CFS Wales wrote to the subject and asked them to get in touch. The subject has also been provided with a letter from Payroll outlining the overpayment. A repayment plan has now been agreed with the subject and the subject has now paid the full £7,663.96 net salary overpayment. Some additional enquiries were required to establish the subject's actions with the overpaid funds. CFSW wrote to the subject requesting that they provide a statement under caution detailing their account of the overpayment of salary. The subject has provided a written explanation for why the overpayment was not noticed. It was not possible to prove the subject acted dishonestly, therefore this case was closed in Q4 and the civil recovery recorded.
7	WARO/18/00171	Betsi Cadwaladr UHB	28/11/2019 - 11/01/2021	Works & Estates Officer	Bribery / Corruption	This case was referred to CFSW by BCUHB LCFS following the receipt of an anonymous allegation relating to a senior manager in the Estates Department. It was alleged that this individual has split a number of contracts for a particular construction company with whom he has personal links to avoid the quotation/tendering process. It is further alleged that the manager has had building work carried out at his home address by this company. An audit has been conducted by BCUHB which have confirmed some of the concerns raised in the initial allegation. There are other issues relating to another Estates Officer which are also being investigated but the original allegation took precedence. The individuals concerned were suspended and one has resigned. They are not aware of the CFSW involvement. Financial investigation and analysis of the forensic findings are completed. The criminal investigation has now concluded, there is no evidence to support the allegation that bribery or corruption has occurred. The disciplinary hearing in the suspects absence was delayed due to COVID-19 and we await the outcome. HR have advised they are currently re-arranging hearings that have been cancelled due to the pandemic. It has been decided that a disciplinary hearing will not be held as the subject has left the HB. This case was closed in Q4.

8	WARO/17/00038	Aneurin Bevan UHB	LCFS 05/05/2017 - transferred to CFS Wales on 17/07/2017- closed on 28/03/2021	Dentist(s)	Fraud by False Representation / False Accounting	This investigation originated as an LCFS case which was then transferred to CFS Wales. The original suspicion was that dentists within this practice had submitted claims for Dental treatment in respect of children who had merely visited the practice as part of educational visits organised by local scouts/beavers groups. LCFS investigation confirmed that claims had been made in respect of some of the children involved. An initial examination of Dental Data indicated that there may be wider issues not confined to claims in respect of child patients which merit further investigation. CFSW completed an analysis of the data, identified some examples of potential treatment splitting and other potential over-claiming. 100 patient records were requested for examination. These were forwarded to the Dental Advisor for analysis. The two owners who are also the Directors of the company were written to and interviews under caution took place in May 2018 when both admitted the parts they played in the frauds. Advice from CPS was if we wished to caution the dentists then we could make that decision. The value of the fraud has been calculated at £3,745.70. The meeting took place on the 24th Oct 2018 between the Dentists, CFSW and the Primary Care Manager whereby the Dentist agreed to pay back the £3,745.70 defrauded plus another £2,342.75 in over claims. They also agreed to pay towards investigation costs. The Dentists have repaid the £6,088.45 to ABUHB and £6,000 towards investigation costs. The two Dentists were cautioned 0n the 18/09/19 for Fraud by False Representation. The GDC held the fitness to practice hearing from the 11th to 18th January. The one dentist received a 4 month suspension whist the other a 2 month suspension. Case was closed in Q4.

Summary of LCFS Cases Closed 1st January 2021 to 31st March 2021

Appendix 6

Case No		Health Body	Start Date	Closure Date	Subject Category	Fraud Type	Outcome / Sanctions
1	WARO/19/00057	Aneurin Bevan UHB	31/05/2019	05/03/2021	Member of public	Prescription Fraud	30weeks sentence suspended for 12 months 20 day rehabilitation order costs £720, comp. £1813.58 and VS £156
2	WARO/19/00110	Aneurin Bevan UHB	23/09/2019	25/02/2021	GP Staff	Theft Abuse of position	guilty plea 26 weeks imprisonment suspended for 24 months, RAR 20 days, Compensation £3882.70, costs £85, Victim S £115.
3	WARO/19/00140	Aneurin Bevan UHB	26/11/2019	11/01/2021	Nurse	Abuse of Position	NFA
4	WARO/20/00028	Aneurin Bevan UHB	21/02/2020	21/01/2021	Hospital Doctor	Fail to Disclose	Repaid £32087.56 in full
5	WARO/20/00072	Aneurin Bevan UHB	29/07/2020	27/03/2021	Nurse	Timesheet	NFA processes changed on ward to ensure cover
6	WARO/20/00083	Aneurin Bevan UHB	10/09/2020	21/01/2021	Audiologist	Fraud Fail to disclose - working on sick	Recovery of £2399.70 resigned prior to disciplinary hearing
7	WARO/20/00121	Aneurin Bevan UHB	09/12/2020	21/01/2021	Consultant	Fail to Disclose - working elsewhere breach of contract	NFA
8	WARO/21/00002	Aneurin Bevan UHB	04/01/2021	12/02/2021	Hospital Doctor	Fraud Fail to disclose - working on sick	NFA
9	WARO/21/00004	Aneurin Bevan UHB	08/01/2021	03/02/2021	Nurse	Fraud Fail to disclose - working on sick	NFA
10	WARO/21/00006	Aneurin Bevan UHB	11/01/2021	12/01/2021	Hospital Doctor	Fail to disclose	£6916.00 monies repaid
11	WARO/21/00026	Aneurin Bevan UHB	08/02/2021	08/02/2021	Member of public	Prescription Fraud	NFA
Case No		**Health Body**	**Start Date**	**Closure Date**	**Subject Category**	**Fraud Type**	**Outcome / Sanctions**
1	WARO/18/00147	Betsi Cadwaladr UHB	18/10/2018	29/03/2021	Miscellaneous (Locum)	Timesheet Fraud	Investigation indicates no fraud found. Subject informed in writing. L&RS Solicitor, has confirmed that she is attempting to arrange financial settlement of the case, which may result in reduced costs to the Health Board due to LCFS involvement. L&R Paralegal confirmed that this case has been settled without having to proceed to Employment Tribunal; with the overpaid shifts and hours recovered total £3,735 from the final settlement.
2	WARO/21/00038	Betsi Cadwaladr UHB	01/03/2021	30/03/2021	Health Care Assistant	Timesheet Fraud	Anonymous allegation of a p/t HCA not working contracted hours and overtaken leave. Enquiries with line manager found employee to be f/t and she had adjusted her working time/hours to suit demand during Covid. No proof of overusing leave or issues with sickness. No substence to the allegation, NFA.
3	WARO/18/00101	Betsi Cadwaladr UHB	20/07/2018	31/03/2021	Patient	Compensation Claim	LCFS assisted the Solicitor at L&RS dealing with claim MN/108/4125/TAJ. Solicitor has replied and informed LCFS that legal advice had been taken and that Involvement of the LCFS led to a significant reduction in settlement from the original claim. LCFS assisted the Solicitor and intelligence provided led to a significant reduced settlement for the Health Board. Case is closed and the LCFS actions leading to settlement for the Health Board, reduced by £40k, is recorded.
4	WARO/18/00058	Betsi Cadwaladr UHB	20/04/2018	31/01/2021	Independent Board Member	Tendering process	LCFS obtained detailed information from the Head of Procurement at NWSSP and referred this to CFS Wales for review. Case discussed with OFM who suggested to liaise with LCFS colleagues in NHS Wales for similar concerns nationally before deciding on progressing the case. LCFS concluded investigation and after consultation and agreement with OFM, the case has been closed with outcome No Fraud Found.

Case No		Health Body	Start Date	Closure Date	Subject Category	Fraud Type	Outcome / Sanctions
1	WARO/20/00003	Cardiff & Vale UHB	06/01/2020	16/03/2021	Registrar	Theft and Money Laundering	Salary Overpayment. Invoice sent to request repayment of £6504.78.ongoing negotiations for repayment plan.
2	WARO/20/00040	Cardiff & Vale UHB	31/03/2020	14/01/2021	Consultant	False Representation	Awaiting further information from original complainant. Case resolved informally with head of workforce, report and letter retained on file
3	WARO/20/00049	Cardiff & Vale UHB	22/05/2020	11/01/2021	Qualified Nurses x3	Theft and Private Sale of NHS PPE	No evidence of theft was found
4	WARO/20/00073	Cardiff & Vale UHB	29/07/2020	12/01/2021	OOH Call Handler	False Representation and Failure to Disclose Information	The subject was "Shielding" However, a social media post suggested that she was on holiday abroad without the knowledge or the approval of her Line Manager. The subject resigned immediately and made a repayment
5	WARO/20/00075	Cardiff & Vale UHB	05/08/2020	03/02/2021	Qualified Nurse	False Representation and Failure to Disclose Information	Subject suspected to have secondary employment at a Care Home while claiming to be on sickness absence from her NHS post and without the knowledge or permission from her main employer (NHS) to do so. No secondary employment was carried out during her sick leave
6	WARO/20/00118	Cardiff & Vale UHB	13/01/2021	18/02/2021	Qualified Nurse	False Representation	No fraud found
7	WARO/21/00017	Cardiff & Vale UHB	01/02/2021	10/02/2021	Staff	False Representation	No fraud found
Case No		**Health Body**	**Start Date**	**Closure Date**	**Subject Category**	**Fraud Type**	**Outcome / Sanctions**
1	WARO/20/00021	Cwm Taf Morgannwg UHB	11/02/2020	14/01/2021	Admin Assistant	Fraud by False Representation	Closed repaid in full £3524.92
2	WARO/20/00038	Cwm Taf Morgannwg UHB	09/03/2020	25/01/2021	Admin Assistant	Fraud by False Representation	Closed no sanction action necessary as no evidence due to alleged employer closed during all of Covid
3	WARO/20/00041	Cwm Taf Morgannwg UHB	26/03/2020	06/01/2021	Agency Nurse	False Timesheets	Closed no sanction action taken. No monies lost as found before payment
4	WARO/20/00106	Cwm Taf Morgannwg UHB	11/11/2020	25/01/2021	Member of the public	Supply of controlled drugs	Closed by SWP no action neighbour dispute no safeguarding issues
5	WARO/20/00100	Cwm Taf Morgannwg UHB	14/10/2020	06/01/2021	Former Nurse	Fraud by False Representation	Closed Civil Sanction repaid in full £13194.29
Case No		**Health Body**	**Start Date**	**Closure Date**	**Subject Category**	**Fraud Type**	**Outcome / Sanctions**
1	WARO/20/00089	Hywel Dda UHB	21/09/2020	05/02/2021	Employee	False Representation	An allegation has been received whereby it is alleged that the subject has altered her status in the e-expenses system and then claimed for mileage that she ordinarily would not be entitled. Following Voluntary interviews, the subject denied the offence, stating that all of her actions were undertaken in line with HB policies and procedures and with the consent of her line manager. No fraud has been proven and the matter referred bac to workforce reference the ongoing internal investigation into other non-fraud related matters.
2	WARO/20/00091	Hywel Dda UHB	23/09/2020	05/02/2021	Employee	False Representation	It is alleged that the subject has submitted inaccurate timesheets resulting in a small overpayment. Initial enquiries reveal that the timesheet was correct and that there is no offence. The matter has therefore been finalised.
3	WARO/20/00092	Hywel Dda UHB	24/09/2020	08/02/2021	Employee	Abuse of position	An anonymous referral was received alleging that the subject, who is a HD employed administrator has access to a Doctor's email account The referral did not contain any information as to any offences being committed. Further inspection revealed that the subject is the Doctor's secretary and as such has access to the Doctor's emails. To date no offences have been identified.

4	WARO/20/00112	Hywel Dda UHB	19/11/2020	31/03/2021	Primary Care	False Representation	Information has been received that historic claims for enhanced services have been submitted by the GP practice, therefore claiming for payments not entitled (Fraud by false representation). The matter was highlighted as a result of a PPV visit, where it is said that claims for payments were being made by the Practice, without the required information being recorded on patient records or the patient engaging with medical programmes. Following a review, it was identified that the subject did indeed receive the medication concerned, however certain clinical procedures may not have been followed, hence PPV seeking redress of the fee claimed. In view of this there appears to be no crime, however a clinical review will be undertaken by the primary care team and the criminal investigation finalised.
5	WARO/20/00114	Hywel Dda UHB	19/11/2020	08/02/2021	Employee	False Representation	It has been reported that a HD employee, has been advertising and selling FM perfume products via Facebook whilst on sick leave form her full-time employment as a Nurse. Enquiries revealed that the subject was indeed on sick leave, however following the upload of the post concerned the subject was contacted by her line manager and advised accordingly.
6	WARO/20/00044	Hywel Dda UHB	14/04/2020	29/03/2021	Patient Travel	False Representation	LCFS enquiries established that the subject has learning difficulties and therefore the case involving false claims for NHS travel expenses is not appropriate for any sanctions.
7	WARO/20/00116	Hywel Dda UHB	19/11/2020	31/03/2021	Employee	False Representation	A report has been made by Swansea Bay that the subject has provided on call locum work from HD, whilst at the same time being on call for his substantive post with SB. Statements have been obtained and a case review undertaken. Enquiries reveal that the subject undertook work for the HB and payment was made in relation to this. Enquiries with Swansea Bay, who referred the matter to HD having had the enquiry for some time reveal that they were not taking forward a criminal sanction and instead looked to seek a civil recovery. No HD offence identified, matter finalised, but a case remains open with Swansea Bay . It is said that an employee is coming into work late and finishing early, but submitting time sheets that reflect otherwise, therefore claiming for additional hour and enhancement. Enquiries to date have highlighted that this is an isolated incident and as such a review of the evidence has been undertaken and the matter is to be dealt with by management and the money / time recovered.

Case No		Health Body	Start Date	Closure Date	Subject Category	Fraud Type	Outcome / Sanctions
1	WARO/18/00143	Powys Teaching Health Board	18/10/2018	19/01/2021	Nurse	Timesheet fraud	No fraud found or proven
2	WARO/18/00159	Powys Teaching Health Board	09/11/2018	24/02/2021	Manager	Abuse of position	No fraud found or proven
3	WARO/19/00073	Powys Teaching Health Board	12/07/2019	14/01/2021	Admin Staff	Working whilst on sick	No fraud found or proven

Case No		Health Body	Start Date	Closure Date	Subject Category	Fraud Type	Outcome / Sanctions
1	WARO/18/00135	Swansea Bay UHB	03/10/2018	14/01/2021	Medical Secretary	Used HB Bank account own use	No fraud found or proven
2	WARO/19/00080	Swansea Bay UHB	17/07/2019	14/01/2021	Nurse	Working whilst sick	No fraud found or proven
3	WARO/20/00042	Swansea Bay UHB	07/04/2020	19/01/2021	HCSW	Working whilst sick	No fraud found or proven
4	WARO/20/00062	Swansea Bay UHB	16/06/2020	01/02/2021	Domestic Assistant	Timesheet Fraud	No fraud found or proven

Case No		Health Body	Start Date	Closure Date	Subject Category	Fraud Type	Outcome / Sanctions
1	WARO/14/00032	Velindre NWSSP	21/02/2014	25/01/2021	Admin Staff	Theft	Suspended sentence of 6 mths, £5,000 repayment received
Case No		**Health Body**	**Start Date**	**Closure Date**	**Subject Category**	**Fraud Type**	**Outcome / Sanctions**
1	WARO/19/00127	Welsh Ambulance	29/10/2019	20/01/2021	Call Handler	payroll fraud / overpayment	Insufficient evidence of fraudulent knowledge although acceptance of overpayment confirmed - mediation and agreement made to repay 7699.87
2	WARO/20/00098	Welsh Ambulance	09/10/2020	17/02/2021	eBay seller	misuse of logo / Fraud S.2	Insufficient evidence to a criminal standard, effective advice and warning offered with removal of items made.
3	WARO/20/00008	Welsh Ambulance	16/01/2020	24/03/2021	NEPTS management	sickness fraud - section 2	Insufficient evidence of working whilst sick - wider team issues presented to management for review and control.
4	WARO/19/00134	Welsh Ambulance	13/11/2019	24/03/2021	service provider	Invoice fraud - section 2	Lack of evidence, isolated incidents, and already being addressed by senior management team. Recommendations for enhanced processes.
5	WARO/20/00035	Welsh Ambulance	16/03/2020	29/03/2021	NEPTS senior team leader	sickness fraud - section 2	No evidence of fraud, secondary employment noted and accepted, dept improvements and guidance issued to team leaders
6	WARO/20/00055	Welsh Ambulance	10/06/2020	29/03/2021	EMT	Abuse of position	No fraud proven, guidance and education addressed within team leaders
7	WARO/19/00055	Welsh Ambulance	23/05/2019	29/03/2021	EMT	sickness fraud - section 2	Limited occurrence employment so insufficient to take forward.