Public Audit Committee Meeting

Thu 13 May 2021, 09:00 - 10:30

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 6th April 2021

John Union

4 - Draft Audit Committee Minutes - v4 - April 2021 JE.NF.pdf (16 pages)

5. Action log following meeting held on 6th April 2021

John Union

5 - Public Audit Action Log V4 - April 2021 for 13 May 2021 meeting je.pdf (3 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 Report

Ian Virgill

7.1 - Progress Report cover May 21.pdf (2 pages)

7.1 - Progress Report May 21.pdf (16 pages)

7.2. Standing Orders, SFI's, Reservation and Delegation of Powers

Nicola Foreman

7.2 - Cover report Updated Standing Orders AC 13 May 2021 je.pdf (2 pages)

7.2 - Appendix 1 - Summary of Updates CVUHB SO's SFI's April 2021 v2.pdf (14 pages)

7.3. Compliance with the Corporate Governance Code

Nicola Foreman

7.3 - Annual CVUHB Self-Ass UK Code of Corporate Governance May 2021 je.NF.pdf (2 pages)
7.3 - Appendix 1 - Annual Assessment UK Corporate Governance Code 2020-2021 JE.NF.pdf (9 pages)

7.4. Board effectiveness survey 2020-2021

Nicola Foreman

7.4 - Cover Report Annual Board Effectiveness Survey 2020-2021 je ns.pdf (3 pages)
7.4 - Appendix 1 - Board Effectiveness Action Plan 2019-2020 update.NF.pdf (6 pages)
7.4 - Appendix 2 - Board Effectiveness Action Plan 2020-2021 NF.pdf (3 pages)
7.4 - Appendix 3 - Board Effectiveness Survey - Board Results 2020-2021.pdf (7 pages)
7.4 - Appendix 4 - Board Effectiveness Survey - A&A Committee Results 2020-2021.pdf (18 pages)
7.4 - Appendix 5 - Board Effectiveness Survey - Charitable Funds Committee Results 2020-2021.pdf (10 pages)
7.4 - Appendix 6 - Board Effectiveness Survey - DHIC Results 2020-2021.pdf (9 pages)
7.4 - Appendix 7 - Board Effectiveness Survey - Finance Committee Results 2020-2021.pdf (9 pages)
7.4 - Appendix 8 - Board Effectiveness Survey - Health & Safety Committee Results 2020-2021.pdf (9 pages)
7.4 - Appendix 9 - Board Effectiveness Survey - MHCLC Committee Results 2020-2021.pdf (9 pages)
7.4 - Appendix 10 - Board Effectiveness Survey - QSE Committee Results 2020-2021.pdf (9 pages)
7.4 - Appendix 11 - Board Effectiveness Survey - S&D Committee Results 2020-2021.pdf (9 pages)

8. Items for Approval & Ratification

NO ITEMS

9. Items for Information and Noting

9.1. Internal Audit reports for information:

Ian Virgill

Assignment **Assurance Rating**

1. Consultant Jab Planning Follow-up: Limited Assurance Report
2. Health and Care Standards
3. IM&T Control and Risk Assessment

9.1.1 - Cons Job Planning Follow-up 2 Final Report.pdf (16 pages)
9.1.2 - H&CS Final report.pdf (9 pages)
9.1.3 - IT Assessment Final report.pdf (34 pages)

10. Review and Final Closure

11. Items to be deferred to Board / Committee

12. To note the date, time and venue of the next Committee meeting:Thursday 10th June 2021 (Special Meeting) at 9.00am Via MS Teams

Unconfirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 6 April 2021 9am – 12:30pm
Via MS Teams

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

AAC 21/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 21/04/002	**Apologies for Absence** Members **noted** that apologies for absence had been received from Rachel Gidman, Assistant Director of Organisational Development.	
AAC 21/04/003	**Declarations of Interest** No declarations of interest were noted.	
AAC 21/04/004 Khan Raj 05/11/2021 15:34:37	**Minutes of the Committee meeting held on 9 February 2021** The minutes of the meeting held on the 9 February 2021 were **received** and **confirmed** as a true and accurate record of the meeting, with the exception of one minor amendment to minute AAC 21/02/021 to change "HEIW" to "Health Board", which was suggested by the Audit Wales Financial Manager (AWFM).	NS

	There were no matters arising that were not included on the agenda or the action log. **The Committee resolved that:** (a) the minutes of the meeting held on 9 February 2021 be approved as a true and accurate record of the meeting, subject to one minor amendment.	
AAC 21/04/005	**Action log following meeting held on 9 February 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. **The Committee resolved that:** (a) the action log of the meeting held on 9 February 2021 be approved as a true and accurate record of the meeting.	
AAC 21/04/006	**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 21/04/007	**Internal Audit Progress and Tracking Reports** The Internal Audit Progress and Tracking 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 2020/21 Internal Audit plan. The HIA advised that the report was brought to each meeting for assurance, and that there were assignments which had been planned to be reported to the April 2021 Audit Committee, which had not been finalised in readiness for the deadline set. The HIA advised that it was recognised that there had been a delay throughout the year in progressing with delivery of the plan due to delays in being able to meet with Health Board managers and staff due to the ongoing effects of the COVID-19 pandemic. The Committee noted that: • the internal audit team had received information from the IM&T team and that work would be progressed and finalised to be included in the annual report. This would be brought to the audit committee workshop on the 13 May 2021, • discussions had commenced with the Medical Director concerning the Consultant Job Planning Follow-up audit and a start date of April 2021 had been agreed. The Medical Director had wanted to move the start from March to April to ensure it was appropriate to carry out the follow-up. The HIA advised the Committee that the outcome would be submitted to the May 2021 meeting.	

	The CC asked the HIA if all of the delayed assignments would be included in the final annual report. The HIA confirmed that they would be included. The HIA advised the Committee that 8 internal audit reports had been finalised since the last meeting and that each of the reports provided a positive outcome with 4 substantial assurance assessment ratings, and 4 reasonable assurance assessment ratings. The Committee noted that the Compliance with the Nurse Staffing Levels Act (Wales) 2016 report provided substantial assurance around the processes that Cardiff and Value University Health Board (CVUHB) had put in place during the COVID-19 pandemic which was to continue monitoring and reporting compliance with the provisions of the Act. The HIA noted that CVUHB had reported issues around difficulties with Mental Health nursing levels however it was recognised that the area of Mental Health was outside of the remit for the Nurse Staffing Levels Act (Wales) 2016 and the issues were not included in the scope of the report providing a substantial assurance assessment rating. The Committee were advised that the assessment outcome for the Tentacle IT System Follow-up report had moved from a limited assurance rating to a substantial assurance rating. The HIA added that the use of Tentacle had ceased with the functionality being delivered from a module within the Patient Management System (PMS) which had been developed specifically to replace Tentacle. The HIA reminded the Committee that the internal audit report for the Lakeside Wing had been circulated to members in February 2021, and that the report had been formally submitted and a reasonable assurance rating had been given. The Committee noted that despite significant time pressures, robust governance arrangements had been applied to the project with no evidence of reduced controls in key areas such as the establishment of a sound project structure, assignment and operation of responsibilities, reporting or project decision making. The HIA advised the Committee that the Risk Management audit was undertaken annually, and that the reasonable assurance assessment rating was the same as 2019/20. However, he advised that the assurance level was at the higher end of the reasonable assurance scale which reflected the progress CVUHB had made around the maturity of its risk management processes. 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 be held with the Executive Nurse Director (END) and the DCG to incorporate it into the plan for next year. The Committee noted that there was one additional adjustment that required the Committee's approval which was a planned piece of work on	IV

	the post contract audit of the costs of the Dragon's Heart Hospital. The Interim Director of Finance (IDF) had requested the work be undertaken following work that been undertaken by KPMG. The HIA added that the contracts would not be finalised for the 2020/21 audit plan, and had requested approval to defer the work into the plan for 2021/22. The HIA advised the Committee that despite the number of adjustments made to the plan, the anticipated delivery was 30 pieces of work, in comparison with 39 pieces of work last year, therefore 30 reviews was a good number given the implications of the COVID-19 pandemic. **The Committee resolved that:** (a) the 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 21/04/008	**Audit Wales Update** The update from Audit Wales was received and the AWFM gave an update on current and planned Audit Wales work. The Committee noted that: • In accordance with the Welsh Government's timetable Audit Wales would review the draft Performance Report and the draft Accountability Report once they were submitted on the 7 May 2021, and that the Financial statements would be reviewed once they had been submitted 30 April 2021, • The Audit Committee on the 10 June 2021 and the Board would consider and approve the audited accounts, performance report and the accountability report alongside the audit report, prior to the document being submitted to Welsh Government in readiness for the 11 June 2021 deadline, • Audit Wales had completed work on the Assessment of Progress against previous ICT recommendations and Test, Trace and Protect (TTP) in Wales in April 2021, • Audit Wales were currently undertaking work on the Structured Assessment 2020 – supplementary outputs, Orthopaedic Services Follow up, Quality Governance and Phase 1 of the Structured assessment 2021 – operational planning, • Work was being undertaken to review the COVID-19 vaccination rollout - A high level overview of the administration planning and the rollout approach of all vaccinations in Wales. The aim of the review was to provide assurance on the efficiency of the rollout and to identify success factors and any barriers, • Planned work that had not yet commenced included review of unscheduled care and a follow up on radiology services, • Between 8 and 12 March 2021, Audit Wales had held an online week of learning, good practice and ideas linked to the COVID-19 learning project "Making Sense of a Crisis: Learning from the	

	CVOID-19 Pandemic". The learning resources produced were available on the Audit Wales website. **The Committee resolved that:** (a) The Audit Wales Update be noted.	
AAC 21/04/009	**Report of the Auditor General on Test, Trace, and Protect (TTP) in Wales** The Report of the Auditor General on Test, Trace and Protect (TTP) was received and the Audit Wales Manager (AWM) advised the Committee that the report set out the main findings of Audit Wales' review of how public services were responding to the challenges of delivering TTP services in Wales. The Committee noted that: • the service was developed largely from scratch and at pace and it was suggested that the service needed to continue to evolve alongside the mass vaccination programme to effectively manage virus rates, • The report gave a high-level overview of what had been, and continued to be a rapidly evolving programme, • The evidence base for the report included document reviews, interviews with staff in Health Boards, Local Authorities, the NHS Wales Informatics Service (NWIS), Public Health Wales (PHW) and the Welsh Government between September and December 2020, and an analysis of key metrics that showed how well the TTP programme had been performing, • the report on Personal Protective Equipment (PPE) would be published next week and would be brought to the next Audit Committee meeting for consideration. The CC asked if the reports had been provided to the Executives and the AWM responded that they had been shared extensively to broad audience. The Vice Chair (VC) asked if the next stage of work would access national data to provide a sense that it could not be simply a matter of Test, Trac and Isolating. The AWM responded that in relation to the PPE report, local data was used and noted that the British Medical Association (BMA) and the Royal College of Nursing (RCN) data would feature at an all Wales level and that consideration would be taken on the results of national surveys. **The Committee resolved that:** (a) The Report of the Auditor General on Test, Trace, and Protect (TTP) in Wales be noted.	DG / NS

AAC 21/04/010	**Assessment of progress against previous ICT recommendations.** The report providing an assessment of progress against previous ICT recommendations was received and the Committee noted that the report presented the findings of the progress made by CVUHB against recommendations that had arisen from previous reviews concerning information governance and information technology. The Committee noted that: • The Health Board (HB) had implemented or was progressing all recommendations previously received and continued to strengthen its information and cyber security resources, • The dramatic increase in remote working and the adoption of new digital platforms as a consequence of COVID-19 had been a challenge for the HB's ICT infrastructure and key areas had received further investment to ensure resilience, • The new directorate structure was near completion and would enable further progress, particularly in the areas of cyber security, service delivery and digital operations, • Audit Wales had concluded that CVUHB had made some progress since the previous ICT audits however further progress was required in areas such as disaster recovery and information governance, • in addition to the outstanding recommendations from previous audits, 5 new recommendations had been made, which brought the total number of recommendations to 13. The CC asked if the recommendations had been picked up on the tracking report and the DCG responded that the old recommendations were already included on the tracking report and that the new ones would be added to enable monitoring of progress. **The Committee resolved that:** (a) The report providing an assessment of progress against previous ICT recommendations be noted, and the management response shown at appendix 1 of the report be approved.	
AAC 21/04/011	**2021-22 Fee Letter** The Audit Wales Audit fee outturn for the past year and the fee estimate for the year ahead letter was received and the AWFM advised the Committee when the Audit Committee had considered the audit plan in February 2021, the fee was unable to be added as the information was not available as it was being considered by the Senedd's Finance Committee. The Committee noted that the letter set out the fee for the year ahead and that the fee estimate for 2021 was 2.6% higher than last year's fee estimate and 1.3% lower than last year's actual fee. Going forward, Audit Wales would be providing all Health Board's in Wales with a separate fee for estimates for financial work on the Health Board's account and its Charitable Fund.	

	The Committee resolved that a) The Audit Wales Fee letter for 2021-2022 be noted.	
AAC 21/04/012	**Review the system of assurance** The report providing an update on the review of the system of assurance was received, and the DCG advised the Committee that it had been recognised that the existing assurance tools in place could be further developed into a more comprehensive Assurance Framework. The Committee noted that developing an Assurance Framework for the Board would further improve the governance of the Health Board and support the achievement of the Health Boards Strategic objectives. The DCG advised that an assurance mapping exercise would be undertaken to give CVUHB a more systematic review and give the Board an element of further assurance in terms of the different levels including management assurance, internal assurance and external review. The DCG advised that the Board Assurance Framework (BAF) tool was well integrated and that an internal audit assessment had given positive assurance on that. The DCG advised that within the BAF, there were various risks and levels of assurance on the controls in place. Each of the levels of assurance could be broken down into the three lines of assurance to help identify where further assurance was required. The CC asked the DCG if the risk register was aligned with the BAF, and the DCG responded that it was aligned to the BAF. She noted that the Audit and Assurance Committee itself was one of the recognised assurance tools, and that if all sources of information were to be mapped out, it could become a bureaucratic exercise and therefore clarity was required on where assurance could be given and from what sources. Informal discussions on reviewing the systems of assurance in place had been undertaken place with the CEO and Chair of the Board prior to the Committee meeting and the DCG would work with the Management Executives (ME) to develop an assurance strategy. **The Committee resolved that** (a) the report providing an update on the review of the system of assurance be noted, and that plans to develop a comprehensive assurance strategy for the implementation of a framework of assurance be approved.	NF
AAC 21/04/013	**Draft Accountability Report 2020-2021** The draft Accountability Report 2020-2021 was received and the DCG advised the Committee that the document was a very early draft which was being brought to Committee for assurance, and that the gaps in information within the document would be updated as the information	

	became available in April and May 2021, and that it was a work in progress. The Committee noted: • In response to the COVID-19 pandemic, HM Treasury had reviewed the financial reporting requirements for 2020-2021, and in order to ease the burden of collating the required information, they had published minimum reporting requirements as per the Financial Reporting Manual (FReM) for a limited time relating to the non-audited elements of the annual report and accounts, • All NHS bodies were required to publish, as a single document, a three part annual report and accounts to include: o A Performance Report, o An Accountability Report – including a corporate governance report, a Staff and Remuneration report and a National Assembly for Wales Accountability and Audit Report, and o Financial Statements. • The 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, and the final report would be considered at the Audit Committee on the 11 June 2021, prior to being submitted to Welsh Government in readiness for the 11 June 2021 deadline. The HIA advised that the draft annual report referred to an environmental report and advised the guidance for 2020-2021 stated that there was no longer a mandate to include the information. The DCG responded and advised that the executives were aware that this requirement had been eased for 2020-2021, however they had felt that it was important to demonstrate CVUHB's commitment to sustainability and that it would be included in the document for this year as it also demonstrated achievement against well-being objectives. **The Committee resolved that:** (a) the minimum reporting requirements outlined in Chapter 3 of the Financial Reporting Manual (FReM) guidance for collating an Annual Report for 2020-2021 as a consequence of the COVID-19 pandemic, be noted (b) the draft Accountability Report 2020-2021, be noted acknowledging that there are gaps in information, which will be completed in April/May 2021, (c) the Audit Committee Workshop being held on the 13 May 2021 to endorse Sign off by the Board on the draft Performance Report (including Wellbeing Statement Sustainability) and the Accountability report be noted.	NF
AAC 21/04/014	**Declarations of Interest, Gifts, Hospitality & Sponsorship** The update report on Declarations of Interest, Gifts, Hospitality and Sponsorship was received and the DCG advised that the Committee had previously agreed that an update on Declarations of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee	

	for information and that the report provided an up to date position for the Financial Year 2020/2021. The Committee noted that: • CVUHB were in a good position and that following February's meeting, where 713 declarations had been submitted, a further 1910 Declarations had been received. • 2,397 Declarations of Interest with 'No Interest' declared had been received. • to date 2,641 Declarations had been received for the year 2020/21 and that assurance should be taken from the significant increase in returns since the February 2021 Committee meeting • Standards of Behaviour messages were shared via Global Emails and CEO connects staff briefings in September, October and December 2020, • Emails and Electronic Staff Record (ESR) messages targeting specific staff members employed at Band 8a and above were circulated in November 2020, January, February and March 2021, • The Risk and Regulation Team continued to work with Betsi Cadwaladr UHB to adopt a new software system to capture and monitor declarations of interest, gifts, hospitality and sponsorship from April 2021. It was predicted there would be an increase in returns received in the new financial year following the adoption of the new software. **The Committee resolved that:** (a) the ongoing work being undertaken within Standards of Behaviour be noted, (b) the update in relation to the Declarations of Interest, Gifts, Hospitality and Sponsorship Register be noted.	
AAC 21/04/015	**Legislative and Regulatory Tracker Report** The Legislative and Regulatory Tracker report was received and the DCG advised the Committee that the report tracked compliance across the organisation and that it included inspections that had been undertaken. The DCG advised that three new entries had been added since the February 2021 meeting: 1) A focused inspection of the Splott Mass Vaccination Centre was undertaken on the 1 March 2021 - An immediate action plan was prepared and completed actions were submitted by the 12 March 2021. Feedback is awaited, 2) A virtual interview was undertaken on the 18 March 2021 with staff at the Hazel Ward at Hafan y Coed. Feedback is awaited, 3) A virtual interview was undertaken on the 10 March 2021 with staff at Ward E12, Hafan y Coed. A draft report had been received and an action plan has been developed.	

	The DCG advised the Committee that 3 further inspections were due to take place: 1) Health Inspectorate Wales (HIW) were scheduled to undertake an inspection of the Teenage Cancer Trust on the 31 March 2021, 2) UKAS were scheduled to undertake inspections at the Haematology and Phlebotomy departments between the 20 and 22 April 2021, 3) The Welsh Scientific Advisory Committee were scheduled to undertake inspections at the Audiology department on the 1 June 2021. **The Committee resolved that:** (a) the inspections which had taken place since the last meeting of the Audit and Assurance Committee in November 2020 and their respective outcomes, be noted, (b) the continued development of the Legislative and Regulatory Compliance Tracker, be noted.	
AAC 21/04/016	**Internal Audit Tracking Report** The Internal Audit Tracking Report was received and the DCG advised the Committee that recommendations made by Internal Audit had reduced from 110 individual recommendations to 106 during the period February to April 2021. The Committee noted that a further 14 recommendations had been added for the current financial year, and that 8 internal audits had been added to the tracker equating to 30 reports in total. These would be added to the tracker once they had been considered by the Committee. **The Committee resolved that:** a) the tracking report in place for tracking audit recommendations made by Internal Audit be noted, b) the progress that would be seen over the coming months in the number of recommendations which were completed/closed be noted.	
AAC 21/04/017 Khan Raj 05/11/2021 15:34:37	**Outstanding Audit Recommendations Update – 2017/18** The Outstanding Audit Recommendations Update report – 2017-2018 was received and the DCG gave an update on the outstanding internal recommendations for the year 2017/2018 and put forward proposals for their management going forward. The Committee noted that: • as of the 30 March 2021, the internal audit tracker recorded 11 recommendations for the financial year 2017/2018, 5 of which were recorded as completed,	

	• following the last meeting the DCG had met with the executives and reviewed whether the outstanding recommendations for 2017/18 should continue to be recorded on the Internal Audit Tracker and what plans were in place to ensure that the recommendations were proactively managed, • 6 of the live recommendations for 2017/18 were recorded as partially completed and once they were signed off they will be removed from the tracker, • To ensure that recommendations are not closed and forgotten, it was proposed that no entry was removed from the tracker until a formal agreement had been reached for the subsequent review of the recommendation subject matter in the new financial year. 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. **The Committee resolved that:** (a) the Outstanding Audit Recommendations Update – 2017/2018 be noted, (b) the proposals for the future recording and removal of historic recommendations from the Health Board's Internal Audit Tracker were approved, (c) that plans to undertake appropriate reviews for entries that are removed from the Health Board's Internal Audit Tracker be agreed.	NF
AAC 21/04/018	**Audit Wales Tracking Report** The Audit Wales Tracking report was received and the DCG advised the Committee that the report gave assurance on the implementation of recommendations which had been made by Audit Wales by means of an external audit recommendation tracking report. The Committee noted that: • 20 external audit recommendations were brought forward from February 2020's meeting and a further 5 recommendations had been added to the tracker which related to the follow up Operating Theatres audit, • a further 4 recommendations had been completed since November 2020, and there were 17 recommendations that were partially complete, • since the Committee meeting in November 2020, 4 actions had no recorded action taken • the Audit Wales reports discussed at today's meeting would be added to the tracker. The CC queried the total number of outstanding actions and the DCG confirmed that there were 21, and that the total of 25 on the tracker included the actions that had been completed for completeness. The completed actions would be removed from the document after the meeting.	

	The Committee resolved that: (a) the progress made in relation to the completion of Audit Wales Recommendations be noted, (b) the continuing development of the Audit Wales Recommendation Tracker be noted.	
AAC 21/04/019	**Counter Fraud Annual Plan 2021-2022** The Counter Fraud Annual Plan 2021-2022 was received and the Local Counter Fraud Specialist (LCFS) advised the Committee that the new plan outlined the planned NHS Counter Fraud work for period April 2021 to 31 March 2022. He advised that the plan was fundamentally the same as the existing approved plan. The Committee noted that: • During 2020-2021, 187 members of staff attended fraud awareness sessions and 81% stated that they "Strongly agreed", and 18% stated that they "Agreed" that the session had improved their knowledge of counter fraud work, • The new plan maintained the current level of resources deployed for counter fraud, which was deemed to be adequate and appropriate, • The total number of proactive and reactive days to be allocated for 2021-2022 was 440 days, • The main change within the plan was the adoption of the Standards for Counter Fraud which comprised of 12 components. A self-assessment had been undertaken against the new standards which provided an assurance that the counter fraud service was currently meeting the requirements of the standard, with the exception of CVUHB's annual counter fraud plan which needed to be signed off by the EDF and then approved by the Audit and Assurance Committee who would then monitor progress on a quarterly basis. The EDF advised the Committee that she would let the CC know when the plan was signed off. **The Committee resolved that:** (a) the Counter Fraud Annual Plan for 2021-2022 be approved.	CP
AAC 21/04/020	**Self-assessment of effectiveness - Verbal** The verbal update on the self-assessment of effectiveness was received and the DCG advised the Committee that to ensure effective governance Committees of the Board were required to undertake a self-assessment of their effectiveness on an annual basis, in accordance with the provisions of the Health Board's Standing Orders. The DCG advised that the results of the surveys should be available by the next committee meeting.	NF

	The Committee resolved that: a) The verbal update on the self-assessment of effectiveness be noted.	
AAC 21/04/021	**Induction Support for Committee Members - Verbal** The verbal update on the Induction Support for Committee Members was received and the DCG advised that the composition of the Committee membership had not been approved by the Board, and it had been suggested that that this committee include the Independent Member – ICT and the Vice Chair within the membership. The Committee noted that there was an opportunity for new members to have an induction on the Audit and Assurance Committee, and to spend time with the CC and familiarise themselves with the standing Audit and Assurance agenda items on a regular basis. **The Committee Resolved that:** (a) The verbal update on the Induction Support for Committee Members be noted.	
AAC 21/04/022	**Clinical Audit Plan** The Clinical Audit Plan 2021-2022 report was received and the EMD advised the Committee that the purpose of the report was to inform them of the proposed tier 1 and tier 2 (national and local) audit plans for each Clinical Board in 2021/2022. The Committee noted that: • Welsh Government had not yet published a National Clinical Audit and Outcome Review Plans (NCAORP) for 2021/2022. However, it was not anticipated that any significant changes would be made from the previous rolling program National Clinical Audit and Outcome Review Plan (NCAORP) 2019/2020, • The HQIP (Healthcare Quality Improvement Partnership) was responsible for several national healthcare quality improvement programmes, including managing and commissioning the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England, the Welsh Government and in some cases other devolved authorities, • NCAPOP covered two main sub-programmes: The National Clinical Audit Programme (NCAP) and the Clinical Outcome Review Programmes (NCORP). HQIP had published a publication schedule for 2021, • CVUHB participate in 38 National Clinical Audits that were mandated by Welsh Government. A Clinical Audit Lead was identified for each audit, the majority of which were undertaken by the clinical leads. There were a further 13 audits that come under the clinical outcome review programme, • For the past three years a formal process had been in place to ensure that all national audit publications were reviewed and the health board results were considered and where necessary the	

	requisite improvements were put in place. The Health Board reported the results, and improvements to Welsh Government, • In February 2018 the committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach: o Tier 1 - Mandatory National Clinical Audits. o Tier 2 - All other national audits and local clinical audits undertaken to address the patient safety and quality agenda, o Tier 3 - Local clinical audits undertaken for any other reason including revalidation and CPD purposes. • The Clinical Boards and Clinical Audit Leads has developed a 2021/2022 Clinical Audit Plan incorporating all Tier 1 and anticipated Tier 2 audits. There was not an expectation that Tier 3 audits would be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remained imperative, • The current Clinical Audit Process had been in place for some years, and whilst this process had served well, there were areas for improvement that had been identified through a recent review of the Quality Assurance Processes in Patient Safety. The EMD advised that steps had been taken in recent months to improve and monitor Clinical Effectiveness and Quality Assurance, including: 1) The establishment of the Clinical Effectiveness Committee in December 2020, which met monthly and all national audit results were presented to the Committee. The Associate Medical Director chaired the meetings, 2) Investment in Team Structure following benchmarking against other Health Boards in Wales along with a review of current resources and team structures identified that an investment would be required to deliver the desired improvements, 3) Capturing Clinical Audit and Improvement Activity - a demonstration was planned with a neighbouring Health Board in Wales for a digital system called AMaT. This system tracked and monitored Clinical Audit activity to provide additional control and to provide real-time insight and reporting for clinicians, wards, audit departments and the health boards. **The Committee resolved that:** (a) The content of the report and the proposed Clinical Audit Plan for 2021/2022 be noted.	
AAC 21/04/023	**Internal Audit Plan 2021/2022** The Internal Audit plan 2021-2022 was received and the HIA advised that following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the plan set out a risk-based plan of work for the year 2021/2022.	

The Committee noted:

- The plan identified the audit assignment, lead executive officer, outline scope, and proposed timing,
- The plan was structured under the six components:

1. Annual audit work - Areas where annual audit work would support the most efficient and effective delivery of an annual opinion,

2. Organisation based audit work – key risks and priorities from the Board Assurance Framework (BAF) and the Corporate Risk Register together with other auditable areas identified and prioritised through the planning approach,

3. Follow up - follow-up work on previous "limited" and "no assurance" reports as well as other high priority recommendations,

4. Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit & Assurance Committee Chairs in response to common risks faced by a number of organisations,

5. The impact of audits undertaken at other NHS Wales bodies that impacted on the Health Board, including Public Health Wales (PHW), Health Education Improvement Wales (HEIW), the NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC),

6. Where appropriate, Integrated Audit & Assurance Plans would be agreed for major capital and transformation schemes and charged for separately.

The HIA advised the Committee:

- that the components were designed to ensure that the internal audit programmes complied with all of the requirements of the Public Sector Internal Audit Standards,
- that an interim audit draft plan had been to ME for review and comment,
- that the Internal Audit & Assurance Service was committed to ensuring its service focused on priority risk areas, business critical systems and the provision of assurance to management across the medium term and in the operational year ahead,
- the Audit & Assurance Service were particularly mindful of the level of uncertainty that existed around the COVID-19 pandemic,
- that there were potential audits looking at individual clinical boards to look at specific risks or priorities they had in each area. Initial discussions had been undertaken with the Chief Operating Officer (COO) around those pieces of work but given the impact of COVID-19, on the Health Board, the COO was keen to allow

	time so that the clinical boards could be on a surer footing and assess their strategic aims and direction, • the Internal Audit Charter was produced and updated regularly to comply with the Public Sector Internal Audit Standards. It sets out the purpose of internal audit and confirmed CVUHB's independence and objectivity of internal audit. The content of the Charter was the same as it was for 2020 and there had been no fundamental changes. **The Committee resolved that:** (a) The Committee approved the Internal Audit Plan for 2021/22. (b) The Committee approved the Internal Audit Charter for 2021/22.	
AAC 21/04/024	**Internal Audit reports for information:** The following Internal audit reports were received: 1. UHW Surge Hospital - Lakeside Wing, 2. Compliance with the Nurse Staffing Levels Act (Wales) 2016, 3. Claims Reimbursement, 4. Charitable Funds, 5. Tentacle IT System Follow-up, 6. Integrated Health Pathways, 7. UHB Core Financial Systems, 8. Risk Management **The Committee resolved that:** (a) The internal audit reports be noted.	
AAC 21/04/025	**Items to be deferred to Board / Committee** There were no items to be brought to the attention of the Board / Committees.	
AAC 21/04/026	**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 21/04/027	**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 **Tuesday 16 May 2021 at 9am.**	

Action Log
Following Audit & Assurance Committee Meeting
6 April 2021
(for the Meeting 13 May 2021)

REF	SUBJECT	AGREED ACTIONS	LEAD	DATE	STATUS/COMMENTS
Completed Actions					
AAC 20/11/010	Management of Clinical Coding Across Wales	To include in a future Board Development session.	Nicola Foreman	**29.04.21**	**COMPLETE -** Taken to the April Board Development session
AAC 20/09/008	Audit Wales (AW) Update	AW reports on TTP to be brought to the next Committee meeting.	AW	**06.04.21**	**COMPLETE -** Update on TTP to be provided at April 2021 meeting.
AAC 19/12/012	Effectiveness of Clinical Audit Report	To consider arrangements to deliver effective programme of Clinical Audit	Stuart Walker	**06.04.21**	**COMPLETE -** To be brought to April 2021 meeting. (deferred)
AAC 21/02/015	Internal Audit Tracking Report	In regards to the outstanding audit actions The DCG added that for the next meeting she would bring back a more clear and updated position on these recommendations with specific narrative around them	Nicola Foreman	**06.04.21**	**COMPLETE -** Update to be brought to the April 2021 Meeting
Actions in Progress					
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**	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 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 be held with the END	Ian Virgil	**06.07.21**	Update to the meeting on 6 July 2021.

		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 21/04/013	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**	Final report would be considered at the Special Audit Committee meeting on the 10 June 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 21/04/019	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**	Update to the meeting on 6 July 2021.
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**	Report on the agenda for 13 May 2021 meeting.

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	**12.01.21**	To be taken to a future S&D Meeting

Report Title:	**Internal Audit Progress Report**								
Meeting:	Audit & Assurance Committee						**Meeting Date:**	13/05/21	
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 progress report provides the Audit Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan; including details and outcomes of reports finalised since the previous meeting of the committee and proposed amendments to the plan.

The progress report highlights the conclusion and assurance ratings for audits finalised in that period.

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.

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

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

The progress report includes a further proposed amendment to the agreed 20/21 Internal Audit plan.

A first round of adjustments to the plan was formally approved by the Audit Committee in July with further adjustments approved in November, February and April.

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

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 amendment to the Internal Audit Plan for 2020/21.

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 May 2021

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

CONTENTS

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.

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

1.1. 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 2020/21 Internal Audit plan.

1.2. 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.

1.3. The plan for 2020/21 was agreed by the Audit & Assurance Committee in April 2020 and is delivered as part of the arrangements established for the NHS Wales Shared Service Partnership - Audit and Assurance Services.

2. ASSIGNMENTS WITH DELAYED DELIVERY

2.1. Full details of the current year's audit plan along with progress with delivery and commentary against individual assignments regarding their status is included at Appendix A. The assignments noted in the table below are those which had been planned to be reported to the May Audit Committee but have not met that deadline.

Audit	Current Position	Draft Rating	Reason
Engagement Around Service Planning	Draft	Reasonable	Delay in commencing fieldwork due to availability of HB Management during Covid
C&W CB – Rostering in Community Children's Nursing	Draft	Reasonable	Delay in commencing fieldwork due to availability of HB Management during Covid
Recruitment & Retention of Staff	Draft	Reasonable	Delay in commencing fieldwork due to availability of HB Management during Covid
Annual Planning Process 21/22	Work in Progress		Commencement of fieldwork pushed back following agreement with lead Executive.
Data Quality Performance Reporting	Work in Progress		Delay in completion of fieldwork due to availability of HB staff.
Infrastructure / Network Management	Work in Progress		Delay in commencing fieldwork due to availability of HB Management during Covid

Cyber Security System Follow-up	Work in Progress		Delay in commencing fieldwork due to availability of HB Management during Covid
Shaping Future Wellbeing in the Community Scheme	Work in Progress		Delay in commencing fieldwork due to availability of Internal Audit resource.

2.2. Whilst the table above provides a brief reason for the delay to each individual assignment, it should also be noted that there has been a general delay throughout the year in progressing with delivery of the plan. This was due to delays in being able to meet with Health Board managers and staff and receive required information, due to the on-going effects of the pandemic.

3. OUTCOMES FROM COMPLETED AUDIT REVIEWS

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

3.2. A summary of the key points from the finalised assignments are reported in Section six. The full reports are included separately within the Audit Committee agenda for information.

FINALISED AUDIT REPORTS (2020/21 Plan)	ASSURANCE RATING	
Consultant Job Planning Second Follow-up	Reasonable	
Health and Care Standards		
IM&T Control and Risk Assessment	Not Rated	

4. DELIVERY OF THE 2020/21 INTERNAL AUDIT PLAN

4.1. From the table in section three above it can be seen that three audits have been finalised since the Committee met last.

In addition, there are three further audits that have reached the draft report stage with the remaining five currently work in progress.

4.2. The 20/21 Internal Audit plan was formally approved by the Audit & Assurance Committee at its April 20 meeting. It was however noted that the content of the plan and the proposed timing of individual audits, would be subject to adjustment to reflect the Health Board's

changing risk profile and the availability of key management and staff during the COVID-19 pandemic.

A first round of adjustments to the plan was formally approved by the Audit Committee in July with a second round then approved at the November meeting.

Due to the ongoing impact of the pandemic a number of additional audits were identified for removal from the plan and these were approved by the Committees in February and April.

4.3. Full details of the proposed updated Internal Audit plan are provided within Appendix 1.

There is one additional adjustment proposed for agreement by the April Audit Committee, as summarised below:

<u>Audit to be deferred from the 20/21 plan:</u>

- CD&T CB – Ultrasound Governance

  Following discussion with the Director of Operations and service management, it was agreed that the audit should be deferred to the 21/22 plan to allow time for effective completion. Commencement had been delayed due to Internal Audit staff absence and the availability of management during Covid.

The adjustment identified above, combined with those previously agreed, mean that there will be a total of 29 audits scheduled for delivery within the 20/21 plan. This will still allow sufficient coverage for the provision of a full Head of Internal Audit annual opinion at the end of the year.

4.4. Appendix B highlights the times for responding to Internal Audit reports. Appendix C shows the Audit & Assurance Key Performance Indicators.

5. FINAL REPORT SUMMARIES

5.1. Consultant Job Planning Second Follow-up

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.

Our testing has concluded that the agreed management actions have now been fully implemented or are in the process of being implemented for the last four outstanding recommendations originally raised.

The overall number of the Health Board's consultants with an up to date, signed off job plan or annual review within the last 12 months remains low and has declined since the previous follow-up audit. Consequently, at the end of January 2021, whilst 80% of Consultants had a job plan in place the compliance rate for valid job plans agreed or reviewed within the last 12 months was only around 18%. However, the development of a new job planning process, the issuing of revised job planning guidance and the implementation of the Allocate e-job planning system in March 2021 should ensure that the compliance rate improves over the next six months.

The implementation of the new system will help to ensure that all the Health Board's job plans are completed using a standard format. The new system will also facilitate the recording of personal, service and health board outcomes within each job plan, and the electronic sign-off of job plans by the Consultant / SAS Doctor and the Health Board.

It was noted during testing that many of the job plans input to the Allocate system so far were incomplete, so we were unable to assess the quality of job plans or the consistent recording of personal, service and Health Board outcomes which is a requirement of the Welsh Government Contract. The Health Board will therefore be expected to develop a mechanism to quality check job plans going forward.

In addition, there is no direct link between the Allocate system and the Payroll / ESR system, so regular checks will need to be carried out to ensure that the number of sessions recorded in job plans reconcile to those being paid.

In summary, although a significant amount of work remains to bring job planning up to the required level, progress made against the original

recommendations and agreed actions means that the level of assurance that can be given around the current processes in place to manage the risks associated with Consultant Job Planning has now increased to **Reasonable Assurance**.

5.2. Health & Care Standards

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.

In recent years the Health Board has made good progress with embedding the Health and Care Standards within the organisation and has worked towards developing a robust annual process for assessment against the standards.

However, the Health Board was unable to undertake its self-assessment process against the standards in 2020 due to the effects of the Covid-19 pandemic. This position was effectively communicated to and approved by the Quality, Safety and Experience (QS&E) Committee and the Health Board did continue to monitor the progress against previously identified actions.

A revised assessment process has been agreed for 2021 and Corporate SBAR assessments are currently being undertaken. Review of a sample of those already completed has confirmed they have been effectively undertaken.

Plans are in place for Executive sign-off of the self-assessments, review by Independent Members and reporting to the QS&E Committee.

The Health Board will need to ensure that the priority actions identified through the SBAR assessments are effectively implemented through 2021/22 and an appropriate process for assessing against all the standards is introduced as the Health Board returns to more normal operating.

5.3. IM&T Control and Risk Assessment

The review provides a baseline picture to the Audit Committee of the processes in place to manage the risks associated with Information Governance (IG) Information Communications Technology (ICT) across the organisation as a whole. As this is a baseline review, the assignment

has not been allocated an assurance rating, but advice and recommendations have been provided to facilitate change and improvement and to focus audit work in the future.

We used the expected controls derived from the Control Objectives for Information and Related Technologies (COBIT) 2019 framework for this review and we have reported using the subheadings of these control processes for governing organisational IT.

COBIT is an IT management framework developed by the Information Systems Audit and Control Association (ISACA) to help organisations develop, organise and implement strategies around information management and governance.

As part of our assessment we scored the individual controls in place at the organisation against the controls we would expect to be in place under each of the headings of the framework. These scores have been represented graphically below to illustrate the strengths and potential for improvement in the organisation's management of IG / ICT.

The scoring reflects the level of compliance with the controls set out within the COBIT framework, and the extent to which they apply across the entire organisation.

The organisation scored well under many of the headings, in particular against: Information Governance; Managed Operations; Managed Budget; Managed Projects; Managed Risk and Managed Security Services.

However, there are opportunities for improvement across a number of areas. The key areas requiring management attention are identified from the scoring. These were: the management of compliance with external requirements; and managed strategy. More detail can be found on these opportunities in section 4 below, and in Appendix A.

CARDIFF AND VALE UHB INTERNAL AUDIT ASSIGNMENT STATUS SCHEDULE

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Quality Statement	16	Nursing	Q2	Final – Issued August 20	Substantial	Sept
Surgery CB – Theatres Directorate Sickness Absence Management	29	COO	Q2	Final – Issued September 20	Reasonable	Nov
Regional Partnership Board	07	Strategic Planning	Q2	Final – Issued October 20	Reasonable	Nov
Governance During COVID-19 (Advisory Review)	46	Corporate Governance / Finance	Q2	Final – Issued October 20	n/a	Nov
Sustainability Reporting	38	Finance	Q2	Final - Issued November 20	Reasonable	Nov
Management of Serious Incidents	18	Nursing	Q2	Final – Issued November 20	Reasonable	Nov
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	28	COO	Q2	Final – Issued November 20	Substantial	Feb
Asbestos Management	40	Finance	Q2	Final – Issued November 20	Reasonable	Feb
MH CB – Outpatient Clinic Cancellations	31	COO	Q2	Final – Issued January 21	Limited	Feb
Compliance with the Nurse Staffing Levels Act	17	Nursing	Q3	Final – Issued February 21	Substantial	April
Integrated Health Pathways	20	Transformation & Informatics	Q2	Final – Issued February 21	Reasonable	April

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
UHW Surge Hospital – Lakeside Wing	**44**	**Strategic Planning**	**Q2**	**Final – Issued February 21**	**Reasonable**	**April**
Risk Management	**02**	**Corporate Governance**	**Q4**	**Final – Issued March 2021**	**Reasonable**	**April**
Claims Reimbursement	**04**	**Nursing**	**Q3**	**Final – Issued March 2021**	**Substantial**	**April**
Charitable Funds	**14**	**Finance**	**Q3**	**Final – Issued March 2021**	**Substantial**	**April**
UHB Core Financial Systems	**13**	**Finance**	**Q3**	**Final – Issued March 2021**	**Reasonable**	**April**
Tentacle IT System Follow-up	**26**	**Transformation & Informatics**	**Q4**	**Final – Issued March 2021**	**Substantial**	**April**
Consultant Job Planning Second Follow-up	**37**	**COO**	**Q4**	**Final – Issued April 2021**	**Reasonable**	**May**
IM&T Control & Risk Assessment	**01**	**Transformation & Informatics**	**Q2**	**Final – Issued May 2021**	**n/a**	**May**
Health and Care Standards	**03**	**Nursing**	**Q3**	**Final – Issued May 2021**	**Reasonable**	**May**
Development of Integrated Audit Plans	**45**	**Strategic Planning**	**Q1-4**	**Advice and support provided to the Health Board through the year in relation to the future development of integrated audit plans.**	**n/a**	**n/a**
Engagement Around Service Planning	06	Strategic Planning	Q3	Draft	Reasonable	July
C&W CB – Rostering in Community Children's Nursing	34	COO	Q4	Draft	Reasonable	July
Recruitment & Retention of Staff	35	Workforce	Q3	Draft	Reasonable	July

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Annual Planning process 21/22	08	Strategic Planning	Q4	Work in Progress		July
Data Quality Performance Reporting	10	Transformation & Informatics	Q4	Work in Progress		July
Infrastructure / Network Management	23	Transformation & Informatics	Q4	Work in Progress		July
Cyber Security System Follow-up	27	Transformation & Informatics	Q4	Work in Progress		July
Shaping Future Wellbeing in the Community Scheme	43	Strategic Planning	Q4	Work in Progress		July
Reviews deferred / removed from plan						
Public Health Audit 1	11	Public Health		Removed to allow allocated days to be utilised for the COVID-19 Governance review – Agreed by July AC		
IT Strategy	22	Transformation & Informatics		Director of Digital requested deferral to the 21/22 plan. The COVID situation has impacted the timing of IT work so the strategy delivery / roadmap needs to be reassessed – Agreed by July AC		
Implementation of New IT Systems	24	Transformation & Informatics		Director of Digital requested deferral to the 21/22 plan. COVID has affected IT system implementations and the audit would need input from departments – Agreed by July AC		
Whistleblowing Policy	05	Corporate Governance		Director of Governance proposed deferral to the 21/22 plan. Work is currently ongoing to update the Health Board's Raising Concerns process which incorporates whistle blowing - Agreed by Nov AC		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Strategic Performance Reporting	09	Transformation & Informatics	Q3	Postponed to the 21/22 plan. Formal performance reporting requirements have been paused by Welsh Government - Agreed by November AC		
Directorate Level Financial Control	15	Finance		Deferral to the 21/22 plan agreed with the acting Director of Finance. Lower risk area and issues with accessing Directorate Managers during Covid – Agreed by the November AC		
ITIL Service Management	21	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - Agreed by November AC		
Departmental IT System	25	Transformation & Informatics		Director of Digital requested removal from the plan due to the current pressures on key IT staff - Agreed by November AC		
PCIC CB – GP Access	32	COO		Deferred to 21/22 as agreed with CB Management. GP Access monitoring paused due to Covid - Agreed by the November AC		
Fire Safety	39	Finance		Director CEF requested deferral to the 21/22 plan due to current pressures on key staff - Agreed by November AC		
Major Capital Scheme – UHW New Academic Avenue	42	Strategic Planning		Removed from the plan as the scheme has not progressed - Agreed by November AC		
Major Capital Scheme – UHW II	41	Strategic Planning		Removed from the plan as the scheme has not progressed - Agreed by November AC		

Planned output.	No	Exec Director Lead	Plnd Qtr	Current progress	Assurance Rating	Audit Cttee
Capital Systems Management	*44*	*Strategic Planning*		Director CEF proposed that this audit be removed from the plan and replaced with the audit of the UHW Surge Facility - Agreed by November AC.		
Clinical Board QS&E Governance	19	Nursing		Determined that Clinical Boards would be unable to engage in this audit due to the pressures of dealing with Covid – Agreed By February AC		
Medicine CB – Bank & Agency Nurses Scrutiny Process	30	COO		The CB Director of Nursing identified that the service would not be able to engage in the audit due to the pressures of dealing with Covid – Agreed by February AC		
Public Health	12	Public Health		Considered inappropriate to carry out an audit in this area given the current situation – Agreed by February AC		
Management of Staff Sickness Absence	36	Workforce		The Director of Workforce identified that it would be inappropriate to carry out this audit at the current time due to service pressures – Agreed by February AC		
Post Contract Audit of DHH Costs	47	Finance	Q4	Proposed for deferral to the 21/22 plan due to timing of completion of the contracts – Agreed by the April AC. Had been added to the plan following request from Director of Finance – Agreed by November AC.		
CD&T CB – US Governance	33	COO	Q3	Proposed for deferral to the 21/22 plan to allow time for effective completion – To be agreed by the May AC.		

INTERNAL AUDIT REPORT RESPONSE TIMES								
Audit	**Rating**	**Status**	**Draft issued date**	**Responses & exec sign off required**	**Responses & Exec sign off received**	**Final issued**	**R/A/G**	
Annual Quality Statement	Substantial	Final	03/08/20	25/08/20	13/08/20	19/08/20	G	
Surgery CB – Theatres Dir Sickness Absence Management	Reasonable	Final	15/09/20	07/10/20	28/09/20	01/10/20	G	
Regional Partnership Board	Reasonable	Final	28/08/20	06/10/20	29/09/20	07/10/20	G	
Governance During Covid-19	n/a	Final	21/08/20	15/09/20	21/10/20	23/10/20	R	
Sustainability Reporting	Reasonable	Final	10/09/20	02/10/20	02/11/20	03/11/20	R	
Management of Serious Incidents	Reasonable	Final	23/10/20	16/11/20	02/11/20	02/11/20	G	
Asbestos Management	*Reasonable*	*Final*	*03/11/20*	*25/11/20*	*10/11/20*	*11/11/20*	*G*	
Specialist CB – Patient Assessment & Provision of Equipment in ALAS	Substantial	Final	03/11/20	25/11/20	20/11/20	24/11/20	G	
MH CB – Outpatient Clinic Cancellations	Limited	Final	17/12/20	12/01/21	04/01/21	13/01/21	G	
Compliance with the Nurse Staffing Levels Act (Wales) 2016	Substantial	Final	17/12/20	12/01/21	25/02/21	26/02/21	R	
Integrated Health Pathways	Reasonable	Final	11/01/21	01/02/21	24/02/21	25/02/21	R	
UHW Surge Hospital – Lakeside Wing	*Reasonable*	*Final*	*11/01/21*	*01/02/21*	*17/02/21*	*22/02/21*	*R*	
Charitable Funds	Substantial	Final	09/03/32	31/03/21	11/03/21	11/03/21	G	
Tentacle IT System Follow-up	Substantial	Final	16/03/21	08/04/21	16/03/21	18/03/21	G	
Claims Reimbursement	Substantial	Final	16/03/21	12/04/21	18/03/21	19/03/21	G	
UHB Core Financials Systems	Reasonable	Final	10/03/21	06/04/21	17/03/21	23/03/21	G	
Risk Management	Reasonable	Final	23/03/21	15/04/21	24/03/21	24/03/21	G	
Consultant Job Planning Second Follow-up	Reasonable	Final	28/04/21	20/05/21	29/04/21	29/04/21	G	
Health and Care Standards	Reasonable	Final	28/04/21	20/05/21	04/05/21	04/05/21	G	
IM&T Control and Risk Assessment	n/a	Final	26/04/21	18/05/21	04/05/21	04/05/21	G	

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2020/21	G	April 2020	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported (to at least draft report stage) against plan to date for 20/21	A	81% 23 from 28	100%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100% 23 from 23	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	G	75% 15 from 20	80%	v>20%	10%<v< 20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100% 20 from 20	80%	v>20%	10%<v< 20%	v<10%

Audit and Assurance Services
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Report Title:	**Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	13/05/2021	
Status:	**For Discussion**	**X**	**For Assurance**		**For Approval**	**X**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Interim Head of Corporate Governance**								

Background and current situation:

The Health Board's Standing Orders (SOs) are based on the model standing orders issued by Welsh Ministers to Local Health Boards. Local Health Boards (LHBs) in Wales must agree standing orders for the regulation of their proceedings and business.

There is a requirement to keep the SO's under review to ensure they remain accurate and current. The Model Standing Orders, Reservations and Delegation of Powers (SO's) were last issued by Welsh Government in September 2019 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). They were reviewed by officials in association with representatives of the NHS Wales Board Secretaries and the NHS Wales Directors of Finance group. The revised model documents are issued in accordance the Ministerial direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) and 23(1) (Special Health Authorities) of the National Health Service (Wales) Act 2006.

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, and that the WHSSC and EASC Standing Orders are to form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.

The purpose of this report is to request that the Audit and Assurance Committee endorse the updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions for submission to the Board on the 27 May 2021 for final approval.

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

- Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in February 2019,
- The Audit and Assurance Committee considered the updates made to the CVUHB standing orders Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions on the 13 May 2020, and endorsed the updates for submission to the Board for final approval,
- A summary of the updates made to the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions is presented at ***Appendix 1*** for approval,
- Once approved by the Board the updated document will be published on the CVUHB website.

Recommendation:

The Committee are requested to:

a) **NOTE** and **ENDORSE** the updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions for CVUHB for submission to the Board on the 27 May 2021 for final approval.

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	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	
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		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Updates to Cardiff and Vale UHB'S

Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

May 2021

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, and that the WHSSC and EASC Standing Orders are to form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.

The table below provides a summary of the updates made:

1.Standing Orders, Reservation and Delegation of Powers

Reference	Update
Miscellaneous	General grammatical updates, updates to web links and references to Welsh Government references.
Statutory Framework	
Page 7 (ii)	HQ Address updated to 2nd Floor, Woodland House, Maes-y-Coed Road Cardiff CF14 4HH.
Page 7 (v)	Paragraph updated to make reference to the requirement for LHB's to make SO's for the regulation of its proceedings and business including provision of the Boards suspension.
Page 8 (vii)	Paragraph moved to (ix)
Page 8 (ix)	Paragraph updated to include paragraph (vii)
Page 9 (xii)	Paragraph updated to reference that NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.
Page 9 (xiv)	Paragraph updated to reference that Part 9 of the Social Services and Well-being (Wales) Act 2014 sets out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services. Web link updated.
Page 9 (xv)	Paragraph moved from Page 11 (xxiii) and inserted on the Well-being of Future Generations (Wales) Act 2015
Page 9 (xvi)	Paragraph updated Welsh Language (Wales) Measure 2011 to include reference to the Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

Reference	Update
Page 9 (xviii)	Paragraph on indemnitees removed as new paragraph added at Page 19, 1.4.4.
NHS Framework	
Page 10 (xx)	Paragraph concerning the NHS Values and Standards of Behaviour Framework*; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems" updated New web link added.
Page 10 (xxii)	Paragraph deleted and moved to Page 9 (xv)
Cardiff and Vale University Local Health Board's Framework	
Page 11 xxiii	Paragraph updated to refer to the Standing Financial Instructions form Schedule 2.1 of these SOs
Membership of the Local Health Board	
Page 14 1.1.1	Paragraph updated to confirm that the membership of the LHB shall be no more than 24 members
Page 14 1.1.2	Paragraph re-worded to clarify that Officer and non-officer such members shall have full voting rights. Associate Members do not have voting rights.
Page 15 1.1.5	New paragraph added: *"In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales."*
Page 15 1.1.6	Paragraph updated: *"A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights."*
Tenure of Board members	
Page 16 1.3.1	Paragraph re-worded: Independent Members and Associate Members *"….These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years."*
Page 16 1.3.2	Reference updated to include: *"An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member."*

Reference	Update
The Role of the LHB Board and responsibilities of individual members	
Page 17 1.4.4	New paragraph added: *"LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith"."*
Reservation and Delegation of LHB Functions	
Page 19-21 2.0.3 & 2.04	2.0.3 Reference to LHB Joint Duty, and the 2.04 NHS Wales Shared Services deleted as new information now included Page 24, 3.2.2 – 3.25
3.1 Joint Committees	
Page 21 3.2.2 – 3.2.4	Information updated: *3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.* *3.2.3 The Board shall establish, as a minimum, the following joint-Committees:* ▪ *The Welsh Health Specialised Services Committee (WHSSC).* ▪ *The Emergency Ambulance Services Committee* *<u>Joint Committee Standing Orders, terms of reference and operating arrangements</u>* *3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:* ▪ *The scope of its work (including its purpose and any delegated powers and authority);* ▪ *Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;* ▪ *Meeting arrangements;* ▪ *Communications;* ▪ *Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);* ▪ *Any budget, financial and accounting*

Reference	Update
	responsibility; ▪ *Secretariat and other support;* ▪ *Training, development and performance; and* ▪ *Reporting and assurance arrangements.* *3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.*
Page 24 3.5	Joint Committees established by the LHB, deleted as no included at 3.2.2 – 3.2.5.
NHS Wales Shared Services Partnership	
Page 24 4	Paragraph added to outline the work of the NHS Wales Shared Services Partnership. Moved from Page 20-21 2.0.3 & 2.04
4.0 Relationship with the Board	
Page 28 5.8-5.17	Paragraphs updated relating to the: • The Stakeholder Reference Group (SRG) • The Healthcare Professionals' Forum (HPF) • The Local Partnership Forum (LPF)
Working In Partnership	
Page 31 6	New paragraph *"The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here:* *https://socialcare.wales/cms_assets/hub-downloads/Partnership-working—-implications-for-health-boards-and-NHS-Trusts.pdf"*
Page 32 6.1	Updates to paragraph concerning Community Health Councils (CHC) to confirm legislation
Meetings	
7.2.4 Page 34	Minor update to state that the Annual Plan of Board Business

Reference	Update
	will be published on the LHB's website.
7.25 Page 34	Minor update to confirm that the Annual General Meeting **must include presentation of the Annual Report and audited accounts.**
Values and Standards of Behaviour	
8.6 Page 46	New paragraph inserted concerning Sponsorship: ***"Sponsorship*** 8.0.1 *In addition to gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.* 8.0.2 *All sponsorship must be approved prior to acceptance in accordance with the* ***Values and Standards of Behaviour Framework*** *and relevant procedures. A record of all sponsorship accepted or declined will also be maintained."*
8.7 Page 47	Paragraph on Register of Gifts & Hospitality up[dated to make reference to Sponsorship, now reads Register of Gifts, Hospitality & Sponsorship.
Schedule of Matters Reserved to The Board	
Page 57	The model schedule of matters reserved to the Board has been updated to: • make reference to decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC), • The list of matters has been re-ordered and re-numbered, see ***Appendix A,*** • Number 6 - Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken now includes the Audit and Assurance Committee as well as the Board
Additional Areas of Responsibility Delegated to Chair, Vice Chair and Independent Members	
Page 63	Updated to reflect membership of the Chair and individual Independent members.

Reference	Update
Delegation of Powers to Committees and Others	
Page 67	Updated to include reference to EASC
Schedule 2.1 Model Standing Financial Instructions for Local Health Boards	
	Updated SFI's included
Schedule 3 Board and Committee Arrangements	
	Terms of Reference for Board and Committee Arrangements updated.
Schedule 4 – Joint Committee Arrangements	
	Terms of Reference for Joint Committee Arrangements updated: • Schedule 4.1 – Welsh Health Services Specialised Services Committee • Schedule 4.2 – Emergency Ambulance Services Committee
Schedule 5 – Advisory Groups	
	Terms of Reference for the Advisory Groups updated: • Schedule 5.1 – Stakeholder Reference Group • Schedule 5.2 – Health Professionals Forum • Schedule 5.3 – Local Partnership Forum
Appendices	
	Appendices updated: • Appendix 1 - Six Principles of Partnership Working • Appendix 2 - Code of Conduct

2.Standing Financial Instructions

Reference	Update
Miscellaneous	The only changes made are: • Inserting UHB name • Changing Director of Workforce and OD to Director of People and Culture • Changing Audit Committee to Audit and Assurance Committee

Appendix A

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs[2] (except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: Set out in sections 3-42 below.
3	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements

6	NO – Audit & Assurance Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Values and Standards of Behaviour framework
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities

24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)
27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Board Secretary
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board

31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board
34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property
35	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB

38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate)
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and

			performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required
49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued

Report Title:	**Compliance with the Corporate Governance Code**								
Meeting:	**Audit Committee**						**Meeting Date:**	**13/05/2021**	
Status:	**For Discussion**	**X**	**For Assurance**		**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Interim, Head of Corporate Governance**								

Background and current situation:

NHS bodies are required to publish, as a single document, a three-part annual report and accounts which includes: the Performance Report, the Accountability Report, and the Financial Statements.

The Accountability Report demonstrates how the UHB meets key accountability requirements to the Welsh Government and includes a requirement to provide an assurance on compliance with the "Corporate Governance Code for Central Government Departments[1]", and the need to explain any areas of non-compliance.

The purpose of this report is to outline Cardiff & Vale UHB (CVUHB) compliance against the UK Code of Corporate Governance for the period April 2020-March 2021, and to seek the Audit Committee's approval to include the assessment in the Annual Report 2020-2021.

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

- An assessment has been undertaken against the applicable elements of the Corporate Governance Code for Central Government Departments" (the Code) and the findings are presented at ***Appendix 1*** for information,
- There were no reported/identified departures from the Code during the reporting period,
- The assessment has 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[2] published in January 2021 which focuses on how NHS bodies have governed during the COVID-19 crisis, with a particular focus on putting citizens first, decision making and accountability, and gaining assurance.

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

Whilst there is no requirement to comply with all elements of the Code, the Health Board considers that it is complying with the main principles of the Code where applicable, and follows the spirit of the Code to good effect and is conducting its business openly and in line with the Code.

Recommendation:

The Audit Committee are requested to:

a) **NOTE** the assessment of compliance against the UK Code of Corporate Governance for April 2020-March 2021,

Khan Raj 05/11/20

[1] Corporate Governance in Central Government Departments: Code of Good Practice, April 2017 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/609903/PU2077_code_of_practice_2017.pdf

[2] Doing it Differently, Doing it Right? | Audit Wales

b) **APPROVE** the self-assessment of compliance against the UK Code of Corporate Governance for inclusion in the Accountability report for 2020-2021.

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	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	
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	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	An EHIA has been undertaken for the full Annual Report 2020-2021 document.

Appendix 1

CVUHB Review Against the UK Corporate Governance in Central Government Departments: Code of Good Practice 2020-2021

This review covers the period April 2020 - March 2021 to comply with the need for all NHS Wales bodies to assess themselves against the Corporate Governance in central government departments: Code of Good Practice 2017[1].

This Code has been reviewed to consider if the relevant provisions are applicable or non-applicable for CVUHB.

Applicable items are outlined in full, those that do not relate to the business of the CVUHB are shown as "non- applicable". In some instances, the paragraph may not be directly applicable but the principles still apply.

Requirement of the Code	Evidence of CVUHB Compliance
Chapter 1 Parliamentary Accountability	
Not applicable	
Chapter 2 The role of the Board	
2.1 Each department should have an effective Board, which provides leadership for the department's business, helping it to operate in a business-like manner. The Board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the department.	CVUHB has a full Board in place comprising of Independent Members and Executive Directors in accordance with the Health Board's Standing Orders.
2.2 The Board forms the collective strategic and operational leadership	The Board is responsible for the oversight of the Health Board, including the implementation of the Integrated Medium-Term Plan (IMTP) (quarterly plans for 2020-2021), organisational strategy, the clinical services plan, providing leadership which is cascaded throughout the organisation.
2.3 The Board does not decide policy or exercise the powers of the ministers.	National policy decisions are made by the Welsh Government, with guidance issued through legislation and guidance. The Board is responsible for advising on and monitoring the effective implementation of policy.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/609903/PU2077_code_of_practice_2017.pdf

Requirement of the Code	Evidence of CVUHB Compliance
2.4 The Board should meet on at least a quarterly basis.	Traditionally, public Board meetings are held Board bi-monthly, with private Board Development Sessions being held in between. During 2020-2021, the frequency of the public meetings increased to monthly, to ensure agile decision making, and openness and transparency during the CVODI-19 crisis.
2.5 Not applicable	
2.6 Not applicable	
2.7 The Board supports the accounting officer in the discharge of obligations set out in Managing Public Money for the proper conduct of business and maintenance of ethical standards.	The Board receives a Financial update report from the Director of Finance at each meeting which outlines the ongoing financial position. The Finance Committee and the Audit Committee support the Board in providing scrutiny and assurance on financial management.
2.8 Not applicable	
2.9 Not applicable	
2.10 Not applicable	
2.11 Not applicable	
2.12 Where Board Members have concerns, which cannot be resolved, they should ensure that their concerns are recorded in the minutes.	If Board Members raise any issues or concerns during a meeting they are always captured in the minutes. Members also have further opportunities to raise issues when the meeting minutes are formally received and confirmed at the next meeting of the Board under the approval of minutes agenda item and under matters arising.
Chapter 3 Board composition	
3.1 The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the Board should be balanced, diverse and manageable in size.	The Board comprises of Independent Members who are appointed by Welsh Government on the merit of their skills and experience.
3.2 The roles and responsibilities of all Board Members should be defined clearly in the department's Board operating framework.	The Model standing orders for NHS Wales stipulate that: **Officer Members -** there should be 9 officer members appointed by the Board whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce

Requirement of the Code	Evidence of CVUHB Compliance
	and Organisational Development; Public Health; Therapies and Health Science. **Non-Officer Members (Independent Members) -** A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding. The IM's also have champion roles within the CVUHB. **Associate Members** - A total of 4 associate members may be appointed to the Board, to include a Director of Social Services (nominated by local authorities in the LHB area), Chair of the Stakeholder Reference Group and Chair of the Healthcare Professionals' Forum.
3.3 Not wholly applicable, however one reference is: *"The Board should be balanced, with approximately equal numbers of ministers, senior officials and non-executive Board members. It should comprise:* • *the Finance Director, who should be professionally qualified"*	The job description for the Executive Director of Finance stipulates that they must be a qualified accountant.
3.4 Not applicable	
3.5 Non-executive Board Members will exercise their role through influence and advice, supporting as well as challenging the executive.	Independent Members understand that their role is to scrutinise and seek assurance through attending Board and Committee meetings. They provide advice and guidance on planning, organisational strategy, monitor performance and operational issues, financial management, effective governance and are also involved in the recruitment, ongoing appraisal and succession planning of the Executive Team.

Requirement of the Code	Evidence of CVUHB Compliance
3.6 Not applicable	
3.7 Not applicable	
3.8 Not applicable	
3.9 Not applicable	
3.10 The Board should provide collective strategic and operational leadership.	The Board provides collective, strategic and operational leadership through discharging its responsibilities through the Board and Committee meetings.
3.11 The Board should include people with a mix and balance of skills.	As outlined in 3.2 above, the Board includes people with a mix of balance and skills as prescribed by the model Standing orders for NHS Wales.
3.12 The mix and balance of skills and understanding should be reviewed annually as part of the Board effectiveness evaluation.	Board Members received annual performance appraisals. The Annual Committee effectiveness survey was undertaken in April 2021, and the overall findings indicated that the Board was operating effectively. The Chair of the Board and each Committee, review the effectiveness of individual meetings as part of the agenda at each meeting.
3.13 The search for Board candidates should be conducted, and appointments made, on merit, with due regard for the benefits of diversity on the Board, including gender.	Public Appointments are supported by the Welsh Government Public appointments team, who ensure that recruitment campaigns, and the appointments process take account of the diversity of the Board.
3.14 Not applicable	
3.15 Not applicable	
3.16 Not applicable	
3.17 Not applicable	
3.18 Not applicable	
3.19 Not applicable	
Chapter 4 Board effectiveness	
4.1 The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively.	• There are formal procedures in place for the appointment of new Board Members, • sufficient time is allowed for members to discharge their duties with provision in the Standing Orders for papers to be circulated at least seven days in advance of the meeting • There is an induction training programme in place for new Independent Members. • The Board and Committees are supported by the Director of

Requirement of the Code	Evidence of CVUHB Compliance
	Corporate Governance and the dedicated Committee Secretariat function.
4.2 Not applicable	
4.3 Not applicable	
4.4 Not applicable	
4.5 The terms of reference for the Nominations Committee will include • identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the Board and of senior management, • scrutinising incentives and rewards for executive Board members and senior officials	The Remuneration and Terms of Service Committee fulfils this function and is developing plans to monitor and deliver succession planning as well as developing leadership. As the Health Board is required to adhere to the agenda for change policy which sets out remuneration, incentives and rewards are not applicable as they are not part of the package.
4.6 The attendance record of individual Board Members should be disclosed in the Governance Statement and cover meetings of the Board and its Committees held in the period to which the resource accounts relate	The Accountability report within the Annual Report 2020-2021 provides the attendance record for Board members.
4.7 Not applicable	
4.8 Not applicable	
4.9 Not applicable apply	
4.10 Where necessary, Board Members should seek clarification or amplification on Board issues or Board papers through the Board Secretary.	All members have access to the Director of Corporate Governance/Board Secretary who is the main governance advisor to the Board.
4.11 An effective Board Secretary is essential for an effective Board.	The Director of Corporate Governance/Board Secretary: • Ensures that there are regular agenda planning sessions with the Chair and Executive lead for the Board and Committees, with effective mechanisms in place to ensure information flows from these fora to the executive directors and independent members, as well as senior management. • Ensures the quality of Board and Committee papers are appropriate and received by members in accordance with the timetable set, • Provides governance support and advice to the Board, • Provides assurance on compliance with relevant legal and regulatory frameworks, including the code,

Requirement of the Code	Evidence of CVUHB Compliance
	• Acts as the focal point for interaction between Independent Board Members and the department • records Board decisions accurately ensuring action points are followed up • arranges Induction and development of Board Members.
4.12 n/a principles apply	
4.13 n/a principles apply	
4.14 Evaluations of the performance of individual Board Members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for Board and committee meetings and other duties).	Board members are subject to annual performance appraisal by the Chair and Chief Executive. The Chair and Chief Executive are subject to appraisals involving the Minister for Health & Social Services, led by Welsh Government.
4.15 All potential conflicts of interest for Non-Executive Board Members should be considered on a case by case basis.	Each Board Member is required to complete and submit a declarations of interest form annually to declare any personal or prejudicial interests relating to the business of CVUHB. Each member is required to update it should new conflicts of interest arise during the year. The DOI information is scrutinised by the Corporate Governance Department and the Audit Committee, and the information is included in the Annual Accountability Report. In addition, the agenda for each Board and Committee meeting includes an agenda item requesting that members declare any interest they have relevant to the meetings business discussions, these are recorded in the minutes.
Chapter 5 Risk Management	
5.1 The Board should ensure that there are effective arrangements for governance, risk management and internal control.	CVUHB has a Risk Management framework and strategy in place which sets out the organisation's approach to governance, risk management and internal control, which is led by the Director of Corporate Governance.
5.2 The Board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year.	The Audit and Assurance Committee is responsible for reviewing the draft Annual Governance Statement, prior to it being submitted to the Board for final

Requirement of the Code	Evidence of CVUHB Compliance
	approval and inclusion in the Annual Report.
5.3 The Board's regular agenda should include scrutinising and advising on risk management.	The Board receives quarterly updates on risk management and the Committees receive regular updates.
5.4 The key responsibilities of non-executive Board members include forming an audit and risk assurance committee.	The Audit and Assurance Committee has been in place since the inception of the health Board.
5.5 The head of internal audit should periodically be invited to attend Board meetings, where key issues are discussed relating to governance, risk management processes or controls.	The Head of Internal Audit attends the Audit and Assurance Committee, Board meetings and other Committee meetings as required.
5.6 The Board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls.	The Audit and Assurance Committee provide assurance to the Board on the effectiveness of the risk management system and systems of internal control through its on own Audit and Assurance Committee annual report, and through the Accountability report. The Risk Management system also goes through an annual internal audit review. Its current review provided reasonable assurance.
5.7 The Board should also ensure that the department's have appropriate and effective risk management processes through the department's teams.	The Board received the Board Assurance Framework at each of its meetings. This is cross referenced to the Corporate Risk Register which provides oversight of significant risks from each of the Clinical Boards. This provides assurance to the Board that robust risk management processes are in place throughout the organisation.
5.8 The Board should ensure there are effective arrangements for internal audit.	The Audit and Assurance Committee receives the annual internal audit plan in March each year and the audit assessment findings of each review undertaken in the reporting period. The full reports are then referred to the relevant Board committee to follow-up the action plans of those which cause concern. In addition to this all internal audit recommendations are tracked by the Corporate Governance Directorate and reported to the Risk and Assurance Committee at each meeting.
5.9 The Board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.	The Audit and Assurance Committee has been in place since the inception of the health Board and is chaired by the Independent Member for Finance,

Requirement of the Code	Evidence of CVUHB Compliance
	supported by at least two other Independent Members.
5.10 Advising on key risks is a role for the Board. The audit and risk assurance committee should support the Board in this role.	The Board receives the BAF at each meeting which provides information on the key risks impacting upon the Strategic Objectives of the Health Board. The Audit and Assurance Committee review the Risk Management Strategy prior to Board approval.
5.11 An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the Audit and risk assurance committee handbook. 3	Any decisions to be made are done so by the Board on the recommendation of the committee.
5.12 The Board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function.	The Director of Corporate Governance and the Corporate Governance Team provide support to the Audit and Assurance Committee.
5.13 The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the Board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the Board.	The draft Annual Governance Statement is presented to the Audit and Assurance Committee for endorsement, prior to submission to the Board. The Audit and Assurance Committee papers are published on the CVUHB website.
5.14 The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the Board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities.	The terms of reference for the Audit and Assurance Committee are published on the CVUHB website. The Committee produces an annual report outlining the business discussions of the Committee which is presented to the Board for assurance.
5.15 All Boards should ensure the scrutiny of governance arrangements, whether at the Board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the	The Board and Committees are required to complete an annual committee effectiveness survey. The Head of Internal Audit is required to provide an annual assessment on the governance framework in place at

Requirement of the Code	Evidence of CVUHB Compliance
department's implementation of, corporate governance policy.	CVUHB as part of the annual reporting process.
Chapter 6 Arm's Length Bodies	
Not applicable	

Report Title:	**Annual Board Effectiveness Survey 2020-2021**										
Meeting:	Audit and Assurance Committee							**Meeting Date:**	13/05/2021		
Status:	**For Discussion**	**X**	**For Assurance**	**x**	**For Approval**		**For Information**				
Lead Executive:	**Director of Corporate Governance**										
Report Author (Title):	**Interim Head of Corporate Governance** **Corporate Governance Officer**										

Background and current situation:

Effective Board and Committee meetings are a key part of an effective governance structure and it is important to ensure that Cardiff and Vale University Health Board's (CVUHB's) organisational governance is compliant with the provisions of its Standing Orders which state that:

10.2.2 The Board shall introduce a process of regular and rigorous self- assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

CVUHB has undertaken a review of the Board and its sub-committees, using survey questions derived from best practice guidance, including the NHS Audit Handbook, and using the following principles:

- the need for sub-committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives,
- the requirement for a committee structure that strengthens the role of the Board in strategic decision making and supports the role of Independent Members in challenging executive management actions,
- maximising the value of the input from Independent Members , given their limited time commitment,
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

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 purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2020-2021, and to provide an update on the action plan following the survey undertaken in 2019-2020.

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

- 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,

- Following the survey undertaken in 2019-2020, the Board Effectiveness Action Plan 2019-2020 is presented at ***Appendix 1*** and outlines the actions completed 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,
- The overall findings are positive which provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committees are effectively supporting the Board in fulfilling its role,
- Out of the questions posed, room for improvement was identified in 5 areas and a Board Effectiveness Action Plan 2020-2021 has been developed to address them which is presented at ***Appendix 2*** and outlines proposed actions to strengthen and develop the areas identifed, it is suggested that this action plan be progressed via Board Development sessions. Assurance is provided by work already in train in many of these areas as referenced in the action plan.
- The individual findings of the Annual Board/Committee Effectiveness Surveys 2020-2021 undertaken in April 2021 are presented at ***Appendix 3 – 11*** for information,
- The individual Board/Committee findings will be presented to each relevant Committee for assurance.

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

To ensure effective governance the Board Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in March/April 2022 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2021-2022.

Recommendation:

The Committee are requested to:

a) **NOTE** the results of the Annual Board Effectiveness Survey 2020-2021, and the action plan for 2020-2021, to be progressed via Board Development sessions,
b) **NOTE** the completed actions within the Board Committee Effectiveness Action plan 2019-2020.

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	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	
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		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Board Effectiveness – Self Assessment 2019-2020 Action Plan

Question asked 2020	Action Required	Lead	Timescale to complete	Progress as at April 2021
The Board is effective and provides leadership and a clear vision for the UHB's business	This work is being taken forward by Mike Farrar and the actions related to this work need to be reviewed and taken forward	Chair/Chief Executive	March 2021	This work has progressed in some areas but has mainly been delayed due to COVID-19. There is a need to reconsider the actions we were tasked with doing as a Board and reconsider how we will take them forward and implement.
The Board has agreed and communicated clear values and behaviours for the organisation and its priorities reflect these.	A communications plan regarding the values of the organisation to be developed to reinforce this area	Director of Corporate Governance and Director of Communications	March 2021	CVUHB's values are embedded within our corporate literature, including our website, intranet, corporate literature, job descriptions, performance appraisals, training programmes, CEO Connects briefings and social media. CVUHB has a Standards of Behaviour Framework policy in place which describes the standards and public service values which underpin the work of Cardiff and Vale University Health Board (the UHB) and reflects current guidance and best practice which all those working in NHS

				Wales must follow. This is published on the website and staff intranet.
The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services and the steps being taken to address them.	This work is in place and is being taken forward. A new Risk and Regulation Officer has been appointed to roll out the risk training within the Clinical Board which will result in a more robust Corporate Risk Register being presented to the Board.	Director of Corporate Governance	March 2021	The Risk and Regulation Team offer training sessions to risk leads through targeted training programmes that are informed by the team's regular interactions with clinical boards and corporate departments. Alongside this the team have provided, since March 2021, a weekly virtual Risk Management online training session which is available to the all staff members. The Risk and Regulation Teams training plan is designed to embed a consistent approach to the management, scoring and recording of risk from ward to board across the Health Board. On 29 October 2020 the Board agreed to use the Good Governance Institute (GGI) Risk Appetite Matrix to set its risk appetite (current (Cautious) and 'working towards' (Open) positions). In December 2020 alternate methods of describing Risk Appetite were examined and it was determined that adding sub-elements to the GGI

				Matrix (particularly those giving greater emphasis to patients and workforce) would enable better application of risk appetite at an operational level.
The Board has a credible strategy to provide quality, sustainable services to patients and there is a robust plan to deliver this.	This work is taking place with the Executive Team supported by the Director of Transformation. Once the programme is finalised there will be clear milestones associated with it which will facilitate the monitoring of progress in a comprehensive and robust way.	Executive Director of Strategic Planning	From December 2020	In March 2020, due to the COVID-19 pandemic the Integrated Medium-Term Plan (IMTP) process was paused and Quarterly Frameworks were introduced for NHS Wales. Organisations were required to produce quarterly plans addressing the priorities set out in these frameworks. Our priorities were shaped by the 2019-2022, IMTP which set out our objectives and plans. A draft Annual Plan for 2021-22 has been submitted to Welsh Government the final plan will be signed off by the Board.
The Board scrutinises and challenges performance against delivery of the strategy. Khan,Raj 05/11/2021 15:34:37	Linked to the above action a framework has now been agreed with the Executive and once the programmes have been agreed performance against the delivery will be easier to monitor in a more structured way.	Executive Director of Strategic Planning	January 2021	In March 2020, due to the COVID-19 pandemic the Integrated Medium-Term Plan (IMTP) process was paused and Quarterly Frameworks were introduced for NHS Wales. Organisations were required to produce quarterly plans addressing the priorities set out in these frameworks.

				Our priorities were shaped by the 2019-2022, IMTP which set out our objectives and plans. A draft Annual Plan for 2021-22 has been submitted to Welsh Government the final plan will be signed off by the Board. Once approved performance against the plan (which is linked to the Strategy) will be monitored by the Board.
The Board identifies and engages with stakeholders, and has formal processes in place to capture feedback from them to inform future strategic planning.	A Board Development session has been undertaken which provided clear direction on engagement and consultation with stakeholders therefore going forward the processes relating to this will be more robust and informed to achieve successful outcomes. There has also been learning from previous engagement taken on board.	Executive Director of Strategic Planning	From December 2021	COVID-19 placed a tremendous strain on our health service provisions, testing our ability to adapt, make agile decisions and to find new ways of working to protect the patient population of Cardiff and the Vale of Glamorgan. National and local services have collaborated to support us in responding the COVID-19 challenges, including staff from social care, nursing homes, public health, Local Authorities, voluntary and community sector, students and Universities. We have witnessed camaraderie to get the job done and delivered great things in partnership and

				through collaborative leadership. A formal engagement exercise has been undertaken in relation to Shaping our Future Clinical Services.
The UHB is always learning and looking for creative ways and innovation to improve the delivery of services.	The Intensive Learning Academy will vastly improve this area particularly around innovation.	Director of Transformation	From January 2021	The Dragon's Heart Institute is in the early stages of development.
We identify and share best practice and benchmark.	The Executive need to consider what areas the Health Board could provide better bench marking on. This work could be linked to the development of the integrated performance report.	Executive Team	January 2021	The Director of Corporate Governance and the Director of Digital Health Intelligence have led a piece of work to develop an integrated performance report, which will be introduced In Summer 2021. This will incorporate information on performance benchmarking.
There is timely provision of information in a form and of a quality that enables the Board to discharge its duties effectively. Khan Raj 05/11/2021 15:34:37	There is a need to ensure that this process is working effectively and deadlines for receipt and publication of reports are adhered to. Now that the Corporate Governance Team is up to its full capacity this should improve going forward.	Director of Corporate Governance	From November 2020	As a consequence of COVID-19 the corporate governance team reviewed its administrative processes and developed a guidance document on Board and Committee preparations which outlines key timescales for deadlines in accordance with the Standing Orders. In addition, a virtual meeting guidance for staff and Independent members, and a Chairs guidance document has

				been issued to support the smooth running of meetings. The Corporate governance team also co-ordinate agenda planning meetings with the Chairs and Executive Directors and issue email reminders to report authors on deadlines for reports, which includes a copy of the CVUHB report template for reports to ensure consistency in the quality of information received.

Board Effectiveness – Self Assessment 2020-2021 Action Plan

The table below identified areas from the Annual Committee Effectiveness Survey 2020-2021 undertaken in April 2021, that suggested a need for Further Improvement

Question asked 2020-2021	Response and Action Required	Lead	Timescale to complete
Board **8. We Identify and Share Best Practice and benchmark**	The Board are proactive in utilising business intelligence to support effective decision making and benchmarking is undertaken through the various NHS Wales professional peer groups, for example the NHS Wales Directors of Nursing Group, NHS Wales Board Secretaries Network etc. **Action** Consider strengthening and developing sharing best practice and benchmarking at a future Board Development session.	Executive Nurse Director, Executive Director for Strategic Planning Executive Medical Director, Chief Operating Officer, Executive Director of Workforce and OD.	Dec 2021
Charitable Funds Committee **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.**	All Committee papers are issued in accordance with section 7.4.3 of the Standing Orders, specifically: *"7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least **10 calendar days** before a formal Board meeting."* *Action* - The Corporate Governance team will continue to adhere to internal performance standards for the review, approval and issuing of minutes, and will ensure that all minutes are issued swiftly. A review of the timeliness of papers being issued against the internal targets set will be undertaken to monitor effectiveness.	Director of Corporate Governance	Dec 2021

	Agenda planning meetings will confirm that minutes have been approved by the Chair and circulated to Members as required.		
Health & Safety Committee **2. The Board is active in its consideration of the Committee's composition**	The Composition of the Health & Safety Committee is outlined in its Terms of Reference which are agreed by the Board. The DCG will liaise with the Chair and review the composition of all Committees and the scheme of delegation within the Standing Orders will be updated.	Director of Corporate Governance	Sept 2021
Health & Safety Committee **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.**	All Committee papers are issued in accordance with section 7.4.3 of the Standing Orders, specifically: *"7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least **10 calendar days** before a formal Board meeting."* *Action* - The Corporate Governance team will continue to adhere to internal performance standards for the review, approval and issuing of minutes, and will ensure that all minutes are issued swiftly. A review of the timeliness of papers being issued against the internal targets set will be undertaken to monitor effectiveness. Agenda planning meetings will confirm that minutes have been approved by the Chair and circulated to Members as required.	Director of Corporate Governance	Dec 2021
Quality, Safety, Experience Committee **The Committee agenda setting process is thorough and led by the Committee Chair.**	All Board/Committee meetings are supported through an agenda planning meeting which reviews the agenda, minutes, action log and length of the meeting. The Committee Chair attends the meeting and is involved in setting	Director of Corporate Governance	May 2021

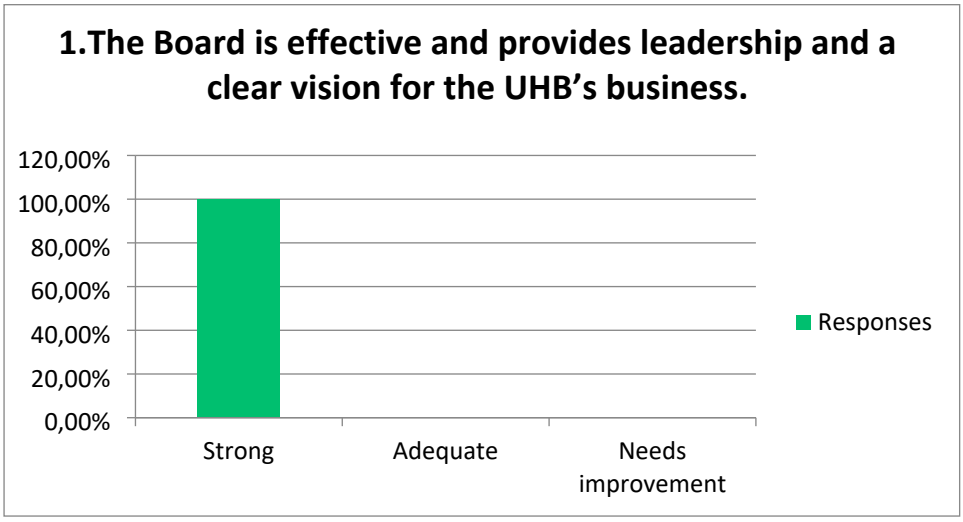
	the agenda with the Director of Corporate Governance. A meeting guidance document will be produced and issued to Officers and Independent Members and all agenda planning meetings will consider the length of the agenda, items for the agenda, time allowed for agenda items, approval of minutes and action logs, terms of reference, quoracy, Chairs report for Board etc		

Appendix 3

Annual Board Effectiveness Survey 2020-2021

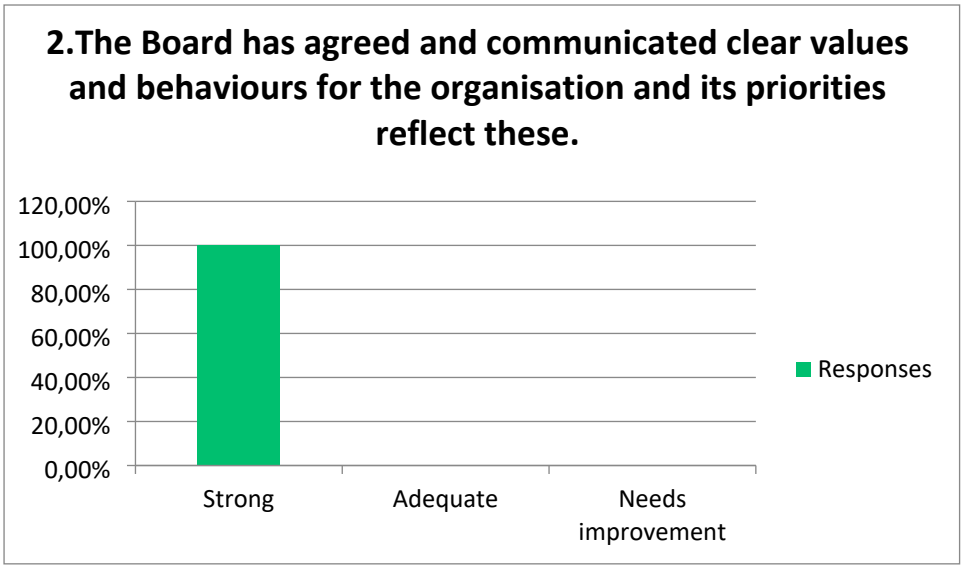
Board Self-Evaluation 2020-2021

- 8 responses received.



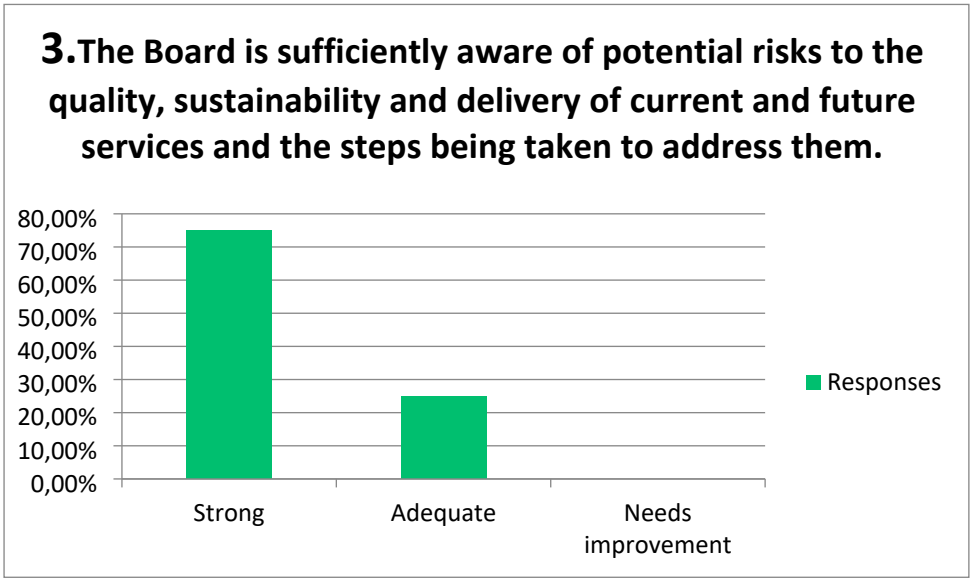
Comments received:

- *A competent Board which has matured well over the last 12 months.*
- *Clear strategy and Board agenda arranged to ensure we deliver it.*



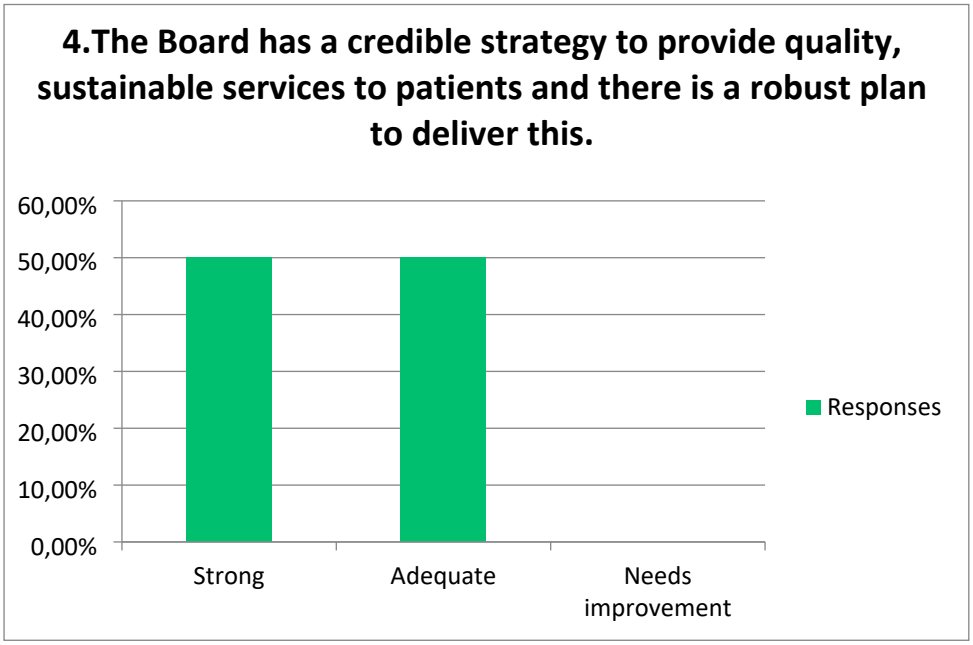
Comments received:

- *The values agreed by the Board have been well communicated over recent years and have never been more important than during the course of the current pandemic. Our values have been extended into our recruitment and staff appraisal and development processes.*
- *All Board members assigned a protected characteristic to promote, values underpin all our work.*



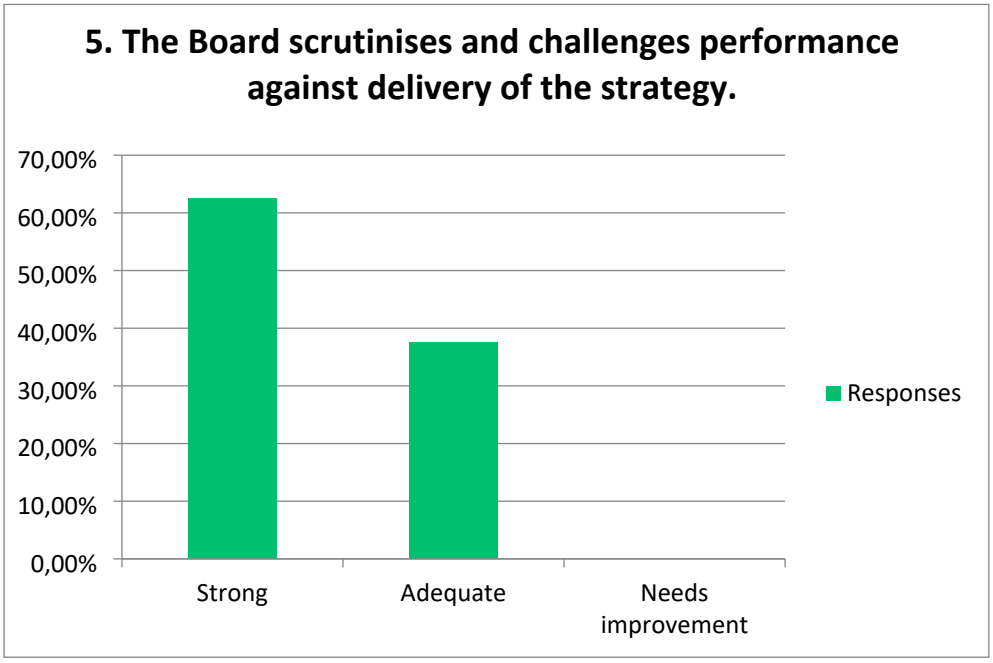
Comments received:

- *There is a robust Board Assurance Framework in place which identifies risks to strategic objectives. This is presented to each meeting of the Board.*
- *A very sound Board Assurance Framework (BAF) has been developed by the Director of Corporate Governance which provides a clear picture of the main risks faced by the organisation. The BAF also has clear links into the strategic objectives of the UHB providing a positive overview for Board members and the public.*
- *Have reviewed risk appetite. Risk register much improved.*



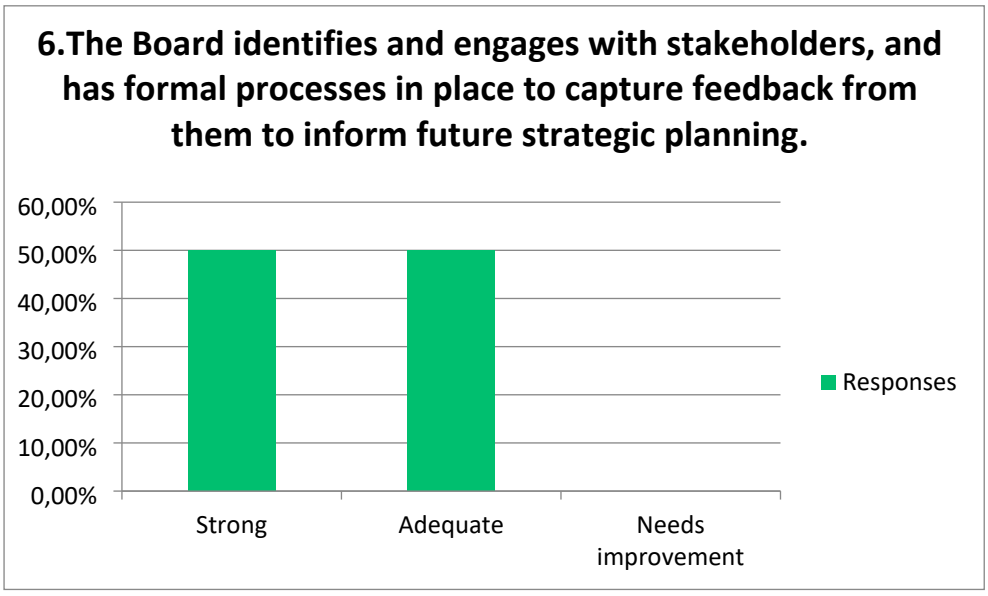
***Comments received**:*

- *The strategy of the organisation is well developed with work currently underway to ensure effective delivery of the strategy in terms of outcomes achieved. Moving towards a "strong" rating.*
- *Current uncertainty and scale of post-covid challenge makes this challenging.*
- *An area of strength, this has been given much focus and good progress made.*



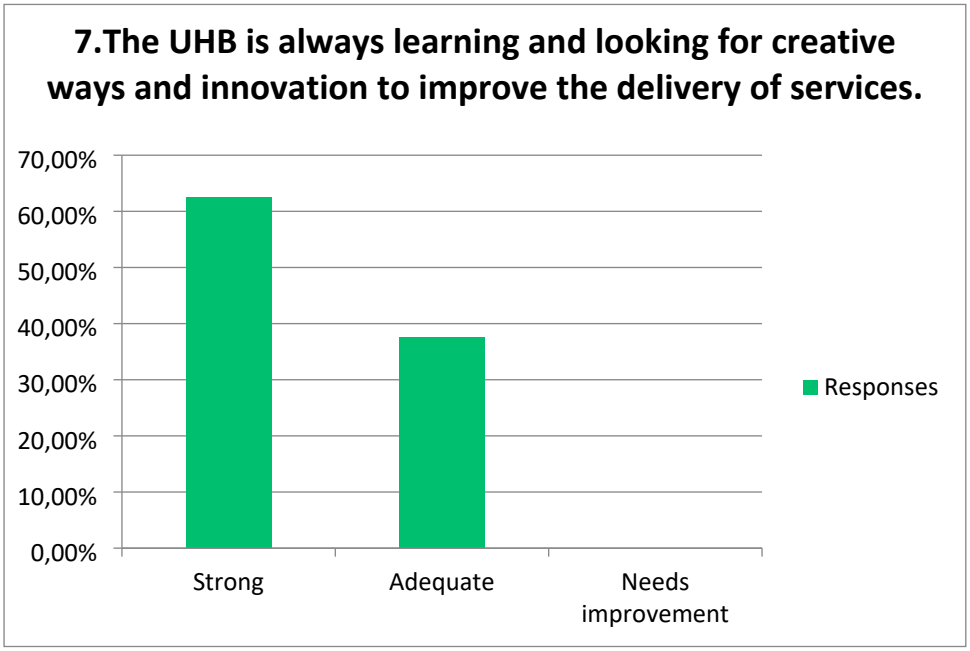
Comments received:

- *Has improved during the last period*
- *Yes and this has seen the execs respond with key priorities to drive delivery.*



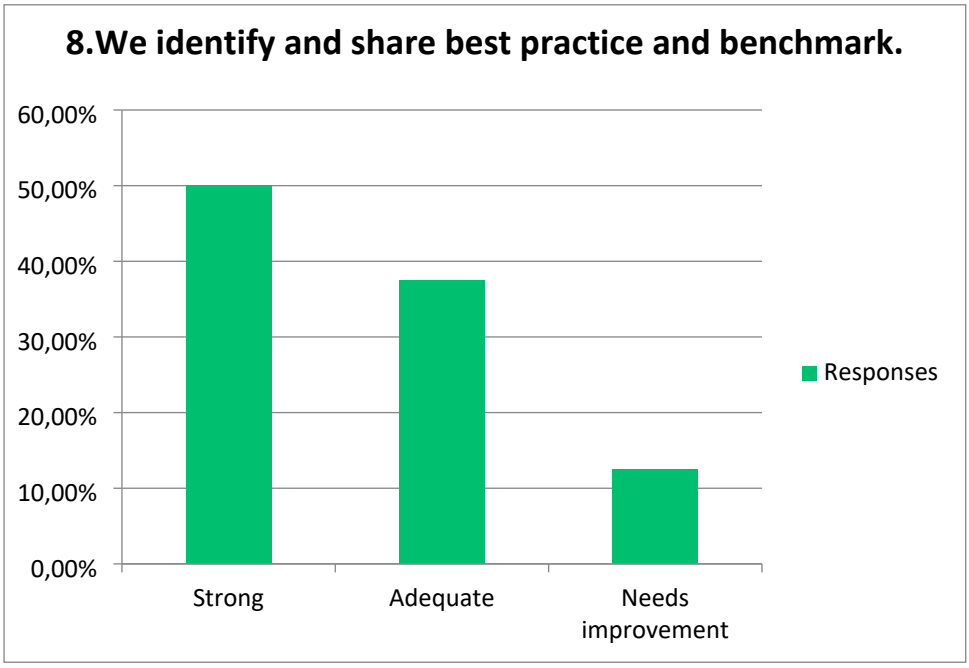
Comments received:

- *This has been a particular strength during the current pandemic with very strong partnership working being particularly evident*
- *I am not aware that the Board has a formally process in place to capture feedback from all stakeholders but this is a function which is generally overseen by the Strategic Planning Team and the Comms and Engagement Team.*
- *Yes ongoing but always an area for improvement.*



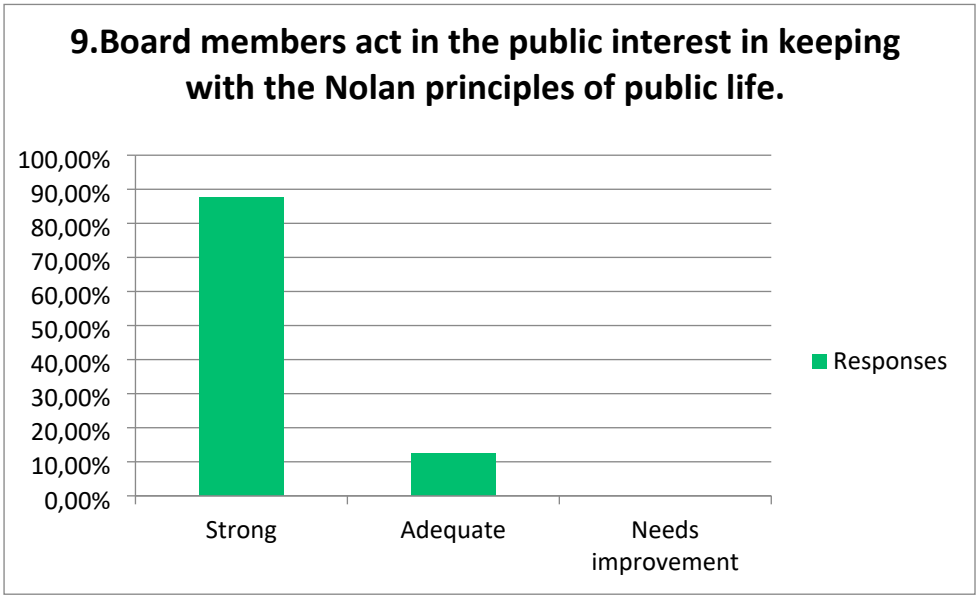
Comments received:

- *Aided by the challenges presented by the pandemic, the Board (in particular executive Board members) has facilitated new and creative ways to provide our services during a very challenging period.*
- *Keen to lead innovation but also adopt and adapt.*



Comments received:

- *Benchmarking is weak across the performance areas considered at Board*
- *Best practice sharing could always be improved further even though the last 12 months has witnessed significant cooperative working throughout the organisation. The "strong" rating reflects the amazing team working that has been undertaken during the year. There will be a need for us to sustain this level of sharing best practice as we move out of the pandemic.*
- *Yes embedded in teams and services*

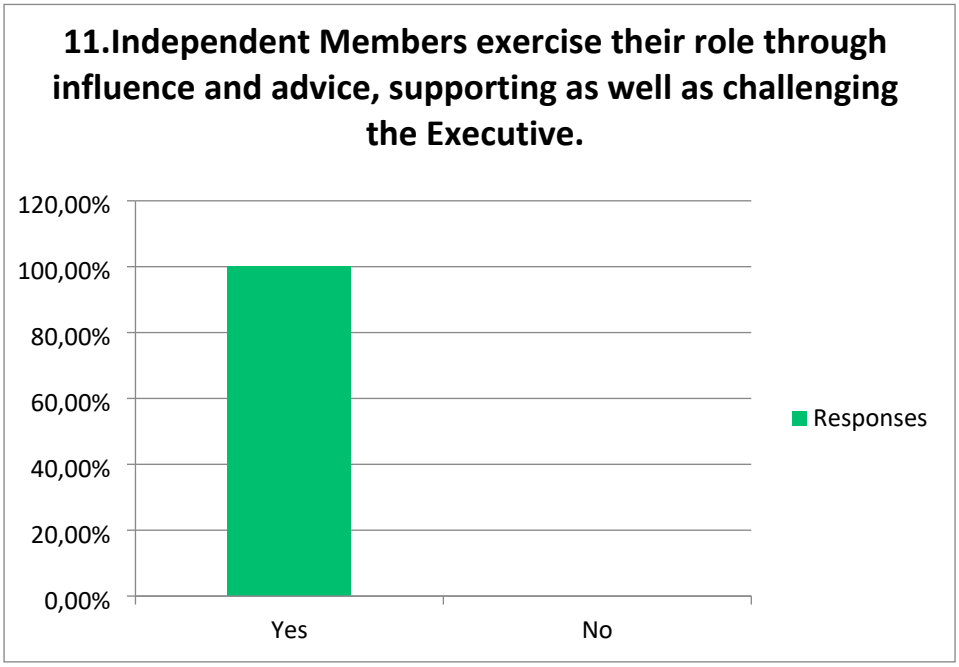


Comments received:

- *Not aware of any concerns, all act in line with the principles in my observation*

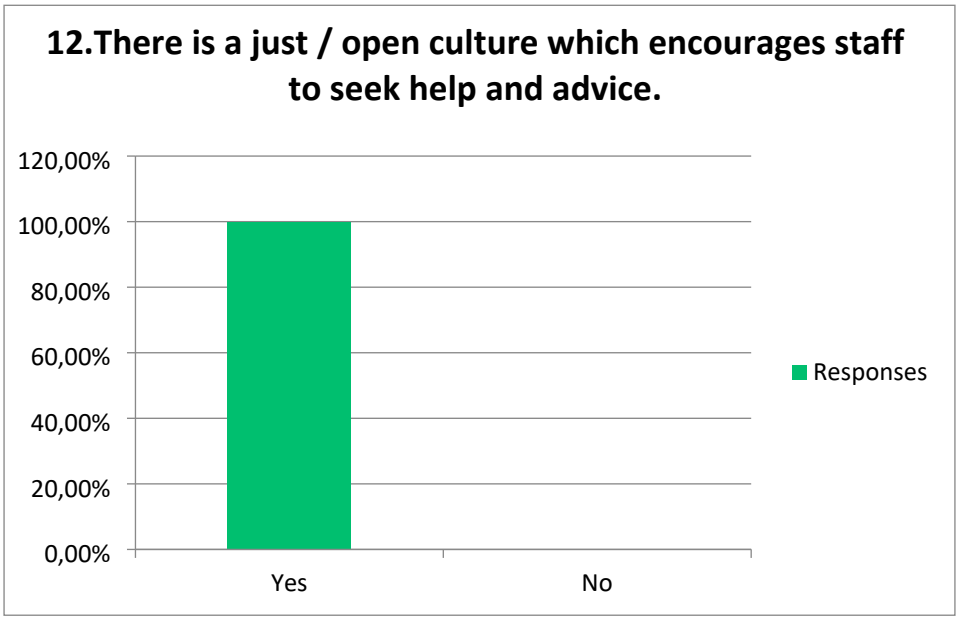
Comments received:

- *Open transparent culture seem by the breadth of issues discussed in public Board*



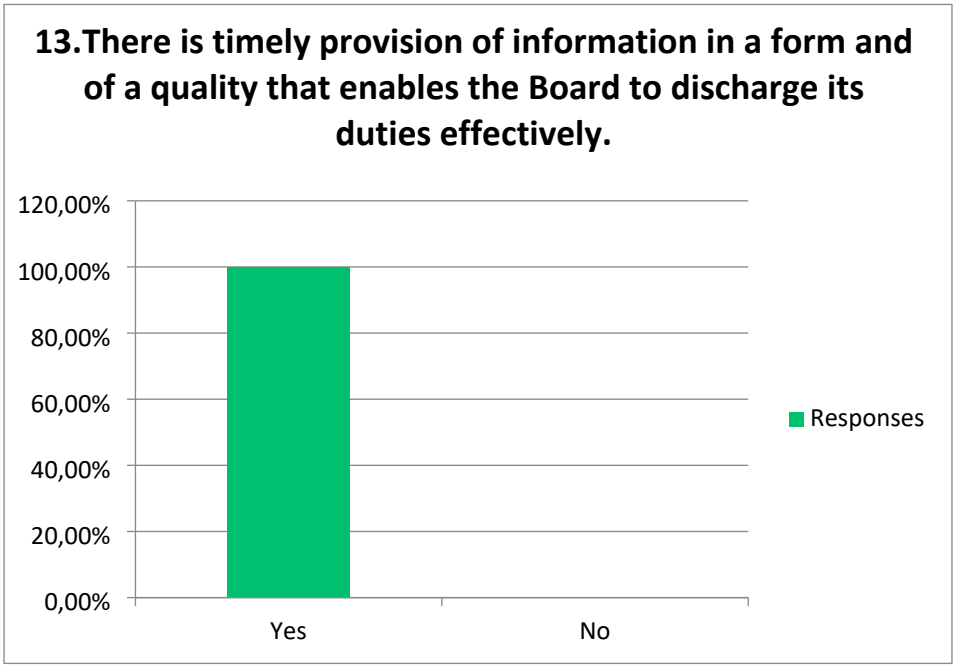
Comments received:

- *Scrutiny, challenge and support are consistently demonstrated by Independent Members who all make a very valuable contribution to the effectiveness of the Board.*
- *Regularly demonstrated.*



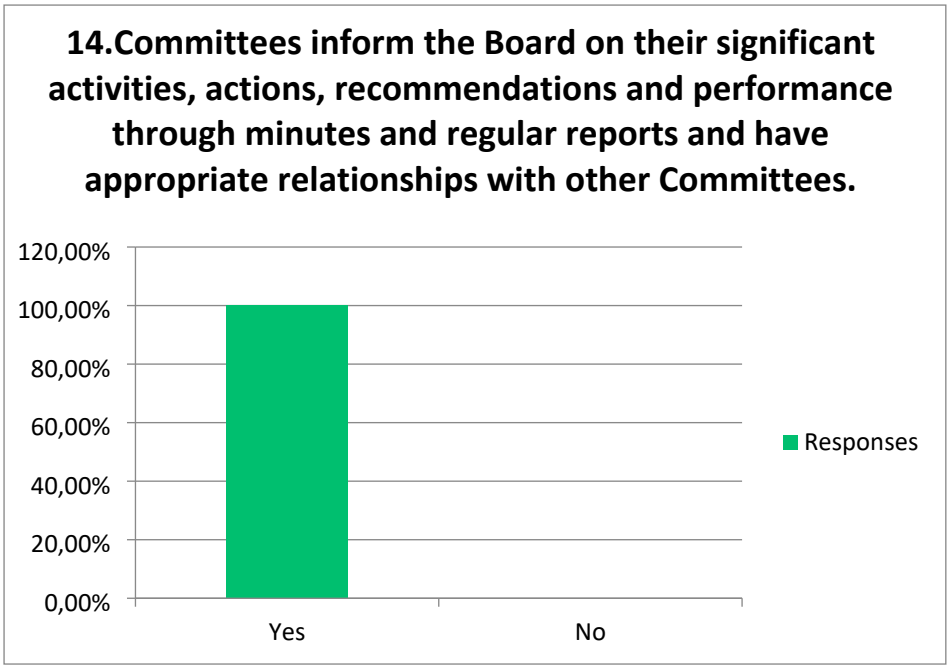
Comments received:

- *In place but we will need to refresh the Freedom to Speak Up process to ensure that all staff are fully aware.*
- *Yes and have revised this, but needs ongoing review and publicizing.*



Comments received:

- *Papers are produced in a timely way. Admincontrol is a useful library function too*



Comments received:

- *Minutes are received by the Board after each Committee meeting in addition to a Chairs report from each Committee Chair to the Board.*
- *Written reports and chance for lead IM to raise items for Board attention.*

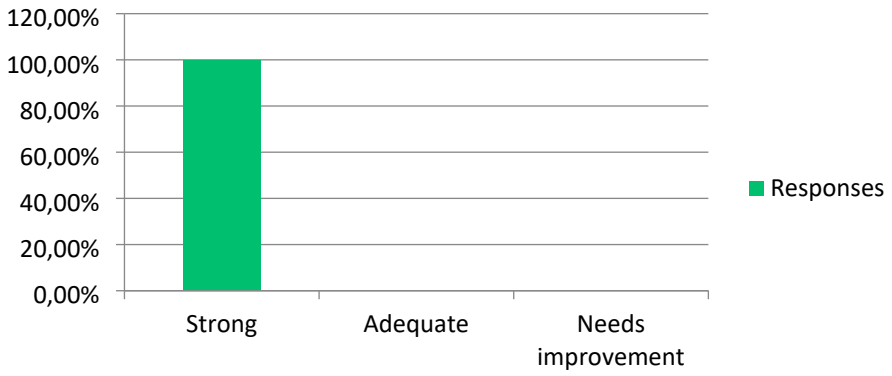
Appendix 4

Annual Board Effectiveness Survey 2020-2021

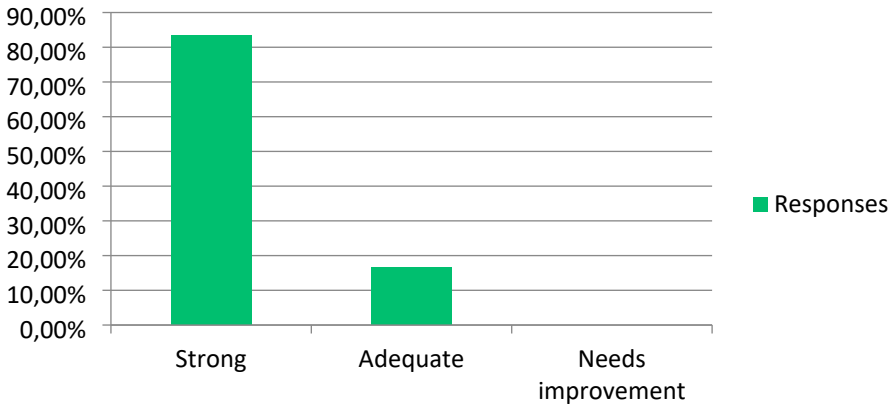
Audit and Assurance Committee Self-Evaluation 2020-2021

- 6 responses received.

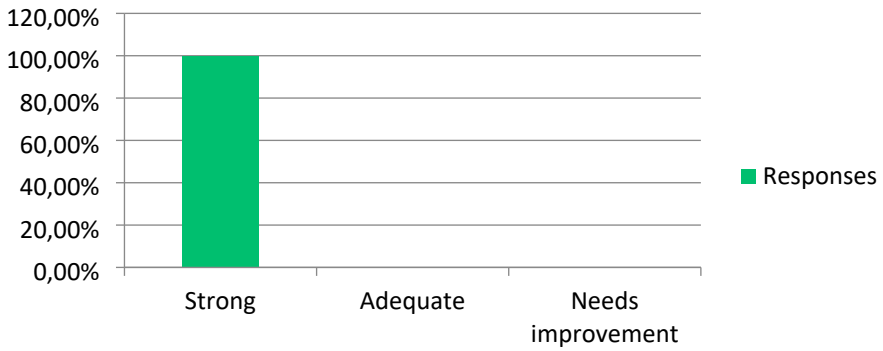
1.The Audit & Assurance Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with Welsh Government guidance and have been approved by the committee and the



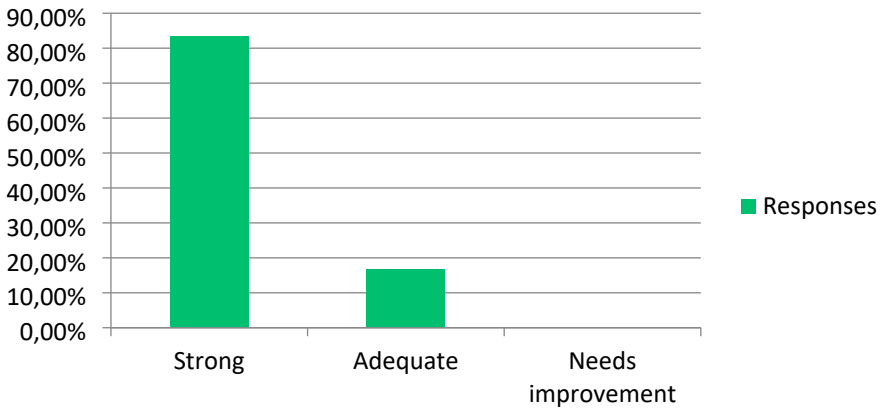
2.The board was active in its consideration of Audit & Assurance Committee composition, including the designation or consideration of an "audit committee financial expert." (At least one committee member should have a financial background)



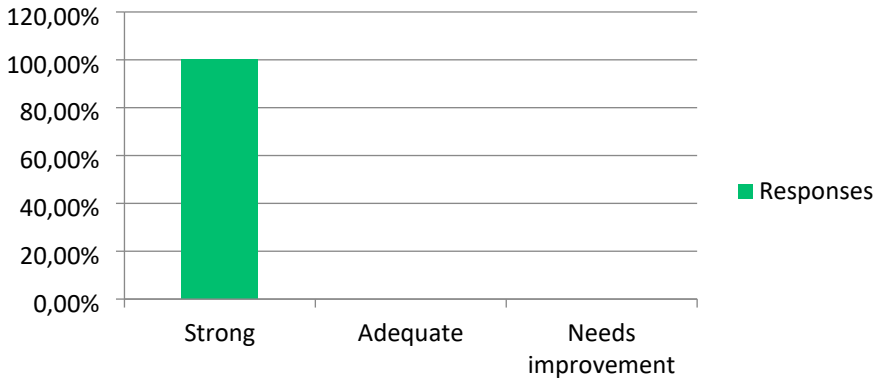
3.The Audit & Assurance Committee's actions reflect independence from management, ethical behaviour and the best interests of the Trust and its stakeholders.



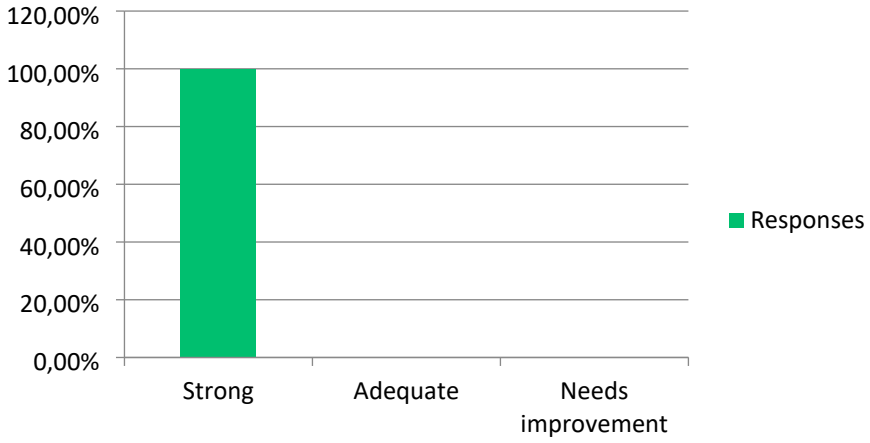
4.The Audit & Assurance Committee's meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible aft



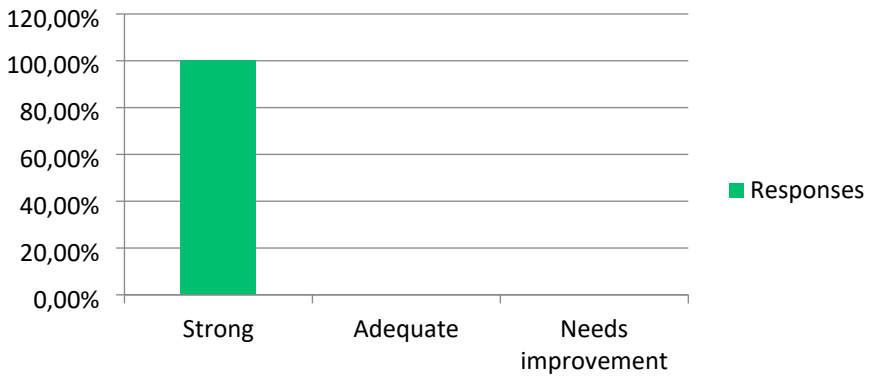
5. Audit & Assurance Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Audit & Assurance Committee's responsibilities.



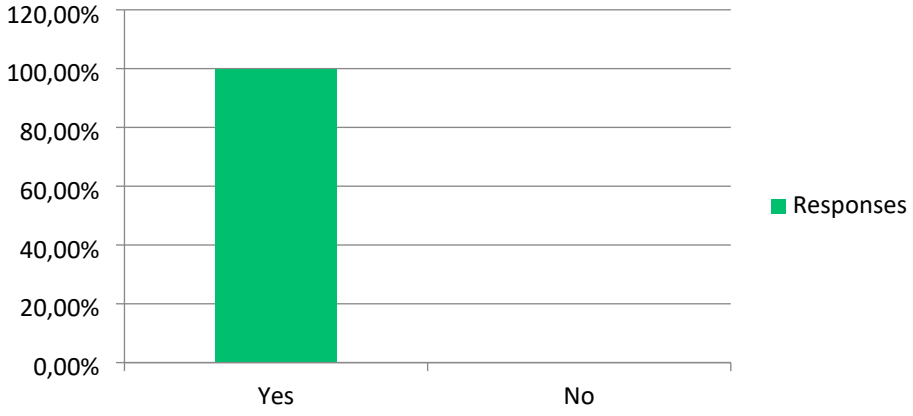
6.Appropriate internal or external support and resources are available to the Audit & Assurance Committee and it has sufficient membership and authority to perform its role effectively.

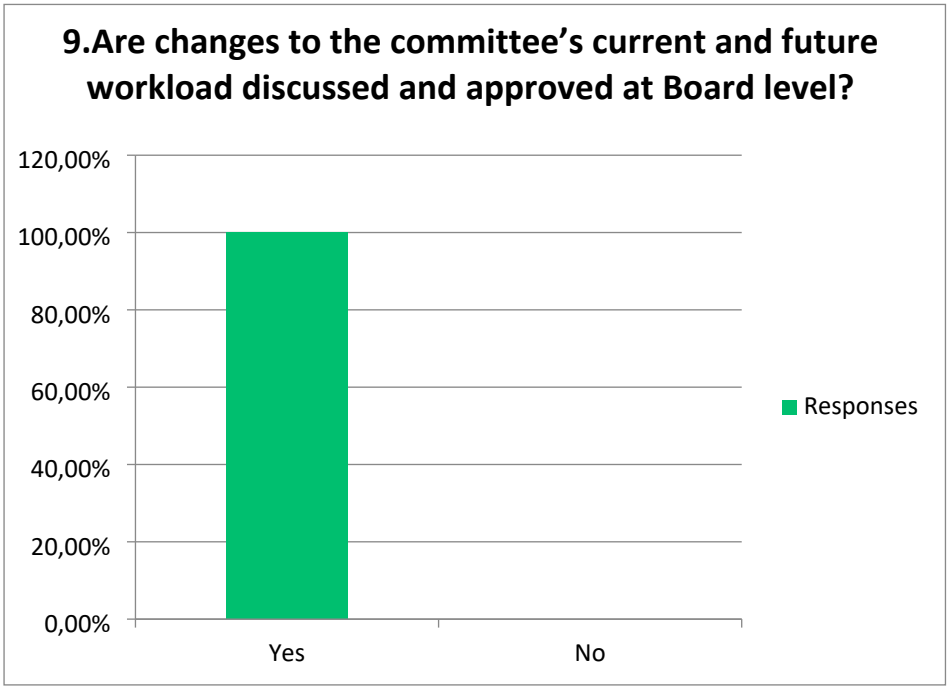


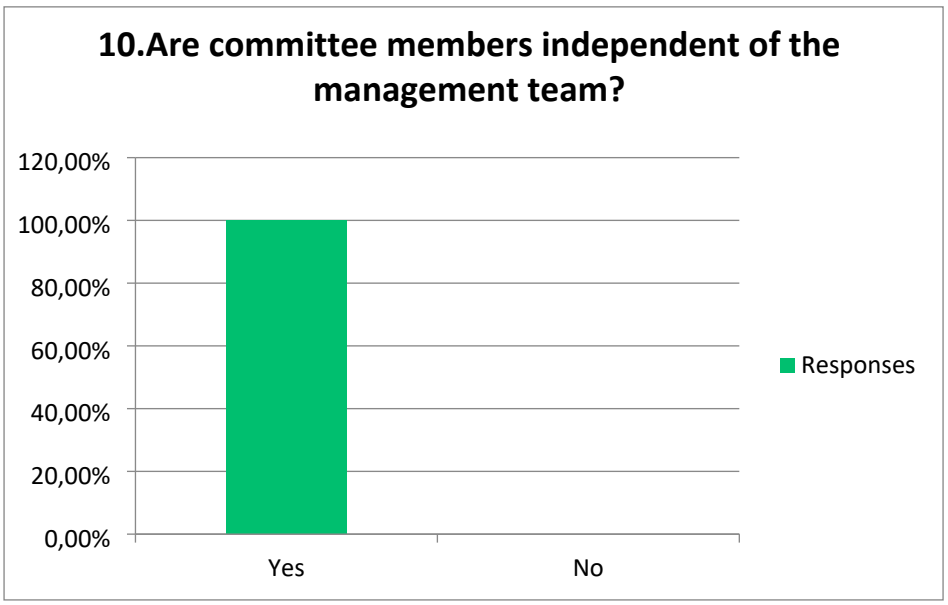
7. The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.



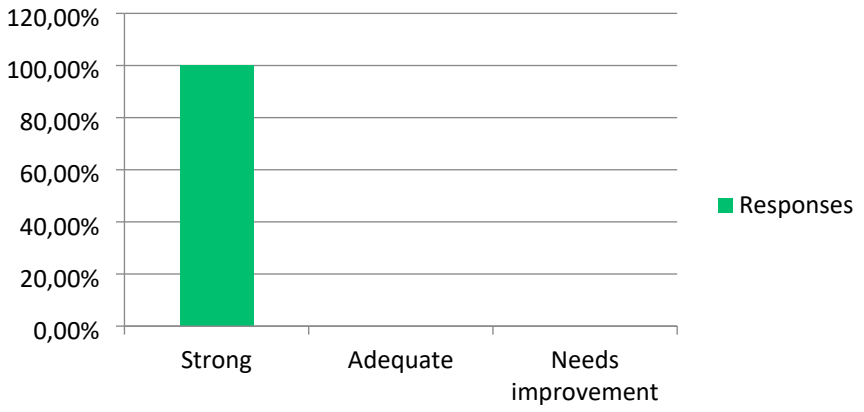
8. Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation?



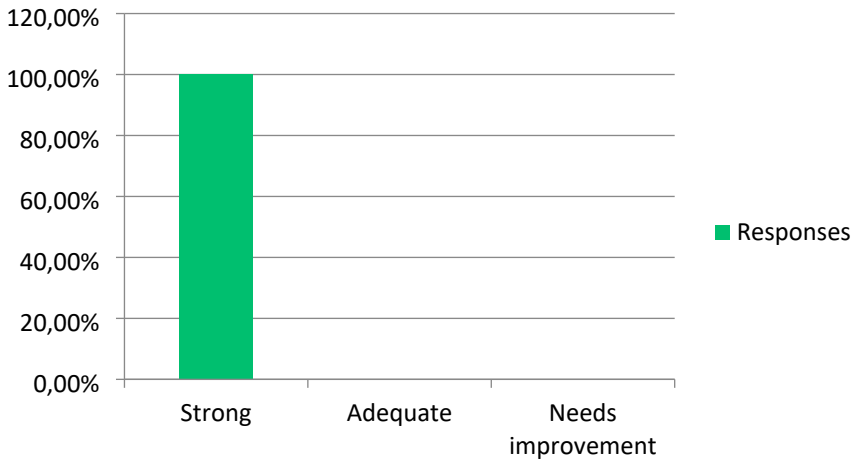


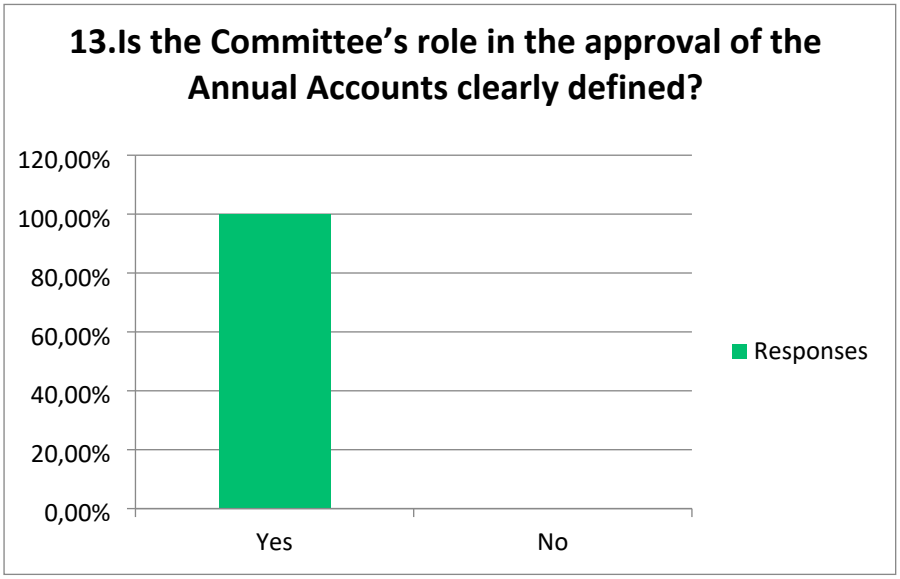


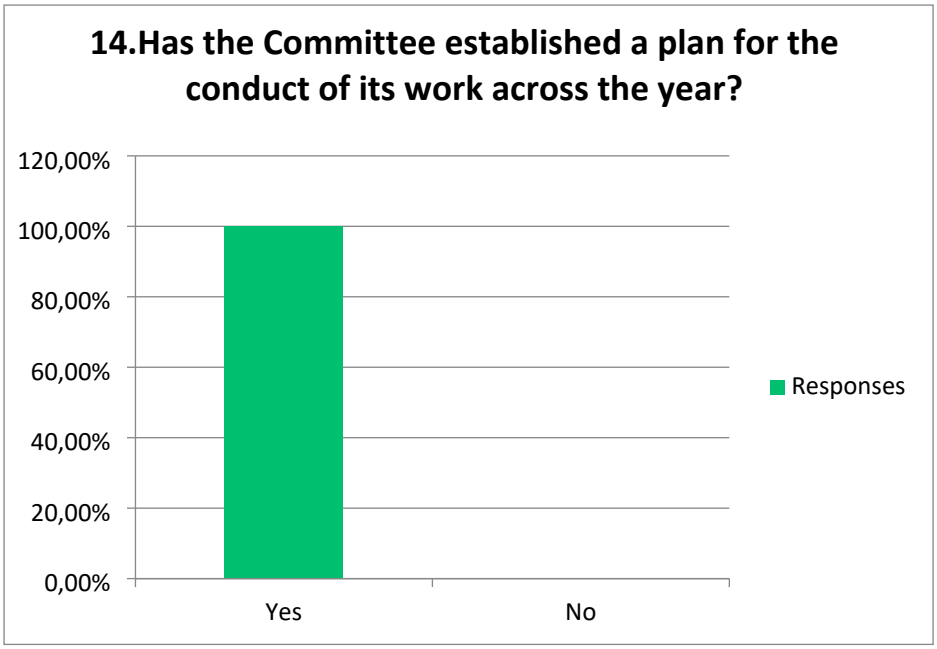
11.There is appropriate consideration of the UHB's financial reporting risks and the related internal controls, which are reflected in the audit committee's discussions and agenda items.

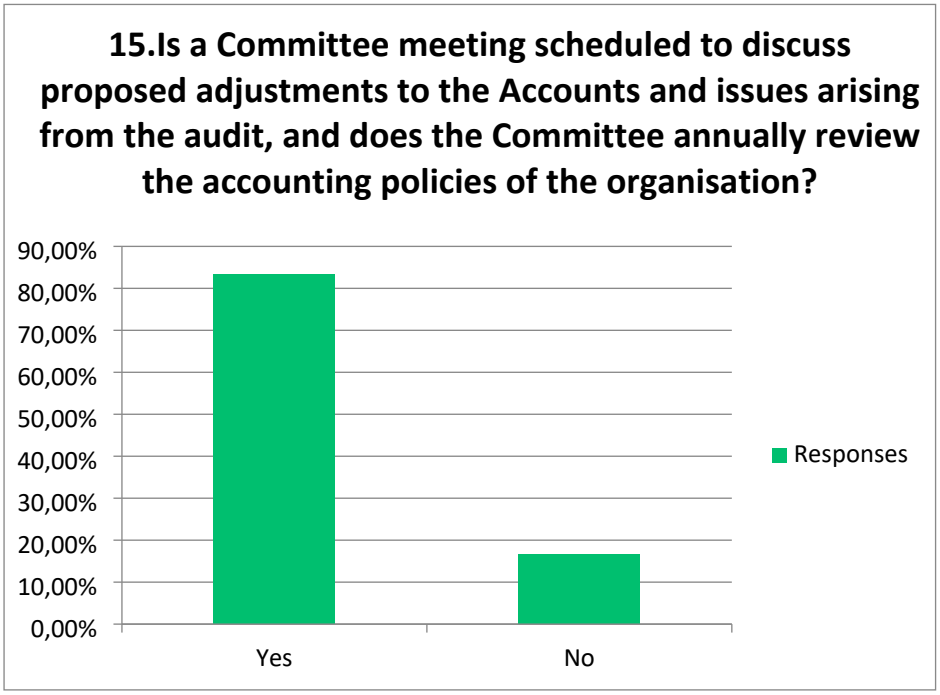


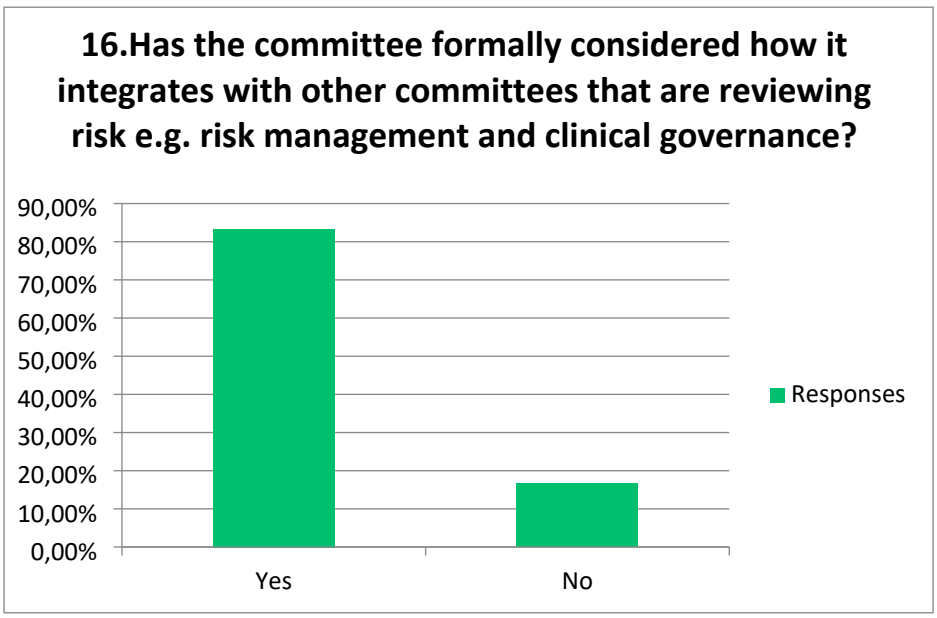
12.The Audit & Assurance Committee's agenda-setting process is thorough and led by the audit committee chair.





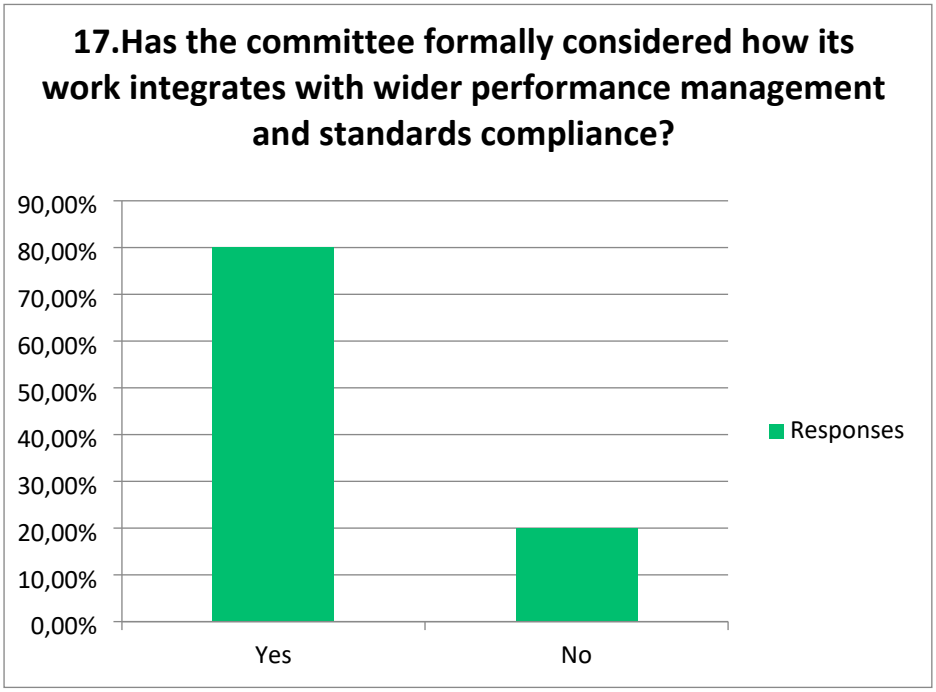


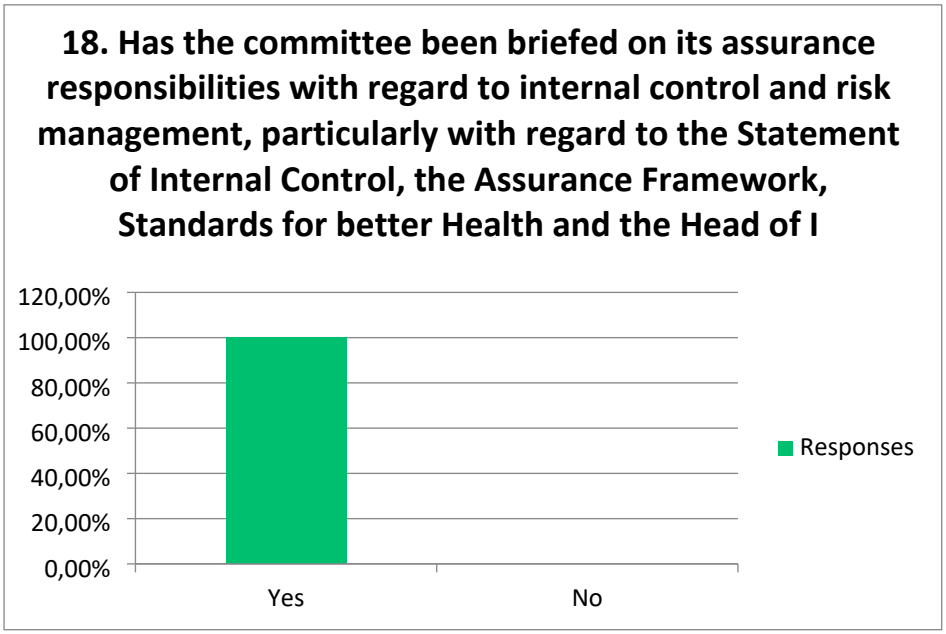




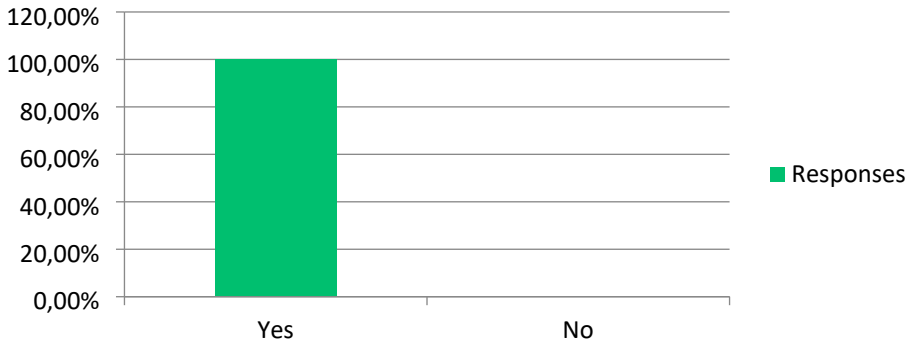
Comments received:

- *A report was presented to the Committee on the interrelationship with other Committee of the Board during the financial year*

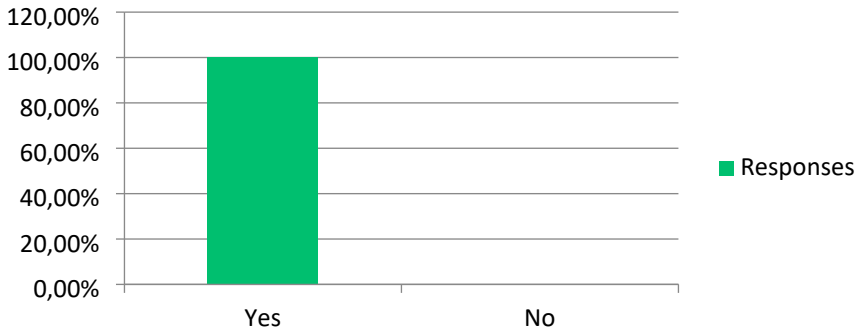


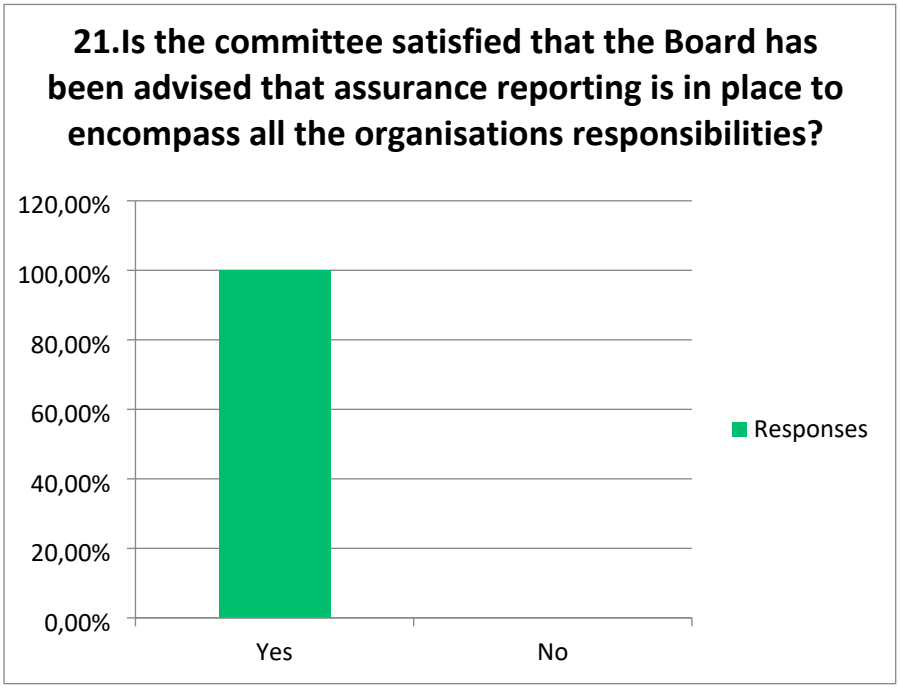


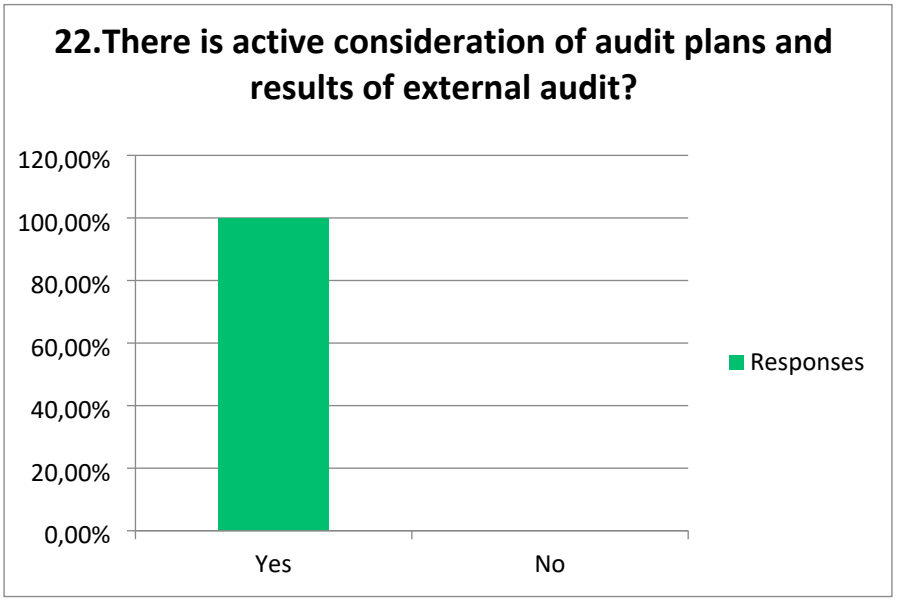
19. Has the committee reviewed whether the reports it receives (including assurance statements from the Head of Internal Audit) are timely and have the right format and content to ensure its internal control and risk management responsibilities are discha

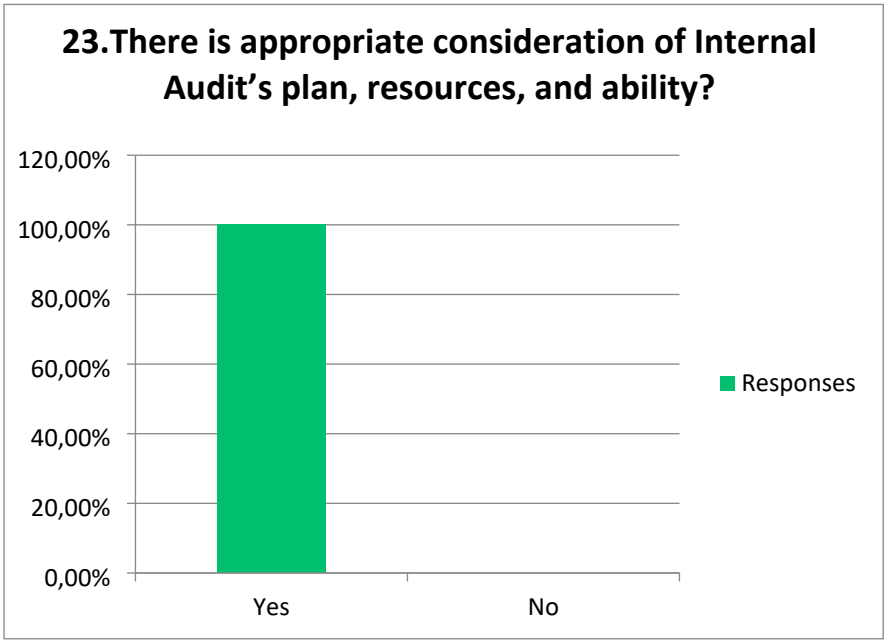


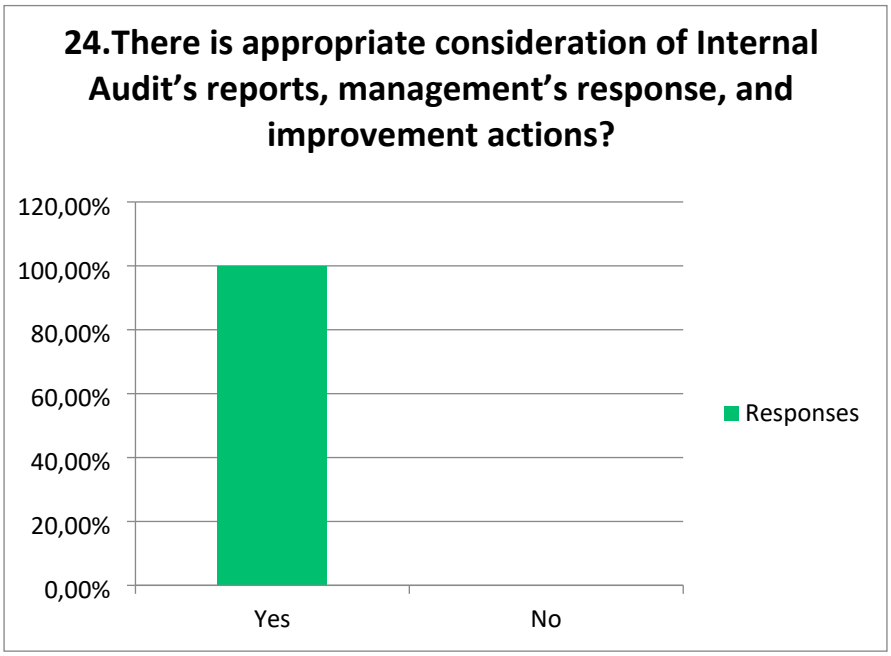
20.Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge both line management and auditors on critical and sensitive matters?

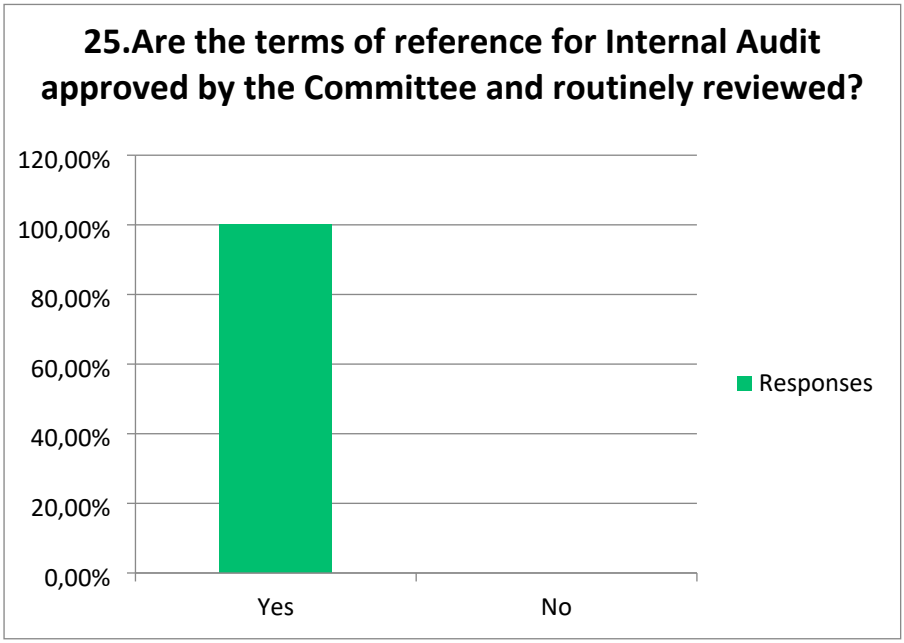






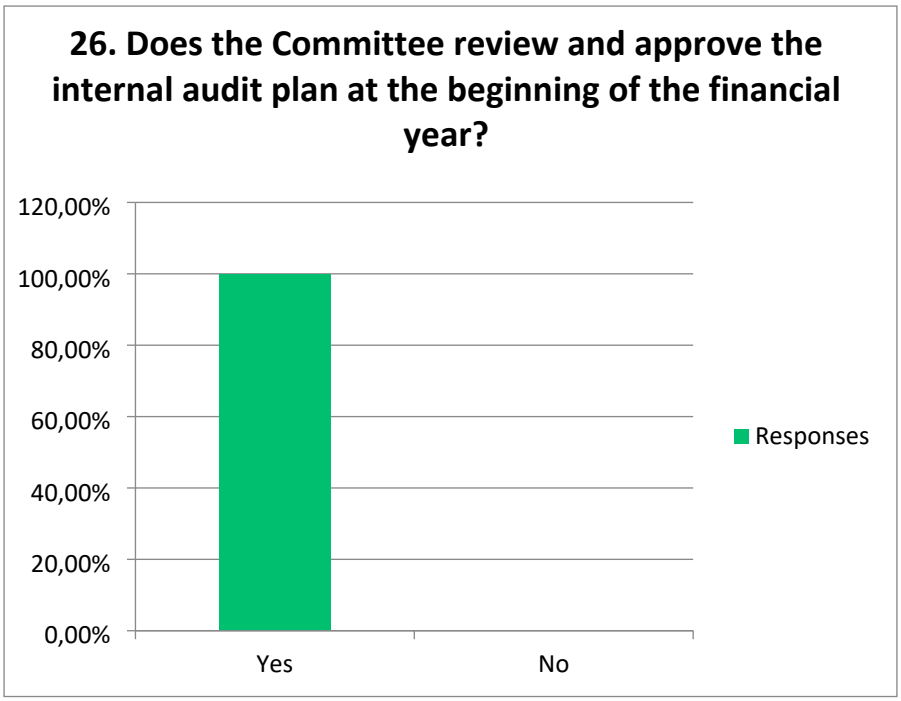


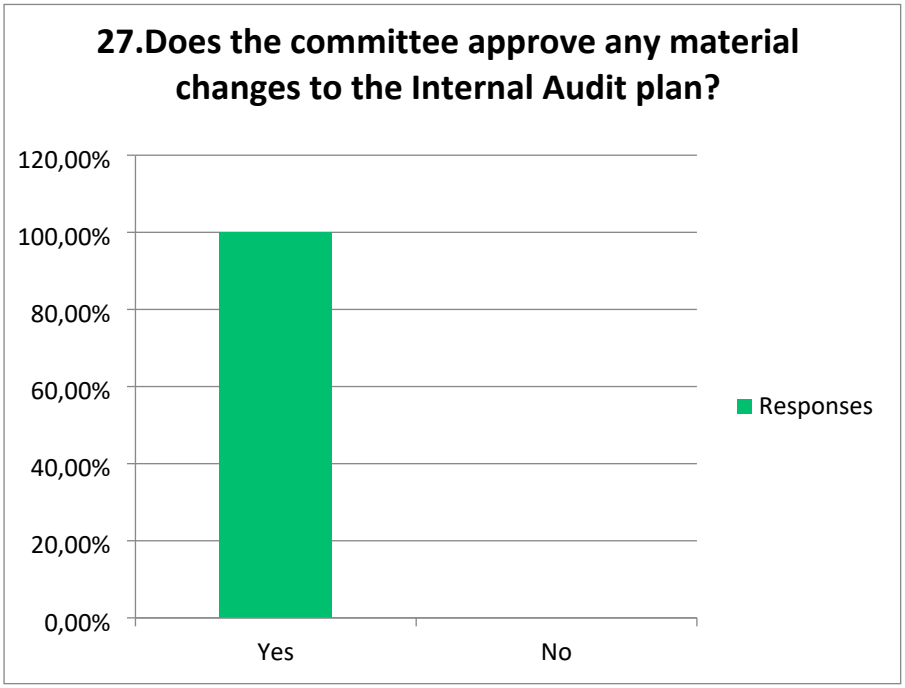




Comments received:

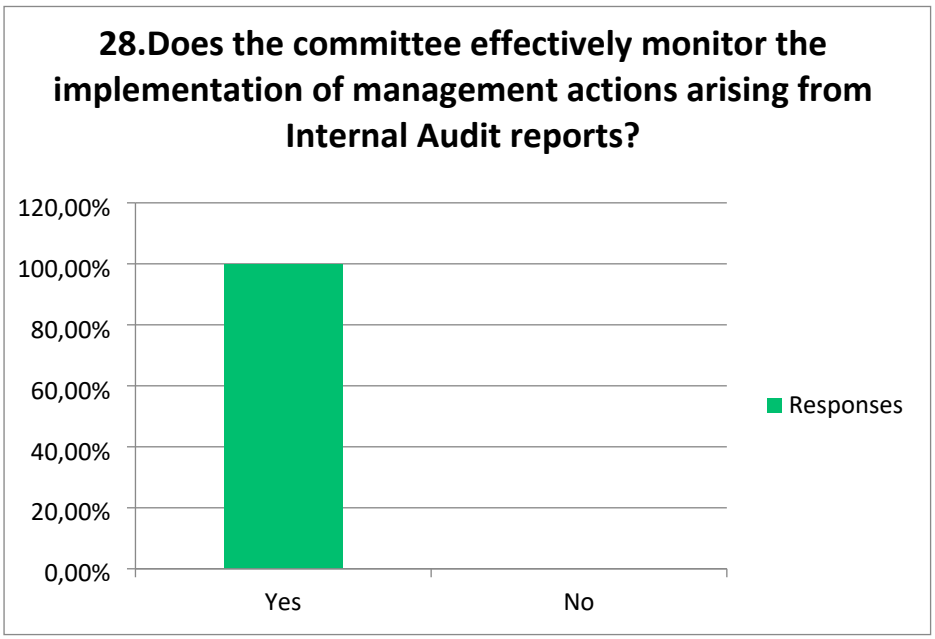
- *This is done as part of the annual plan for the year approval*





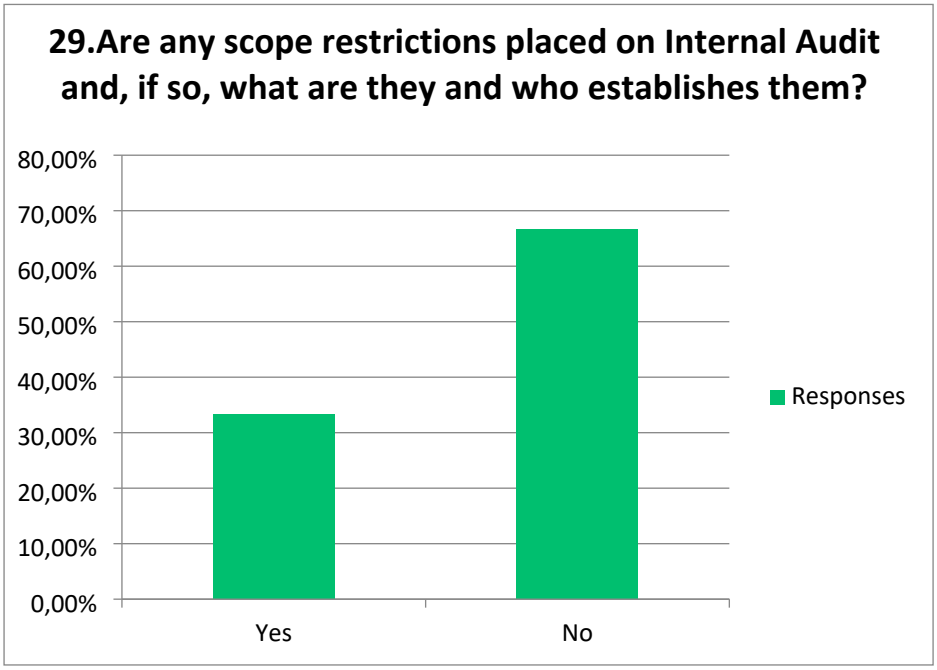
Comments received:

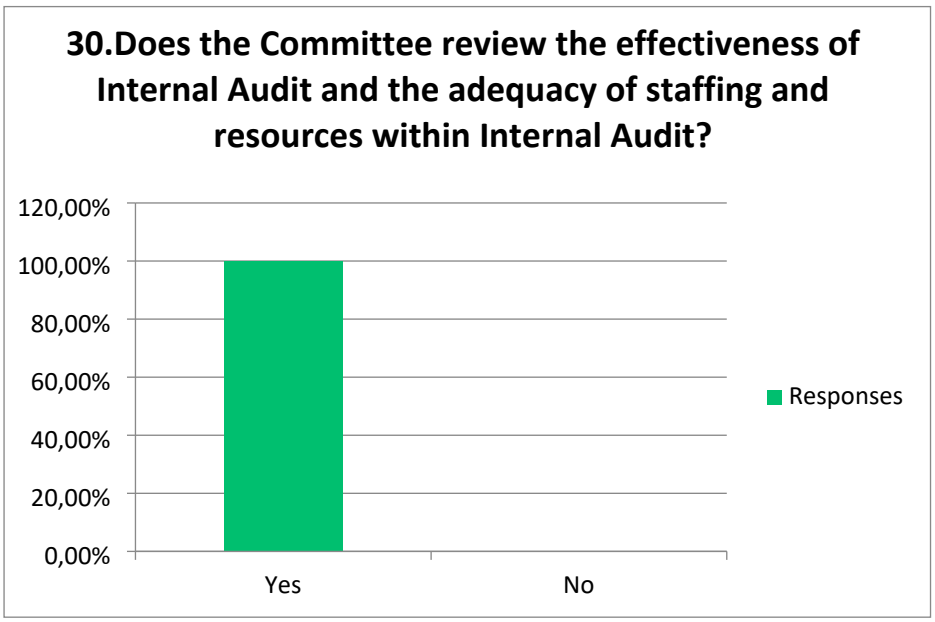
- *The Committee approved in addition to the Management Executive*

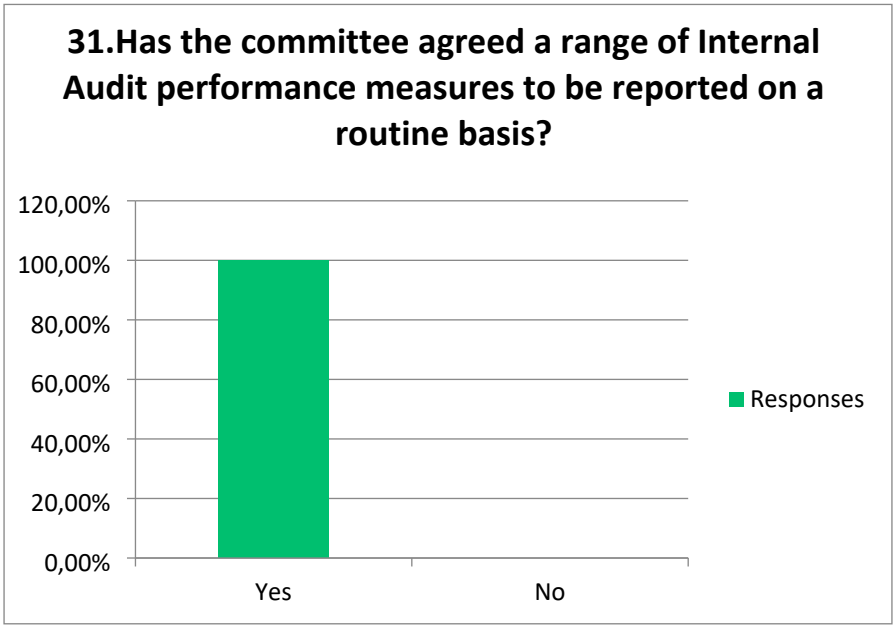


Comments received:

- *Tracking reports are presented to each Committee meeting*

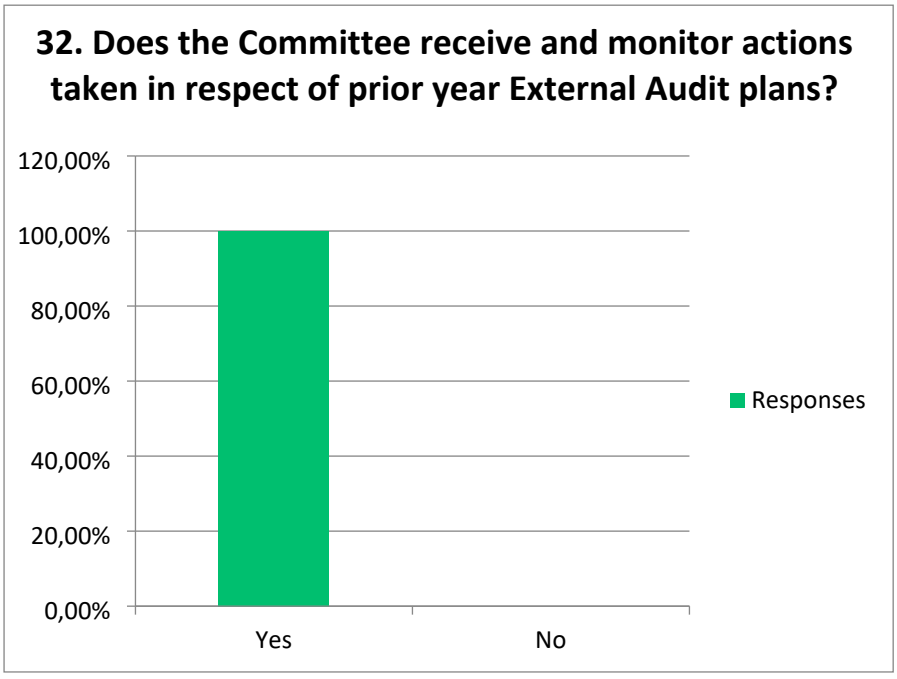






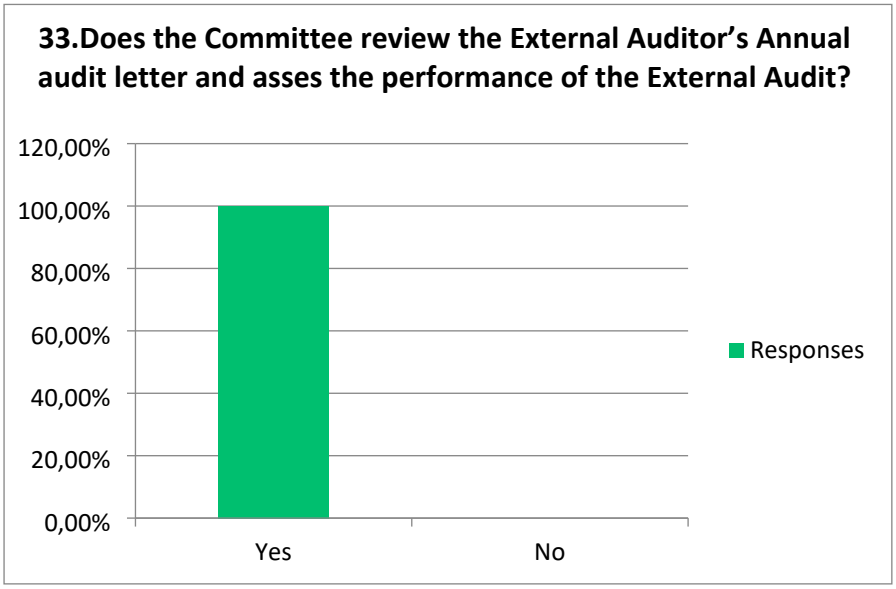
Comments received:

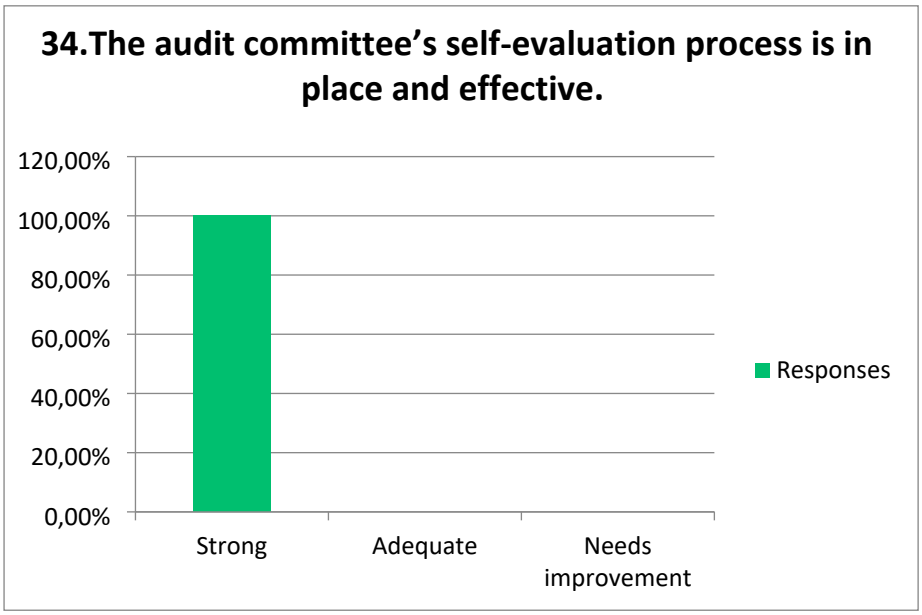
- *This is done as part of the annual planning process.*
- *Not sure.*

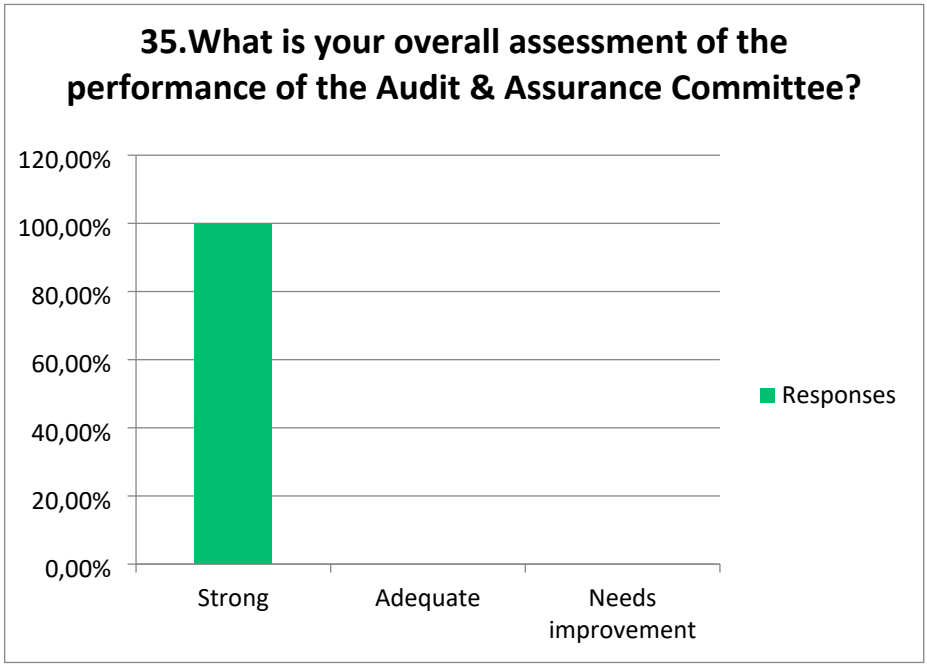


Comments received:

- *These are tracked at each Committee*





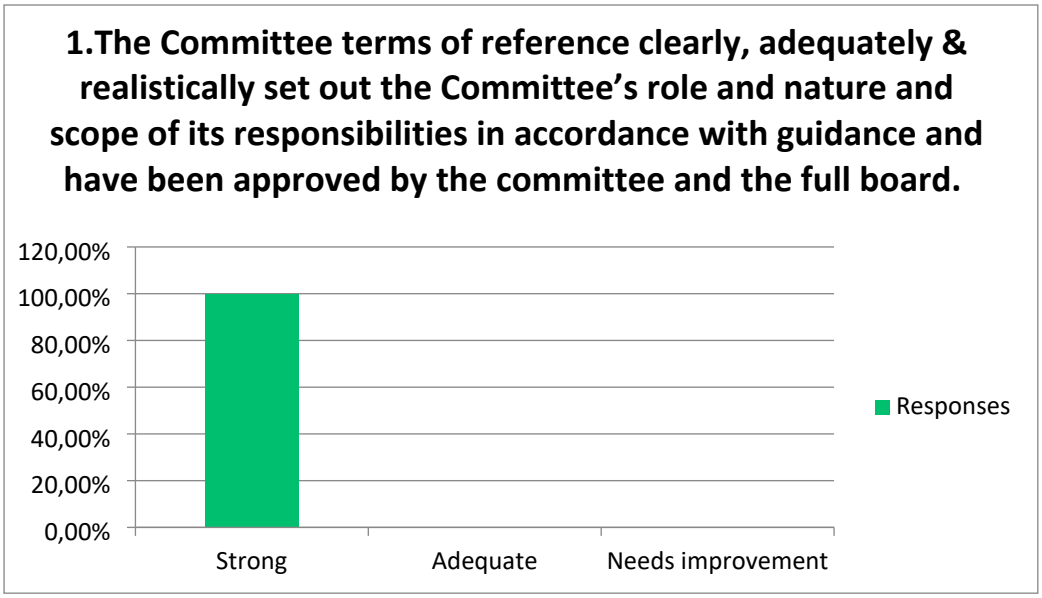


Appendix 5

Annual Board Effectiveness Survey 2020-2021

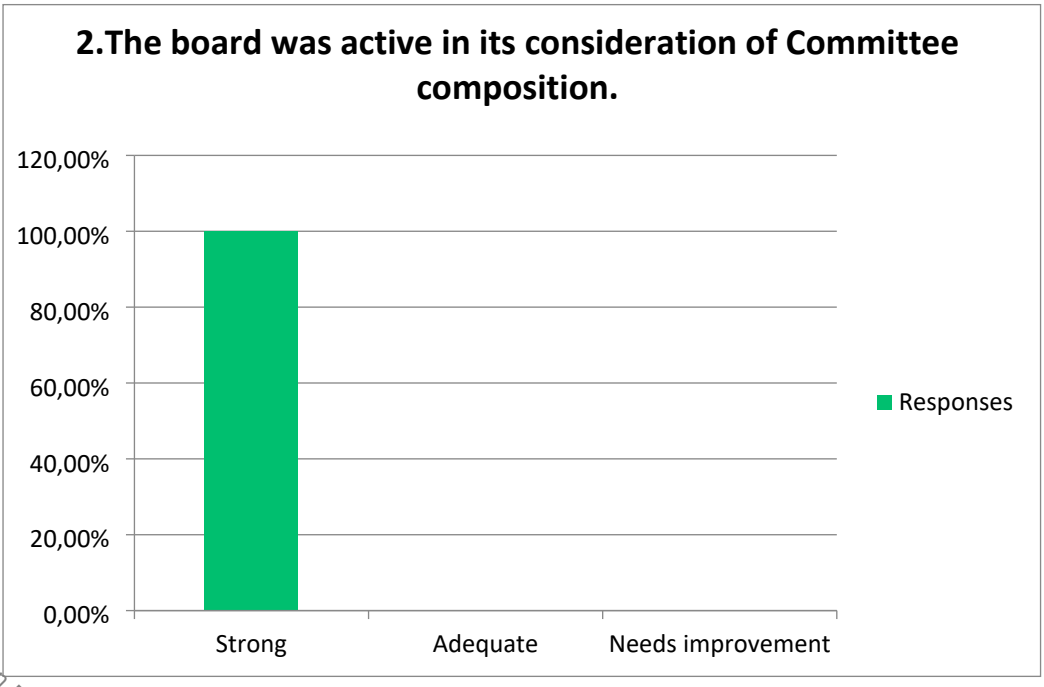
Charitable Funds Committee Self-Evaluation 2020-2021

- 5 responses received.



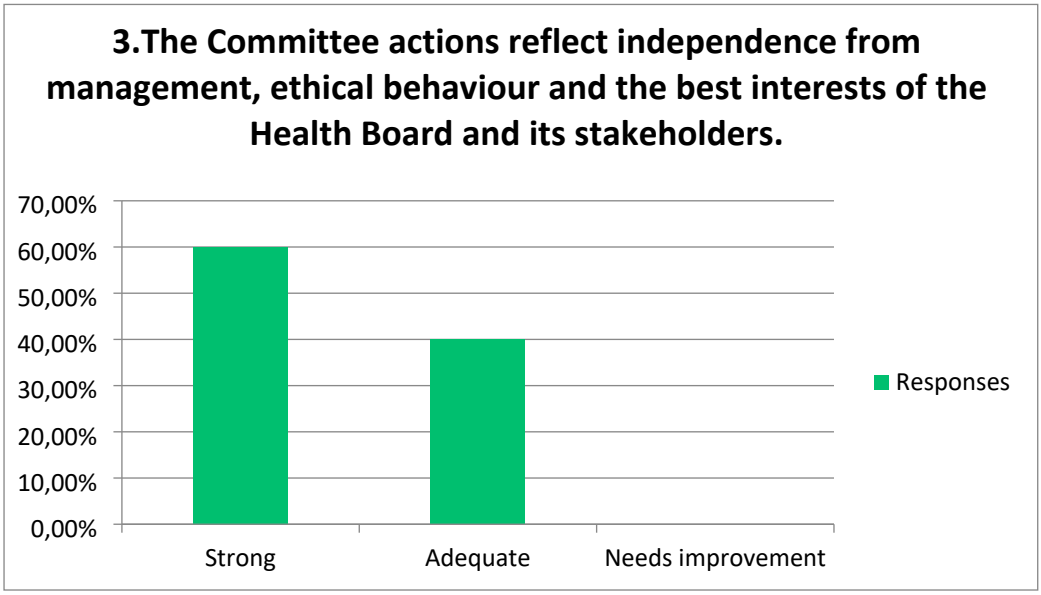
Comments received:

- *clearly set out*



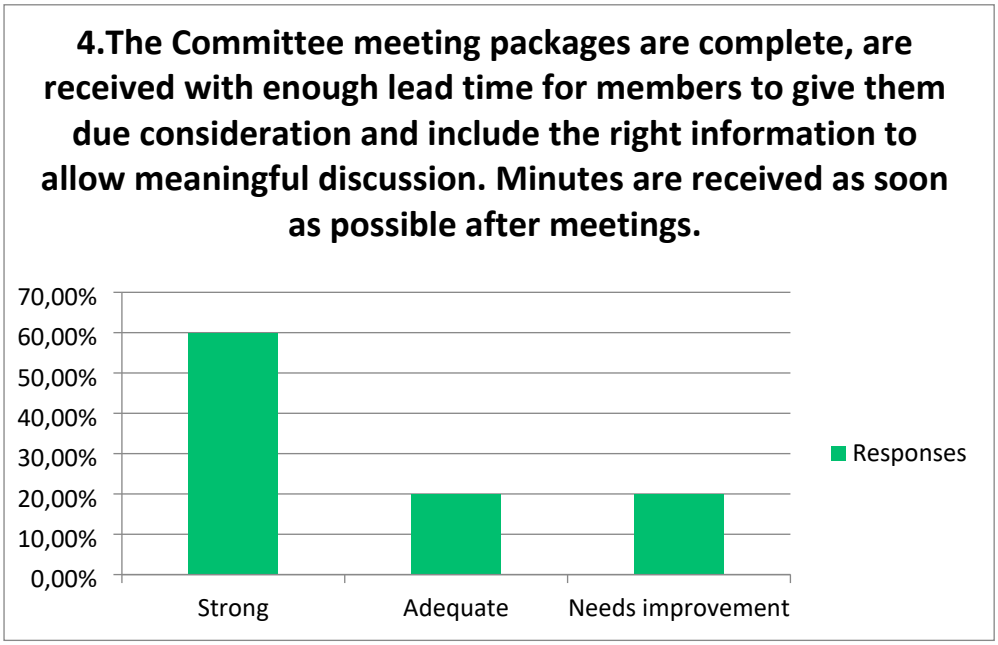
***Comments received**:*

- *Yes, membership purposefully selected*



Comments received:

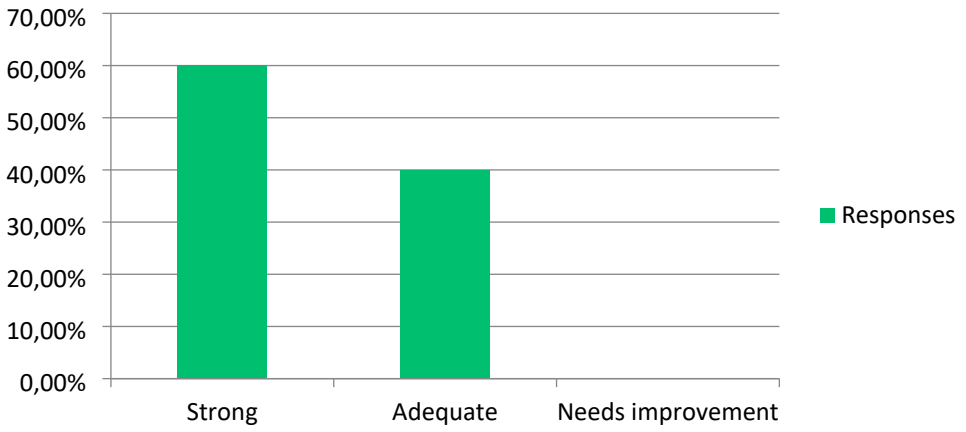
- *It has best interest of the charity at its heart.*
- *Yes, though do need to be mindful of which "hat" we are wearing.*



Comments received:

- *Timely and comprehensive.*

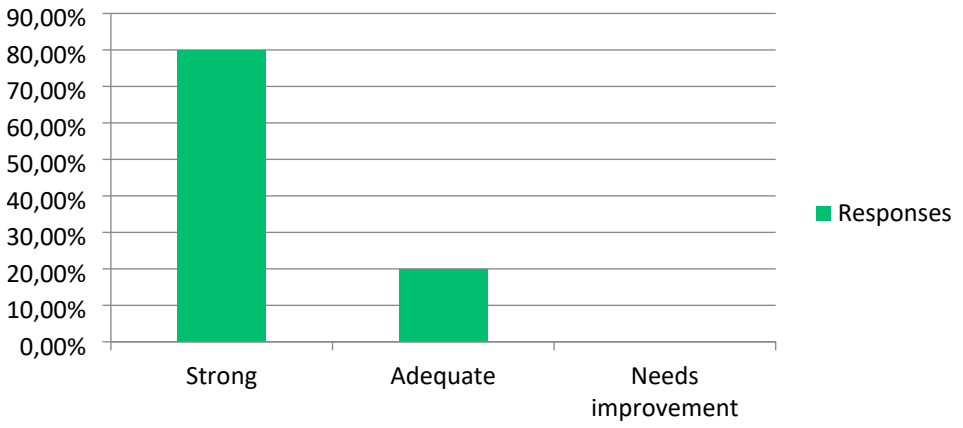
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.



Comments received:

- *Yes, they sometimes over run though.*

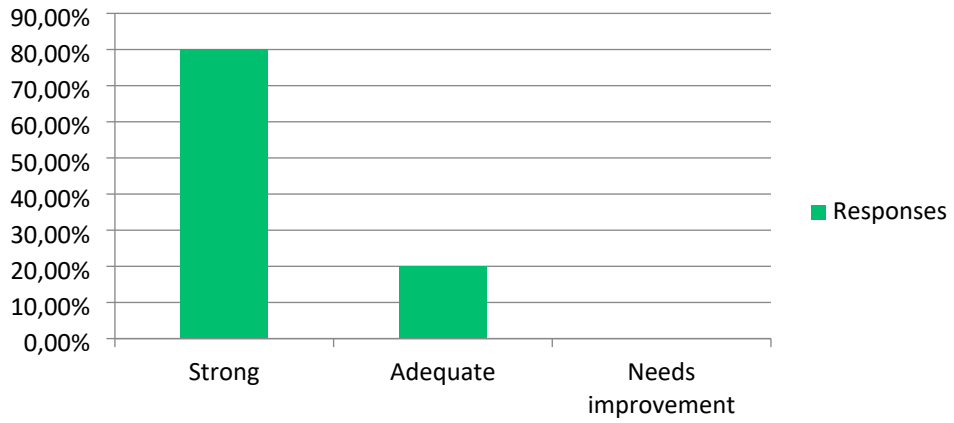
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.



Comments received:

- *Good support*

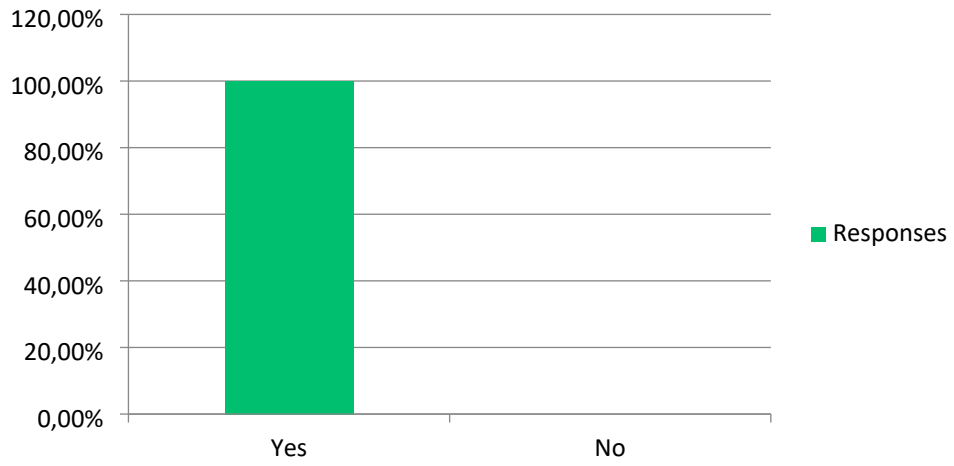
7. Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

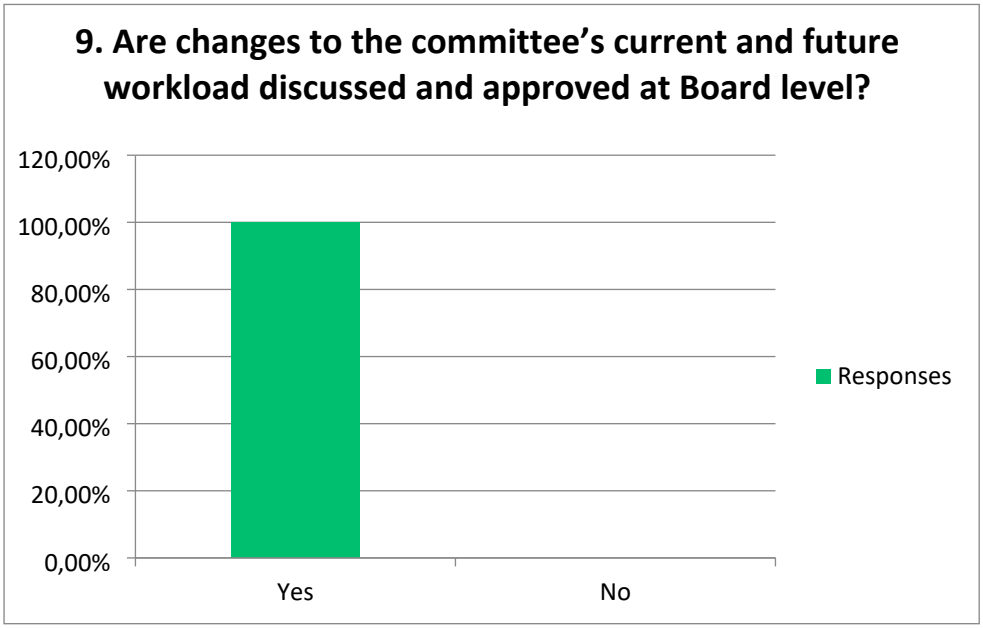


Comments received:

- *yes trustees meetings regularly held and Board updated*

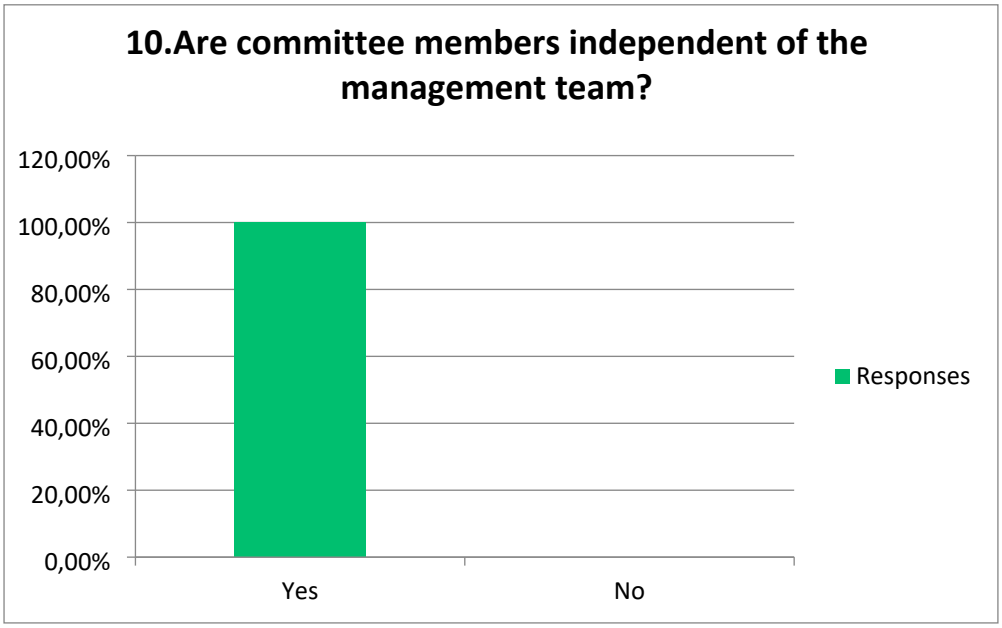
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

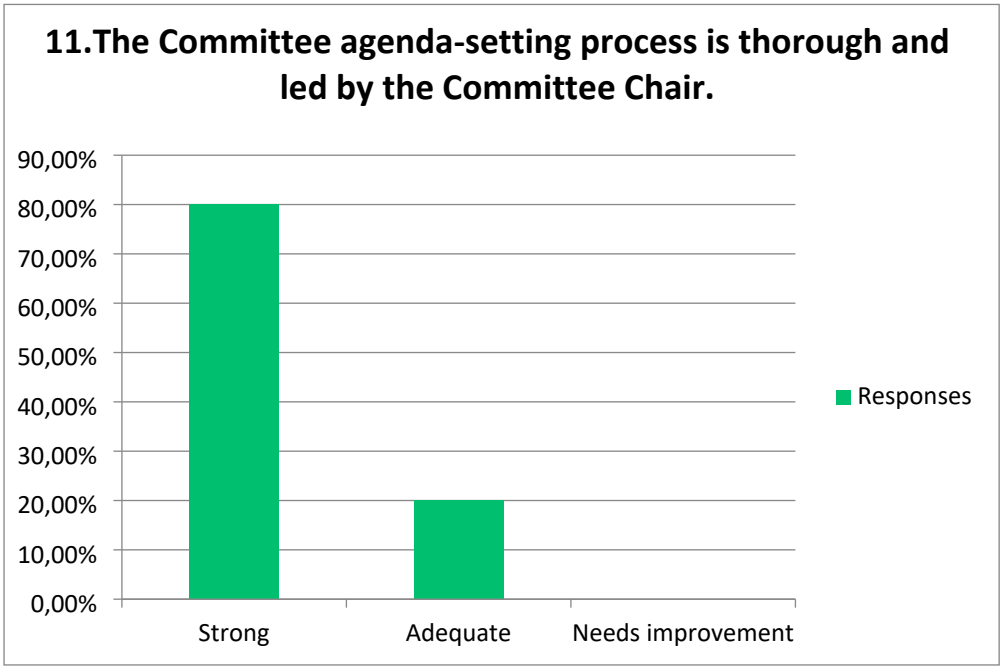




Comments received:

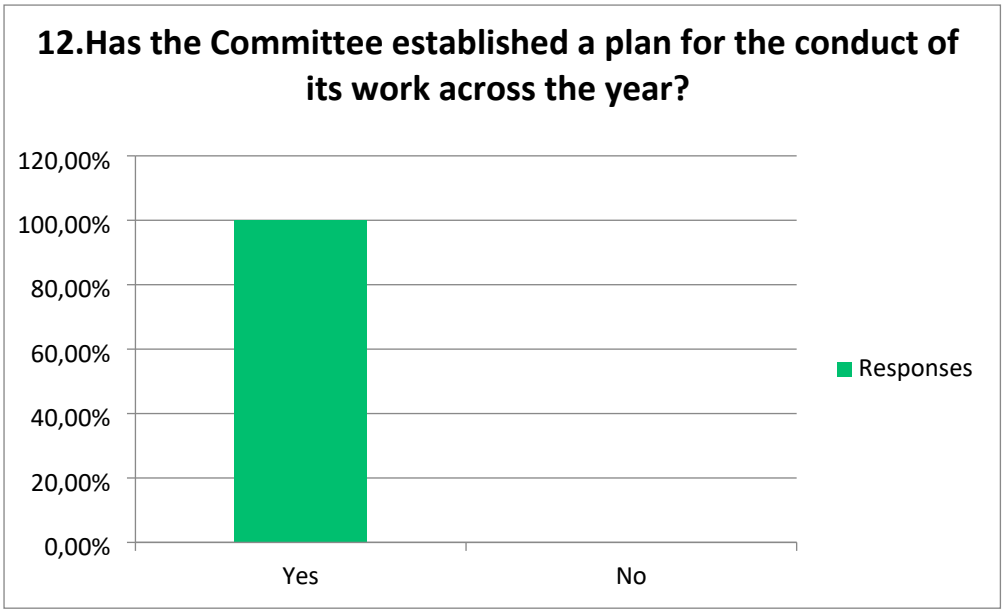
- *Cannot answer, as do not attend the meeting*
- *At the trustees meeting*





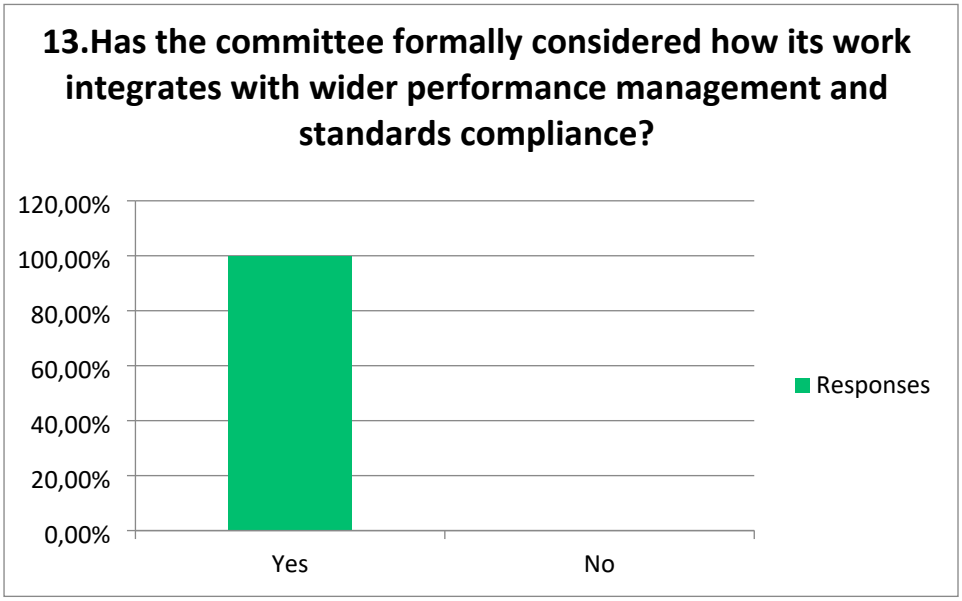
Comments received:

- *Yes in discussion with exec lead.*



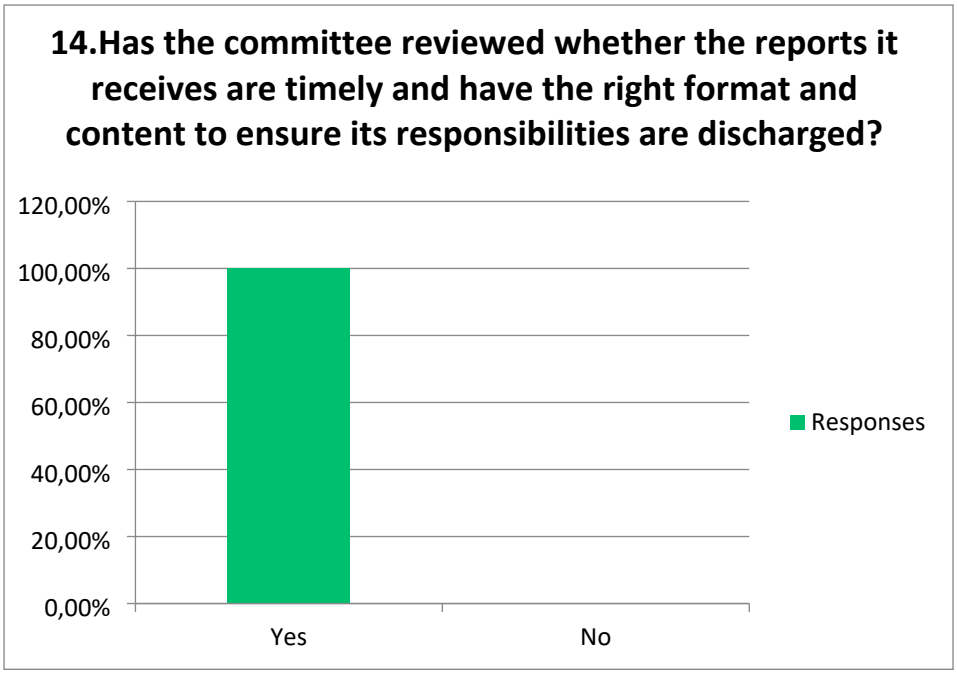
Comments received:

- *Had a good plan for this.*



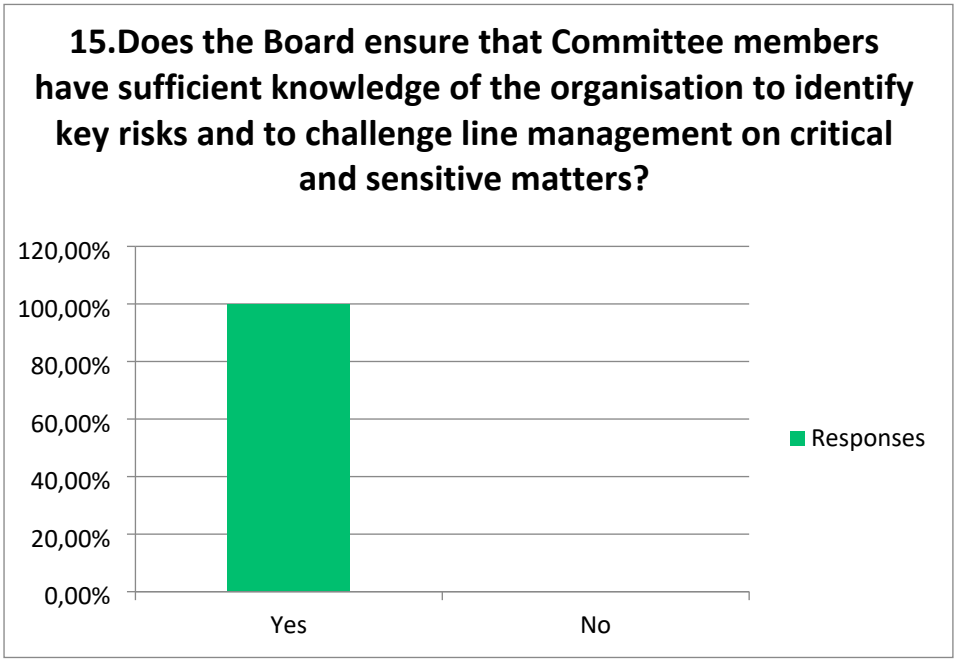
Comments received:

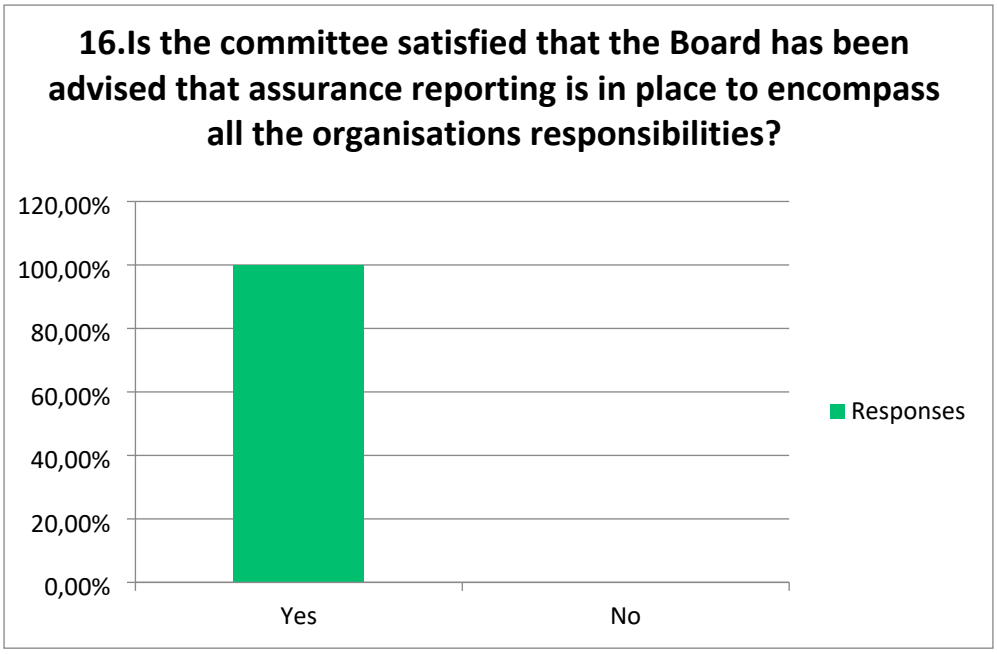
- *yes but i am not fully aware of this*



Comments received:

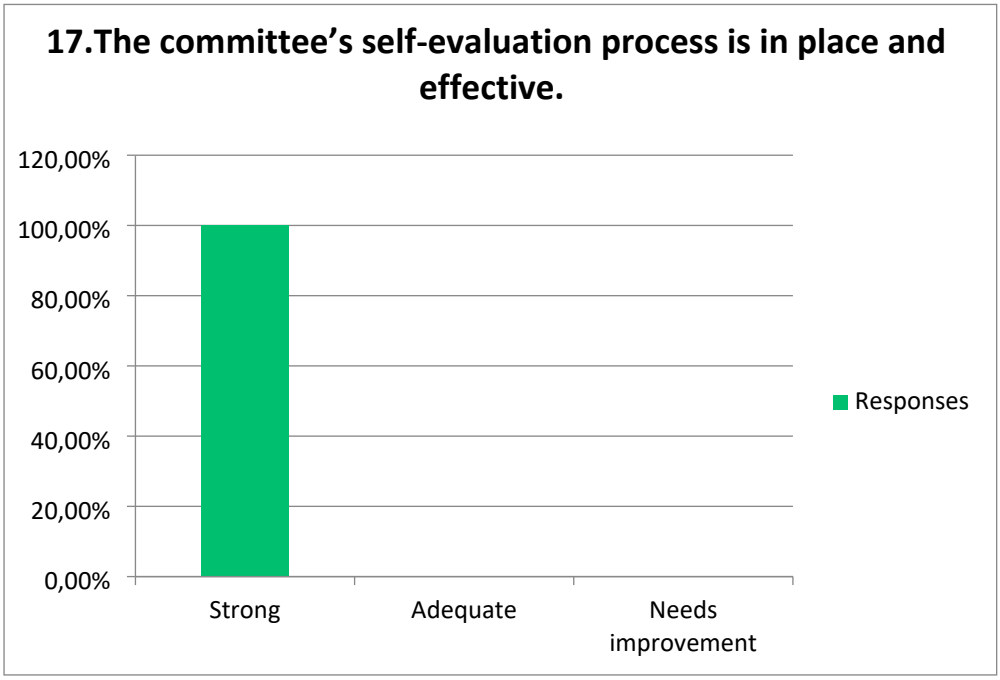
- *Good scrutiny*





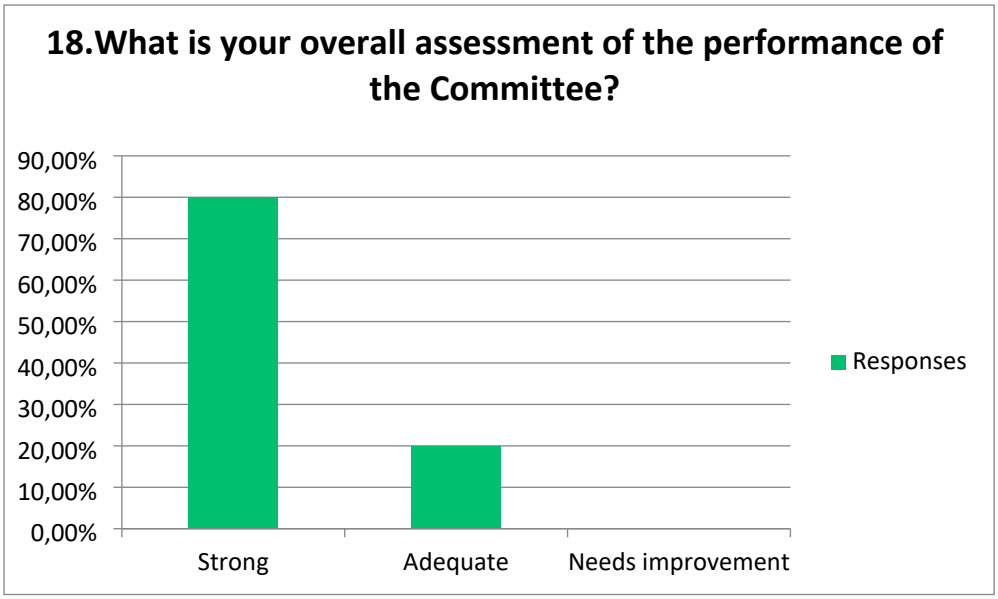
Comments received:

- *opportunity at board for lead IM to raise key issues and minutes widely shared*



Comments received:

- *All able to input to this*



Comments received:

- *Does good work with good governance*

<u>Overall Self Evaluation comments:</u>

- *Much improved in last 2 years*

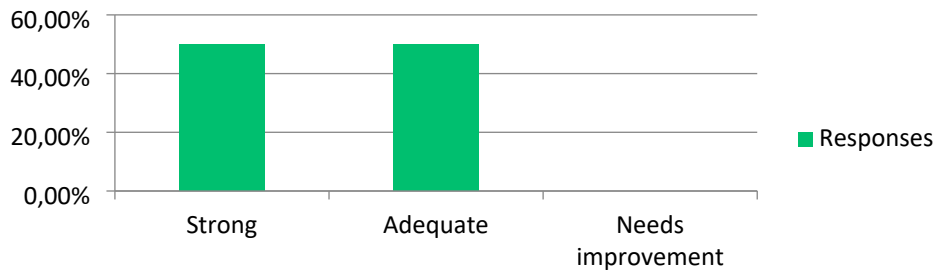
Appendix 6

Annual Board Effectiveness Survey 2020-2021

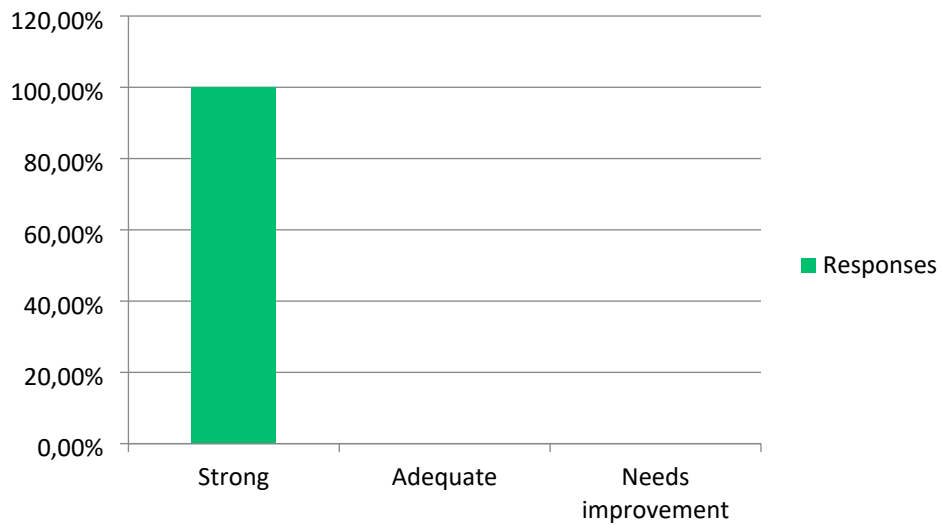
Digital & Health Intelligence Committee Self Evaluation 2020-2021

- 2 responses received

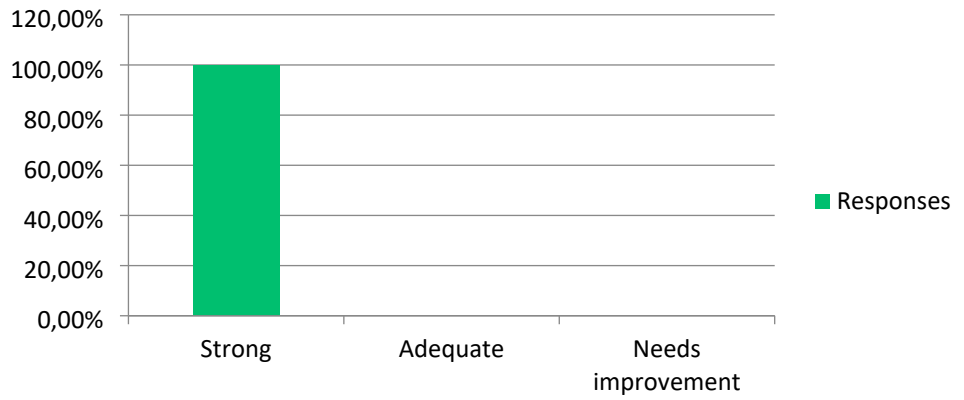
1. The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full board.



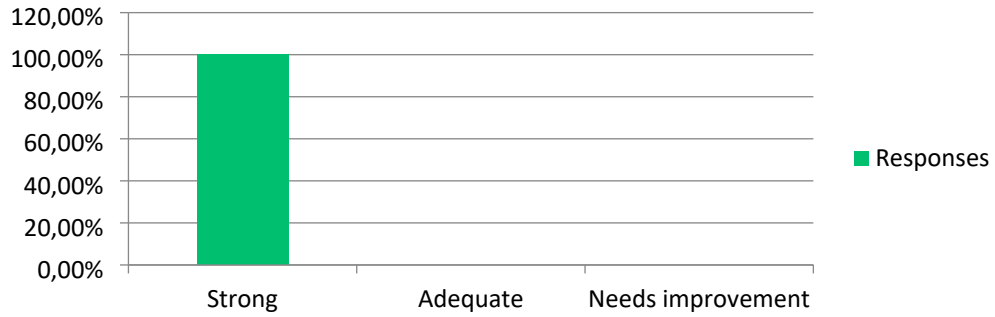
2.The board was active in its consideration of Committee composition.



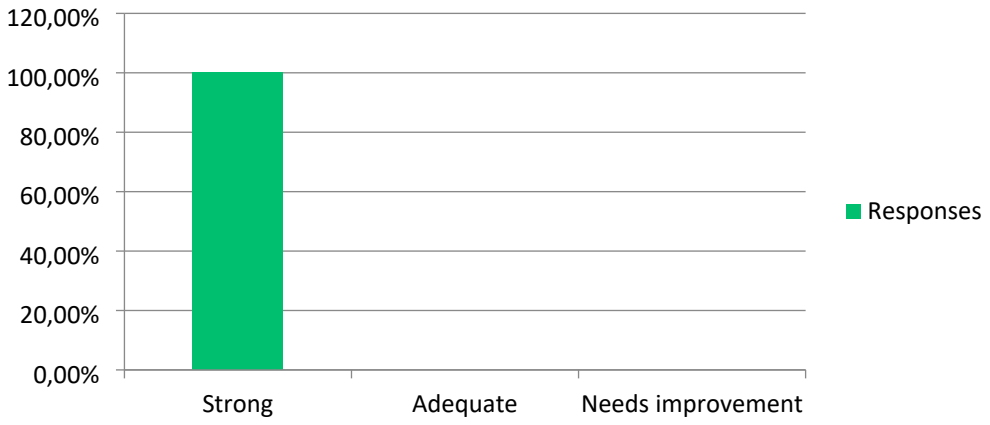
3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



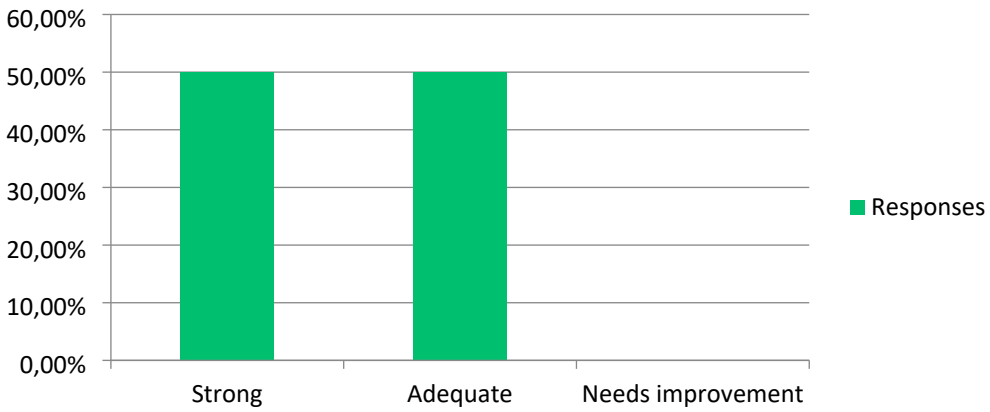
4. The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



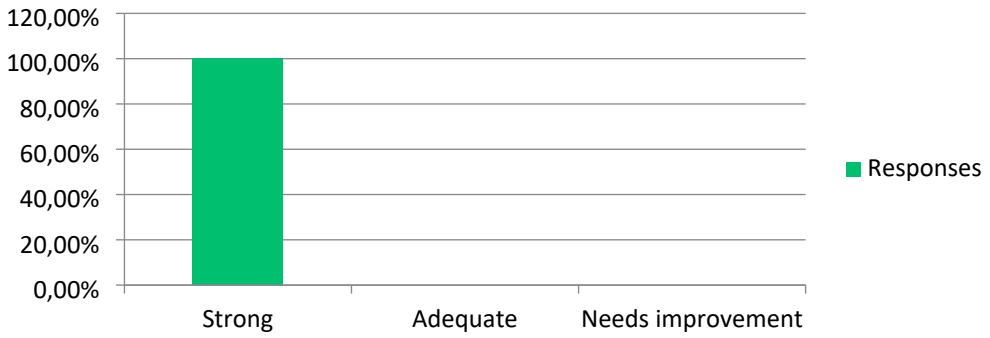
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.



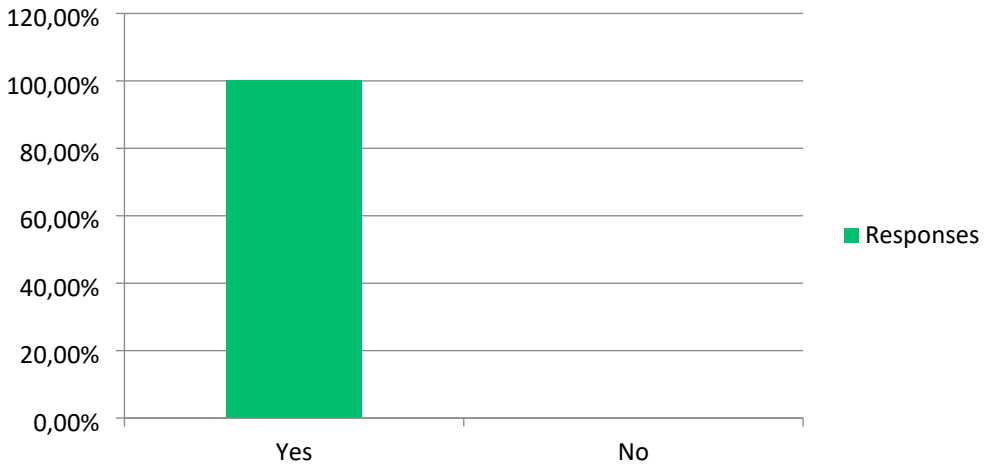
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

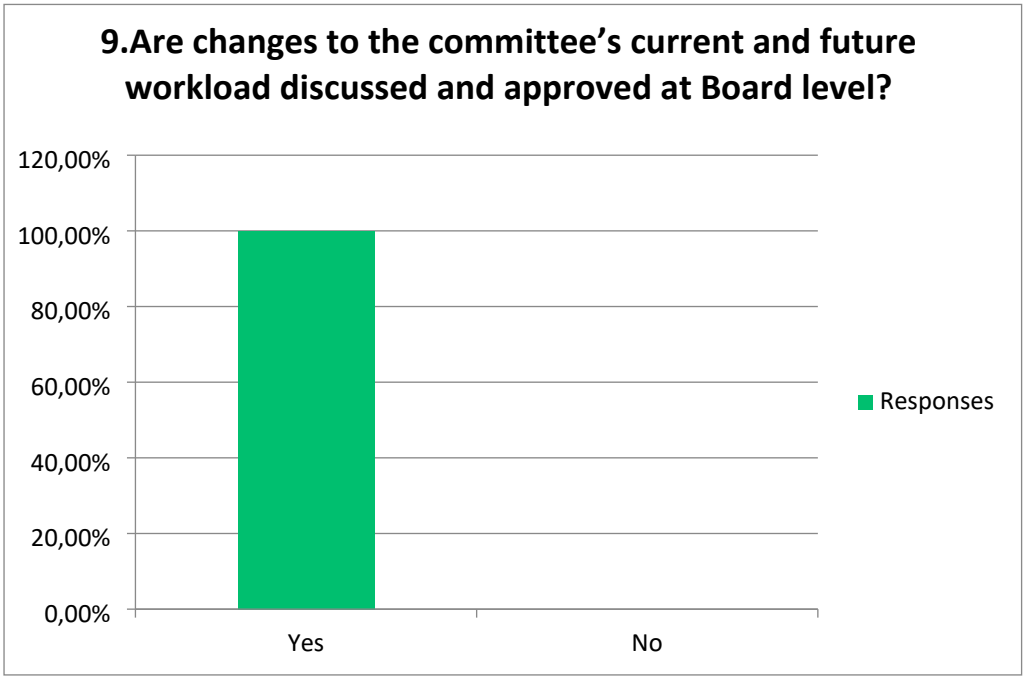


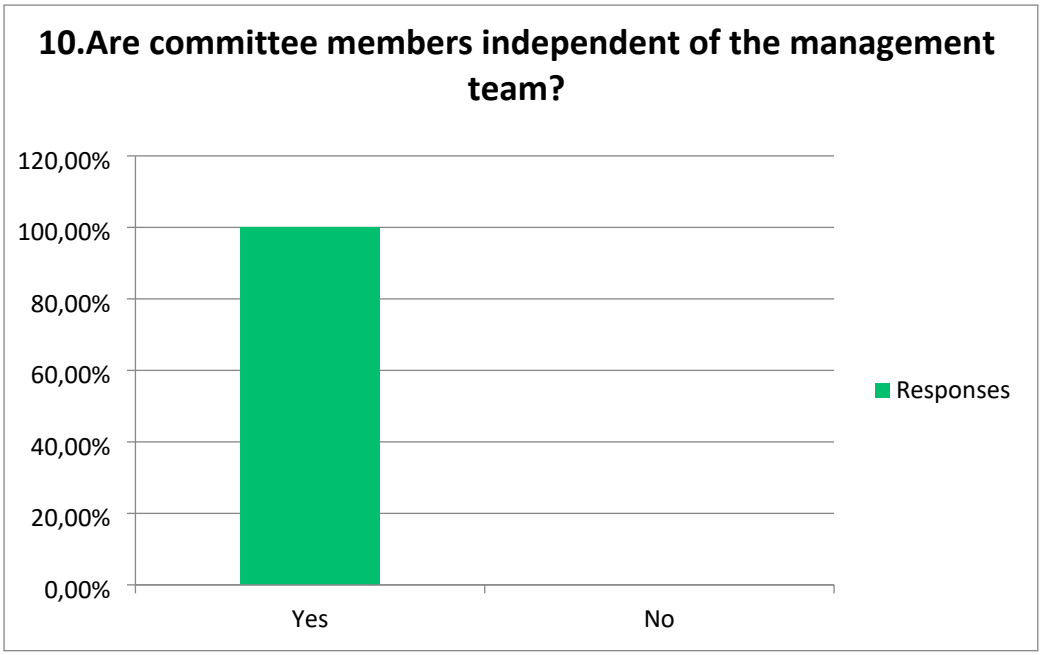
7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

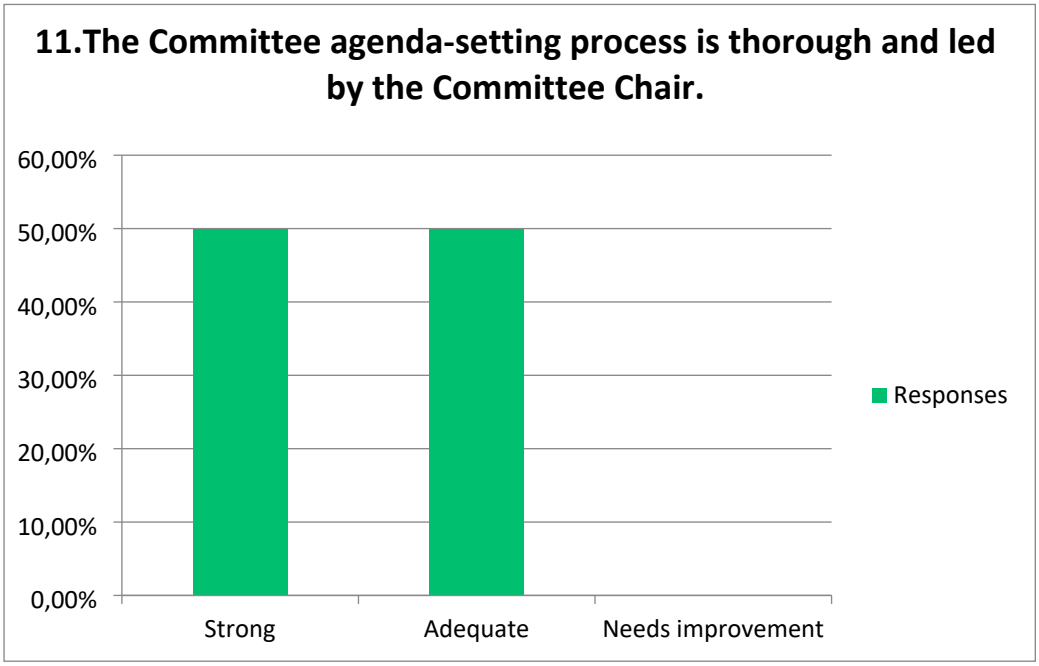


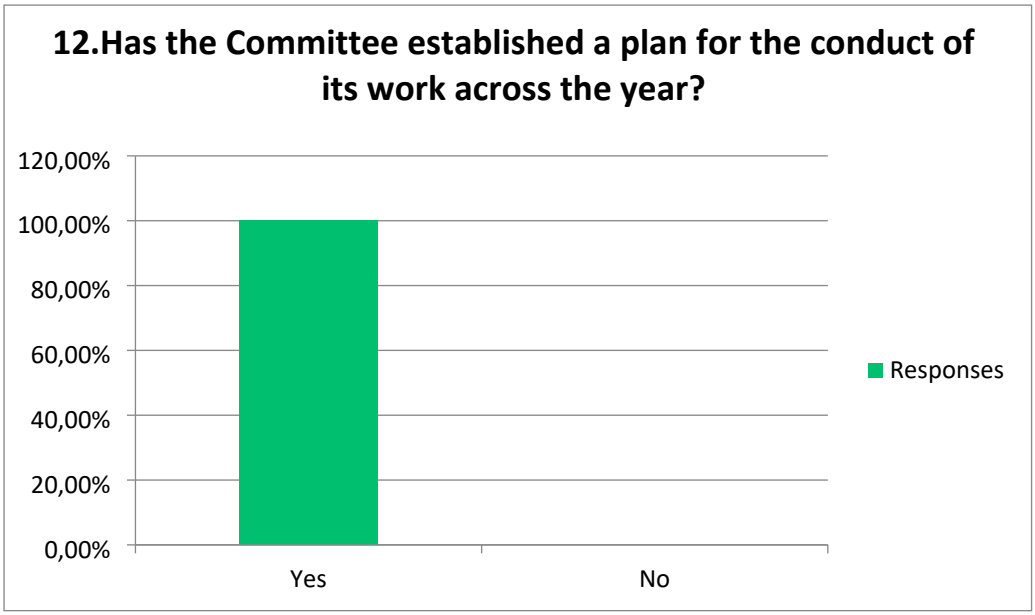
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

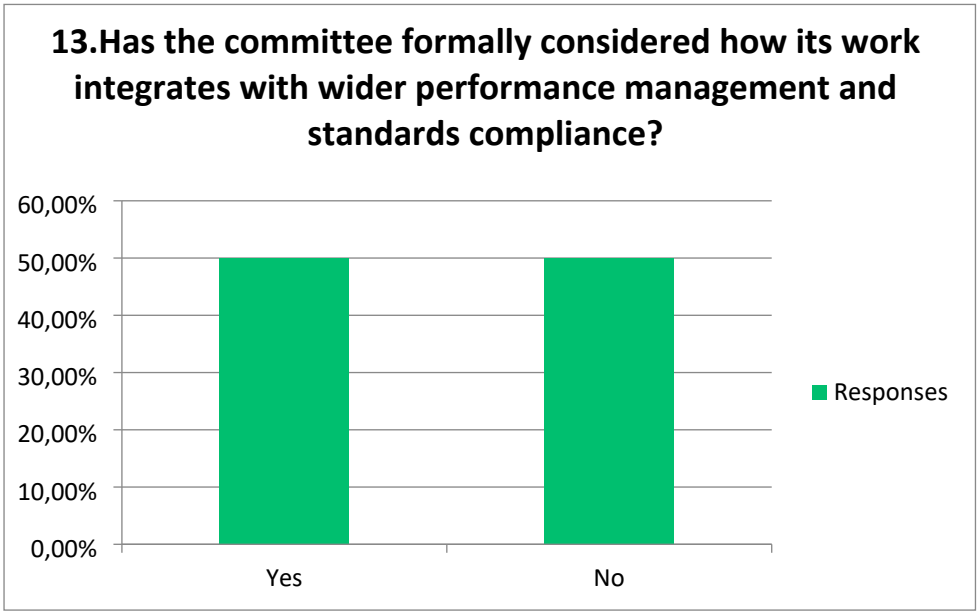


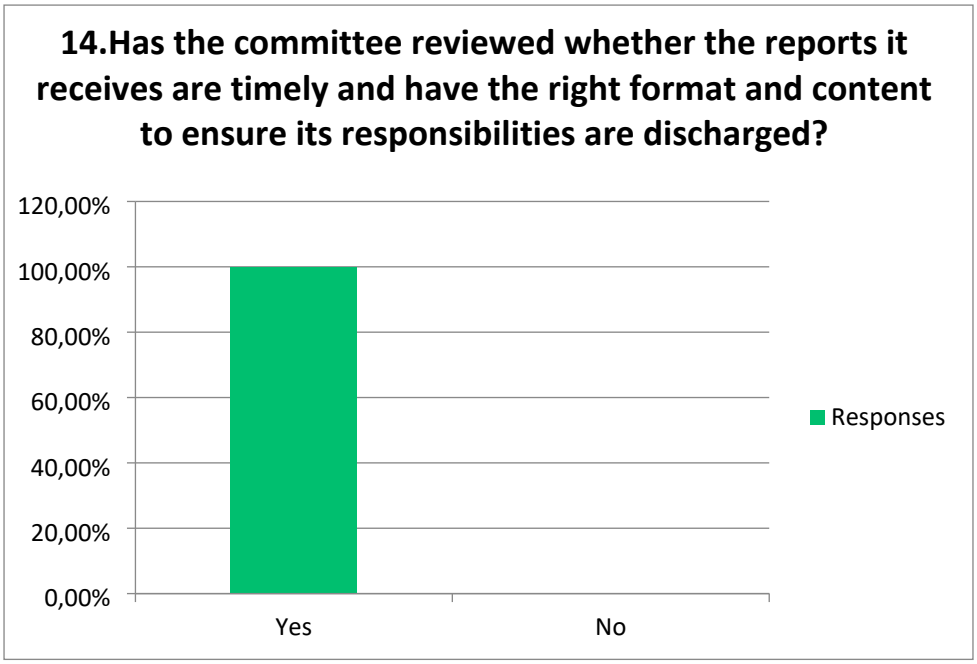




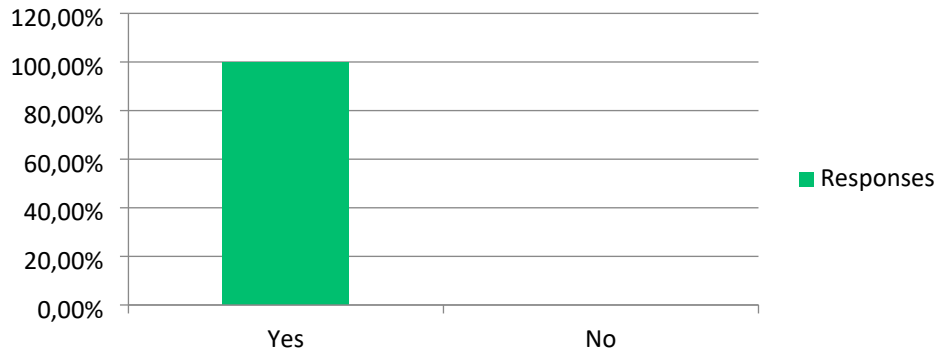




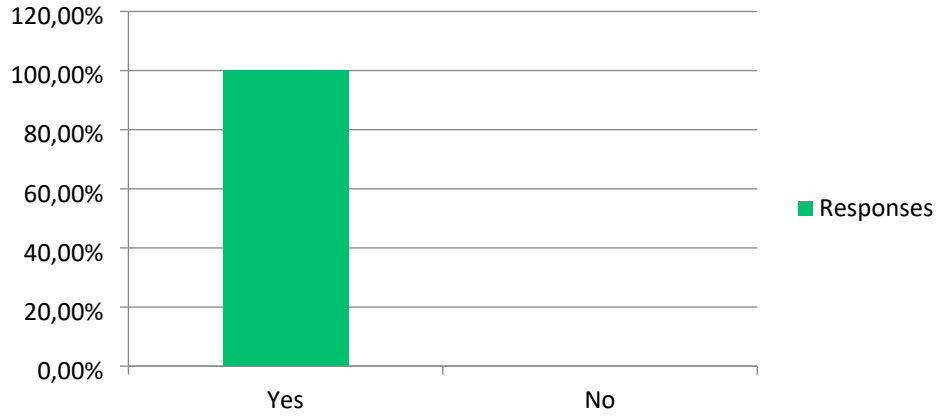


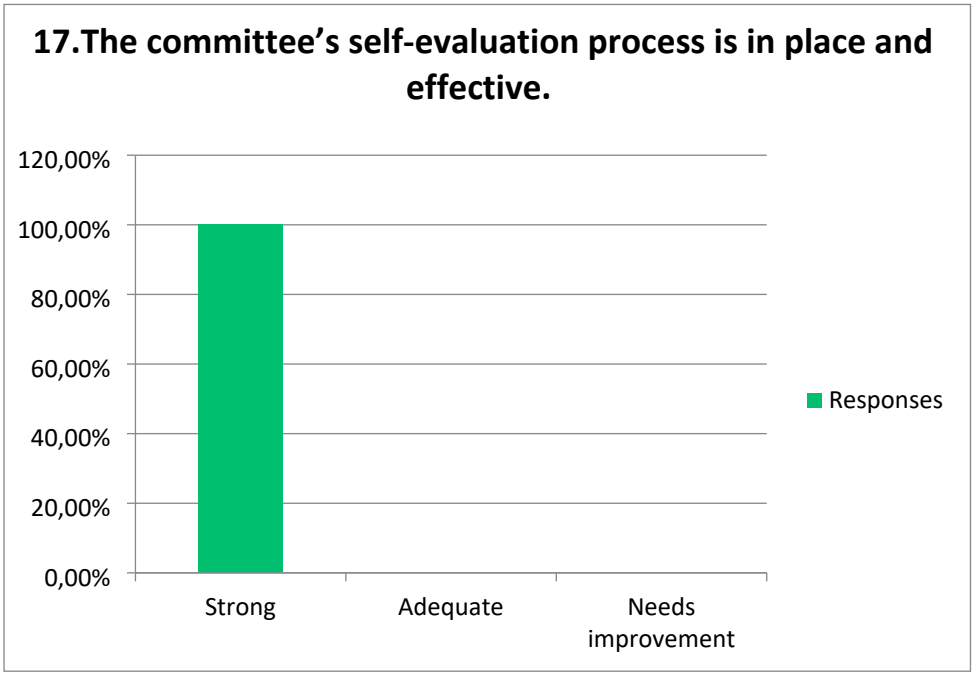


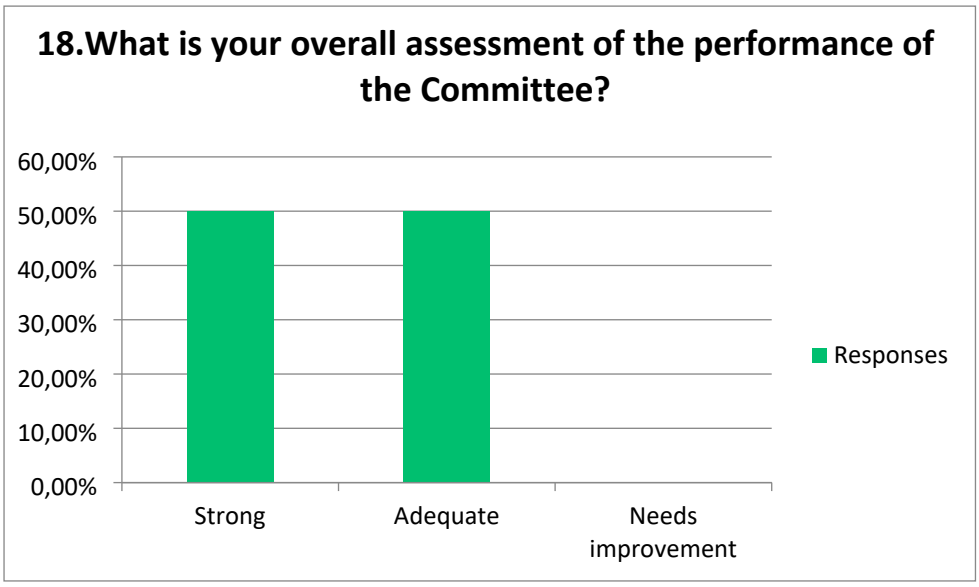
15.Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?



16.Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?







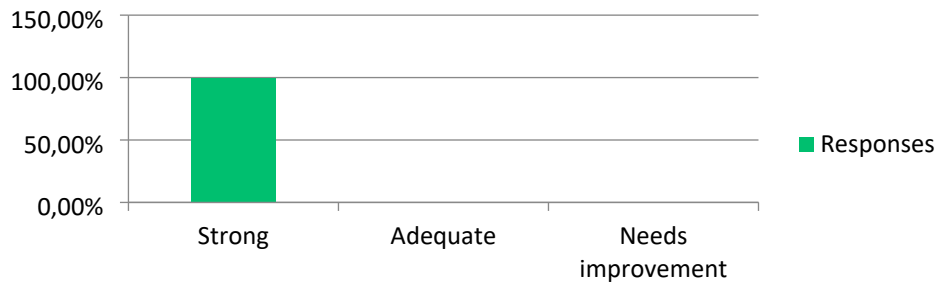
Appendix 7

Annual Board Effectiveness Survey 2020-2021

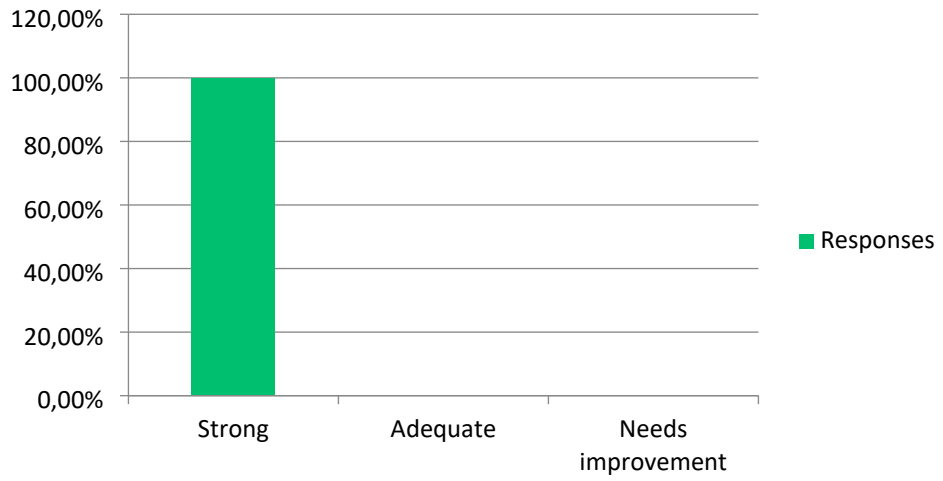
Finance Committee Self Evaluation 2020-2021

- 4 responses received

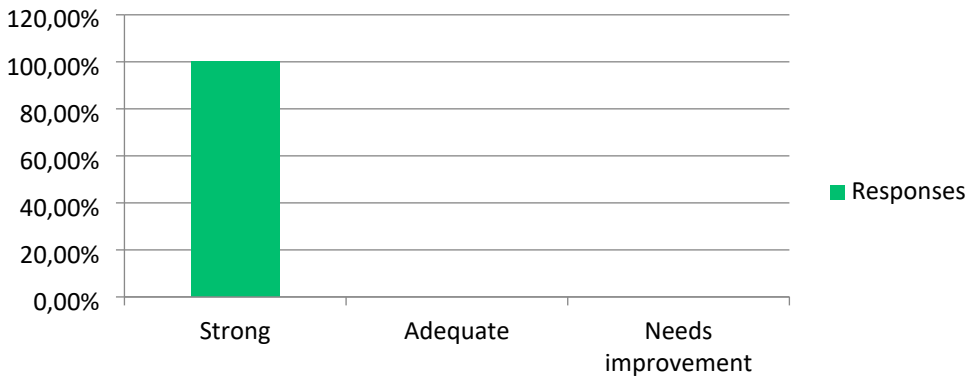
1.The Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full board.



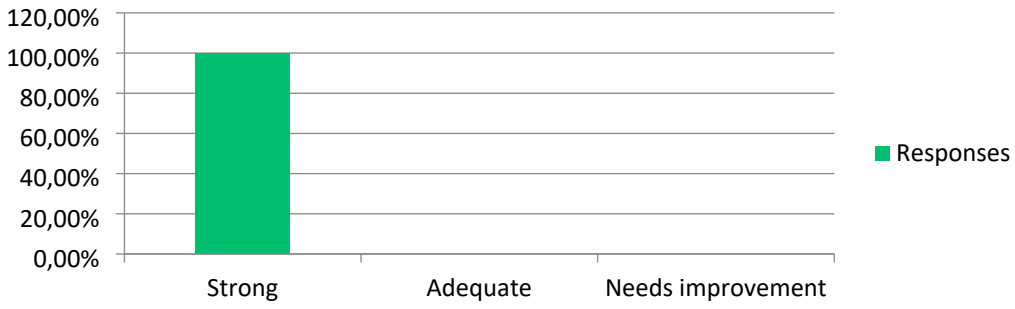
2.The board was active in its consideration of Committee composition.



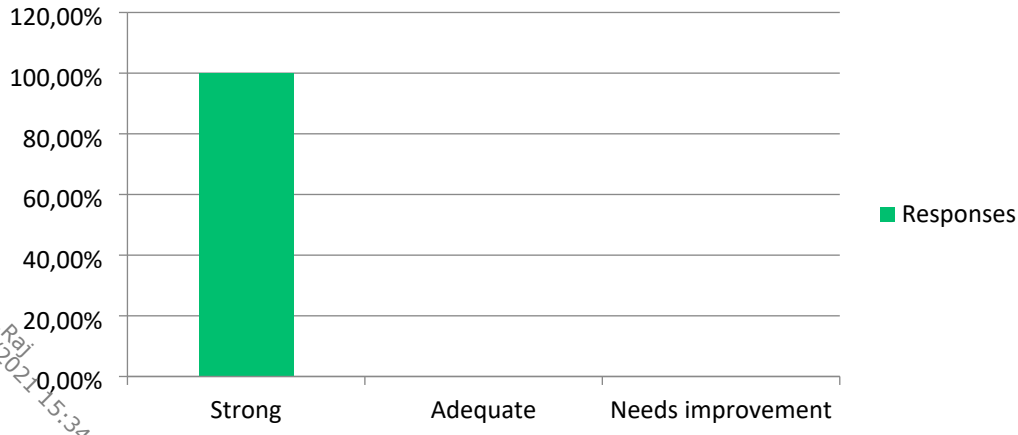
3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



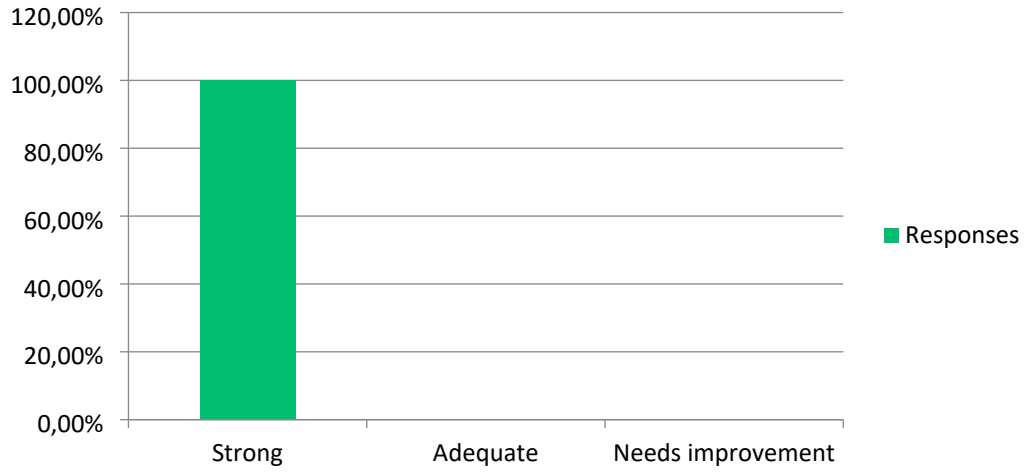
4.The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



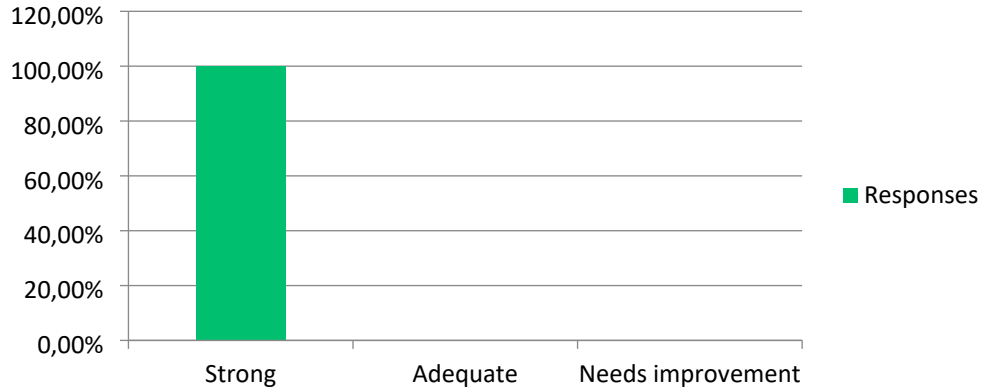
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.

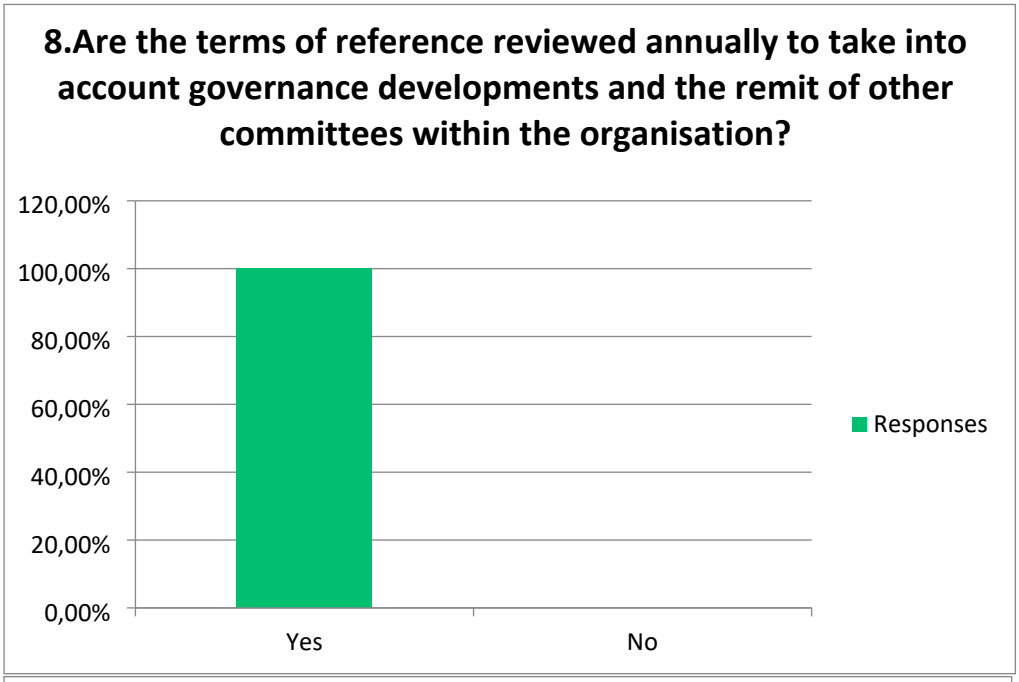


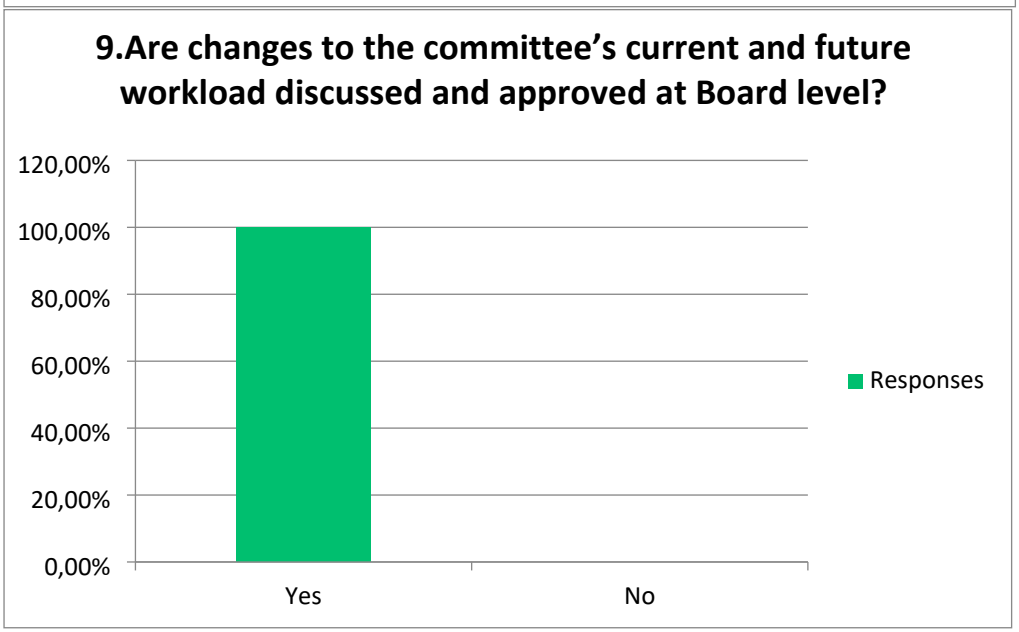
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

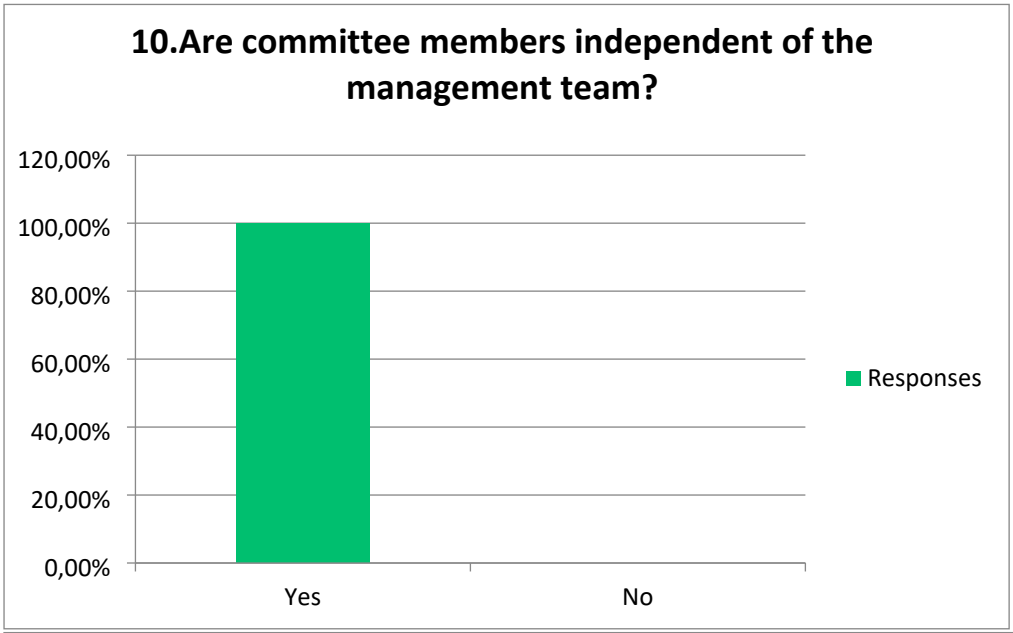


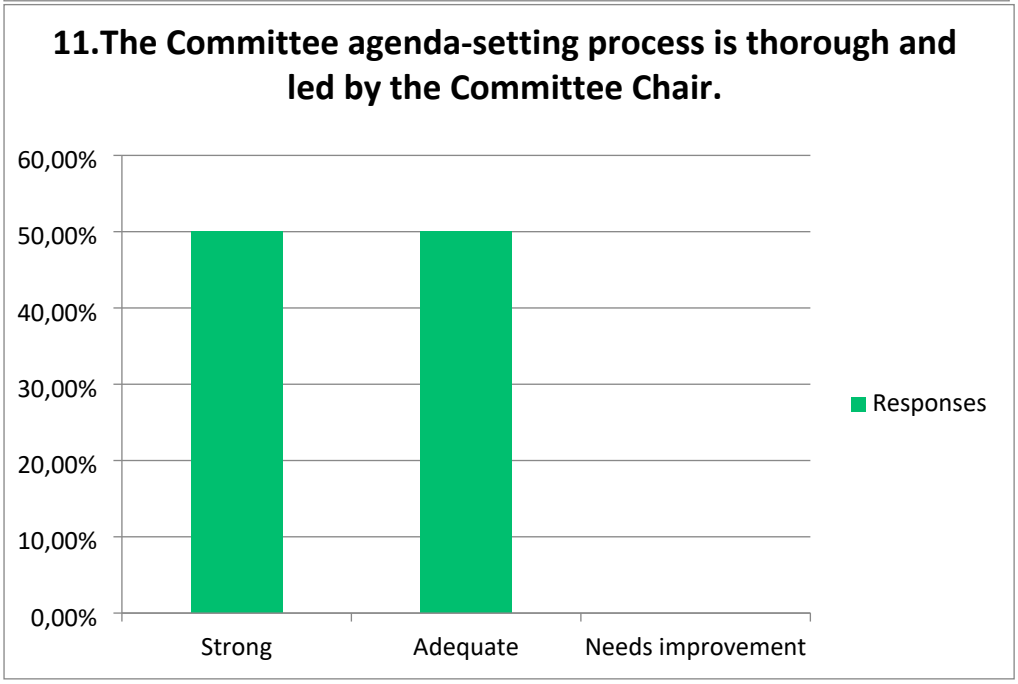
7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

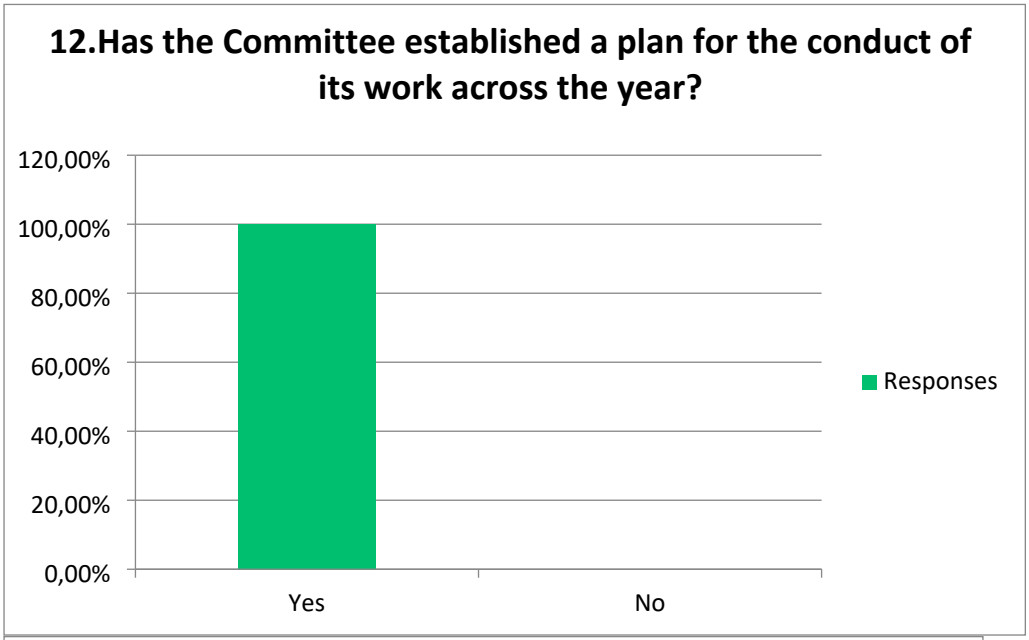


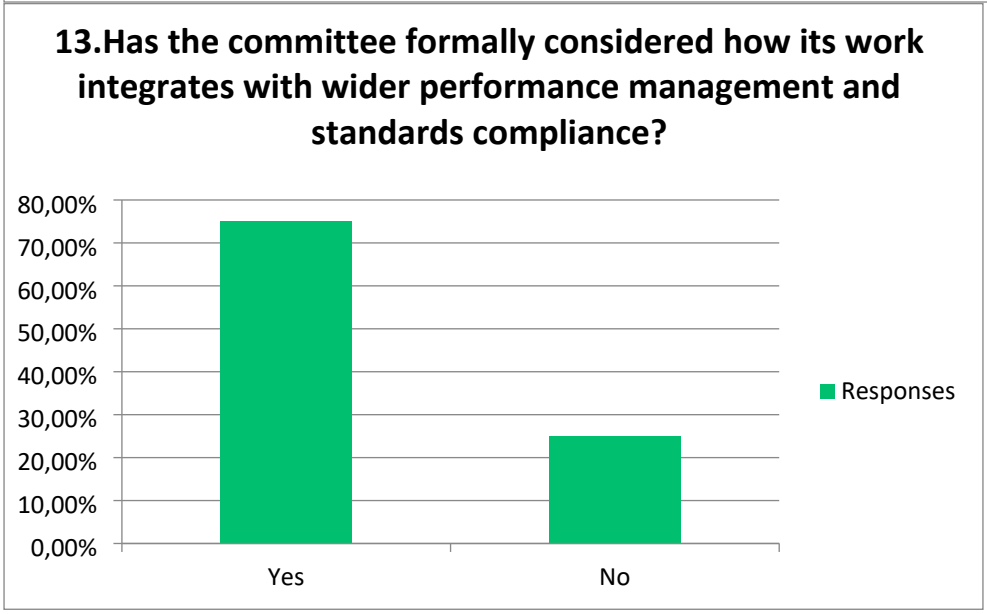


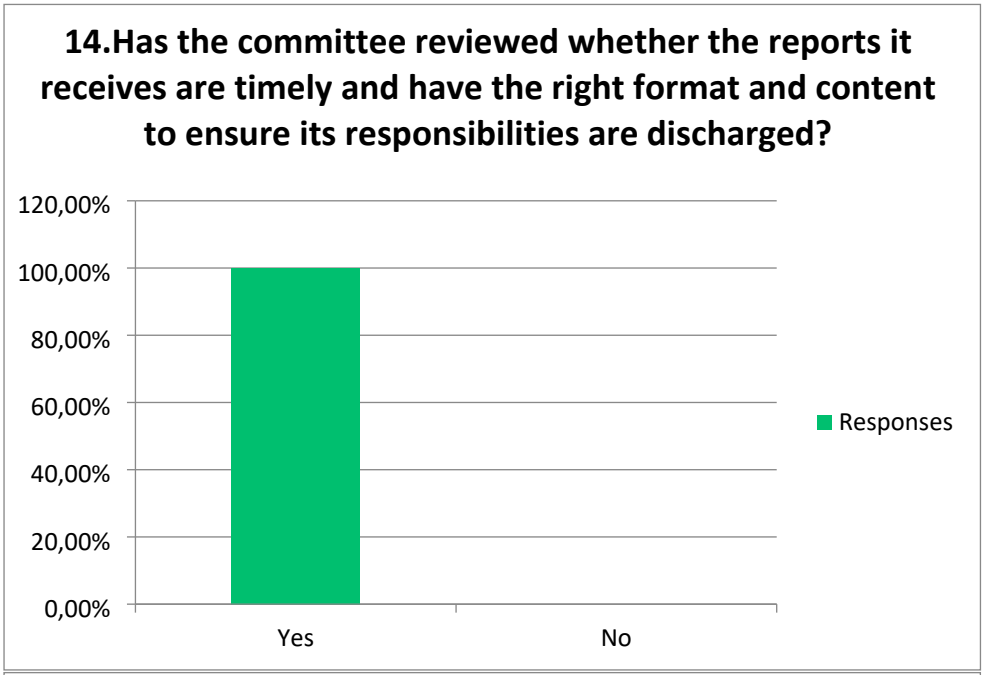


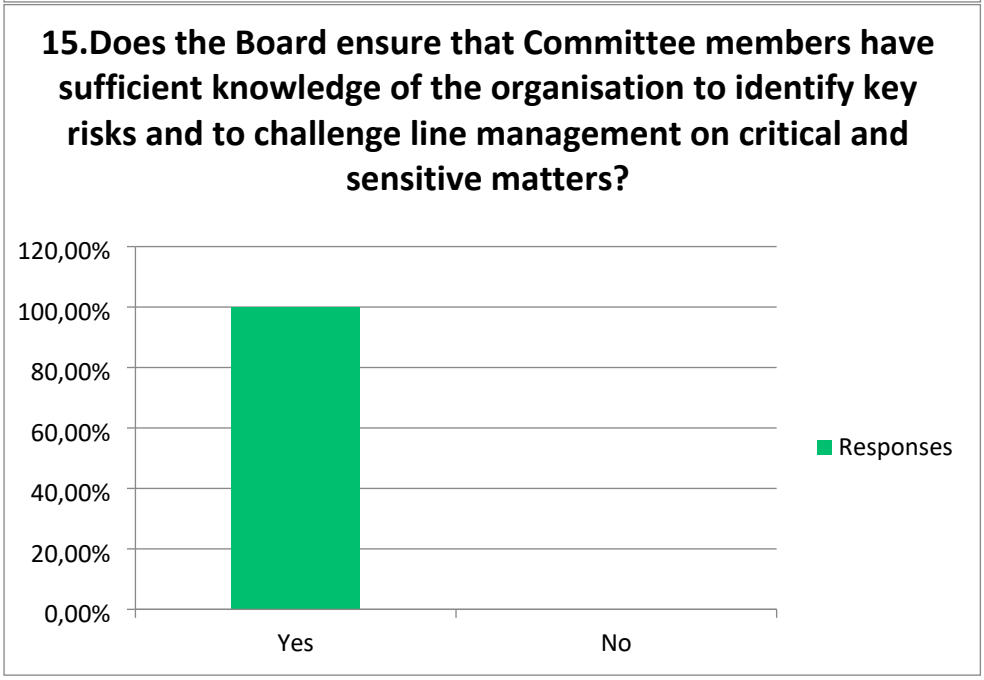




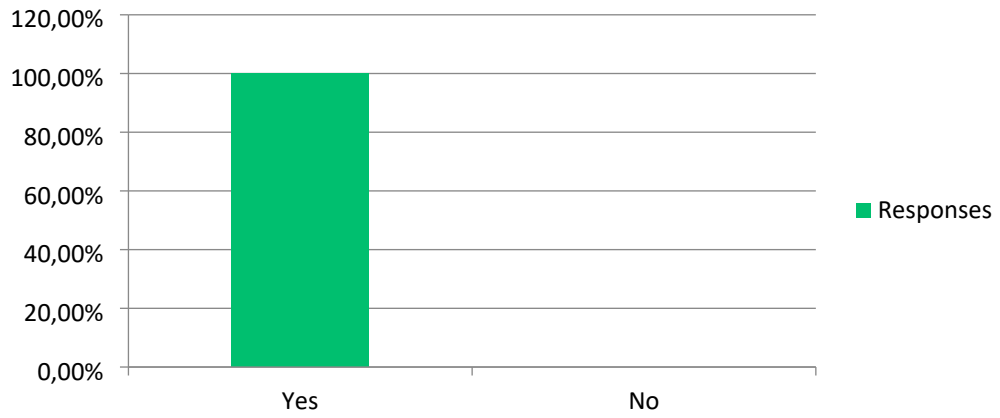




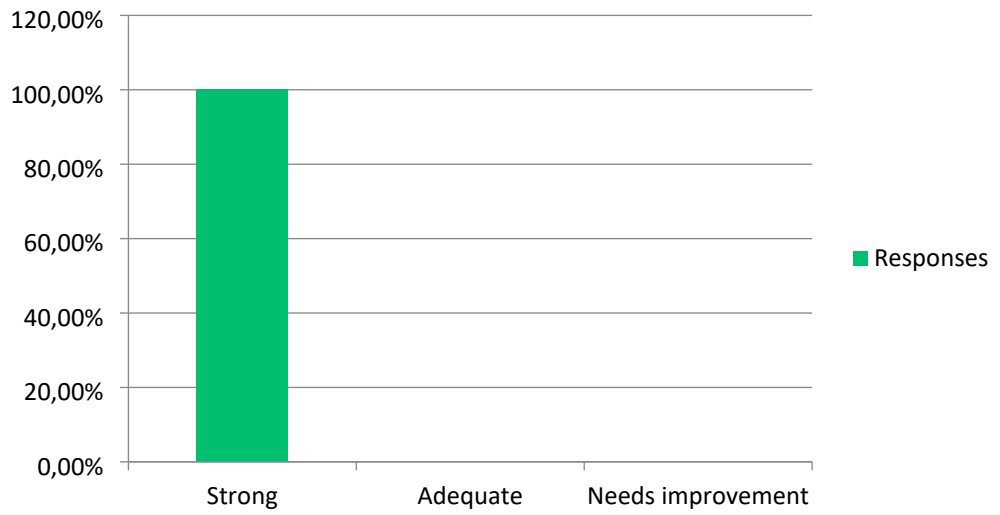


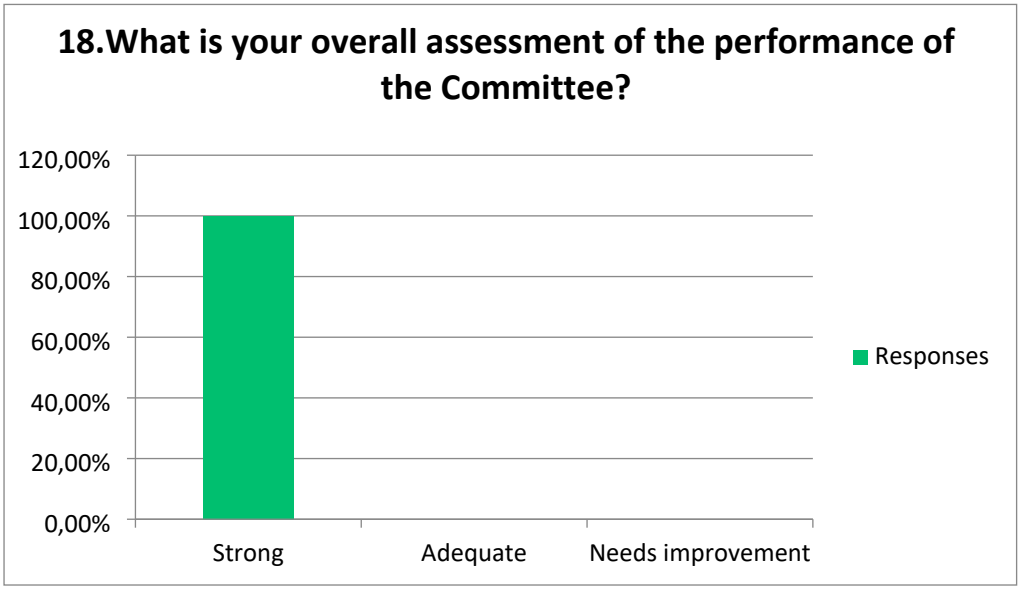


16.Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?



17.The committee's self-evaluation process is in place and effective.



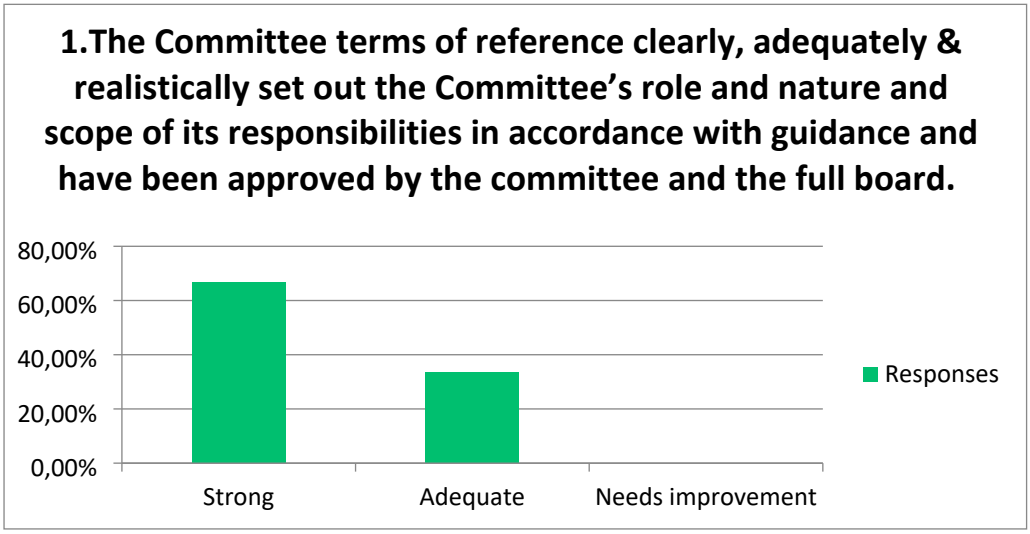


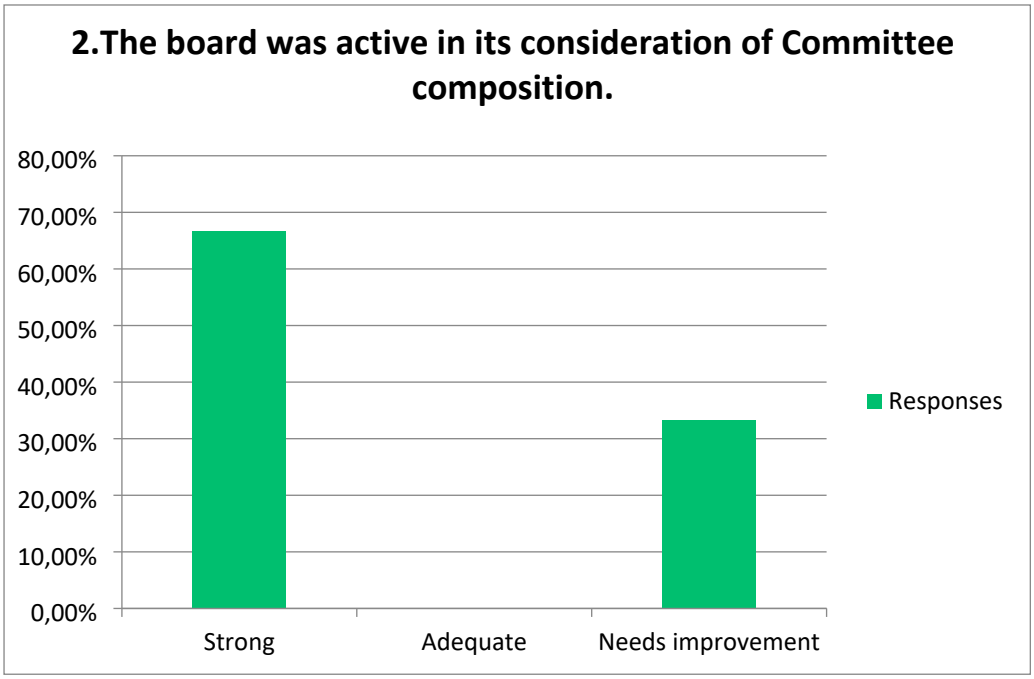
Appendix 8

Annual Board Effectiveness Survey 2020-2021

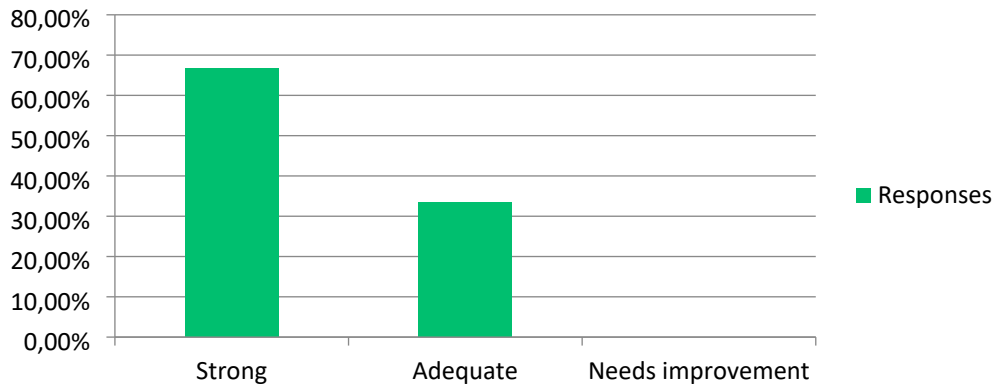
Health & Safety Committee Self Evaluation 2020-2021

- 3 responses received

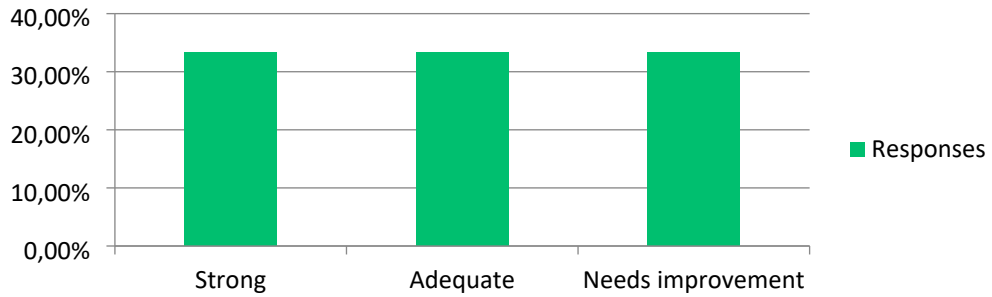




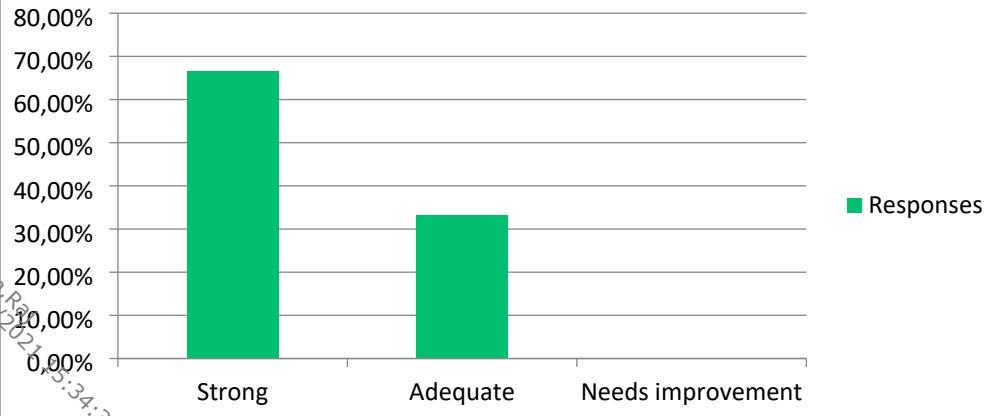
3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



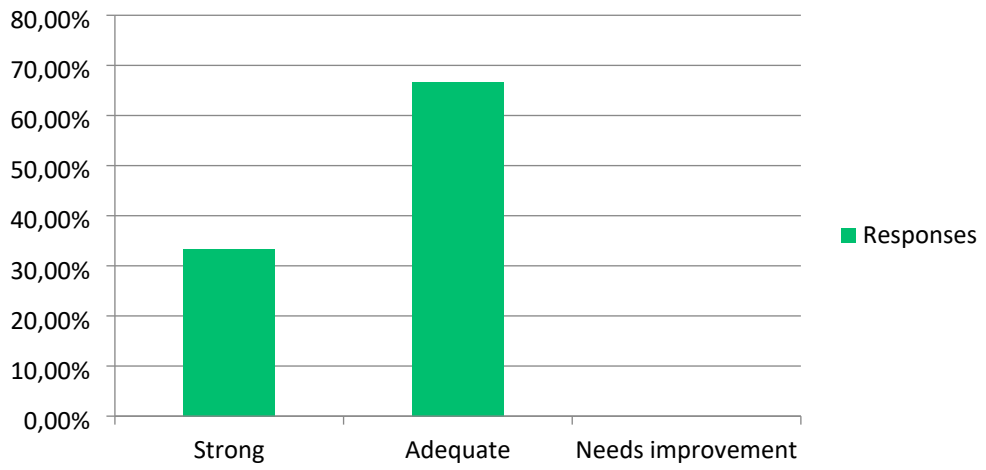
4.The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



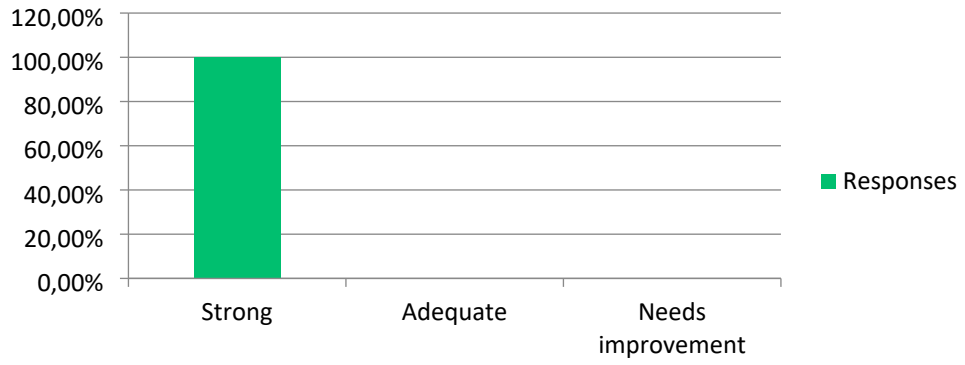
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.

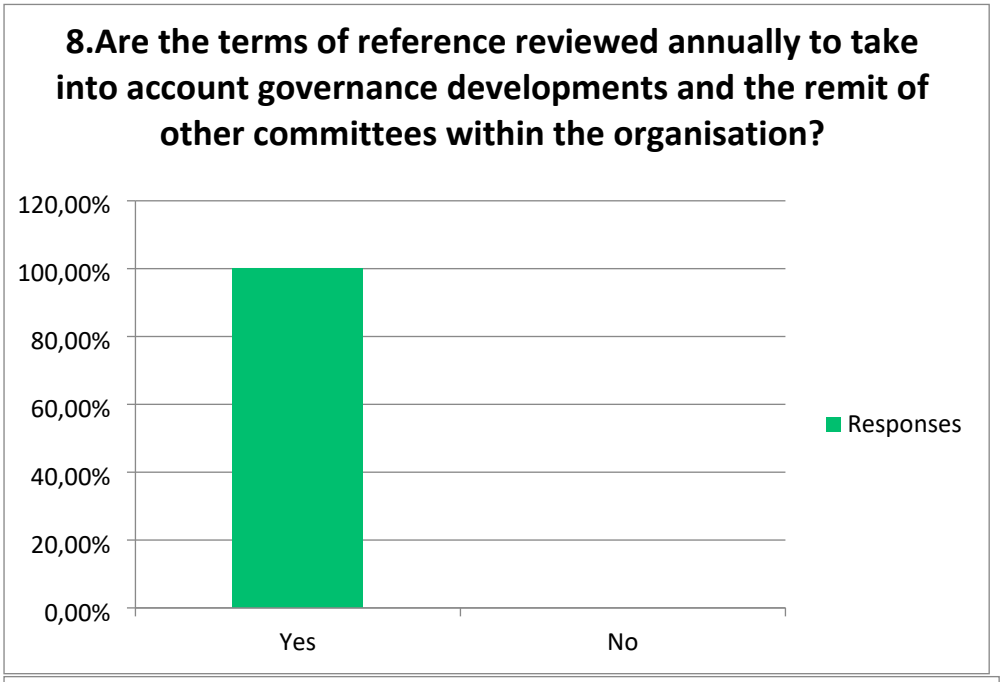


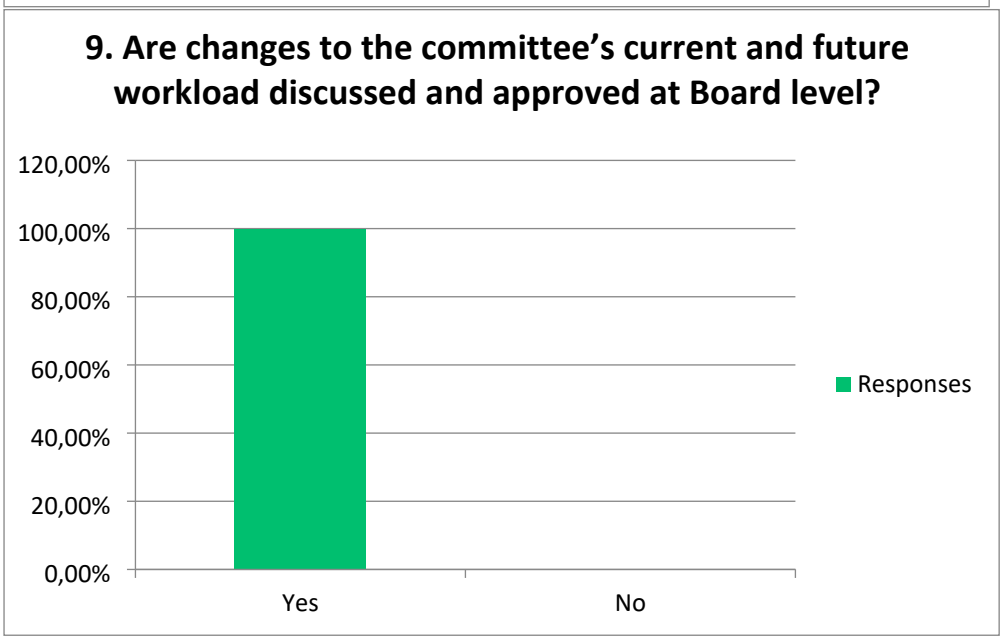
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

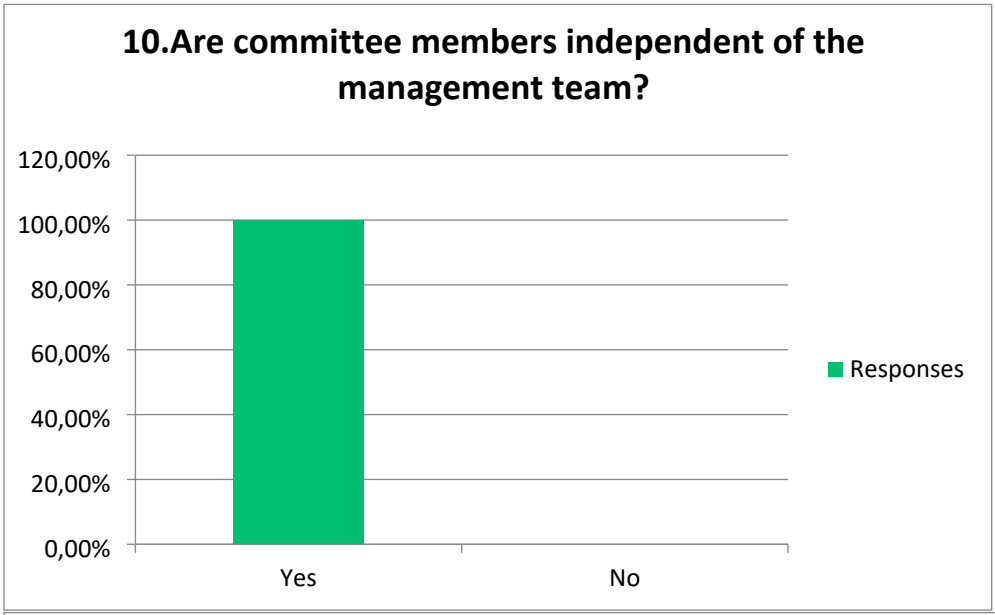


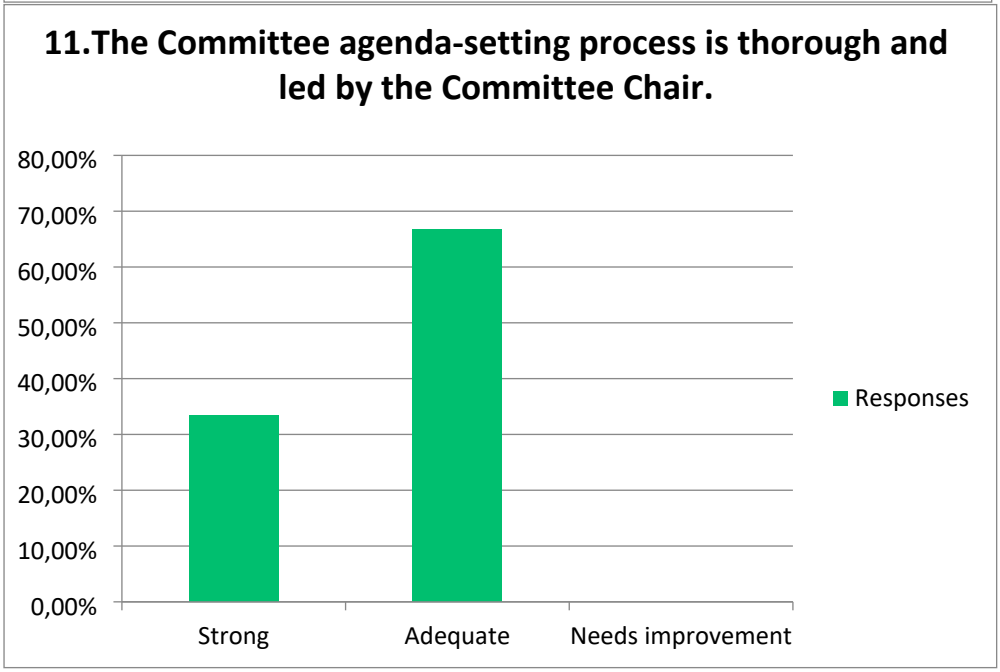
7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

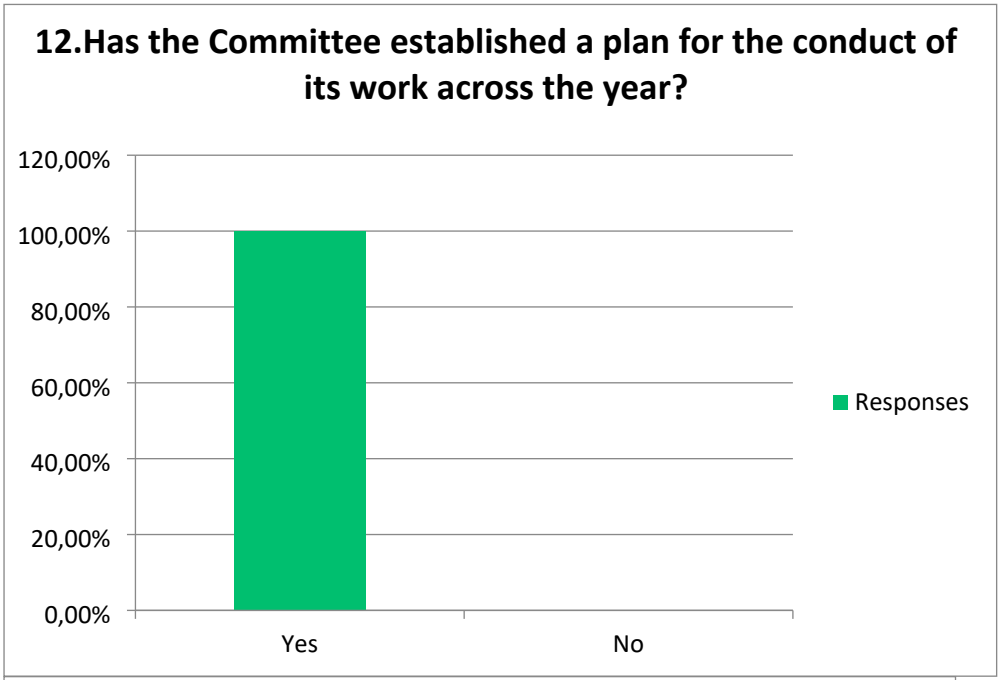


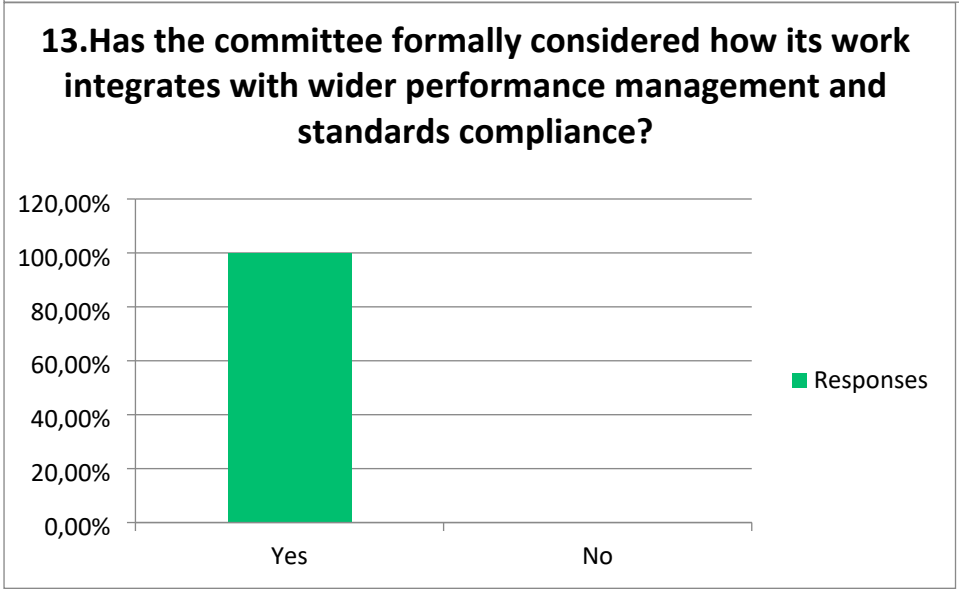








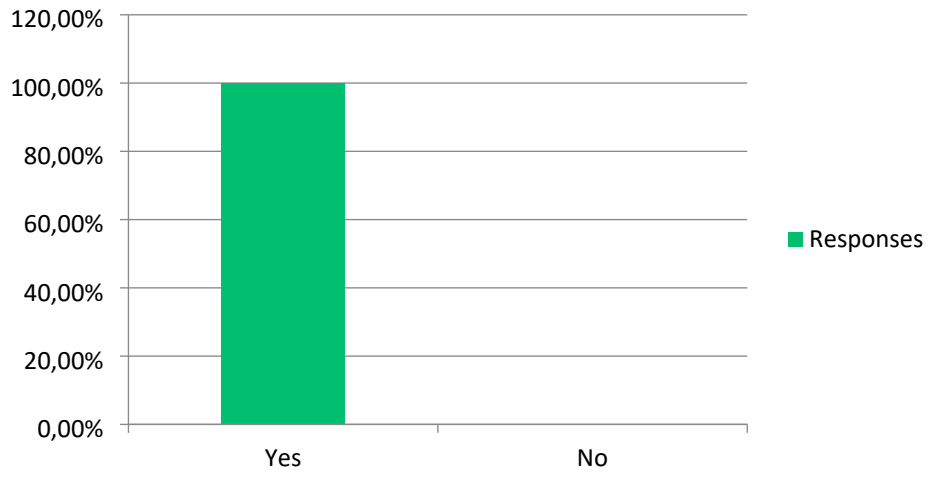




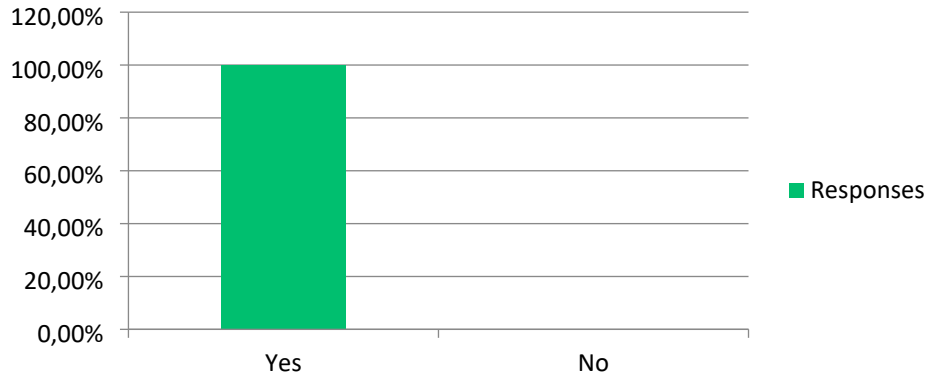
Comments received:

- *Report to Audit Committee on interrelationships between Committees*

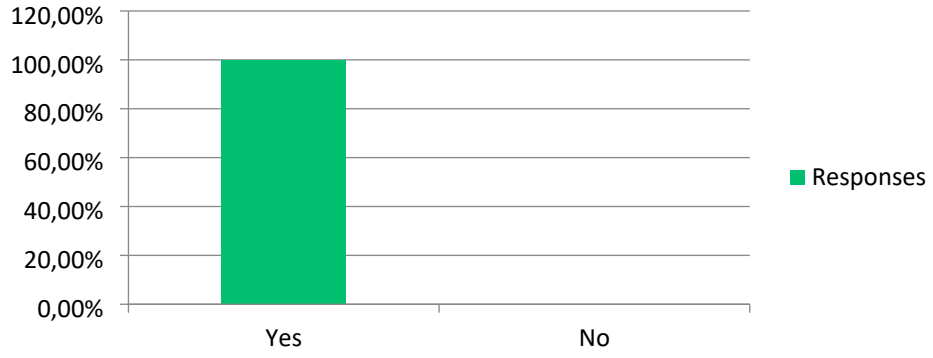
14.Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?



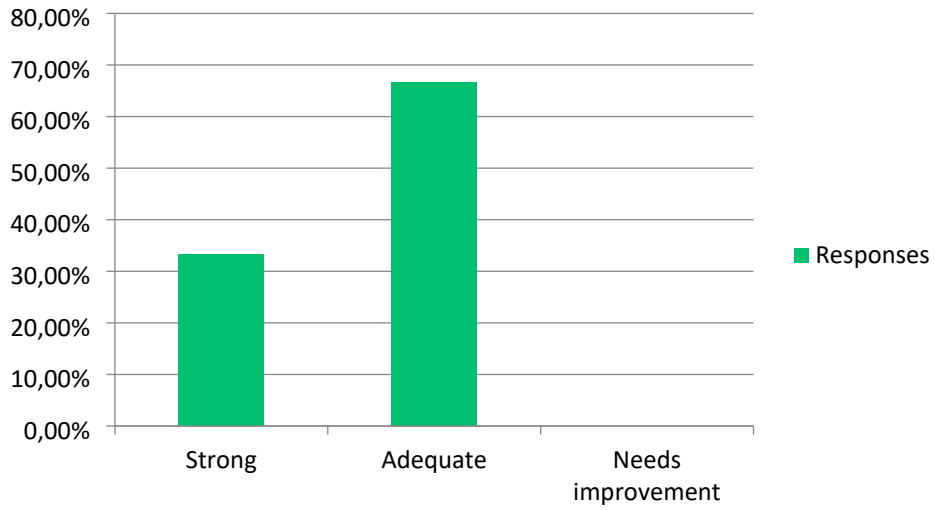
15.Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?NHS Handbook status: 2 - should do

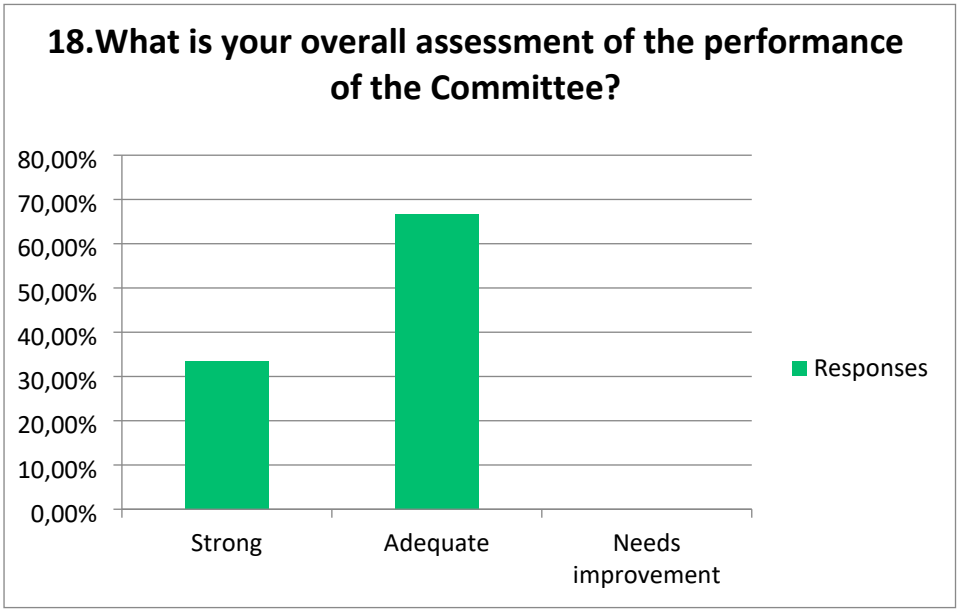


16.Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?



17.The committee's self-evaluation process is in place and effective.





Additional comments received:

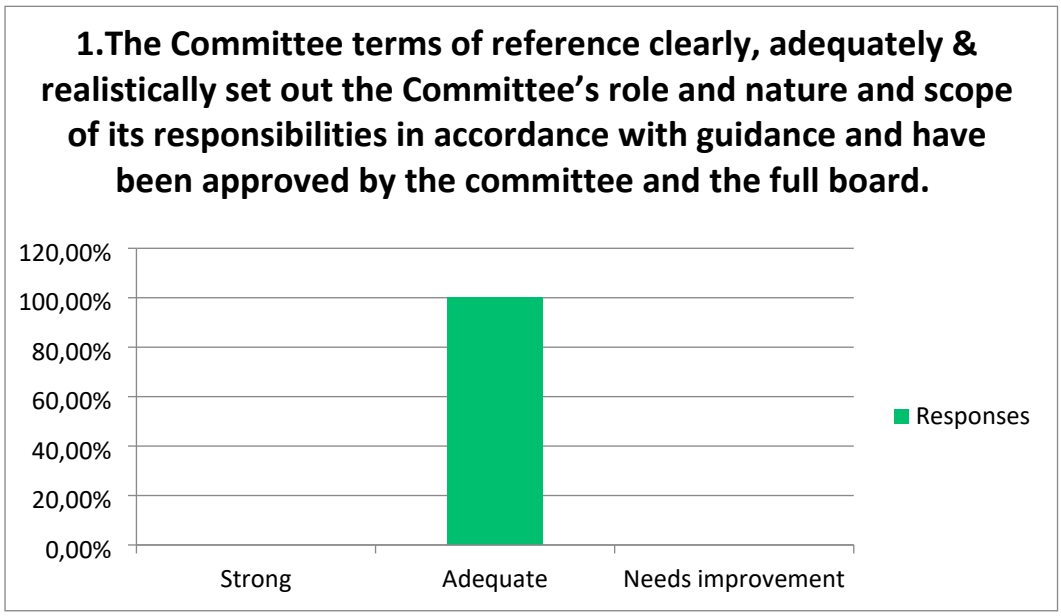
- *Committee needs reinvigorating which hopefully will coincide with appointment of new Head of H&S but also needs more buy in at Executive level*

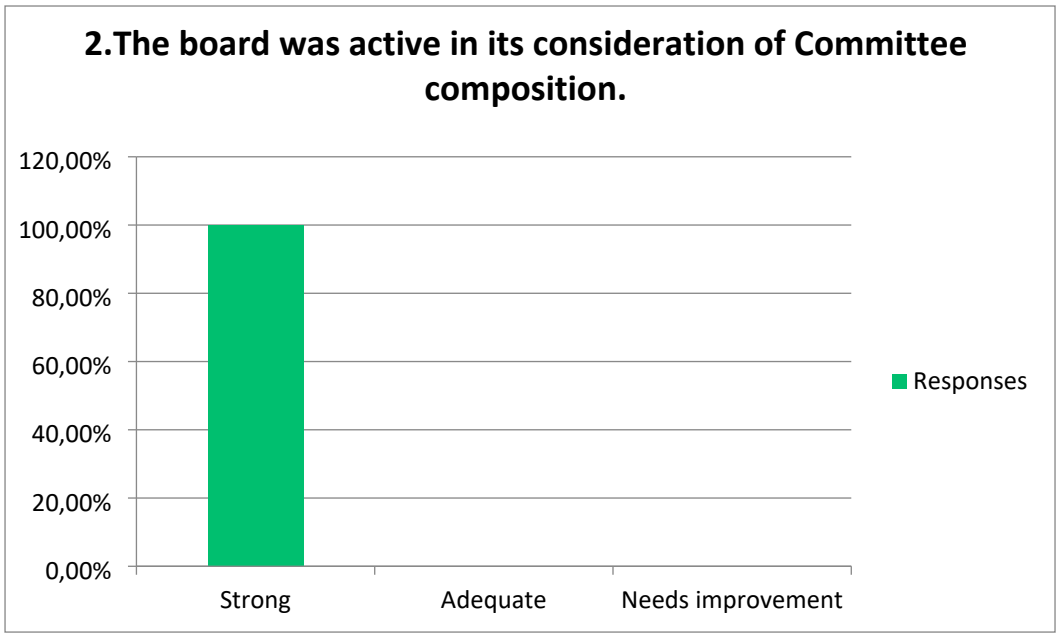
Appendix 9

Annual Board Effectiveness Survey 2020-2021

Mental Health and Capacity Legislation Committee Self Evaluation 2020-2021

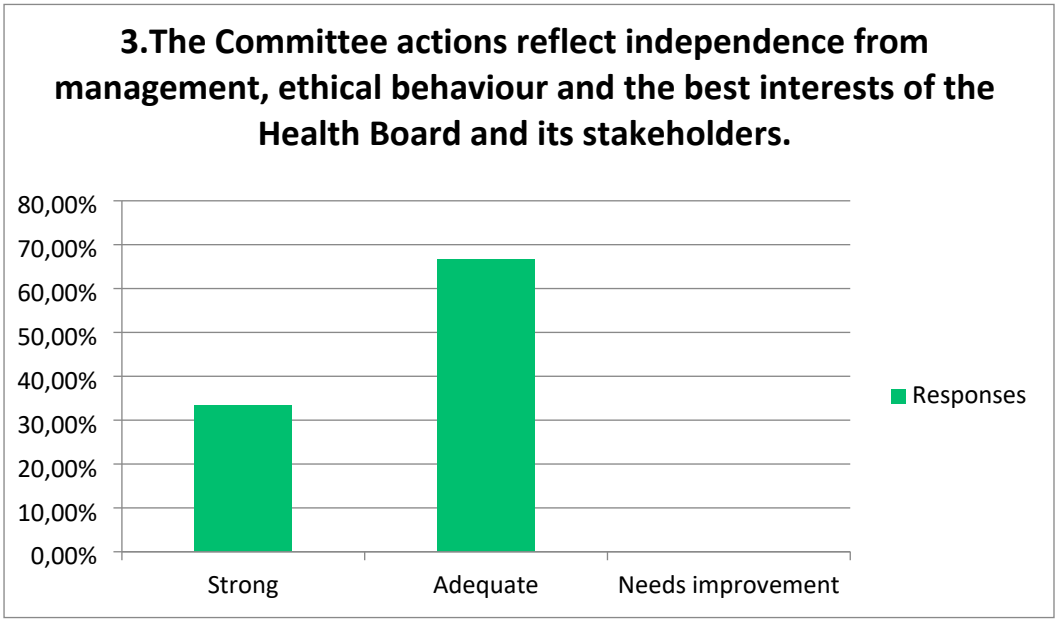
- 3 responses received

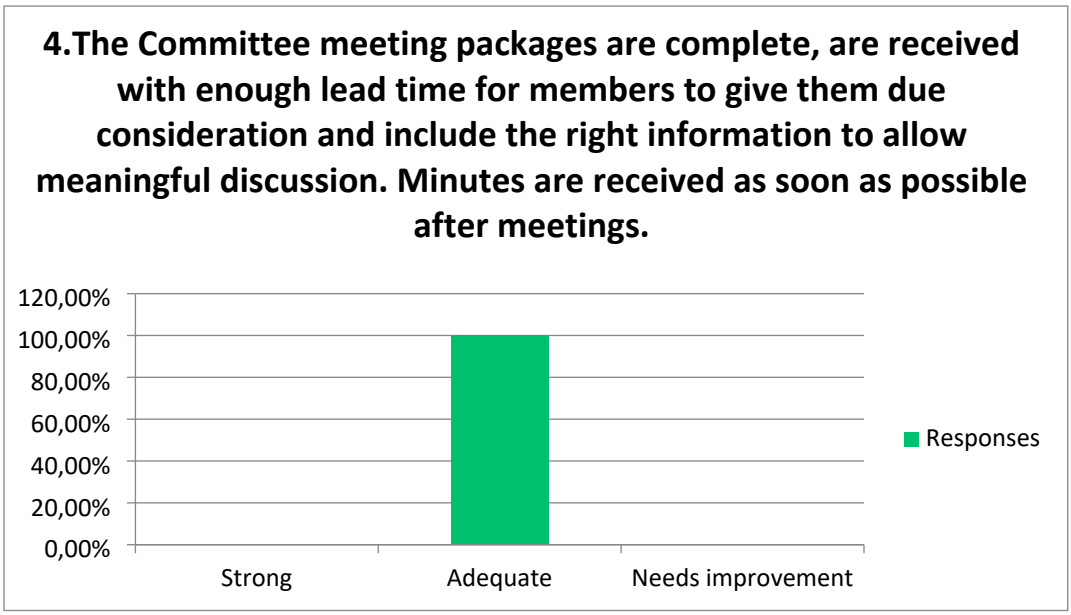




Comments received:

- *All Committees of the Board are approved on an annual basis as are the composition of the Committees.*

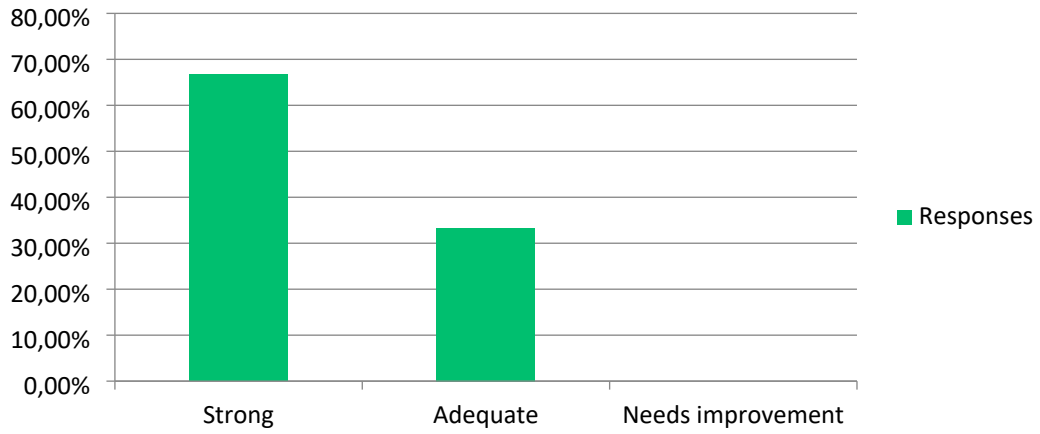




Comments received:

- *Maybe a little too much information*

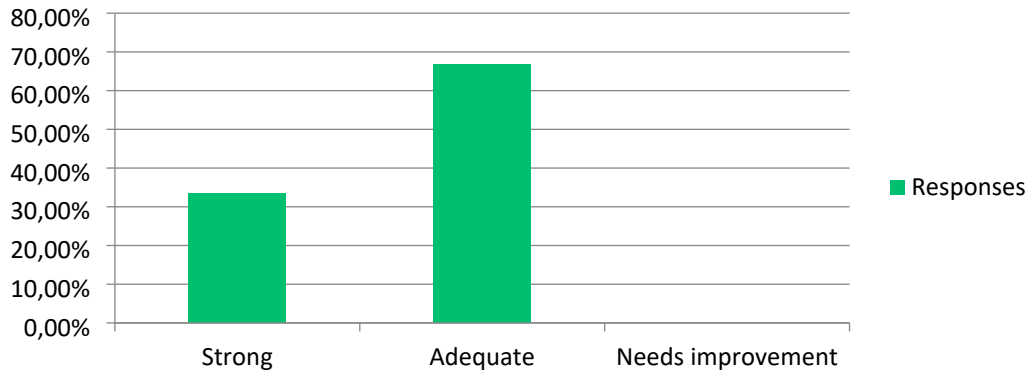
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.



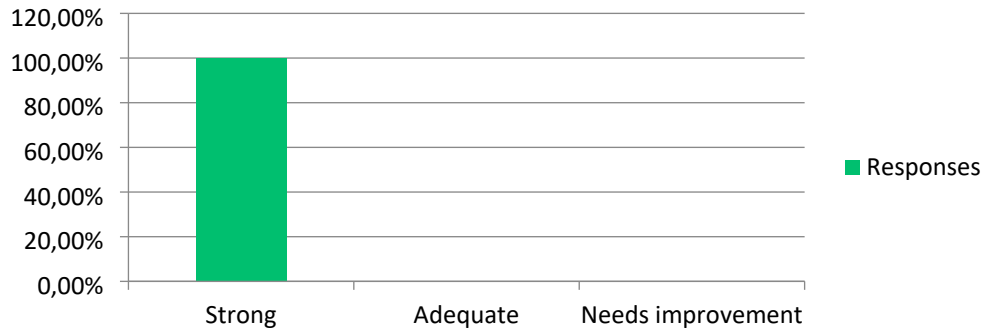
Comments received:

- *Sometimes the Committee has a tendency to drift into discussion about individual service user experience.*

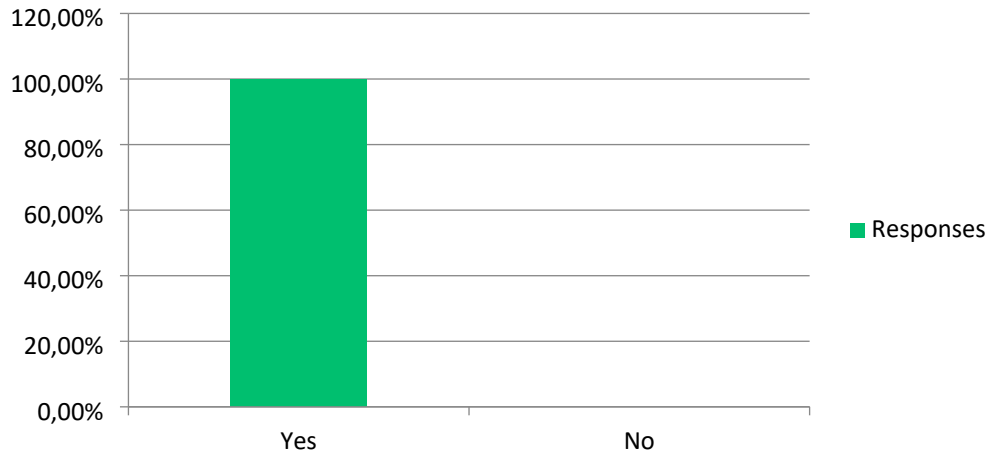
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.

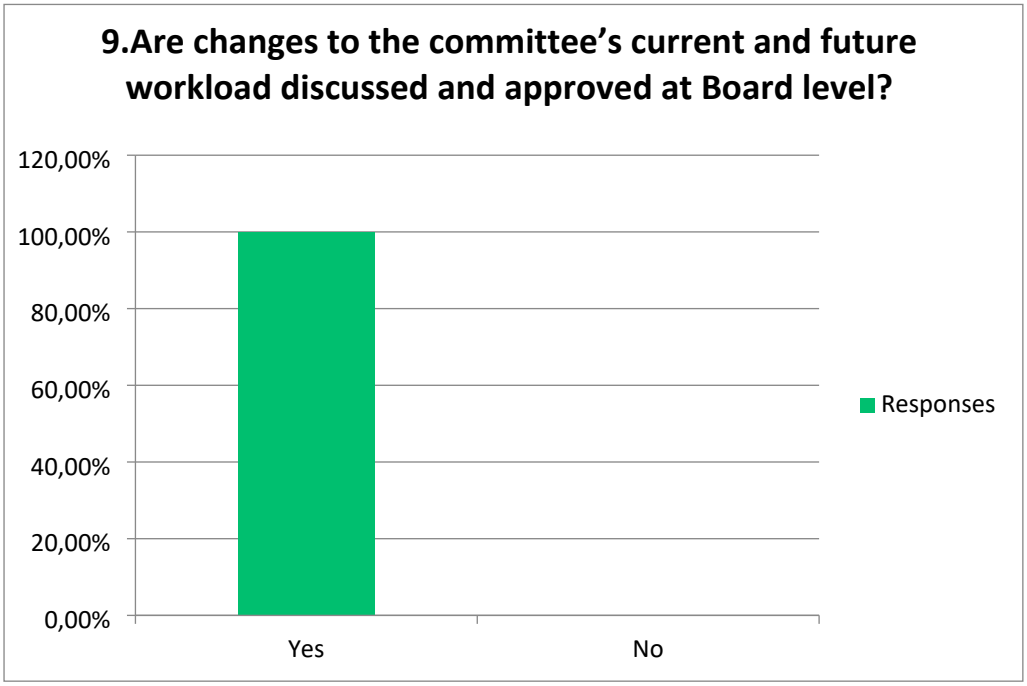


7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.



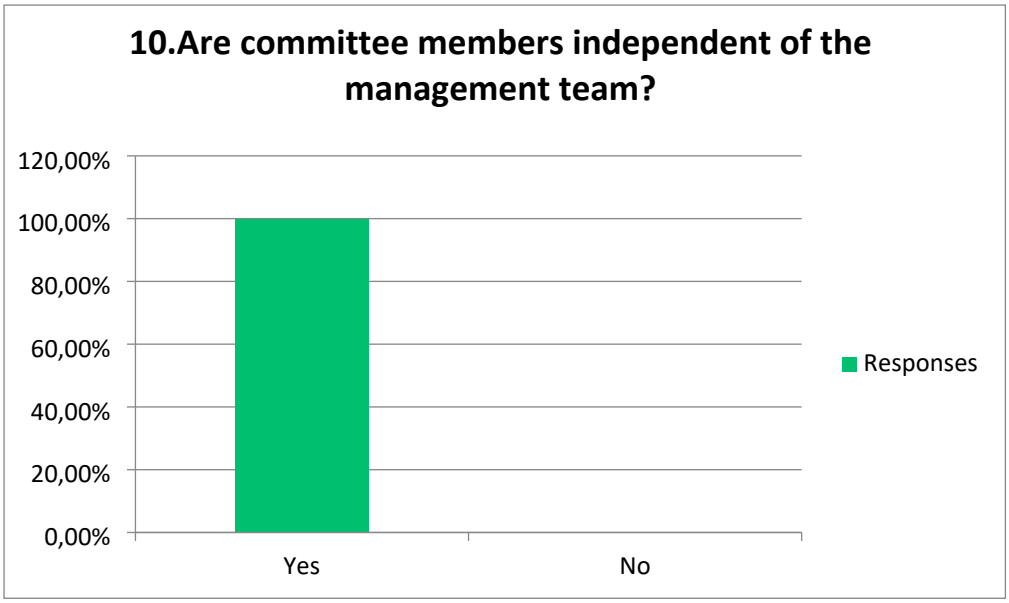
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

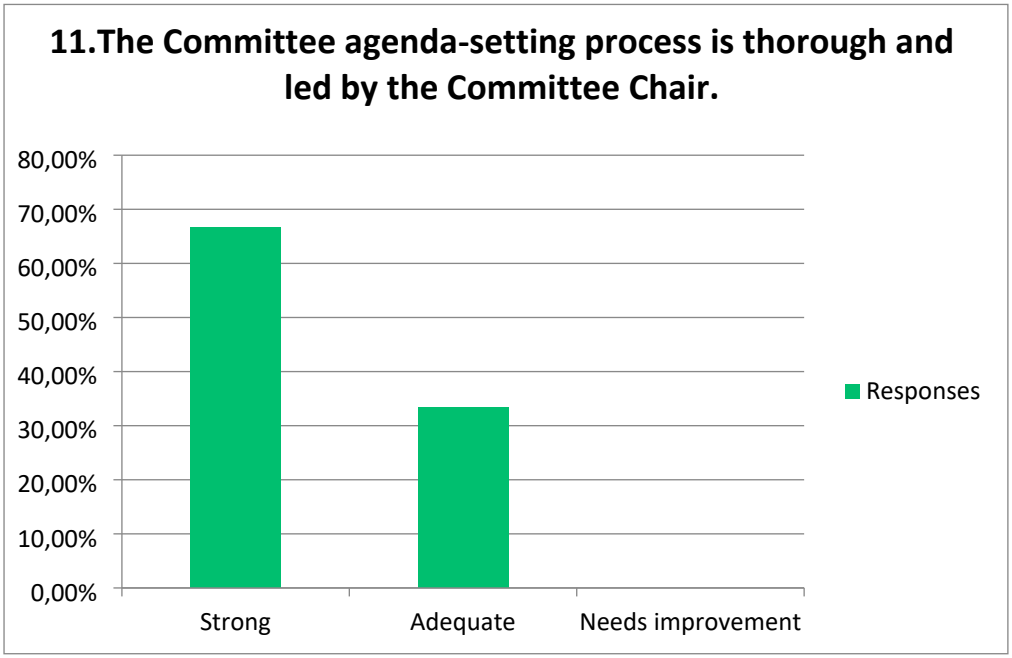


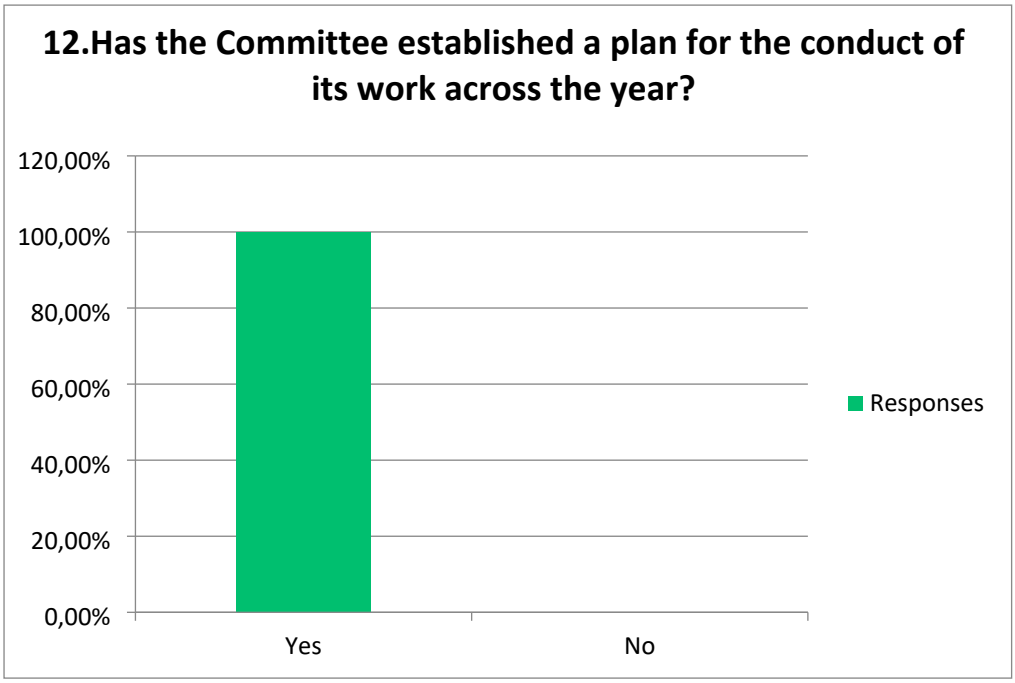


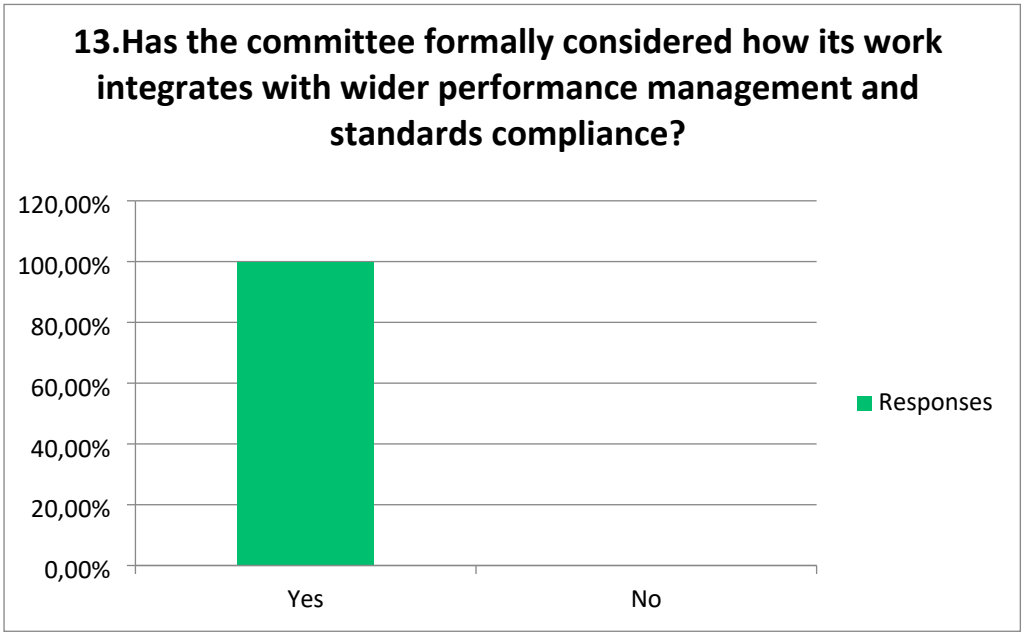
Comments received:

- *An annual plan of business is agreed each year.*



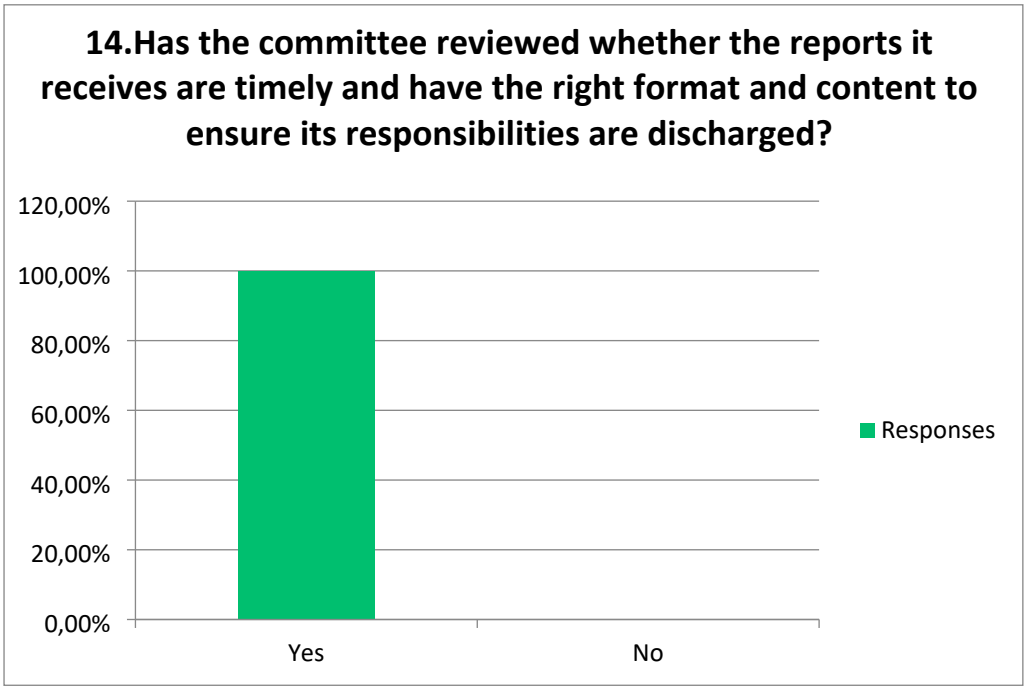


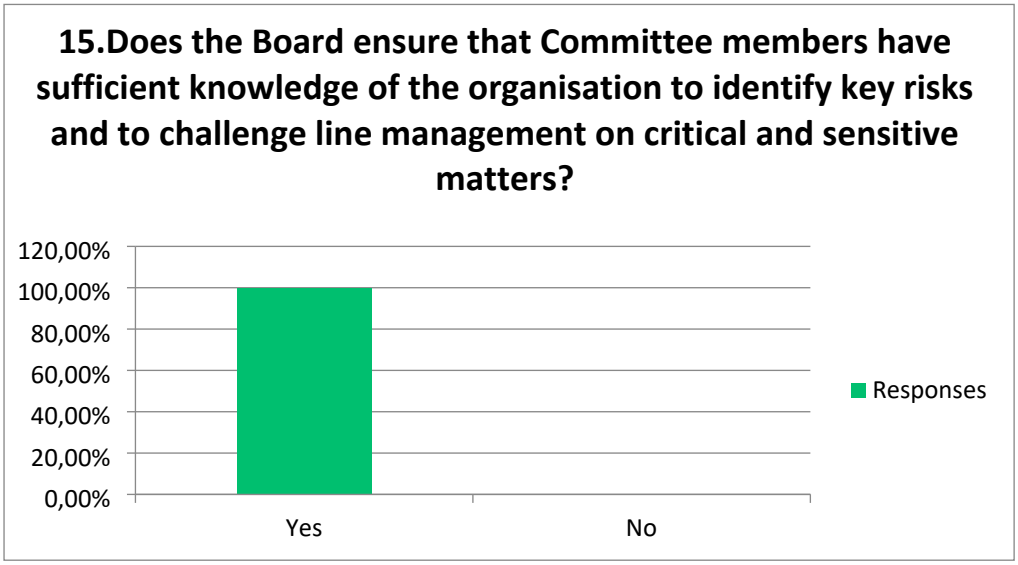




Comments received:

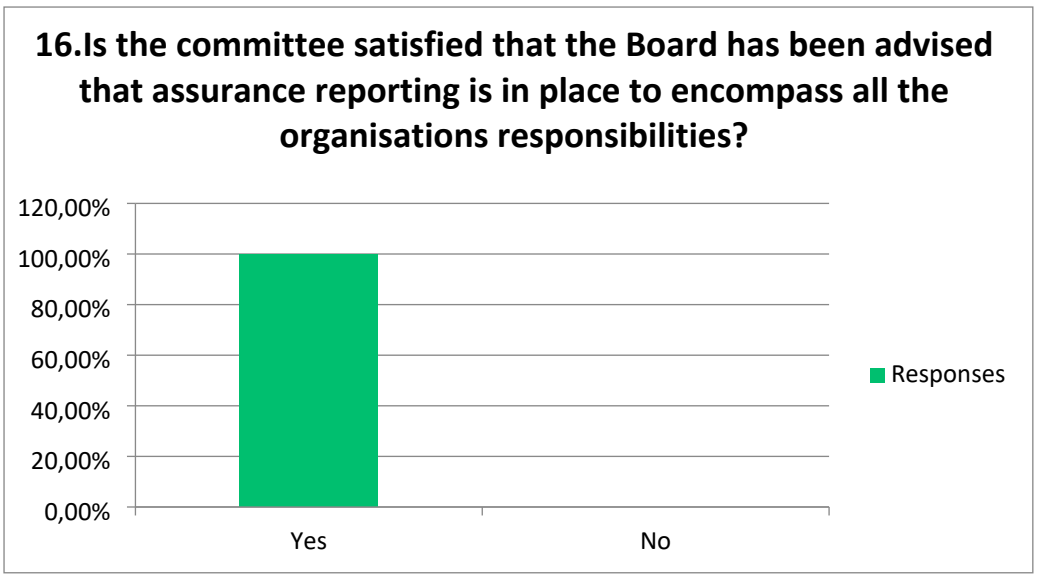
- *An annual report has been done to Audit Committee to look at interrelationships between Committees*

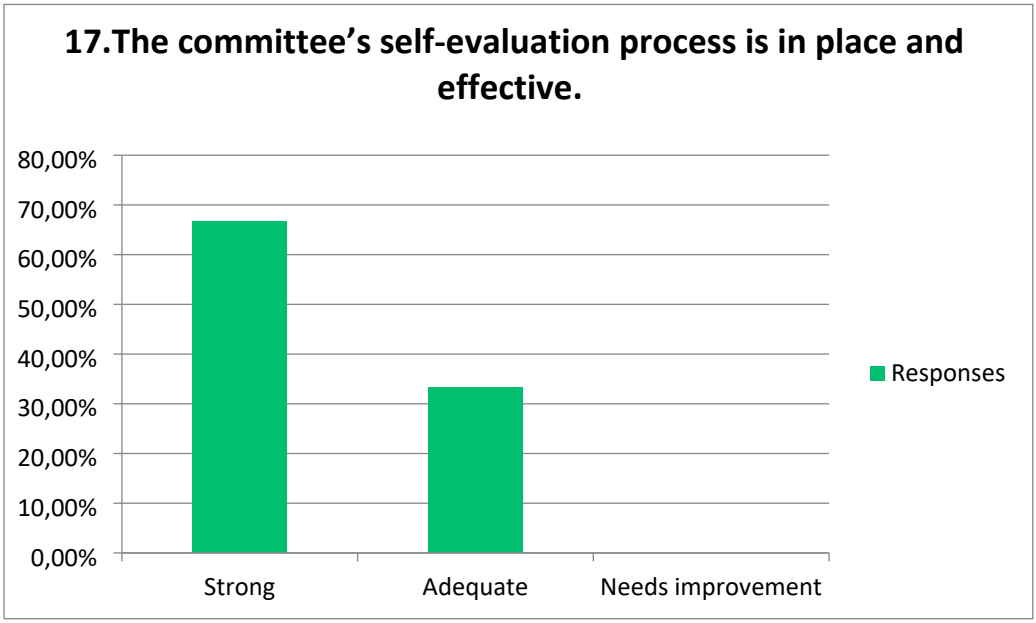


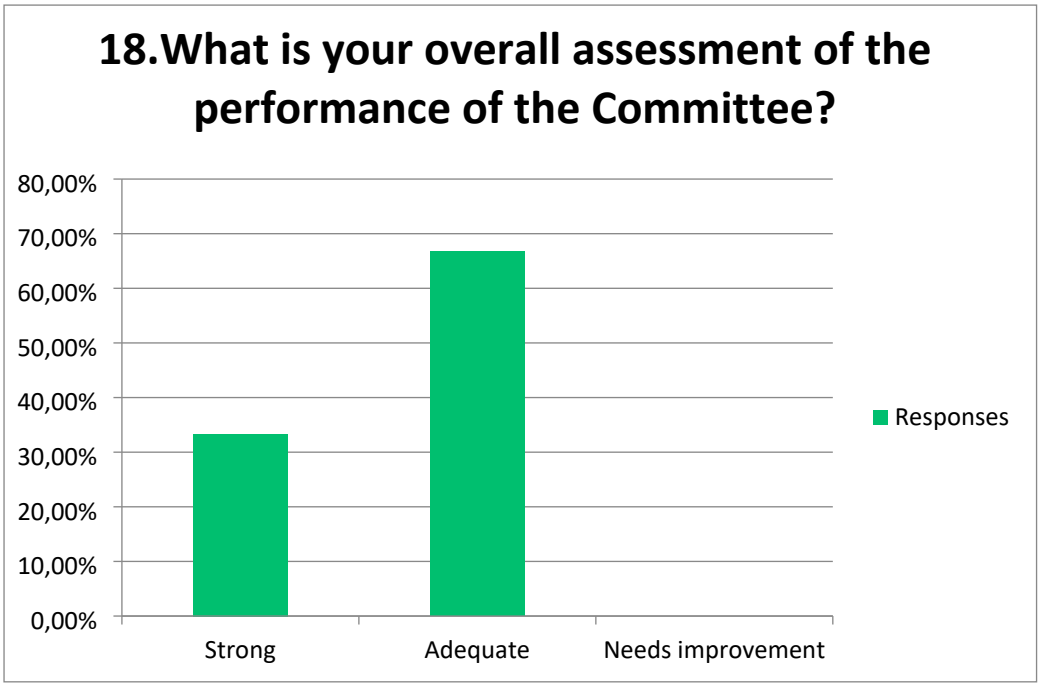


Comments received:

- *Training has been undertaken with this Committee during the last financial year*





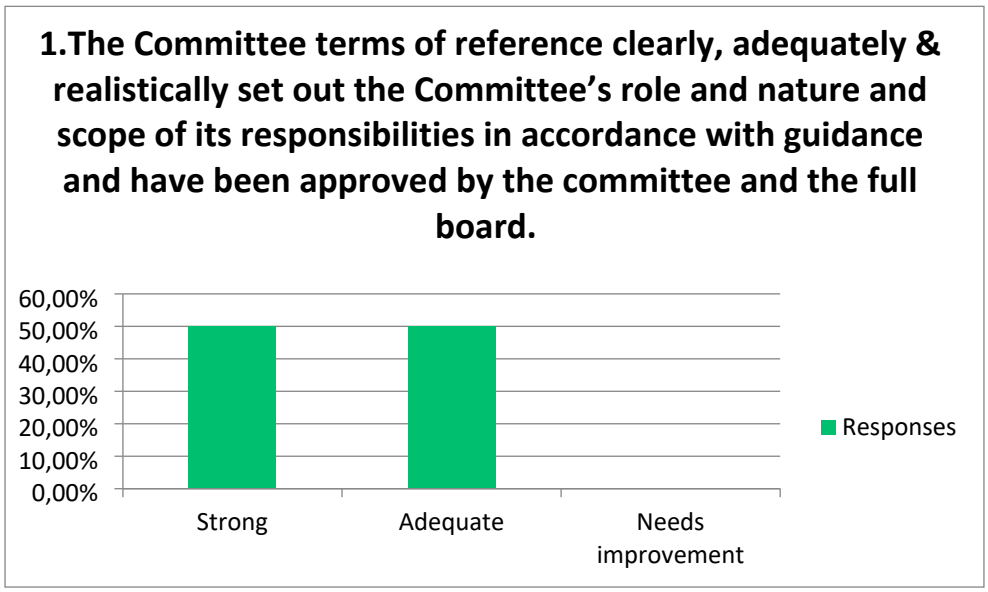


Appendix 10

Annual Board Effectiveness Survey 2020-2021

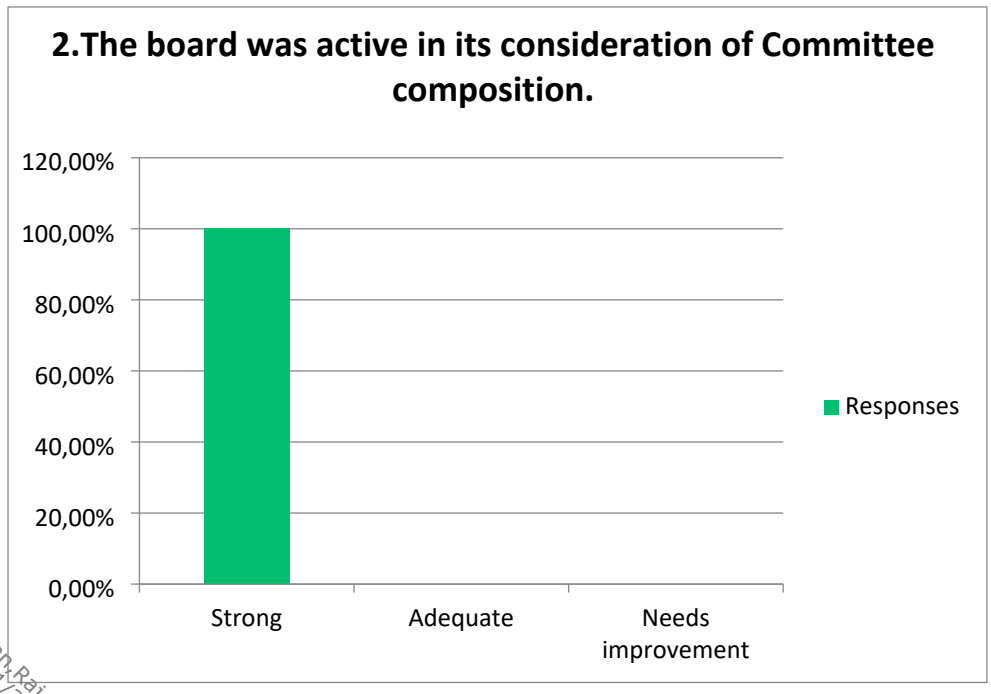
Quality, Safety and Experience Committee Self Evaluation 2020-2021

- 4 responses received



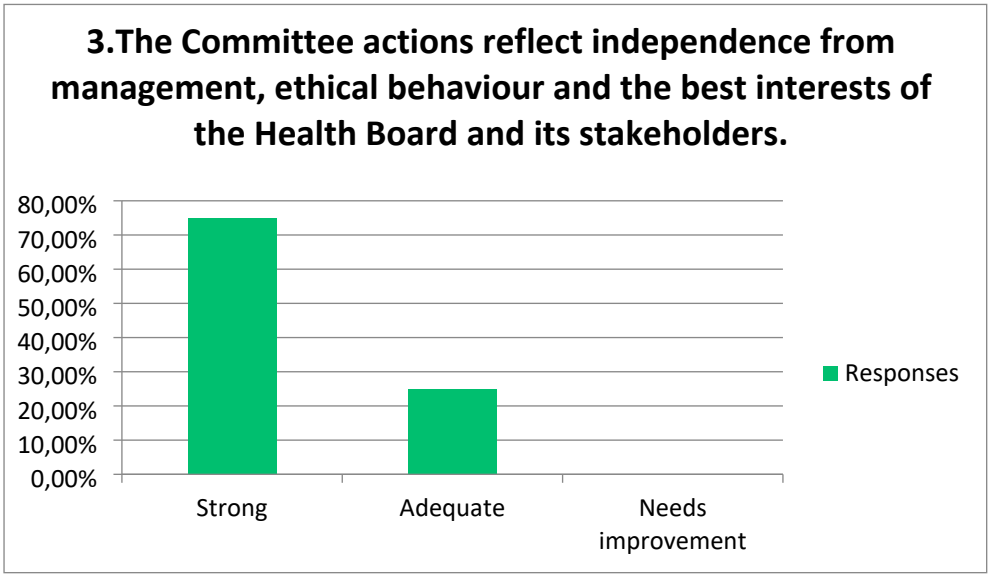
Comments received:

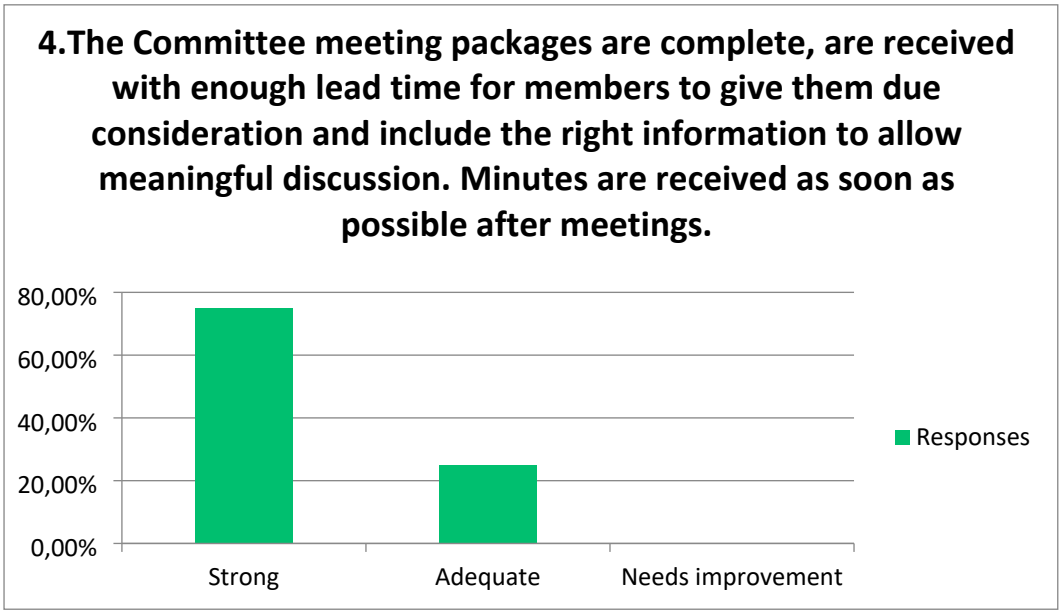
- *A key priority area and focus for us*



Comments received:

- *Always interested and attentive to these issues*

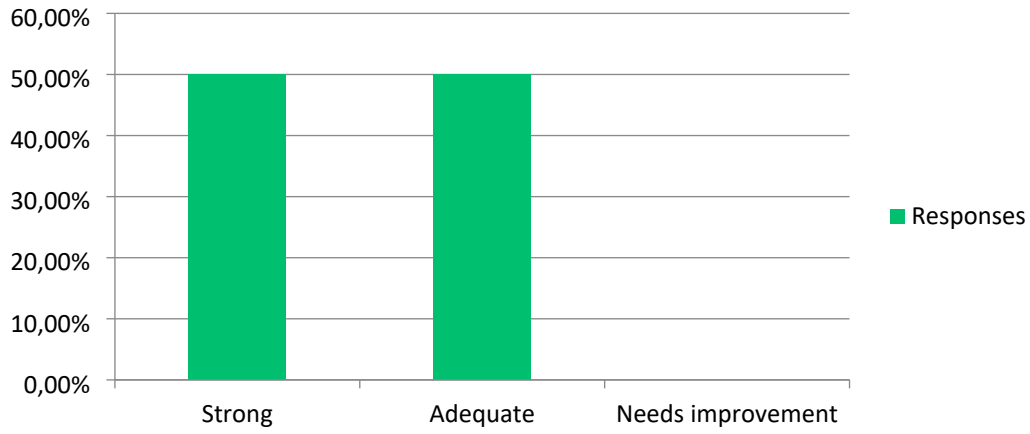




Comments received:

- *Yes but a lot of papers and lengthy*

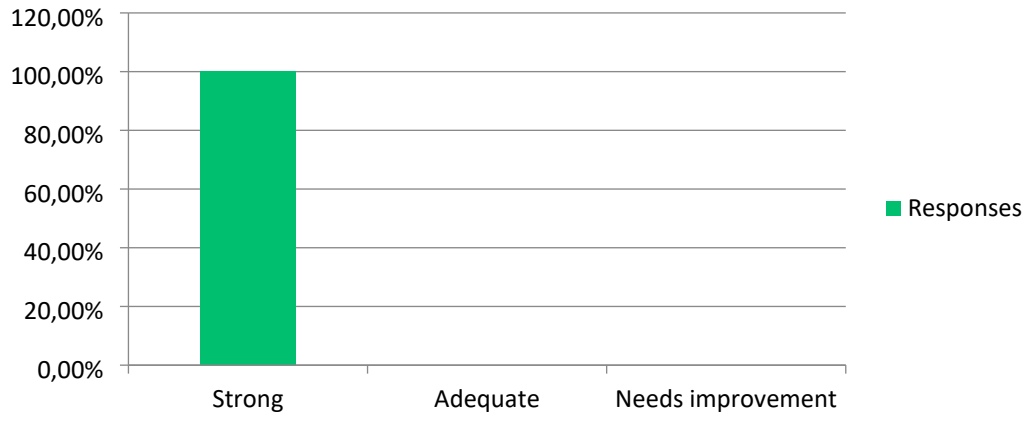
5.Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.



Comments received:

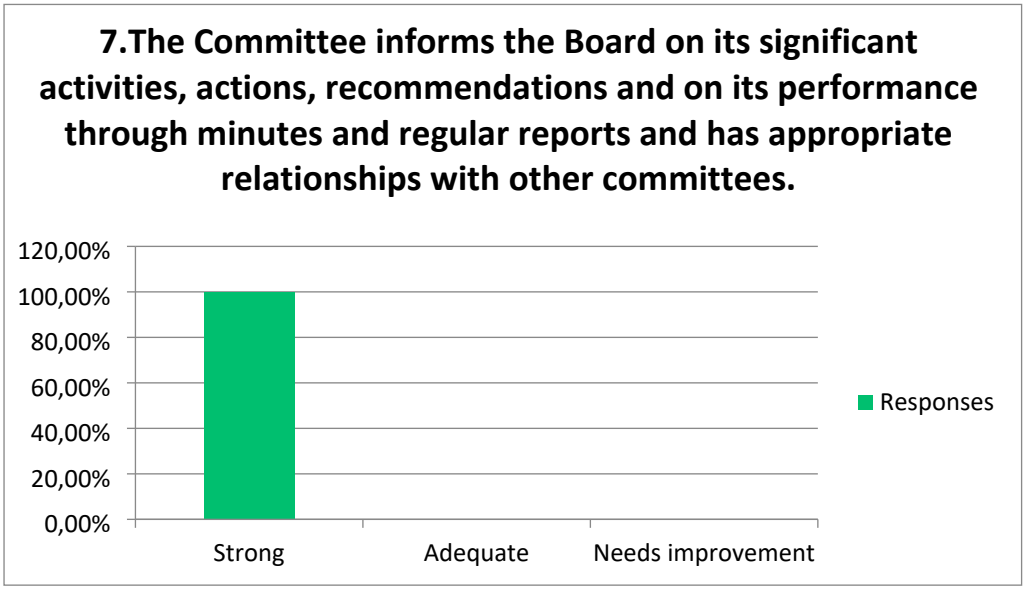
- *Meetings often run over the time allocated on the agenda*
- *Agenda remains heavy and full*

6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.



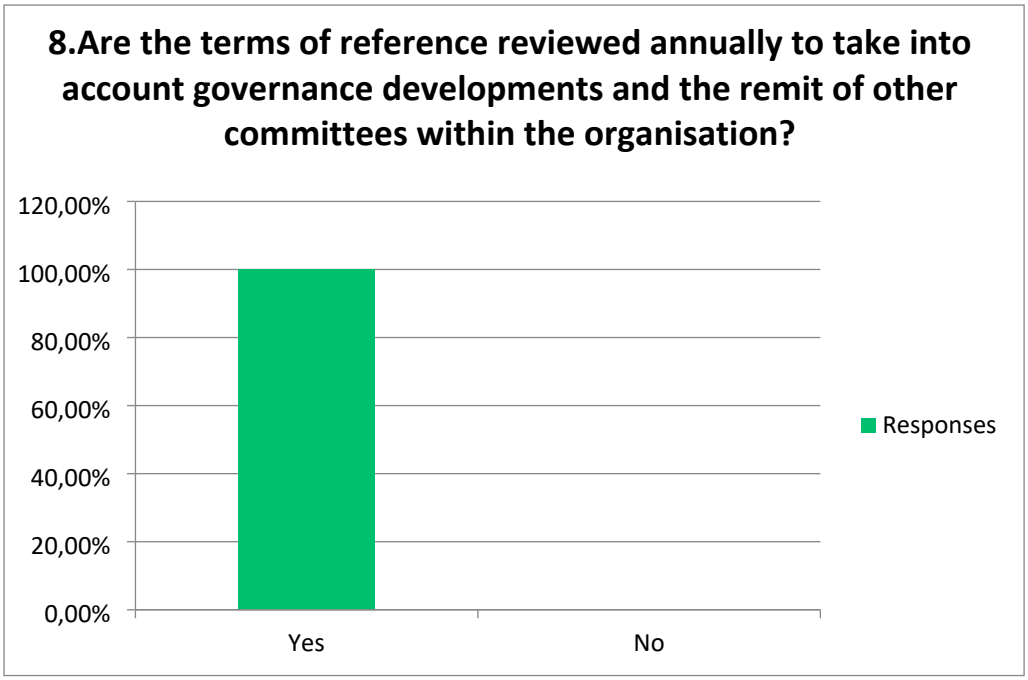
Comments received:

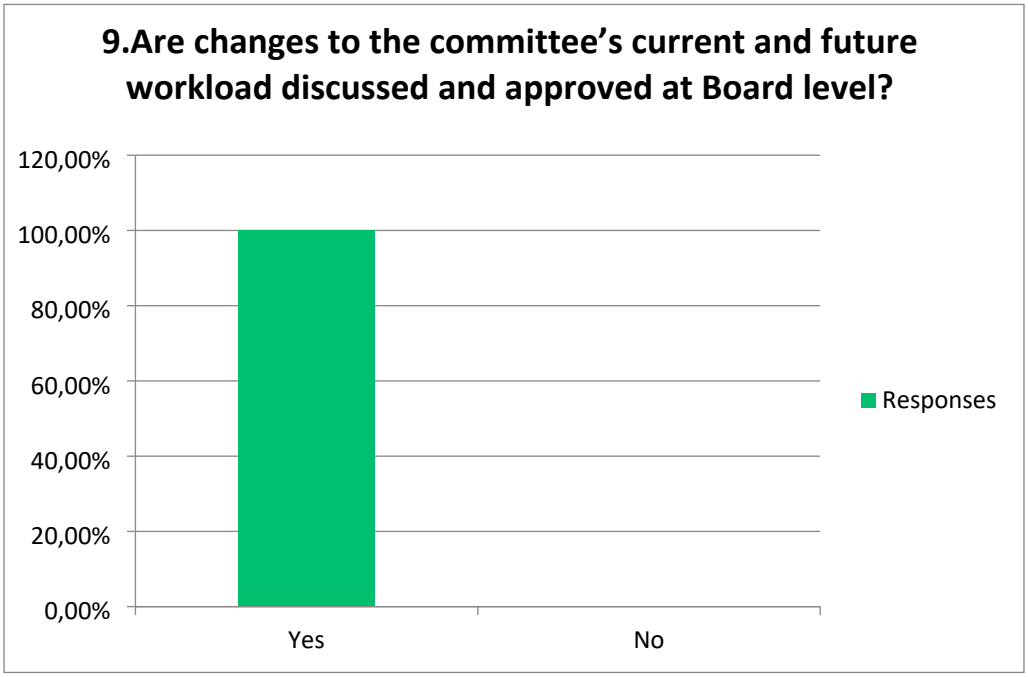
- *Good support from patient experience team and others*

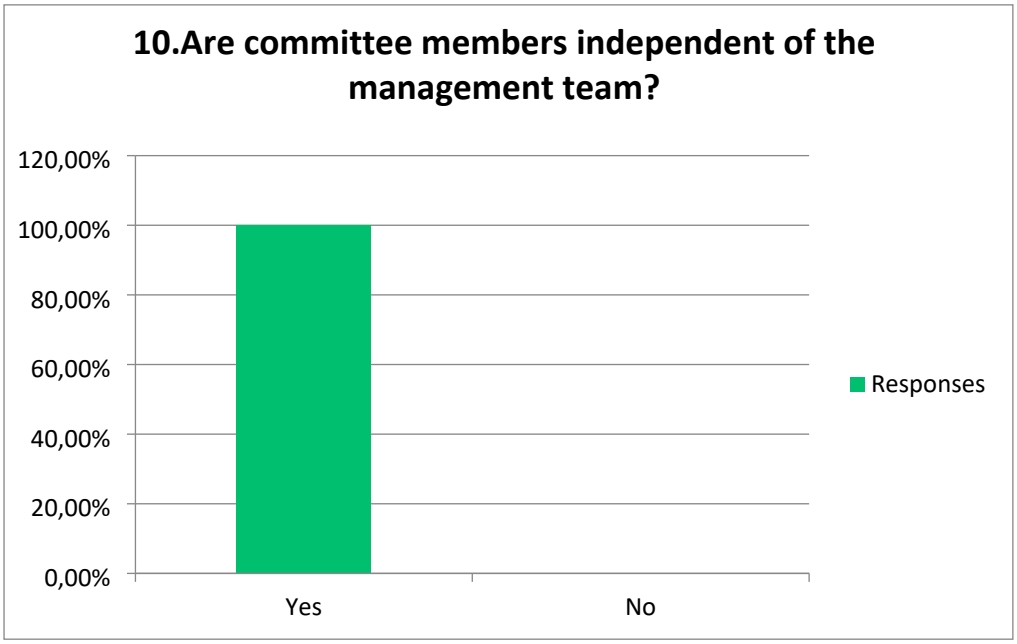


Comments received:

- *Yes minutes attached to board and chair can raise issues for Board attention*

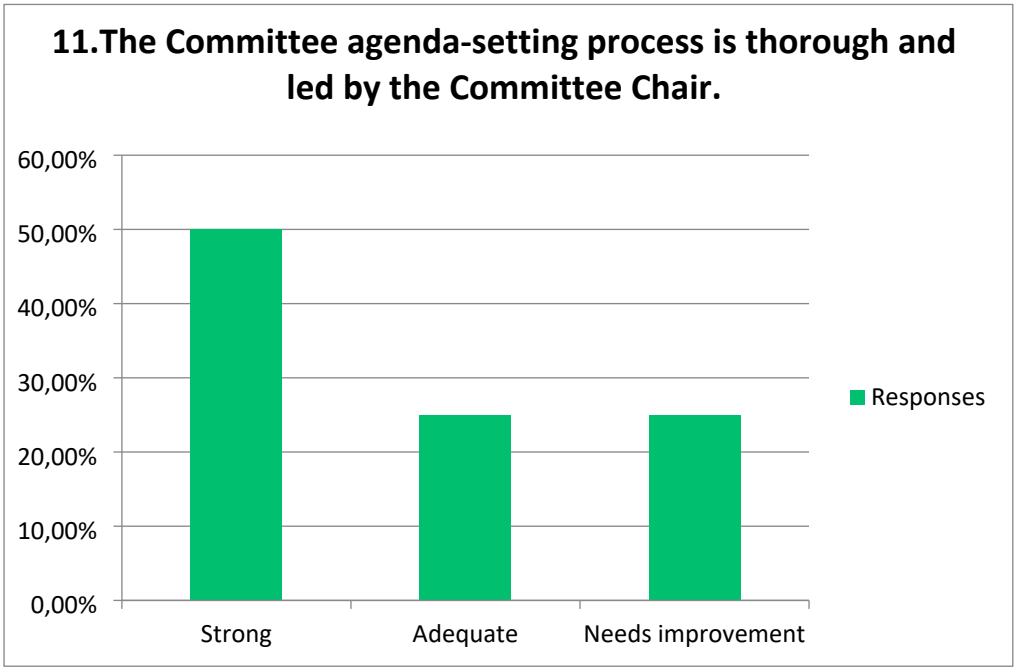


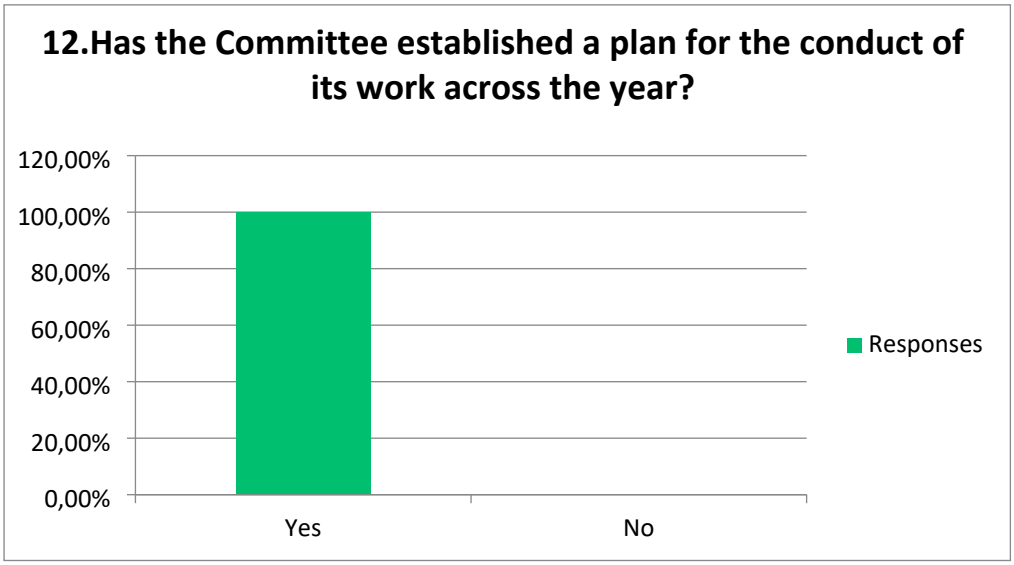




Comments received:

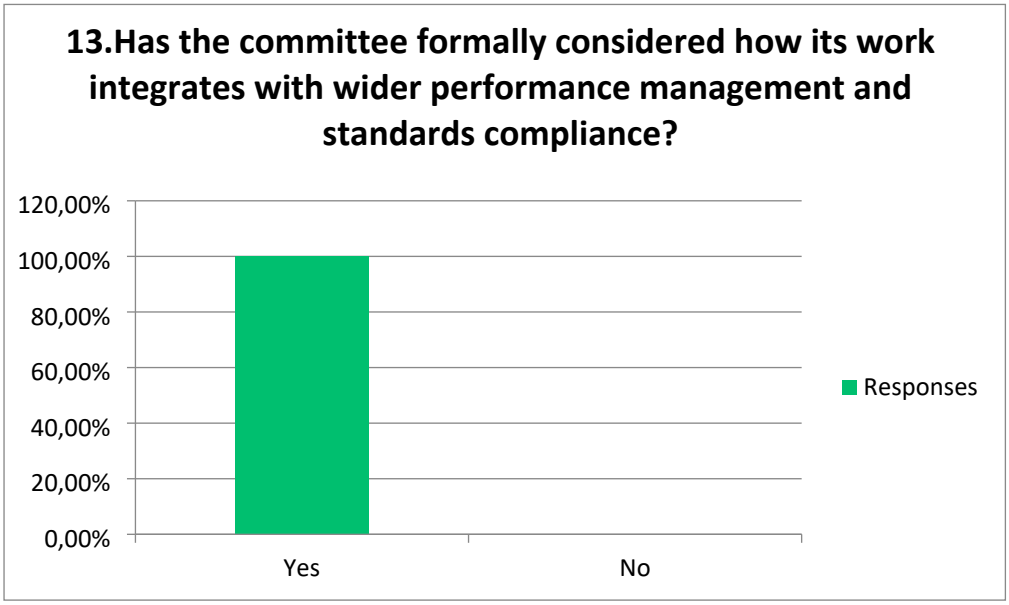
- *Strong challenge for assurance from IMs*





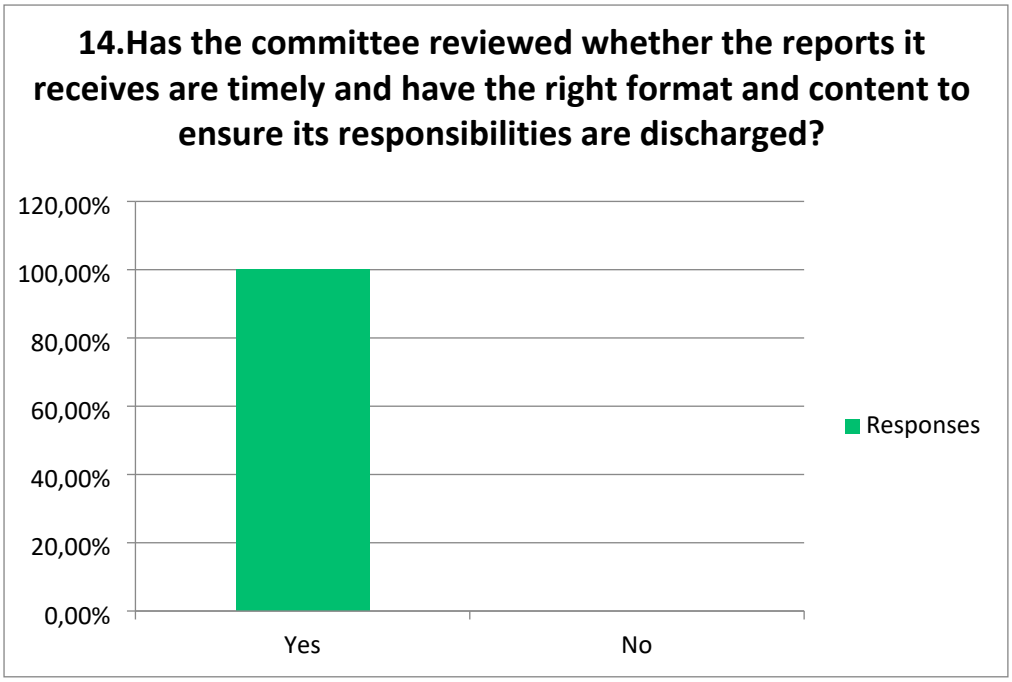
Comments received:

- *Always a forward plan*



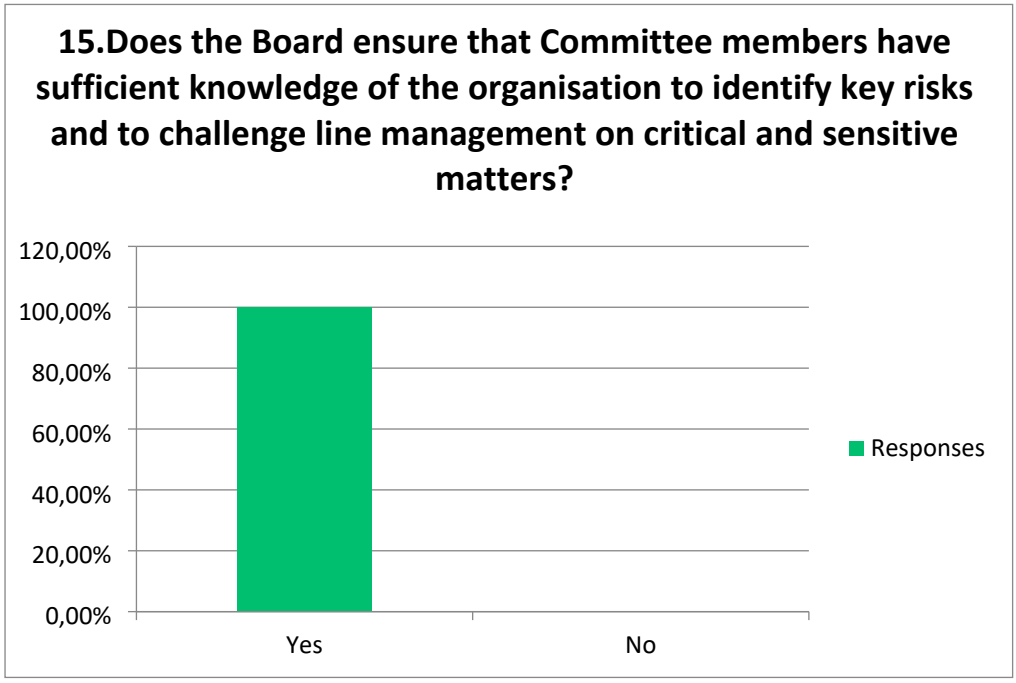
Comments received:

- *Yes, consideration undertaken*



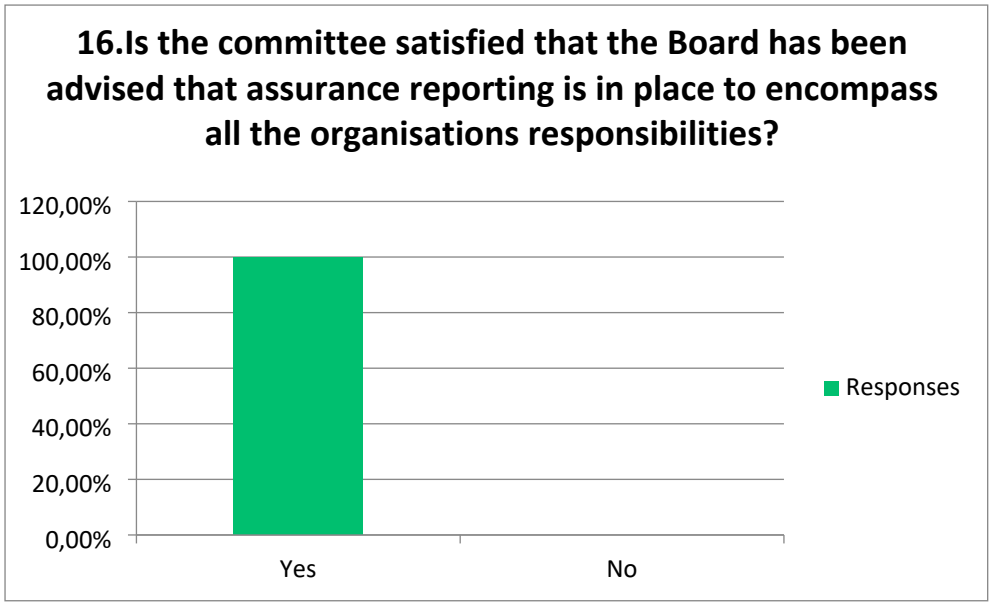
Comments received:

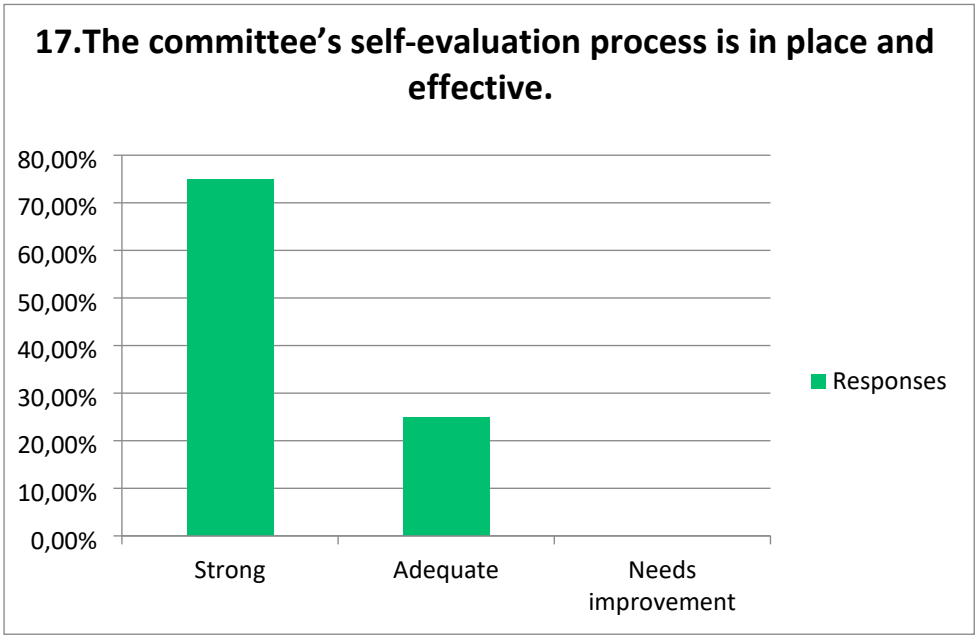
- *Yes adjustments requested as need arises*



Comments received:

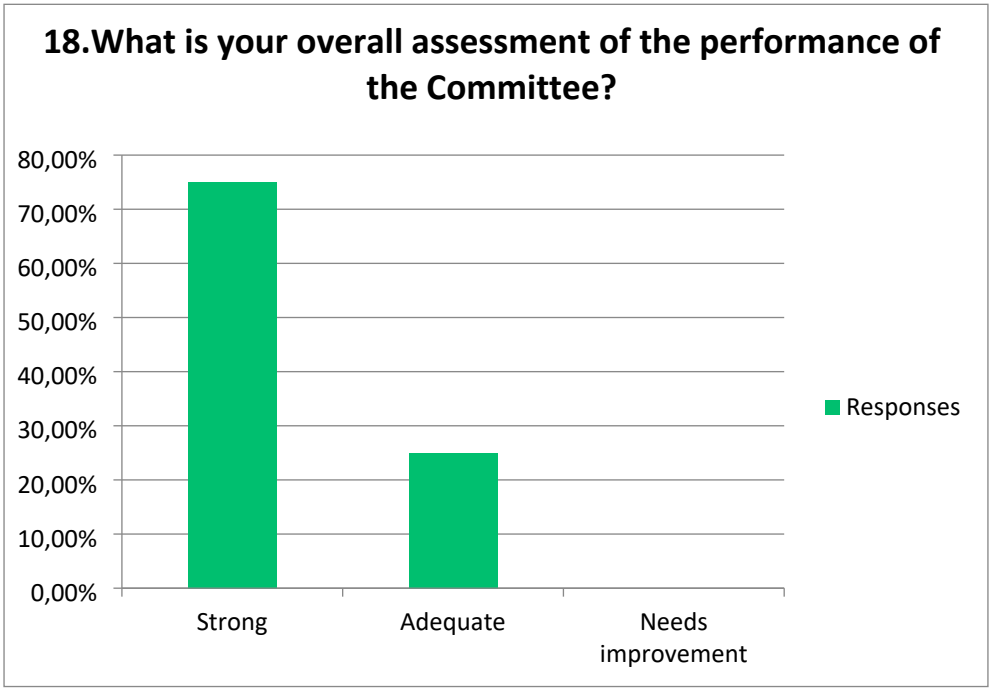
- *Yes induction, though patient safety walk rounds suspended due to COVID*





Comments received:

- *Frequently review and amend as needed/guided*



Comment received:

- *only issue is length of agenda*

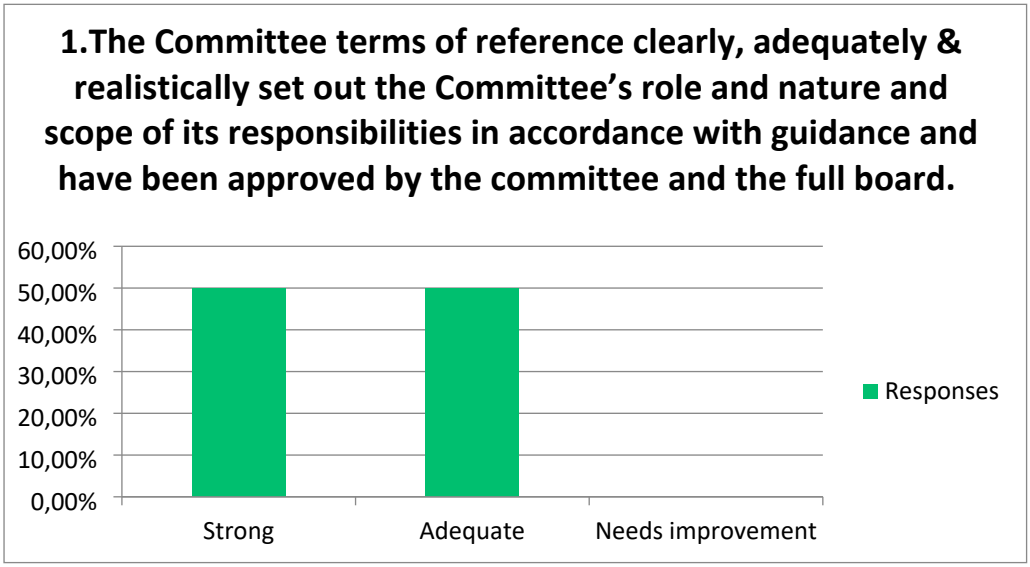
Additional comments received:

- *improved as time goes on*

Annual Board Effectiveness Survey 2020-2021

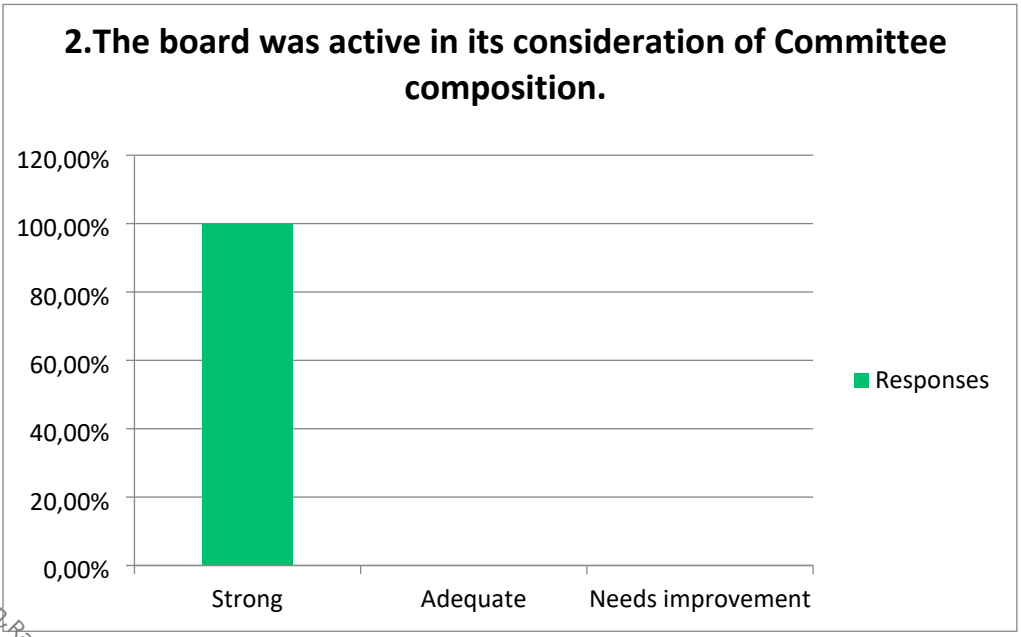
Strategy and Delivery Committee Self Evaluation 2020-2021

- 2 responses received

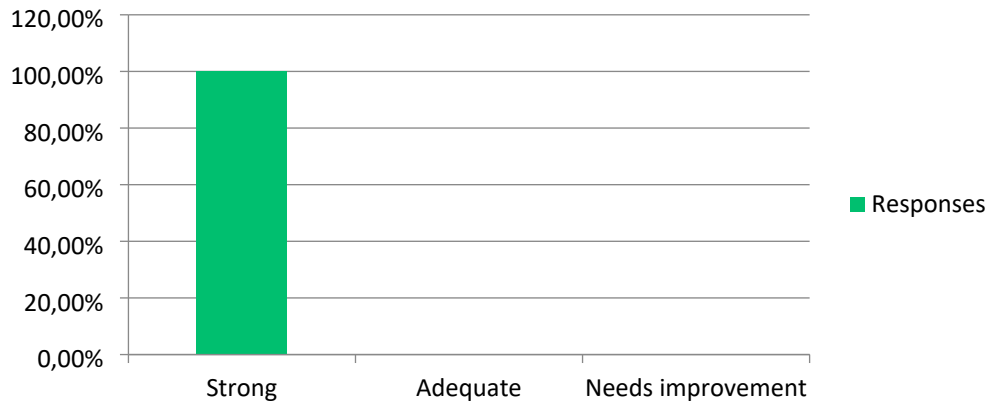


Comments received:

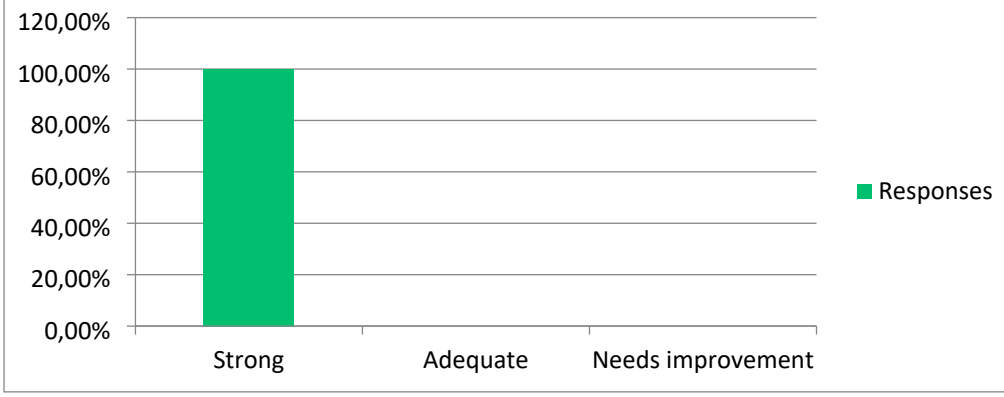
- *The Committee covers a wide breadth. It is still evolving how it wishes to seek assurance regarding delivery of the strategy, but progress has been made on this during the year.*



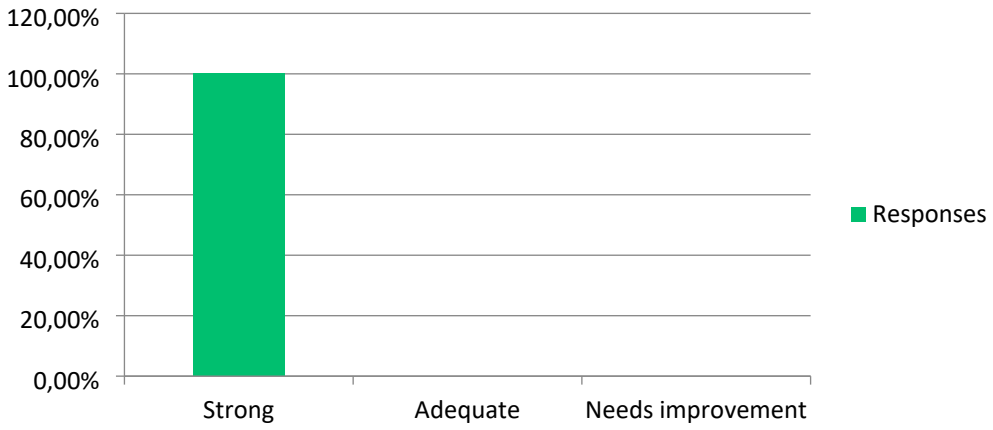
3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.



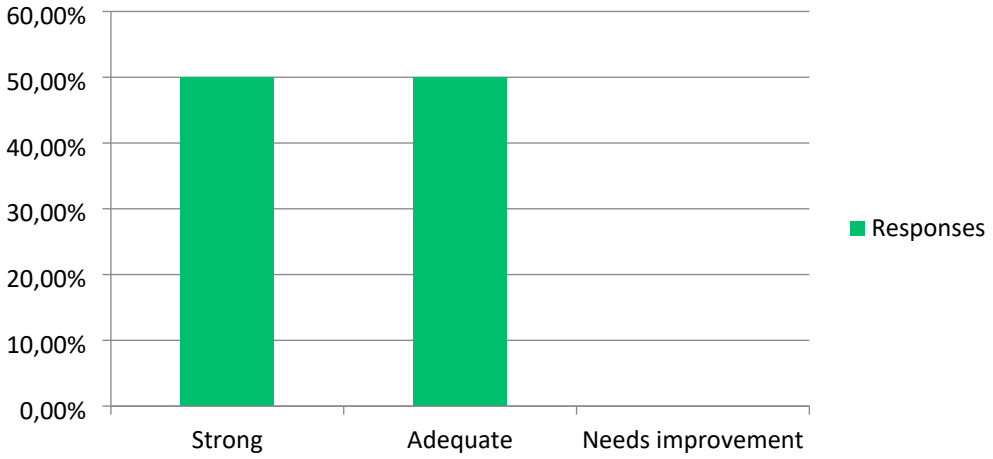
4.The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



5.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 committee's responsibilities.



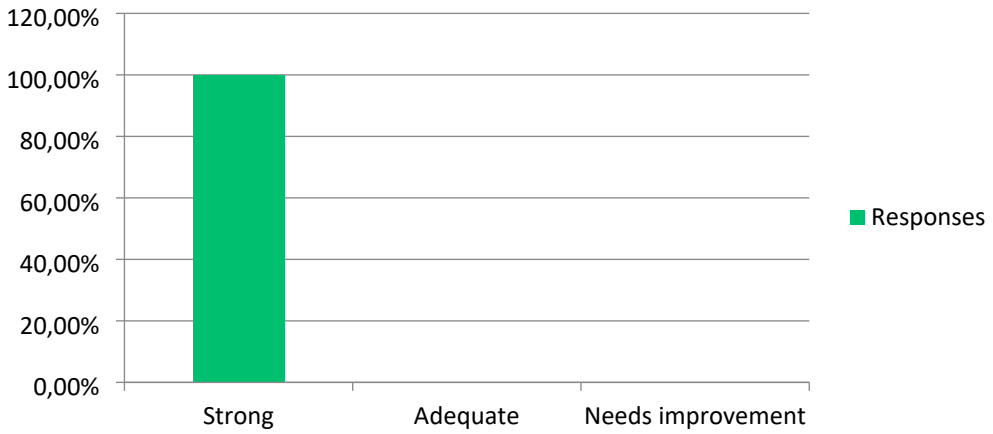
6.Appropriate internal or external support and resources are available to the Committee and it has sufficient membership and authority to perform its role effectively.



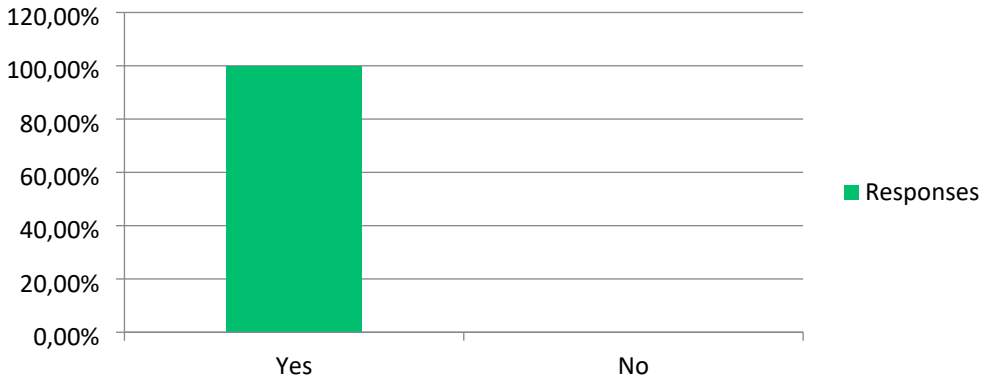
Comments received:

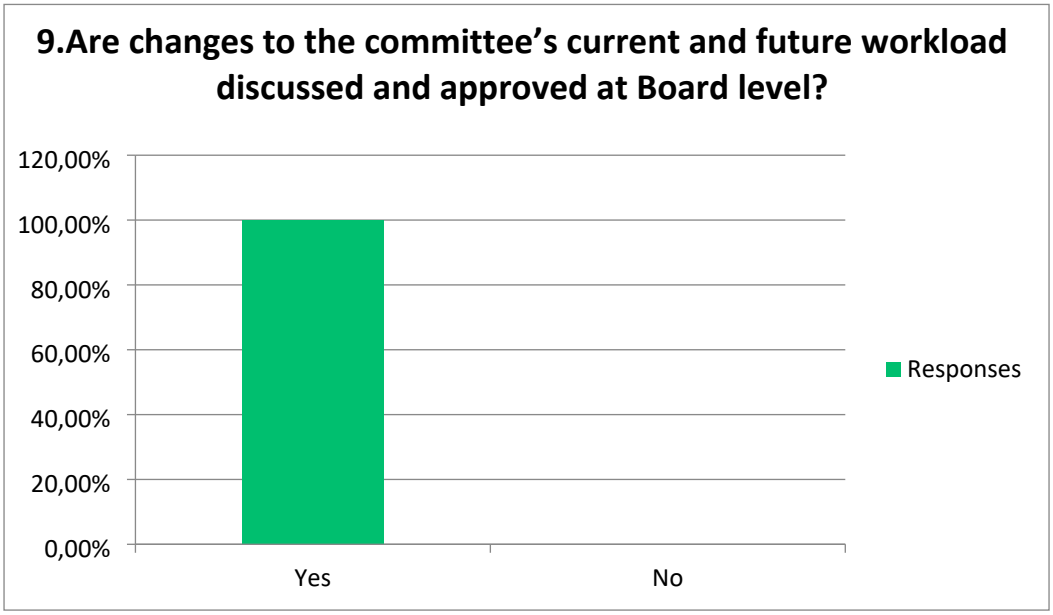
- *The Strategic Planning Team has a role to play in ensuring the strategy elements of the agenda are supported but the tea, doesn't have adequate resources at present to support this fully.*

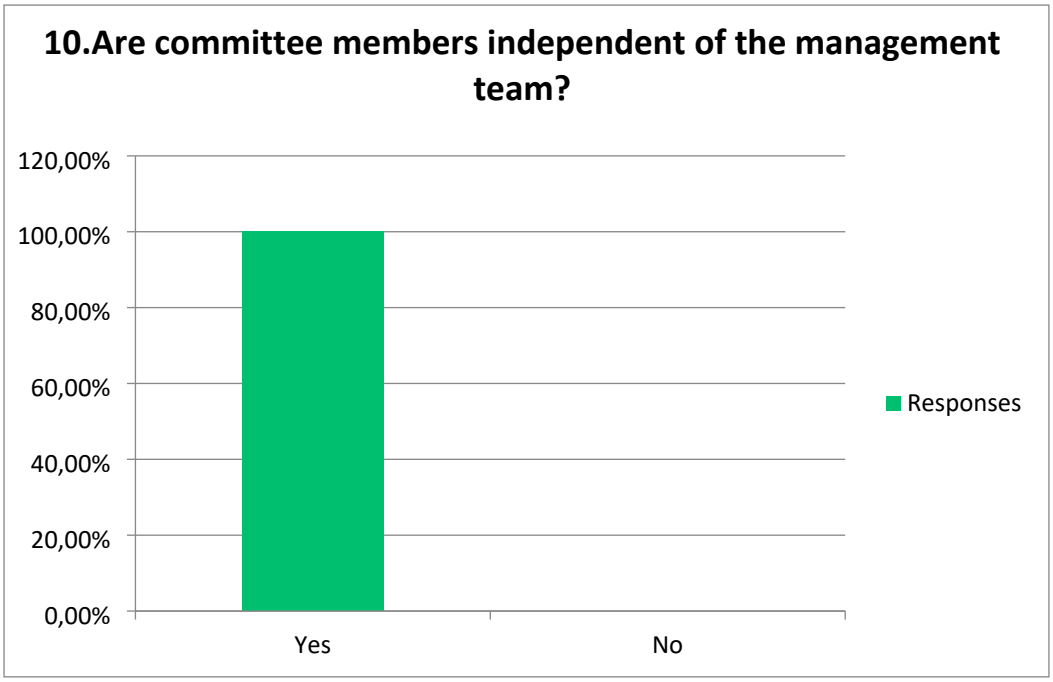
7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.

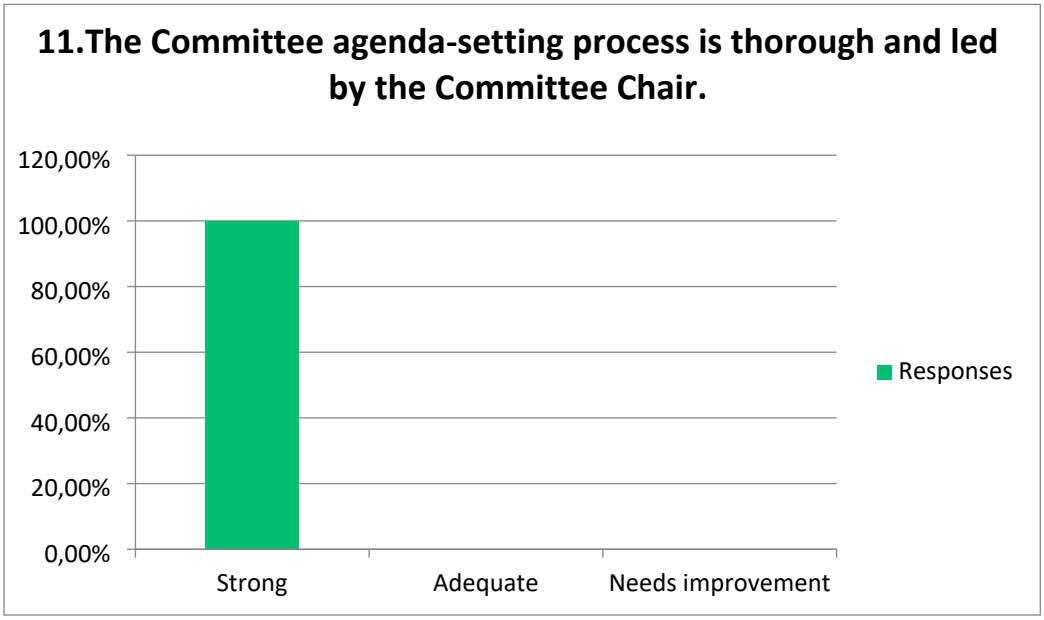


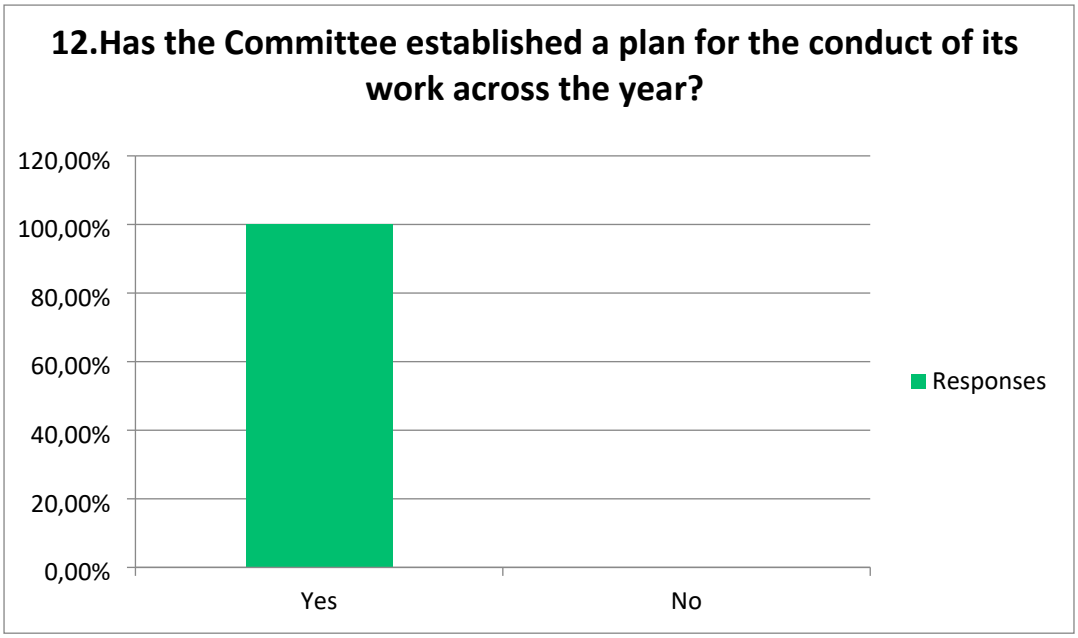
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

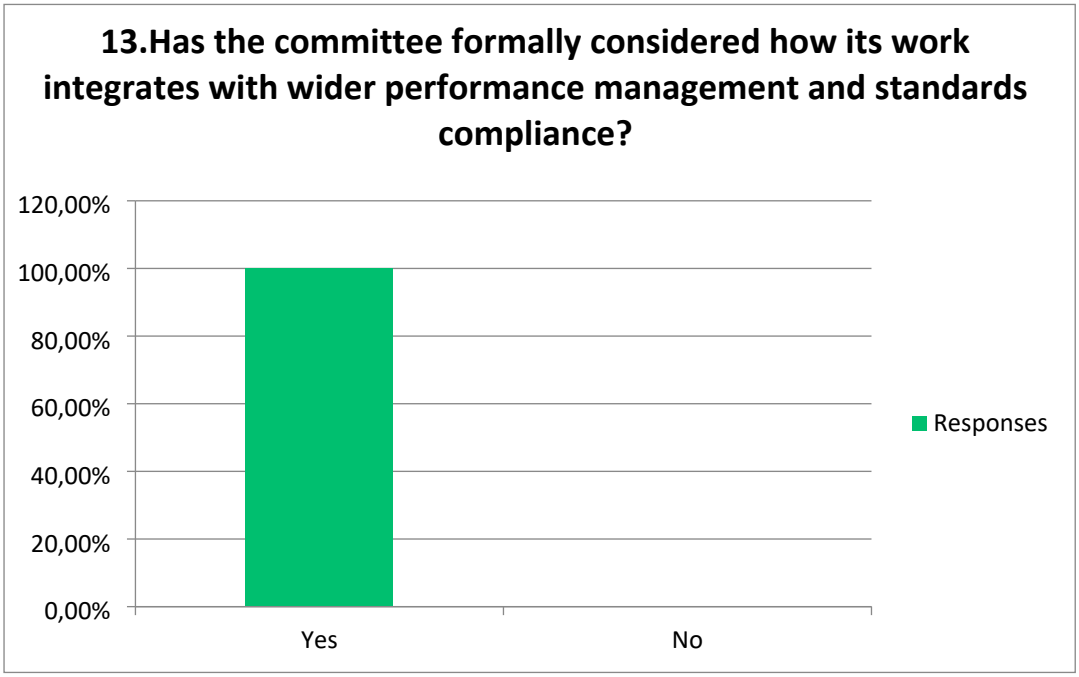


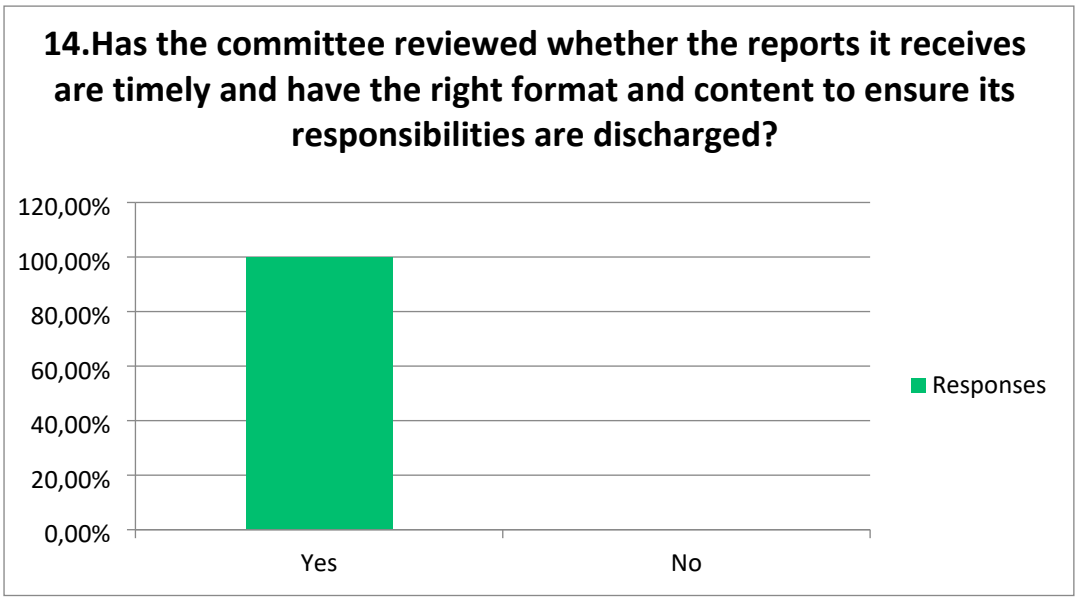


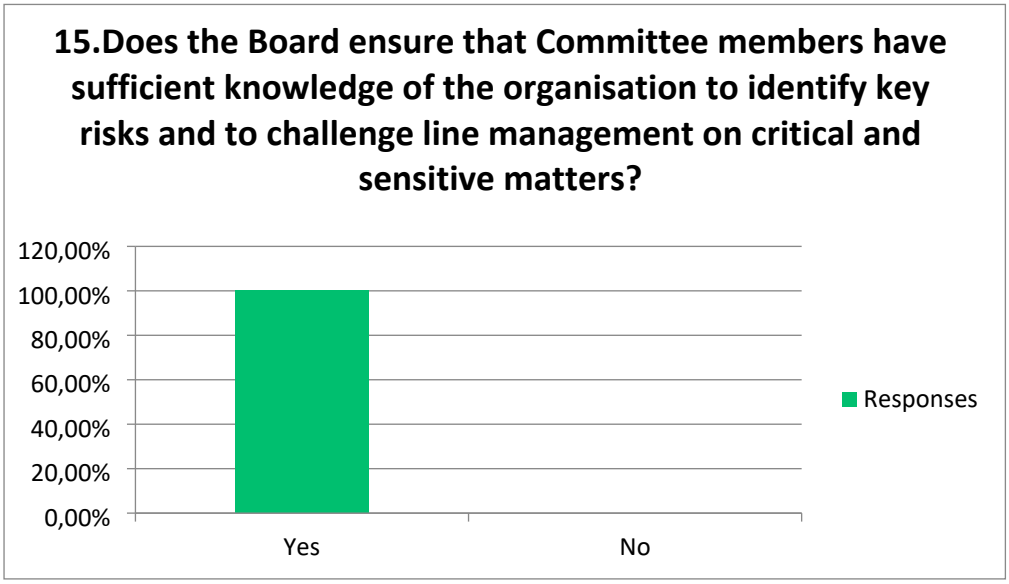


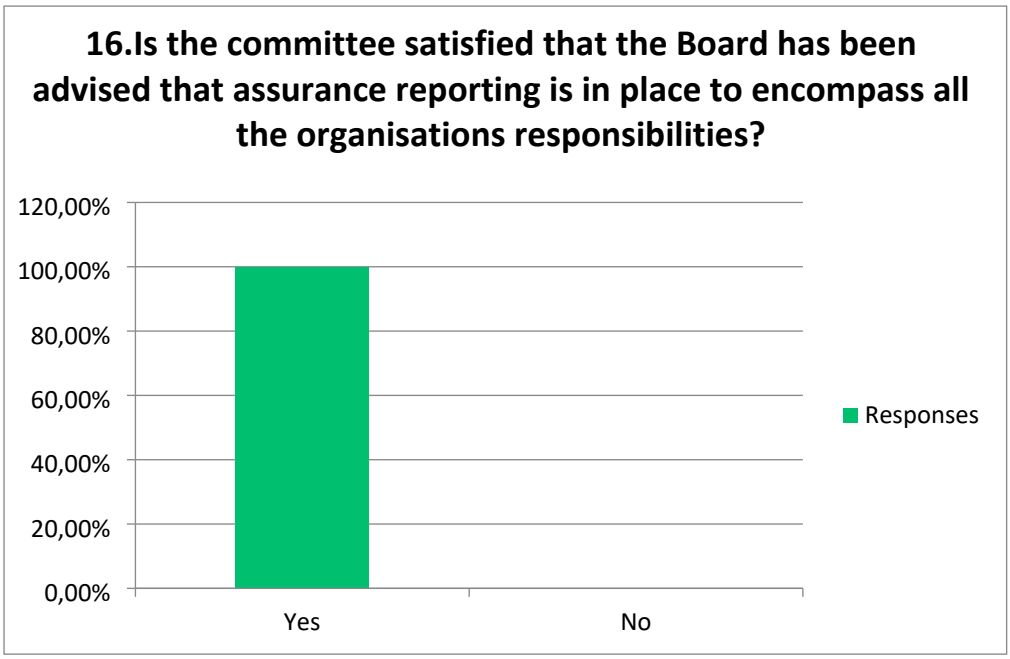


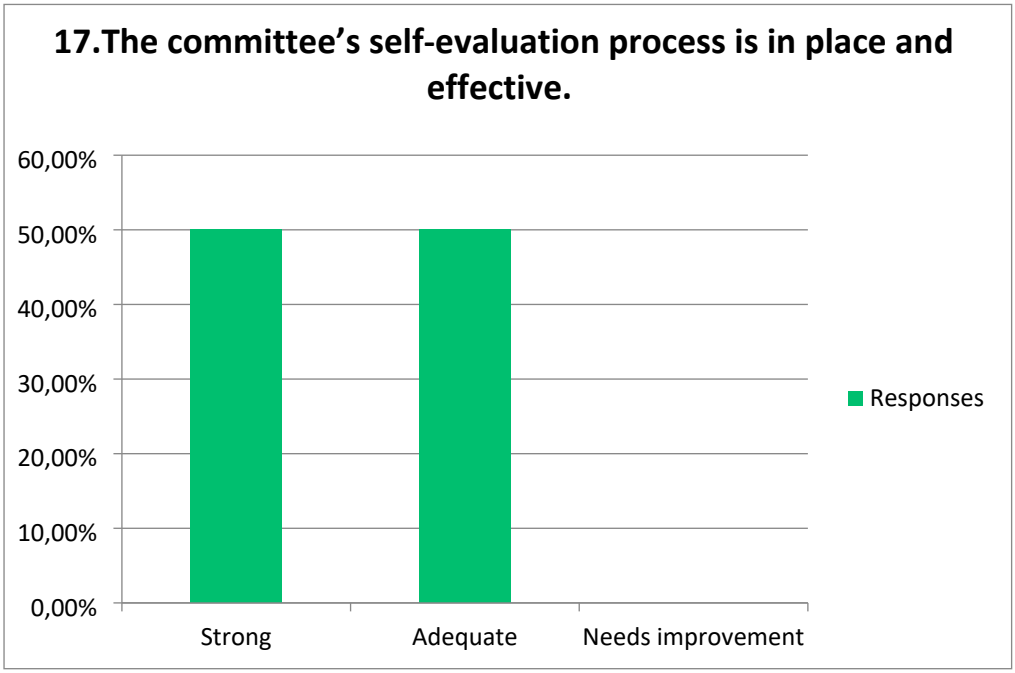


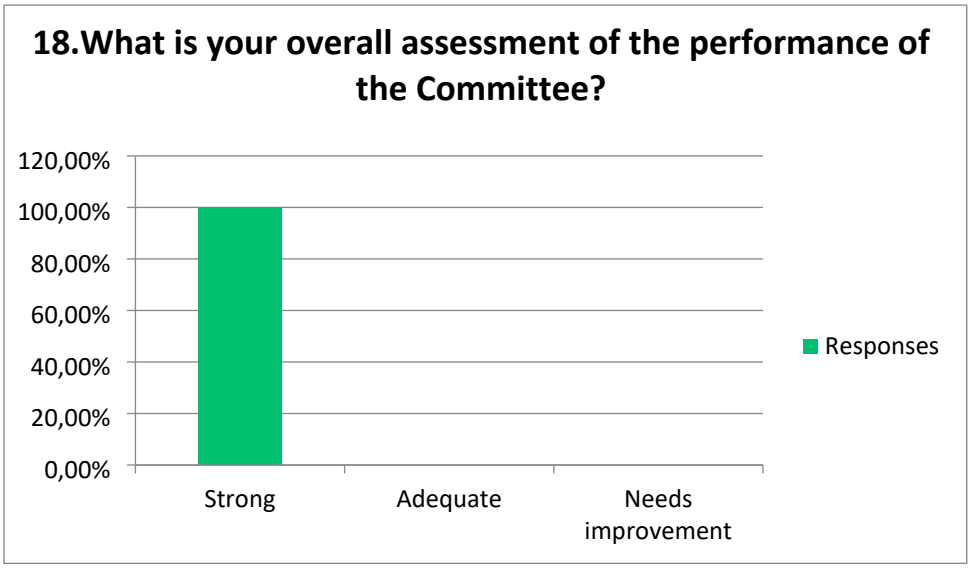












Cardiff and Vale University Health Board

Consultant Job Planning Second Follow-Up

Final Internal Audit Report

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

Review reference:	C&V-2021-37
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Auditor/s:	Ian Virgill, Ken Hughes
Executive sign off:	Stuart Walker, Executive Medical Director
Distribution:	Richard Skone, Assistant Medical Director for Workforce Peter Durning, Assistant Medical Director (Medical Workforce & Revalidation) Clinical Board Clinical Directors Clinical Board Directors of Operations David Yeandle, Senior Medical Workforce Advisor
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 Service Strategy and Terms of Reference, 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 the Cardiff and Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

This follow-up review of Consultant Job Planning was completed in line with the 20/21 Internal Audit Plan. The opinion provided through this review is a key component, which will inform the Head of Internal Audit's Annual Opinion.

This was the second follow up review of the original report that was issued in May 2018 that identified six issues and resulted in an overall assurance rating of 'Limited Assurance'. The first follow-up report issued in January 2020 identified that only two issues had been fully addressed, and this also resulted in an overall assurance rating of 'Limited Assurance'.

The relevant lead Executive for the assignment was the Medical Director.

2. Scope and Objectives

The overall objective of this review was to provide the Health Board with assurance regarding the implementation of the agreed updated management actions from the follow-up Consultant Job Planning audit that was undertaken as part of our 2019/20 work programme.

The scope of this follow up review **does not** aim to provide assurance against the full scope and objectives of the original audit. The 'follow up review opinion' provides an assurance level against the implementation of the agreed action plan only.

The areas that the review sought to provide assurance on are:

- Appropriate progress has been made with the implementation of the agreed management responses within the agreed timescales;
- Adequate evidence is available to support the level of progress that has been made; and
- The actions implemented have effectively addressed the issues highlighted during the original audit.

3. Associated Risks

The potential risks considered in this review were as follows:

- Sessions worked may not be sufficient to allow for adequate provision of the service; and
- Consultants job plans may not reflect actual conditions or be developed by mutual consent.

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 review did not aim to provide assurance against the full scope and objectives of the original audit. The 'follow-up' 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.

Reasonable Assurance		**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. **Follow up** - All high level recommendations implemented and progress on the medium and low level recommendations.

Our testing has concluded that the agreed management actions have now been fully implemented or are in the process of being implemented for the last four outstanding recommendations originally raised.

The overall number of the Health Board's consultants with an up to date, signed off job plan or annual review within the last 12 months remains low and has declined since the previous follow-up audit. Consequently, at the end of January 2021, whilst 80% of Consultants had a job plan in place the compliance rate for valid job plans agreed or reviewed within the last 12 months was only around 18%. However, the development of a new job planning process, the issuing of revised job planning guidance and the implementation of the Allocate e-job planning system in March 2021 should ensure that the compliance rate improves over the next six months.

The implementation of the new system will help to ensure that all the Health Board's job plans are completed using a standard format. The new system will also facilitate the recording of personal, service and health board outcomes within each job plan, and the electronic sign-off of job plans by the Consultant / SAS Doctor and the Health Board.

It was noted during testing that many of the job plans input to the Allocate system so far were incomplete, so we were unable to assess the quality of job plans or the consistent recording of personal, service and Health Board outcomes which is a requirement of the Welsh Government Contract. The Health Board will therefore be expected to develop a mechanism to quality check job plans going forward.

In addition, there is no direct link between the Allocate system and the Payroll / ESR system, so regular checks will need to be carried out to ensure that the number of sessions recorded in job plans reconcile to those being paid.

In summary, although a significant amount of work remains to bring job planning up to the required level, progress made against the original recommendations and agreed actions means that the level of assurance that can be given around the current processes in place to manage the risks

associated with Consultant Job Planning has now increased to **Reasonable Assurance**.

5. Summary of Audit Findings

Follow up work was undertaken to confirm the progress that the Health Board has made against the agreed management responses from the original audit, as detailed within Appendix A.

Priority rating	No of management responses to be implemented	Fully actioned	Partially actioned	Not actioned
High	3	2	1	0
Medium	1	1	0	0
Low	0	0	0	0
Total	**4**	**3**	**1**	**0**

In summary, progress against the four management responses that required implementation is as follows:

- The Health Board compliance rate for completed, signed off job plans as reported to the Strategy and Delivery Committee at the end of January 2021 remains low. Whilst some 80% of Consultants and SAS Doctors had completed job plans in place, only around 18% of these had been signed off or reviewed within the last 12 months. However, this is being addressed by the implementation of a revised job planning process and a new electronic job planning system. This will see new job plans being developed or existing job plans refreshed and entered onto the new system for the period April 2021 to March 2022. At the time of our audit, only 153 of 889 job plans were on the new system. However, the entering of job plans onto the system has been delayed due to Covid. The sign-off process has also been delayed and to date none of the job plans on the new system have yet been fully signed off.
- The implementation of the Allocate e-job planning system means that there is a single, standardised job plan format in use;
- The revised job planning guidance includes a new paper template to record SPA measures, and these can also be recorded within the new electronic job plan, although this had not yet been done for some of the job plans reviewed on the system; and
- Job plans must now be recorded on the Allocate e-job planning system that requires a three-way sign-off consisting of electronic sign-off from the Directorate Manager, Clinical Director and Clinical Board Director as well as the Consultant / SAS Doctor.

Finding 1 - Annual Job Plans (Operating effectiveness)	Risk
In accordance with Job Planning guidance issued by the Cardiff & Vale UHB, job planning must be completed annually for all consultants. The Welsh Government Consultants Contract also states that annual job plan reviews should ideally take place within one month of the consultants' incremental date. A sample of 28 consultants from across the Medicine and Children & Women's Clinical Boards was selected for testing to ascertain whether each consultant had a documented, individual job plan in place that had been completed or reviewed within the last 12 months. Despite multiple requests Job Planning documentation was not provided for 6/28 consultants selected for testing; one from the Medicine Clinical Board and five from the Children & Women's Clinical Board. Only 10/22 job plans received had been completed within the last 12 months, although documentation relating to 6 job plans was undated.	Sessions worked may not be sufficient to allow for adequate provision of the service.
Recommendation 1	**Priority level**
Clinical Boards must ensure that all consultants complete a job plan or have their existing job plan reviewed on an annual basis.	**High**
Updated Management Response (Jan 2020)	**Responsible Officer/ Deadline**
Annualised job planning requires a systematic process in place at CBD level to ensure it happens, alongside a centralised recording and assurance process to measure compliance with this requirement.	Executive Medical Director / Initial proposal to be taken to MLT in Feb 2020.

A new process will need to be defined and agreed that supports this, with a centralised electronic monitoring system adopted - see below.	Implementation of centralised monitoring system by Aug 2020. CBD process in place by end of 19/20 financial year.

Current Position

Implemented.

A new job planning procedure and guidance that has been agreed with the BMA was approved by the Strategy and Delivery Committee in March 2021.

A new electronic job planning system has also been purchased, and this is in the process of being implemented and updated with new, refreshed job plans for all Consultants and SAS Doctors that will run for the period April 2021 to March 2022. However, implementation of the new system has been severely hampered by Covid, and as at the 16th April 2021, only 153 of 889 job plans had been entered onto the system. We also note that the Health Boards compliance rate (as per the old paper-based system) as at the end of January 2021 was less than 20%.

Finding 2 - Job Planning Documentation (Operating effectiveness)	Risk
Job Planning documentation was only provided for 22/28 consultants tested. Review of the documentation provided identified a number of issues with the quality and completeness of the documentation: • The job plan template provided within the UHB Job Planning guidance had only been used for six of the job plans received. In accordance with UHB Job Planning guidance, use of the standard job plan template should be encouraged but is not compulsory as long as all the relevant information is provided. However, the majority of non-standard job plans reviewed did not contain all the necessary information. • The number and split of sessions between DCC and SPA recorded on ESR did not agree to job planning documentation for 13 of the 22 consultants that provided documentation; • Six of the 22 job plans provided were 'summary sheets' and did not provide any detail to support the number of sessions recorded in ESR; • The information provided in the job planning documentation reviewed was inconsistent with much of the information lacking detail of the tasks that would be carried out in each session; and • Some of the job planning documentation provided was incomplete.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 2	**Priority level**
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	**High**

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.	
Updated Management Response (Jan 2020)	**Responsible Officer/ Deadline**
All UHB Job Plans should be completed according to a standardised format. It will no longer be acceptable for job plans to be recorded in local formats. This is essential for introduction of a centralised IT monitoring system. This format will not be the current template, but one utilised to facilitate digital recording of the job plan.	Executive Medical Director / Aug 2020.
Current Position	
Implemented. The implementation of the Allocate e-job planning system means that there is now a single, standardised job plan format in use that must be used by all Consultants and SAS Doctors.	

Finding 3 - Outcomes Measures (Operating effectiveness)	Risk
A key requirement of the Job Planning process is that all consultants must have outcome measures agreed for the year ahead that reflect UHB operational targets and the use of SPA sessions. The UHB guidance states that outcome measures should be written in a format that is sufficiently detailed and can be measured, i.e. as SMART outcome measures. The UHB guidance also includes a template for recording and monitoring outcome measures. However, no evidence was provided for any of the consultants tested that they had set and recorded outcome measures for the year ahead. There is therefore no assurance that outcome measures are being agreed and monitored.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation 3	**Priority level**
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.	**High**
Updated Management Response (Jan 2020)	**Responsible Officer/ Deadline**
The addition of SMART outcomes to job plans is a subsequent step to introducing a centralised recording process and will take longer to implement, and indeed a change in organisational job planning culture. As such I would propose this is an action for after the full introduction of the centralised digital solution and new process.	Executive Medical Director / 2021/22 job planning round
Current Position	

Partially Implemented.

The revised job planning procedure and guidance issued in March 2021 requires job plans to include measurable outcomes. This includes a table of outcome measures against activities for all Supporting Professional Activities (SPA). A paper template is also included in the revised guidance to record SPA outcomes.

The new electronic job planning system currently being implemented facilitates the recording of Health Board, Service and Personal outcome measures in a consistent format. A sample of 114 job plans entered onto the Allocate system was reviewed to assess whether outcome measures were being fully recorded. Of these, 63 job plans only had Health Board outcomes recorded, 28 job plans had Health Board and Service outcomes and 15 job plans had Health Board and Personal outcomes, whilst only 8 job plans had Health Board, Service and Personal outcomes recorded.

Finding 6 - Agreement of Job Plans (Operating effectiveness)	Risk
Job Plans should be mutually agreed and signed by both the Consultant and the appropriate clinical manager to evidence this agreement. However only one of the Job Plans reviewed had been signed and dated by the Consultant and only three Job Plans had been signed by the Consultants clinical manager. It was noted that the majority of job plans reviewed were stored in electronic format which does not lend itself to manual signatures. However, there is a facility within all Microsoft Word and Excel documents which allows them to be signed off digitally.	Consultants job plans may not reflect actual conditions or be developed by mutual consent.
Recommendation	**Priority level**
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.	**Medium**
Updated Management Response (Jan 2020)	**Responsible Officer/ Deadline**
Fully agree that we need a digital solution - which we are starting the process of developing the right Business Case for. This will need associated new admin support. The trial was unsuccessful, but the principle is already in place in a number of other organisations and another pilot attempt is not necessary.	Executive Medical Director / BC finalised by the end of financial year 19/20.

Current Position
Implemented. The Allocate e-job planning system has been purchased and will ensure that job plans are agreed and signed off by the Consultant and the Health Board. The job plan sign-off procedure has been documented within the revised job planning guidance that was issued in March 2021. This requires the job plan to be signed off by the Directorate Manager, Clinical Director and Clinical Board Director once it has been signed off by the Consultant. It was noted at the time of our audit that although there were 153 'live' job plans on the system, to date none have yet been fully signed off.

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.

Follow up - All recommendations implemented and operating as expected.

 **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.

Follow up - All high level recommendations implemented and progress on the medium and low level recommendations.

 **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.

Follow up - No high level recommendations implemented but progress on a majority of the medium and low recommendations.

 **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.

Follow up - No action taken to implement recommendations.

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.

Health and Care Standards

Final Internal Audit Report

Cardiff and Vale University Health Board

2020/21

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Ian Virgil – Head of Internal Audit
Executive sign off:	Ruth Walker – Executive Nurse Director
Distribution:	Carol Evans, Assistant Director Patient Safety and Quality Angharad Olyer, Head of Patient Safety and Quality Assurance
Committee:	Audit & Assurance Committee

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1. Introduction and Background

Our review of Health & Care Standards was completed in line with the 2020/21 Internal Audit plan for Cardiff and Vale University Health Board (the 'Health Board').

The new Health & Care Standards came into force on 1st April 2015 and incorporate a revision of Doing Better: Standards for Health Services in Wales (2010) and the 'Fundamentals of Care Standards' (2003).

The Standards provide a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality and that they are doing the right thing, in the right way, in the right place at the right time and with the right staff.

The Health and Care Standards have been designed so they can be implemented in all health care services, settings and locations. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used to identify strengths and highlighting areas for improvement.

The relevant lead Executive for the review is the Executive Nurse Director.

2. Scope and Objectives

The objective of the review was to establish if the UHB has adequate procedures in place to ensure that the standards are effectively utilised to improve clinical quality and patient experience and that appropriate processes are in place to assess performance against the standards.

The main areas that the review sought to provide assurance on were:

- The Health & Care Standards are effectively implemented across the Health Board and are being utilised to improve the quality and safety of services;
- An appropriate process is in place to assess performance against the standards, taking account of the effects of the Covid-19 pandemic; and
- The Health Board has appropriate processes in place to oversee, monitor and report the utilisation and assessment of the standards.

3. Associated Risks

The potential risks considered in the review were as follows:

- The standards are not effectively utilised across the Health Board; and
- The Health Board is not aware of its performance against the standards.

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 the Health and Care Standards 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.

In recent years the Health Board has made good progress with embedding the Health and Care Standards within the organisation and has worked towards developing a robust annual process for assessment against the standards.

However, the Health Board was unable to undertake its self-assessment process against the standards in 2020 due to the effects of the Covid-19 pandemic. This position was effectively communicated to and approved by the Quality, Safety and Experience (QS&E) Committee and the Health Board did continue to monitor the progress against previously identified actions.

A revised assessment process has been agreed for 2021 and Corporate SBAR assessments are currently being undertaken. Review of a sample of those already completed has confirmed they have been effectively undertaken.

Plans are in place for Executive sign-off of the self-assessments, review by Independent Members and reporting to the QS&E Committee.

The Health Board will need to ensure that the priority actions identified through the SBAR assessments are effectively implemented through 2021/22 and an

appropriate process for assessing against all the standards is introduced as the Health Board returns to more normal operating.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Effective implementation and utilisation of the Standards across the Health Board			✓	
2	Assessment of performance against the standards			✓	
3	Oversight and monitoring of the utilisation and assessment of the standards			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

6. Summary of Audit Findings

From a review of the processes underpinning the utilisation, embedding and assessment of the Health and Care Standards in 2020 and plans for 2021, the following observations can be noted under the individual objectives:

Objective 1 – The Health & Care Standards are effectively implemented across the Health Board and are being utilised to improve the quality and safety of services.

- Up until 2019 the Health Board had been making good progress towards ensuring that the Health and Care Standards were effectively embedded across the organisation and were being appropriately utilised;
- The Health Board had aligned 16 of the 22 standards to existing Groups or Committees who are then responsible for the effective utilisation and assessment of the Standards.

- The Covid-19 pandemic impacted further embedding during 2020. The Health Board has however continued to monitor and report the progress being made with the implementation of the priority actions identified through the 2019 self-assessment process;
- A report was submitted to the December 2020 meeting of the QS&E Committee outlining the progress made against previously amber and red rated actions. Review of the 63 actions detailed within the report identified that 6 were recorded as red rated. Progress against a number of these had been impacted by the pandemic. 10 of the actions had moved to a green rating with 47 remaining as amber rated; and
- Going forward, the Health Board will need to ensure that the remaining 5 standards are allocated to groups or committees and that all the identified groups and committees are then effectively driving the utilisation of the Standards across the organisation.

Objective 2 - An appropriate process is in place to assess performance against the standards, taking account of the effects of the Covid-19 pandemic.

- Since 2016 the Health Board has been developing its self-assessment process. Corporate assessments were undertaken for the 16 standards aligned to lead Groups or Committees, with Clinical Boards completing self-assessments for the remaining standards;
- The Health Board's usual self-assessment process was necessarily stood down during 2020 due to the impact of the Covid-19 pandemic;
- In a paper submitted to the QS&E Committee in February 2021, it was agreed that a more limited self-assessment would be undertaken in 2021 for the 16 aligned standards. The leads will submit a short structured SBAR assessment of their current position and an outline of the main improvements planned / required for 21/22.
- A timetable is in place for all the self-assessments to be completed by the end of April 2021;
- We reviewed the completed self-assessments for Standard 2.5-Nutrition and Hydration and Standard 5.1-Timely Care. We identified that both self-assessments had been appropriately undertaken with an overall rating provided, details of the supporting assessment, areas of progress during 20/21 and key improvement actions for 21/22; and
- The timetable includes provision for the completed self-assessments to be signed off by an identified Executive member and Independent Member during May 2021.

Objective 3 - The Health Board has appropriate processes in place to oversee, monitor and report the utilisation and assessment of the standards.

- The Health Board's adjusted approach to the management and assessment of the standards during the pandemic has been regularly reported to the QS&E Committee. The Committee has formally noted and approved the approach; and
- Details of the UHBs compliance against the Standards is scheduled to be reported to the June 2021 meeting of the QS&E Committee

Appendix A - Assurance opinion 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.

Cardiff & Vale University Health Board

IM&T Control and Risk Assessment

Final Internal Audit Report

2020/21

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

Contents **Page**

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Executive sign off:	David Thomas, Director of Digital & Health Intelligence
Distribution:	James Webb, Information Governance 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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, 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 & Vale University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The baseline review of the arrangements in place for the management and control of Information Governance (IG) and Information Communications Technology (ICT) at Cardiff & Vale University Health Board (the organisation or Health Board) has been completed in line with the 2020/2021 Internal Audit Plan. The review seeks to provide a baseline picture to the Audit Committee of the processes in place to manage the risks associated with IG / ICT across the organisation as a whole.

As this is a baseline review, the assignment has not been allocated an assurance rating, but advice and recommendations have been provided to facilitate change and improvement and to focus audit work in the future.

2. Scope and Objectives

The objective of the audit is to establish the processes and mechanisms in place for management of IG/ ICT within the organisation. The review sought to provide a baseline picture of the organisation's status and provides suggestions for areas of improvement or future development.

The areas considered within the review are:

Information Governance

- The information governance process in place.
- IG policies and procedures in place.

ICT and Security

- ICT responsibilities are clear.
- ICT strategy, linked to organisational strategy.
- The ICT governance process in place.
- The funding / resource available for ICT and its sustainability.
- IT security policies and procedures.
- ICT provision and support arrangements across the organisation.
- IT continuity and disaster recovery processes.
- Compliance against obligations (e.g. GDPR, NIST, PCI DSS etc.)
- The process to track ICT assets.
- IG / ICT risk identification and management.

3. Associated Risks

The potential risks considered in this review are as follows:

- the IM&T strategy does not effectively support the organisation in delivery of its objectives and not supported by effective governance and/or delivery arrangements;

- un-coordinated IM&T related financial activities in both the business and IT functions, covering budget, cost and benefit management and prioritisation of spending;
- the IM&T services provided do not fully meet the needs of the organisation;
- IM&T services are subject to loss of service;
- inappropriate access to systems and data; and
- breach of legal compliance requirements

4. Conclusion

We used the expected controls derived from the Control Objectives for Information and Related Technologies (COBIT) 2019 framework for this review and we have reported using the subheadings of these control processes for governing organisational IT.

COBIT is an IT management framework developed by the Information Systems Audit and Control Association (ISACA) to help organisations develop, organise and implement strategies around information management and governance.

As part of our assessment we scored the individual controls in place at the organisation against the controls we would expect to be in place under each of the headings of the framework. These scores have been represented graphically below to illustrate the strengths and potential for improvement in the organisation's management of IG / ICT.

The scoring reflects the level of compliance with the controls set out within the COBIT framework, and the extent to which they apply across the entire organisation.

The organisation scored well under many of the headings, in particular against: Information Governance; Managed Operations; Managed Budget; Managed Projects; Managed Risk and Managed Security Services.

However, there are opportunities for improvement across a number of areas. The key areas requiring management attention are identified from the scoring. These were: the management of compliance with external requirements; and managed strategy. More detail can be found on these opportunities in section 4 below, and in Appendix A.

The percentage score for each objective is set out in the table below.

Control area	Percentage	No. of observations/ Recommendations
Information Governance	81%	1
Ensured Governance Framework Setting and Maintenance	64%	1
Managed Compliance with External Requirements	50%	1
Ensured Risk Optimization	100%	0
Managed Risk	78%	2
Managed I&T Management Framework	66%	2
Managed Strategy	60%	3
Managed Budget and Cost	74%	1
Managed Human Resources	29%	1
Managed Security	36%	3
Managed Security Services	78%	-
Managed Assets	64%	1
Managed Operations	89%	1
Managed Continuity	52%	1
Managed Projects	77%	-
Total	**-**	**18**

5. Summary of Audit Findings

Objective 1: Information Governance

Control Area: Information Governance (81%)

There is an established process for Information Governance (IG) at the Health Board with key strategic responsibilities such as Senior Information Risk Owner (SIRO) and Caldicott guardian assigned to appropriate officers.

There is an IG department and team in place to support the Health Board, however this is small and covers a wide range of responsibilities including core IG matters, General Data Protection Regulations (GDPR), along with Freedom of Information (FOI) and some IT Security items.

There is a suite of IG control documents to support the IG agenda, these are available on the intranet, and form part of induction and organisational training.

IG issues are monitored via the Digital Committee, and there is an Information Governance sub group underneath this to further monitor IG and make decisions on how to enact IG matters.

The Health Board has a publication scheme in place, along with a disclosure log and an Information Asset Register.

The structures underneath the committee and the IG Subgroup are not fully integrated. There are Quality Groups and leads within clinical boards, however there is limited interface between these and the central IG process. The size of the IG team means that there is limited opportunity for the IG team to attend clinical board meetings and there is no forum for IG leads across the organisation to meet and discuss issues. In addition there is no process for clinical boards to formally submit a statement of compliance into the IG sub group or committee.

The lack of this process means that the Caldicott Guardian and SIRO cannot be fully assured that processes are operating effectively across the organisation.

See Observation/Recommendation 1 at Appendix A.

Objective 2: ICT and Security

Control area: Ensured Governance Framework Setting and Maintenance (64%)

There is a formal governance structure in place for IM&T with a defined Committee (Digital & Health Intelligence Committee (DHIC)) which has a committee work plan which includes monitoring the committee effectiveness.

The governance structures have been revised recently with the establishment of a Digital Management Board (DMB) with a remit to oversee the implementation of the Digital Strategy, and with specific programme

channels underneath this. We note however that the Covid pandemic has impacted on the progress of this structure, with meetings delayed.

However, the structured framework for management and governance of IM&T is not properly functional at present. The DHIC has formally delegated responsibility for IM&T for the organisation. However, departments with devolved control over their IM&T do not attend and are not part of this Committee. We note that the new structure as designed aims to overcome this historical position with participation in the DMB from clinical boards, however as noted above, due to Covid the implementation of this has been delayed.

The lack of current key stakeholder involvement in the Committee and the designed steering group means that the Health Board may not have full visibility of the IM&T provision across the organisation as a whole and the delegated Committee may not be able to fully deliver on its remit.

See Observation/Recommendation 2 at Appendix A.

Our internal audit work includes IM&T. Our reports and outcomes from our work is monitored both by the DHIC and the Audit Committee.

Control Area: Managed Compliance with External Requirements (50%)

The policies in place are aligned to compliance requirements as they refer to relevant legislation and standards and are reviewed periodically or when there is a significant compliance change.

The DHIC has a remit to gain assurance for the Board over compliance against relevant legislation for IM&T, which is set out in its terms of reference. There is identification and monitoring of some of these compliance requirements, in particular the information governance related items through the Committee.

However, there is no structure to ensure compliance with all external requirements relating to IM&T. There is no register or record of the existing compliance requirements or the consequences of non-compliance.

In addition, there is no process to fully assess the status of compliance and report upwards to committee for items such as the payment card industry data security standard (PCI/DSS), or the directive on the security of networks and information systems (NISD). Consequently, the Committee may not be fully aware of the assurance it needs to seek over compliance with external requirements, or indeed how well the Health Board is complying.

See Observation/Recommendation 3 at Appendix A.

Control Area: Ensured Risk Optimization (100%)

There is an organisational Risk Management Strategy in place. The strategy is supported by a formally defined active risk management process which includes a structure for escalation via the Audit Committee.

IM&T risks are monitored with a clear escalation from the D&HI Directorate to the Digital & Health Intelligence Committee and Audit Committee, with the greatest risks included on the organisational risk register.

There were no recommendations under this objective.

Control Area: Managed Risk (78%)

As noted above, the risk management process works to ensure that executives and independent members are informed of the risks with the highest score. However, there is no process to formally notify senior management of risks being managed at a lower level which contain a severe or catastrophic worst-case scenario.

See Observation/Recommendation 4 at Appendix A.

There is a process for including risks within business cases, and the identification and collation of informatics related risks within a consistent risk register format. The impacts of risks are assessed and actions are defined to manage the risk within accepted tolerance levels.

However, although there are processes in place to manage issues and incidents as they occur, these processes are not fully linked to the risk management process. This means that any underlying risks may not always be identified and recorded within the risk register immediately.

See Observation/Recommendation 5 at Appendix A.

Control Area: IM&T Management Framework (66%)

As noted above, historically there is a high level of devolved responsibility for IM&T with departments able to source their own IM&T without reference to the D&HI Directorate. This leads to a lack of overarching control and oversight over IM&T within the organisation as a whole. The autonomy afforded to clinical Boards may result in conflicting decisions or decisions that do not fit with the Digital Strategy of the organisation. It can also lead to unforeseen demands placed on the D&HI Directorate in the event that additional support is needed for these systems. We note that the developing structure aims to overcome this with greater involvement and communication between the D&HI Directorate and Clinical Boards via the DMB.

See Observation/Recommendation 6 at Appendix A.

The positioning and role of the D&HI Directorate is historical and organic, as is the support provision across the organisation. We note that the

establishment of the DMB and programme channels allows for both sharing of information and some overarching control of organisational IM&T.

There is a formal structure in place within the D&HI Directorate. This has recently been reviewed and restructured to better fit the organisation and better enable delivery of the Digital Strategy. As part of this the roles and mandates of the departments within the D&HI Directorate are being re-defined, with new roles being established.

There is a management framework in the D&HI Directorate with regular heads of department meetings occurring.

Roles and responsibilities for D&HI Directorate functions are made clear via job descriptions and there is consideration of cover needs and succession planning in the operation of the departments in order to minimise the potential disruption in the event of staff loss.

There are regular senior team meetings for the D&HI Directorate that allow for tracking and management of performance and progress tasks, with KPIs currently being developed.

There are policies in place for key IM&T topics to provide guidance and these are subject to regular review and are available on the website. There are also guidance documents for further items such as 'bring your own device' (BYOD). We note however, that there are some departments that manage their own systems and these do not fully fit within the digital structure. Whilst there is an expectation that they will comply with the D&HI Directorate way of working, and there are structures in place to share information and requirements, the mechanisms for assurance are not fully formalised, particularly for items such as change control where there is no organisational policy or procedure.

See Observation/Recommendation 7 at Appendix A.

Control Area: Managed Strategy (60%)

There is a Digital Strategy in place which was developed with a focus on stakeholder needs and key stakeholder groups are identified. The Digital Strategy is explicitly linked to the organisational strategy and sets out the high-level objectives for delivery. In addition, the Health Board's IMTP includes a digital section that defines the strategic priorities for IM&T.

The Digital Strategy and associated documents includes consideration of a baseline of the current strategic position, but this is incomplete, with no full assessment of IT skills within the D&HI Directorate or wider organisational IT skills.

There has also been an assessment of the digital maturity of the organisation in respect of the delivery of an electronic medical record. Again this process is not fully complete with no strategic assessment of maturity against key areas such as the 'ability of leadership to leverage technology',

the 'level of accepted technology risk', or the 'approach to innovation', 'culture' and 'knowledge level of users'.

The lack of a full baseline and maturity assessment means that the organisation is not fully aware of its starting position and of barriers to implementing its Digital Strategy.

See Observation/Recommendation 8 at Appendix A.

The Digital Strategy and associated documentation explains the need for change and includes a high level indication of the changes needed in terms of governance and structure. An indication of benefits to the changing model are included and the risks and implication of not changing and investing are included in a Case for Investment paper.

The Digital Strategy is grouped into programmes such as the Patient and Clinician channels and the specific projects have been identified to form an outline roadmap to deliver the Digital Strategy.

In terms of delivery of projects within the Digital Strategy / Roadmap, although there is no reference to the use of the various sourcing approaches such as internal development, external purchase or joint partnerships, we note that the organisation is in a good position. There are well established links with Cardiff University and the Medicentre enables partnerships and start-ups to be progressed.

The roadmap has not been fully defined however, with no clarification or assessment of the resource requirements, dependencies, overlaps and synergies among projects and no formal prioritisation of the projects.

See Observation/Recommendation 9 at Appendix A.

There are champions for the Digital Strategy, namely the Director of D&HI, Assistant Director for Informatics, the Chief Clinical Information Officer and the Director of Digital Transformation. We note that the mechanisms for driving forward the Digital Strategy are being developed with the establishment of programme channels to ensure the Digital Strategy is embedded within the Health Board.

Although the Digital Strategy has been to Board and Committee, and included in Chief Executive updates, it is not easily available on the website for all stakeholders and there has been no full communication of it and its aims.

See Observation/Recommendation 10 at Appendix A.

Control Area: Managed Budget and Cost (74%)

Prioritisation of capital expenditure is against business cases to ensure the appropriate benefits and strategic fit and there is a record of projects and funding requirements linked to the Digital Strategy.

Funding is in place for IM&T, both revenue and capital. However, due to the devolved nature of some systems the total expenditure on IM&T for the organisation is difficult to establish. There has been recent work to evaluate the total expenditure and this has indicated a total of approximately £20m. This represents only 1.5% of the total health board expenditure (compared to a recommended 3-5% spend)

There is a defined D&HI Directorate budget and performance monitoring process. However, the Directorate budget is based on the previous year, with changes factored in. The budget does not appear to link to the strategy or work plan and so does not fully reflect the organisation's requirements. This means that the Health Board may not be sighted on the financial resource needed to achieve the Digital Health Strategy, and that overspending may happen against budgets.

The capital funding for digital is unstable, with only a £500k initial allocation and the funding available unclear throughout the year with a significant proportion provided towards the end of the year. This lack of a consistent, agreed and funded budget for both capital and revenue funding leads to difficulties in planning D&HI works and delivery of the Digital Strategy.

See Observation/Recommendation 11 at Appendix A.

Control Area: Managed Human Resources (29%)

As noted previously the D&HI Directorate is currently being restructured in order to better fit the needs of the organisation and new roles have been identified as part of this process. As part of this there is a clear structure with posts at each level which will allow for succession planning.

The Directorate contains staff who are qualified in various IT skills. Training is provided for D&HI staff, and training needs are identified via the PADR process. However, we note that there has been no full assessment of skills held within the directorate, and what skills are required in order to support IM&T across the organisation and to deliver the Digital Strategy. Consequently, there has been no full identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place the D&HI Directorate may struggle to implement the Digital Strategy.

See Observation/Recommendation 12 at Appendix A.

In terms of the skills within the wider organisation, there is training provision to staff and the Digital Strategy explicitly considers this need in the wider organisation and for patients in terms of digital inclusion.

Control Area: Managed Security (36%)

There is an IT Security Manager in place, and the revised D&HI Directorate structure includes increased resource for cyber security, however this is not in place yet. The lack of defined cyber security resource has meant that although the Health Board has maintained key cyber security requirements

such as patching and monitoring, it hasn't been able move the cyber security agenda forward or maximise the use of the nationally procured tools such as the logarithm Security Incident and Event Management (SIEM).

Cyber Security is included within the Digital Strategy, however there is no cyber work plan which would allow the Health Board to develop its cyber security position.

See Observation/Recommendation 13 at Appendix A.

Guidance is provided on cyber security with Security Policies in place and reminders provided using Health Board communications. The national Cyber Security Training module is available, however the health board has not mandated this for all staff.

See Observation/Recommendation 14 at Appendix A.

As noted above, although the Health Board has access to the Security Information and Event Management System (SIEM) the lack of resource means that this is not being used for active monitoring of cyber security within the organisation.

There is only limited reporting on cyber security, in the context of incidents and overall strategic position. There is no reporting on the current status of the health boards security position and there are no KPIs to track status of this and demonstrate the success of the team in improving the position.

See Observation/Recommendation 15 at Appendix A

Control Area: Managed Security Services (78%)

Systems for antivirus protection, web and mail filtering have been deployed at the Health Board. There has been increased collaboration with national cyber groups including the NHS Wales Operational Security Service Management Board (OSSMB). Regular alerts are provided as part of this group which are then assessed and acted upon locally.

The network is governed by a standard NHS Wales code of connection. The Code of Connection (CoCo) process is designed to ensure that appropriate levels of assurance are provided for organisations requiring a connection to the NHS Wales Network. In order to provide this assurance, the NWIS Cyber Security Team requires documentation to be completed by any organisation wishing to connect.

The network is secured using firewalls, with rules subject to regular review, and segmentation and there is device level authentication in place.

Vulnerability scanning and management, together with intrusion detection, is work in progress, in particular due to the current lack of resource within the cyber security team.

There were no additional recommendations under this objective as the key actions required should be considered as part of observation / recommendation 14 in the section above.

Control Area: Managed Assets (64%)

Although there are records of physical IT assets held within the D&HI Directorate such as the financial asset register, SCCM, Snow asset system, excel, there is no single record of all assets held by the Health Board and their current status in terms of configuration, warranty etc.

See Observation/Recommendation 16 at Appendix A

There is a process in place for patching of IT equipment, in particular desktops and laptops are patched using SCCM. Servers and network equipment are not always fully patched however, apart from patching for critical issues. This is both to reduce the risks associated with patch failure and due to staff resource. However, this decision and the associated risks and patching procedure are not formally documented within a patch policy or procedure. This means that senior management may not be fully aware of the position, and the organisation is reliant on staff knowledge.

See Observation/Recommendation 17 at Appendix A

There is an infrastructure sustainability plan which aims to ensure that the network and core infrastructure is kept up to date, and risks relating to older items in use are included on the risk register to highlight the issues.

The asset management process includes a process for the disposal of IT equipment that ensures data is kept secure and destroyed and allows assets to be tracked to disposal.

Control Area: Managed Operations (89%)

Risks to the operation of IM&T services are considered, with mitigations in place for the key risks such as fire and loss of power to servers.

Server rooms are kept secure and clear of waste. The main server rooms have air conditioning and there is a process in place for monitoring the environment of the server rooms using equipment that ensures warnings are produced in the event of abnormal temperature, humidity or smoke conditions.

The designed architecture is highly resilient with virtualisation extensively used, which minimises the risks associated with the loss of individual servers.

The server rooms have dual power supplies to ensure continuity and there is Uninterruptible Power Supply (UPS) in place for the server room with enough capacity to ensure a full load. Emergency generators are operational on each site and there are tests of these.

There were no recommendations under this objective.

Control Area: Managed Continuity (52%)

There is organisational guidance for business continuity which makes it explicit that departments should develop have their own continuity plans.

The D&HI Directorate has enacted a highly resilient architecture using virtualisation and multisite locations so threats to service loss have been managed down as much as possible.

There is an IT Disaster Recovery Plan which sets out the position with respect to the services provided by the D&HI Directorate, and there are detailed procedures underpinning this to allow for recovery of those systems. However, there is no consideration of recovery time objective / recovery point objective (RTO / RPO) within the plan and there is nothing that formally considers the order in which services across the organisation will be prioritised for recovery in the event of a major outage.

Many systems within the Health Board are subject to devolved control, and so those departments maintain their own continuity and recovery documentation, however this means that from an organisational perspective there is a lack of assurance that all these will be in place.

As such we note that there is no holistic, overarching IM&T BCP for the organisation which fully identifies the business critical activities based on business impact analyses (BIA), the priorities for recovery and the measures in place for each system used within the Health Board. Accordingly, the RTO /RPO for each of the IT systems used within the Health Board is not fully defined and agreed, and executives and stakeholders may not be aware of the full continuity position and risk.

See Observation/Recommendation 18 at Appendix A.

There is a Backup process in place. Backups of electronic data are taken on a regular and structured basis, with a structure for testing these

Control Area: Managed Projects (77%)

There is organisational guidance for project management, with a toolkit available for use that ensures good management practices are followed.

There is a record of all IT projects underway. IT projects are run in alignment with PRINCE2 methodology. The D&HI Directorate includes project managers with the appropriate certification and training is provided on project management to D&HI Directorate staff.

There were no recommendations under this objective.

Observation 1 – IG Processes (Operation)

The structures underneath the committee and the IG Subgroup are not fully integrated. There are Quality Groups and leads within clinical boards, however there is limited interface between these and the central IG process. The size of the IG team means that there is limited opportunity for the IG team to attend clinical board meetings and there is no forum for IG leads across the organisation to meet and discuss issues. In addition, there is no process for clinical boards to formally submit a statement of compliance into the IG sub group or committee.

The lack of this process means that the Caldicott Guardian and SIRO cannot be fully assured that processes are operating effectively across the organisation.

Recommendation

An IG Forum should be established for the IG leads from each clinical board to meet to discuss issues and to coordinate IG matters across the Health Board at an operational level.

Management Response, Responsible Officer and Deadline

We agree with the recommendation; the intention is for IG issues to be picked up at Clinical Board Q&S briefings but this will require additional capacity to ensure that the IG function is able to support the Clinical Boards. This will be reviewed as part of finalising the D&HI structure.

IG Manager by 30 June 2021

Observation 2 – Governance Framework (Operation)

The structured framework for management and governance of IM&T is not properly functional.

The DHIC has formally delegated responsibility for IM&T for the organisation. However, departments with devolved control over their informatics do not attend and are not part of this Committee. We note that the new structure as designed aims to overcome this historical position with participation in the DMB from Clinical Boards, however due to Covid the implementation of this has been delayed.

The lack of key stakeholder involvement means that the Health Board may not have full visibility of the informatics provision across the organisation as a whole and the delegated Committee may not be able to fully deliver on its remit.

Recommendation

The revised governance framework for IM&T / digital should be implemented to ensure that there is a holistic structure for the organisation, with participation from Clinical Boards.

Where control over aspects of IM&T has devolved to departments, the assurance flows to the DHIC should be clarified to ensure the committee can maintain oversight over the whole organisation.

Management Response, Responsible Officer and Deadline

The Digital Service Management Board, to include Clinical Board representation, will be re-established to meet on a regular quarterly basis, from 27 May 2021 onwards. As part of the DSMB function, alignment of informatics and ICT services that sit outside D&HI directorate will be mapped and included for completeness of oversight at UHB level.
Director of Digital & Health Intelligence 31 May 2021

Observation 3 – Monitoring Compliance (Operation)
There is no register of compliance requirements for IM&T and there is no structured process to identify all the compliance requirements relating to IM&T, assessing the compliance status and feeding the position in relation to requirements, status and consequences upwards to committee for items such as PCI/DSS, or NISD.
Recommendation
A register of compliance requirements for all IM&T related legislation and standards should be developed along with a process for assessing status and reporting upwards to Committee.
Management Response, Responsible Officer and Deadline
Agreed. A register of compliance for all IM&T related legislation and standard will be developed to support the NIS Directive and data security standards, which will be managed through the Head of Digital Operations. Director of D&HI 31 July 2021

Observation 4- Communicating Managed Risks (Operation)
While the Digital & Health Intelligence Directorate risk register is monitored via the standard Health Board process and within the Directorate, with escalated risks reported via Committee and Board, there is no process to formally notify executives of risks being managed at a lower level which contain a severe or catastrophic worst-case scenario.
Recommendation
Management should consider providing an annual report that identifies risks that have a low likelihood but have a severe worst-case scenario. This would ensure that executives are aware of the risks and worst cases that are being managed at a lower level, but hold the potential for severe adverse effects should they materialise.
Management Response, Responsible Officer and Deadline
The D&HI directorate risk register is shared with the D&HI Committee at each meeting. An annual report to capture the low risk high impact risks will be produced and shared at the committee and with the Management Executive team. Director of D&HI 30 September 2021

Observation 5 – Link of Risks to Events (Operation)
The link from the risk management process to the event / issue / problem management process is not fully defined, with no automatic identification of underlying risks that are causing issues and addition of these onto the risk register. This means that any underlying risks may not always be recorded in good time.
Recommendation
The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.
Management Response, Responsible Officer and Deadline
The risk identification process to support the event and problem management process will be developed and documented, for inclusion as part of the management or risk assurance documentation to be presented at the regular D&HI committee. Head of Digital Operations 30 Sept 2021

Observation 6 - Management Framework– (Operation)
There is a lack of overarching control and oversight over IM&T within the organisation as a whole with clinical boards having the ability to make their own decisions and source informatics. This may result in conflicting decisions or decisions that do not holistically fit the organisation.
Recommendation
The Health Board should ensure greater links with clinical boards and the D&HI Directorate are developed using the DMB to ensure all decisions are aligned with the organisations digital strategy.
Management Response, Responsible Officer and Deadline
The DSMB is being re-established to meet again from 27 May (each quarter) where decisions and actions relating to IM&T will be captured to ensure alignment with the UHB's digital strategy. Director of D&HI 31 May 2021

Observation 7– Policies (Operation)
There are some departments that manage their own systems and these do not fully fit within the digital structure. Whilst there is an expectation that they will comply with the digital way of working, and there are structures in place to share information and requirements via the DMB, the mechanisms for assurance are not fully formalised, particularly for items such as change control where there is no organisational policy or procedure.
Recommendation
Departmentally managed systems should comply with good practice for the management of digital. The D&HI Directorate should produce good practice guidance documentation for the health board overall as leaders of the digital services provision, with all departments required to comply for areas such as change control.
Management Response, Responsible Officer and Deadline
The D&HI directorate will produce updated good practice guidance documentation, based on ITIL and industry standards, for dissemination across all IM&T functions across the UHB. Director of D&HI 30 Sept 2021

Observation 8 - Baseline (Operation)

The Digital Strategy and associated documents includes consideration of a baseline of the current strategic position, but this is incomplete, with no full assessment of IT skills within the D&HI Directorate or wider organisational IT skills.

There has also been an assessment of the digital maturity of the organisation in respect of the delivery of an electronic medical record. Again this process is not fully complete with no strategic assessment of maturity against key areas such as the 'ability of leadership to leverage technology', the 'level of accepted technology risk', or the 'approach to innovation', 'culture' and 'knowledge level of users'.

The lack of a full baseline and maturity assessment means that the organisation is not fully aware of its starting position and of barriers to implementing its Digital Strategy.

Recommendation

A review of the current strategic position of the Health Board in relation to its digital provision and maturity across all domains should be undertaken.

Management Response, Responsible Officer and Deadline

The D&HI directorate will undertake a complete baseline assessment against the digital maturity standards (HIMMS) to assist in determining the current position and help inform the digital strategy roadmap. This will be presented at D&HI committee.

Director of D&HI 30 Sept 2021

Observation 9 - Roadmap – (Operation)
The roadmap has not been fully defined however, with no clarification or assessment of the resource requirements, dependencies, overlaps and synergies among projects and no formal prioritisation of the projects.
Recommendation
The roadmap should be fully defined in order to help deliver the Digital Strategy.
Management Response, Responsible Officer and Deadline
The current roadmap has been produced to align with the channel programme boards; a more detailed roadmap to include resources and dependencies will be developed for approval at D&HI committee. Director of D&HI 30 Sept 2021

Observation 10 – Strategy Communication (Operation)
Although the Digital Strategy has been to Board and Committee, and included in Chief Executive updates, it is not easily available on the website for all stakeholders and there has been no full communication of it and its aims.
Recommendation
The Strategy should be available on the Health Board website, and flagged, with a communication plan to push awareness with all stakeholders.
Management Response, Responsible Officer and Deadline
The digital strategy is available as a public document and is accessible via the UHB's website. A communication plan for internal consumption is being developed. This will form the basis of a broader comms plan to share with all stakeholders. Director of D&HI 30 Sept 2021

Observation 11 – Budgets (Operation)

The budget for the D&HI Directorate does not fully reflect the organisation's requirements. This means that the Health Board may not be sighted on the financial resource needed to achieve the Digital Strategy, and that overspending may happen against budgets.

In addition the funding for digital is unstable, with the total capital funding available for Digital unclear throughout the year and a significant proportion provided towards the end of the year. This lack of a consistent, agreed and funded budget for both capital and revenue funding leads to difficulties in planning D&HI works and delivery of the Digital Strategy.

Recommendation

The D&HI Directorate budget should be set to reflect the actual need of the organisation.

The capital expenditure budget should be reviewed with the intent to providing a stable funding position to allow for delivery of the digital strategy.

Management Response, Responsible Officer and Deadline

A Case for Investment has been produced and shared with the Management Executive team which sets out the capital and revenue requirements for the life of the digital strategy (2020-2025). Discussions on affordability and potential sources of funding are taking place with executive management. Decisions on funding are expected to be made during the second quarter of 2021/22
Director of D&HI 31 Aug 2021

Observation 12 – Workforce (Operation)

The workforce planning process is disjointed without a single plan for the Informatics Directorate that brings together the resolution for both resource gaps identified via departmental planning and the skills gap identified via the PADR process.

There has been no full assessment of what skills are held within the D&HI Directorate and the skills and resource needed to support organisational IM&T and implement the Digital Strategy. Consequently, there has been no full identification of the skills gap and no development of a structured staff development plan in order to close the gap. Without this development plan in place the organisation may struggle to implement the strategy.

Recommendation

A full assessment of the current skills within the directorate, alongside the required resource and skills for the Digital Strategy should be undertaken. Once the gaps in skills have been identified a formal plan to upskill staff should be developed.

Management Response, Responsible Officer and Deadline

All staff within the D&HI directorate are expected to complete the PADR and objective setting process, which will identify current training and development needs. These will be compared with the known and expected requirements to deliver the digital strategy and will form the annual plan of training and development.

Director of D&HI 30 Sept 2021

Observation 13– Security Management (Operation)
The lack of defined cyber security resource has meant that although the Health Board has maintained key cyber security requirements such as patching and monitoring, it hasn't been able move the cyber security agenda forward and there is no cyber security work plan which would allow the health board to develop its cyber security position.
Recommendation
A formal cyber security workplan should be developed. This should be based on a formal assessment of the current position of the health board and define the actions needed to improve the position.
Management Response, Responsible Officer and Deadline
A full cyber security work-plan, including NIS directive requirements will be completed as soon as the cyber team is in place. Recruitment is currently underway. Head of Digital Operations 31 July 2021

Observation 14 – Cyber Awareness(Operation)
Although training on cyber security is available, the national training has not been mandated for all staff within the health board.
Recommendation
The national cyber security training should be mandated for all staff.
Management Response, Responsible Officer and Deadline
Accepted. The national cyber resilience unit at Welsh Government has been approached for assistance in producing the training plan for staff across the UHB. Director of D&HI 30 June 2021

Observation 15 – Cyber Security Reporting (Operation)
There is only limited reporting on cyber security, with no reporting on the current status of the health boards security position and no KPIs to track status of this and demonstrate the success of the team in improving the position.
Recommendation
Formal reporting on cyber security should be established, along with a suite of cyber security KPIs in order to show the status of cyber security and the progress of the team in managing issues.
Management Response, Responsible Officer and Deadline
A formal report on cyber security will form part of the suite of documents to be shared regularly at the D&HI committee. Director of D&HI Sept 2021

Observation 16 –Assets (Operation)
There is no single record of all assets held by the Health Board and their current status in terms of configuration, warranty etc.
Recommendation
Consideration should be given to developing a single register of assets and their configuration status for the Health Board. This should include a process for identifying critical assets and ensuring regular assessment of the need for replacement of these.
Management Response, Responsible Officer and Deadline
The new IT portal and service desk solution procured in March 2021 will be populated to create a single register of all IM&T assets. Head of Digital Operations 30 Sept 2021

Observation 17 – Patch Management (Operation)
Servers and network equipment are not always fully patched, apart from patching for critical issues. This is both to reduce the risks associated with patch failure and due to staff resource. However, this decision and the associated risks and patching procedure are not formally documented within a patch policy or procedure. This means that senior management may not be fully aware of the position, and the organisation is reliant on staff knowledge
Recommendation
A patch management policy, and associate procedure should be developed.
Management Response, Responsible Officer and Deadline
Agreed. A full patch management policy will be created to include all related procedures. Head of Digital Operations 31 July 2021

Observation 18 – Continuity (Design)
There is no holistic, overarching IM&T BCP for the organisation which fully identifies the business critical activities based on business impact analyses (BIA), the priorities for recovery and the measures in place for each system used within the Health Board. Accordingly the RTO /RPO for each of the IT systems used within the Health Board is not fully defined and agreed, and executives and stakeholders may not be aware of the full continuity position and risk.
Recommendation
The organisation should develop an overarching BCP / DR process. This should: • consider all the systems and use a business impact analysis to identify the business critical systems to prioritise for recovery; • departments with devolved control should feed into this process to ensure all system have appropriate plans and that the plans do not conflict; • RTO / RPO should be agreed for each system with the key stakeholders; and • The full position should be defined and agreed with executives to ensure that they accept the position and associated risks.
Management Response, Responsible Officer and Deadline
Agreed. Working with colleagues in corporate planning, a full BCP/DR process will be developed and shared with Management Executive. Director of D&HI 30 Sept 2021